



EXPRESS SCRIPTS®
Medicare (PDP)

Express Scripts Medicare (PDP) 2025 Formulary (List of Covered Drugs or “Drug List”)

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

Formulary ID Number: 25060, v6

This formulary was updated on 08/26/2024. 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 26, 2024. 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, 2026. 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](https://www.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 formulary during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes. Updates to the formulary are posted to our website at [express-scripts.com](https://www.express-scripts.com).

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

- **Immediate substitutions of certain new versions of brand-name drugs and original biological products.** We may immediately remove a drug from our formulary if we are replacing it with a certain new version of that drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. When we add a new version of a drug to our formulary, we may decide to keep the brand-name drug or original biological product on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions.

We can make these immediate changes only if we are adding a new generic version of a brand-name drug or adding certain new biosimilar versions of an original biological product that was already on the formulary (for example, adding an interchangeable biosimilar that can be substituted for an original biological product by a pharmacy without a new prescription).

If you are currently taking the brand-name drug or original biological product, we may not tell you in advance before we make an immediate 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 for you the drug that is being changed. 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?”

This drug list was updated in August 2024.

Some of these drug types may be new to you. For more information, see the section below titled “What are original biological products and how are they related to biosimilars?”

- **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 remove a brand-name drug from the formulary when adding a generic equivalent or remove an original biological product when adding a biosimilar. We may also apply new restrictions to the brand-name drug or original biological product or move it to a different cost-sharing tier, or both. We may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, we must notify affected members of the change at least 30 days before the change becomes effective. Alternatively, when a member requests a refill of the drug, they may receive a one-month supply of the drug and notice of the change.
 - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the drug you have been taking. 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 2025 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2025 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the formulary for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 08/26/2024. 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 148. 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

This drug list was updated in August 2024.

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 work just as well as and usually cost less than brand-name drugs. There are generic drug substitutes available for many brand-name drugs. Generic drugs usually can be substituted for the brand-name drug at the pharmacy without needing a new prescription, depending on state laws.

What are original biological products and how are they related to biosimilars?

On the formulary, when we refer to drugs, this could mean a drug or a biological product. Biological products are drugs that are more complex than typical drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, biosimilars work just as well as the original biological product and may cost less. There are biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state laws, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand-name drugs.

For discussion of drug types, please see the *Evidence of Coverage*, **Chapter 3, Section 3.1**, “The ‘Drug List’ tells which Part D drugs are covered.”

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 prescriber 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 prescriber 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.

This drug list was updated in August 2024.

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 prescriber 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 prescriber 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 approved, this would lower the amount you must pay for your drug. In certain Express Scripts Medicare plans, you cannot ask us to change the cost-sharing tier for any drug in the specialty tier, if applicable.
- 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 a formulary, tier or utilization restriction exception. **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 prescriber 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 prescriber.

This drug list was updated in August 2024.

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 prescriber 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 prescriber 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 prescriber 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

This drug list was updated in August 2024.

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 148

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.

This drug list was updated in August 2024.

- **The drug tier for your drug.** Each covered drug is in one of five 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: Preferred Generic Drugs	This tier includes many commonly prescribed preferred generic drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: Generic Drugs	This tier includes prescribed generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than brand drugs.
Tier 3: 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 4: 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. Ask your prescriber if switching to a lower-cost generic or preferred brand-name drug may be right for you.
Tier 5: Specialty Tier Drugs	This tier includes very high cost brand-name and generic drugs.	To learn more about medications in this tier, you may contact a pharmacist using the information provided on the front and back covers of this formulary.

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>.

This drug list was updated in August 2024.

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](https://www.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 Express Scripts® Pharmacy, our home delivery service, as well as through select retail network pharmacies. It may also be available through other network pharmacies. Consider using our home delivery service 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 prescriber 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.

V: This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	4	PA
AMBISOME	5	PA
<i>amphotericin b</i>	4	PA; MO
<i>amphotericin b liposome</i>	5	PA
ANCOBON	5	MO
CANCIDAS	5	
<i>casprofungin</i>	4	
<i>clotrimazole mucous membrane</i>	2	MO
CRESEMBA ORAL	5	PA
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION 40 MG/ML	4	MO
DIFLUCAN ORAL TABLET 100 MG, 200 MG	4	MO
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	5	MO

Drug Name	Drug Tier	Requirements/Limits
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	4	MO
<i>fluconazole</i>	2	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	4	PA; MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	4	PA
<i>flucytosine</i>	5	MO
<i>griseofulvin microsize</i>	4	MO
<i>griseofulvin ultramicrosize</i>	4	MO
<i>itraconazole oral capsule</i>	4	MO; QL (120 per 30 days)
<i>itraconazole oral solution</i>	4	MO
<i>ketoconazole oral</i>	2	MO
<i>micafungin</i>	4	MO
MYCAMINE INTRAVENOUS RECON SOLN 50 MG	4	MO
NOXAFIL ORAL SUSP, DELAYED RELEASE FOR RECON	5	PA; MO; QL (32 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NOXAFIL ORAL SUSPENSION	5	PA; MO; QL (630 per 30 days)
NOXAFIL ORAL TABLET, DELAYED RELEASE (DR/EC)	5	PA; MO; QL (96 per 30 days)
<i>nystatin oral</i>	2	MO
<i>posaconazole oral suspension</i>	5	PA; MO; QL (630 per 30 days)
<i>posaconazole oral tablet, delayed release (drlec)</i>	5	PA; MO; QL (96 per 30 days)
SPORANOX ORAL CAPSULE	4	MO; QL (120 per 30 days)
<i>terbinafine hcl oral</i>	2	MO
TOLSURA	5	PA; MO; QL (120 per 30 days)
VFEND IV	4	PA; MO
VFEND ORAL SUSPENSION FOR RECONSTITUTION	5	PA; MO
VFEND ORAL TABLET	4	PA; MO
VIVJOA	5	PA; QL (18 per 84 days)
<i>voriconazole intravenous</i>	5	PA; MO
<i>voriconazole oral suspension for reconstitution</i>	5	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>voriconazole oral tablet</i>	4	PA; MO
ANTIVIRALS		
<i>abacavir</i>	2	MO
<i>abacavir-lamivudine</i>	2	MO
<i>acyclovir oral capsule</i>	2	MO
<i>acyclovir oral suspension 200 mg/5 ml</i>	4	MO
<i>acyclovir oral tablet</i>	2	MO
<i>acyclovir sodium intravenous solution</i>	4	PA; MO
<i>adefovir</i>	4	MO
<i>amantadine hcl</i>	2	MO
APTIVUS	5	MO
<i>atazanavir</i>	4	MO
BARACLUDE	5	MO
BIKTARVY	5	MO
CIMDUO	5	MO
COMBIVIR	4	MO
COMPLERA	5	MO
<i>darunavir</i>	5	MO
DELSTRIGO	5	MO
DESCOVY	5	MO
DOVATO	5	MO
EDURANT	5	MO
<i>efavirenz oral tablet</i>	4	MO
<i>efavirenz-emtricitabin-tenofovir</i>	5	MO
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	5	MO
<i>emtricitabine</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>emtricitabine-tenofovir (tdf) oral tablet 100-150 mg</i>	5	MO
<i>emtricitabine-tenofovir (tdf) oral tablet 133-200 mg, 167-250 mg, 200-300 mg</i>	4	MO
EMTRIVA ORAL CAPSULE	4	MO
EMTRIVA ORAL SOLUTION	3	MO
<i>entecavir</i>	4	MO
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	5	PA; MO; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	5	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG	5	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	5	PA; MO; QL (28 per 28 days)
EPIVIR	4	MO
EPZICOM	5	MO
<i>etravirine</i>	5	MO
EVOTAZ	5	MO
<i>famciclovir</i>	2	MO
<i>fosamprenavir</i>	4	MO
FUZEON SUBCUTANEOUS RECON SOLN	5	MO

Drug Name	Drug Tier	Requirements/Limits
GENVOYA	5	MO
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	5	PA; MO; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	5	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG	5	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	5	PA; MO; QL (28 per 28 days)
INTELENCE ORAL TABLET 100 MG, 200 MG	5	MO
INTELENCE ORAL TABLET 25 MG	4	MO
ISENTRESS HD	5	MO
ISENTRESS ORAL POWDER IN PACKET	5	MO
ISENTRESS ORAL TABLET	5	MO
ISENTRESS ORAL TABLET, CHEWABLE 100 MG	5	MO
ISENTRESS ORAL TABLET, CHEWABLE 25 MG	3	MO
JULUCA	5	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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
KALETRA ORAL SOLUTION	4	MO
KALETRA ORAL TABLET 100-25 MG	4	MO
KALETRA ORAL TABLET 200-50 MG	5	MO
<i>lamivudine</i>	2	MO
<i>lamivudine-zidovudine</i>	2	MO
LEDIPASVIR-SOFOSBUVIR	5	PA; MO; QL (28 per 28 days)
LEXIVA ORAL TABLET	5	
LIVTENCITY	5	PA; LA; QL (120 per 30 days)
<i>lopinavir-ritonavir oral solution</i>	4	MO
<i>lopinavir-ritonavir oral tablet</i>	2	MO
<i>maraviroc</i>	5	MO
MAVYRET ORAL PELLETS IN PACKET	5	PA; MO; QL (168 per 28 days)
MAVYRET ORAL TABLET	5	PA; MO; QL (84 per 28 days)
<i>nevirapine oral suspension</i>	4	
<i>nevirapine oral tablet</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>nevirapine oral tablet extended release 24 hr 400 mg</i>	4	MO
NORVIR ORAL POWDER IN PACKET	4	MO
NORVIR ORAL TABLET	4	MO
ODEFSEY	5	MO
<i>oseltamivir</i>	2	MO
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	2	QL (20 per 90 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	2	QL (30 per 90 days)
PIFELTRO	5	MO
PREVYMIS ORAL	5	PA; MO; QL (30 per 30 days)
PREZCOBIX	5	MO
PREZISTA ORAL SUSPENSION	5	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	4	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	5	MO
RELENZA DISKHALER	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
RETROVIR ORAL CAPSULE	4	MO
RETROVIR ORAL SYRUP	4	MO
REYATAZ ORAL CAPSULE 200 MG, 300 MG	5	MO
REYATAZ ORAL POWDER IN PACKET	5	MO
<i>ribavirin oral capsule</i>	2	MO
<i>ribavirin oral tablet 200 mg</i>	2	MO
<i>rimantadine</i>	4	MO
<i>ritonavir</i>	2	MO
RUKOBIA	5	MO
SELZENTRY ORAL SOLUTION	3	MO
SELZENTRY ORAL TABLET 150 MG, 300 MG	5	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	3	MO
SOFOSBUVIR-VELPATASVIR	5	PA; MO; QL (28 per 28 days)
SOVALDI ORAL PELLETS IN PACKET 150 MG	5	PA; MO; QL (28 per 28 days)
SOVALDI ORAL PELLETS IN PACKET 200 MG	5	PA; MO; QL (56 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
SOVALDI ORAL TABLET 200 MG	5	PA; MO; QL (56 per 28 days)
SOVALDI ORAL TABLET 400 MG	5	PA; MO; QL (28 per 28 days)
STRIBILD	5	MO
SUNLENCA ORAL	5	
SYMFI	5	MO
SYMFI LO	5	MO
SYMTUZA	5	MO
TAMIFLU	4	MO
<i>tenofovir disoproxil fumarate</i>	4	MO
TIVICAY ORAL TABLET 10 MG	3	
TIVICAY ORAL TABLET 25 MG, 50 MG	5	MO
TIVICAY PD	5	MO
TRIUMEQ	5	MO
TRIUMEQ PD	4	MO
TRUVADA	5	MO
TYBOST	3	MO
<i>valacyclovir oral tablet 1 gram</i>	2	MO; QL (120 per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	2	MO; QL (60 per 30 days)
VALCYTE	5	MO
<i>valganciclovir oral recon soln</i>	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>valganciclovir oral tablet</i>	2	MO
VALTREX ORAL TABLET 1 GRAM	4	MO; QL (120 per 30 days)
VALTREX ORAL TABLET 500 MG	4	MO; QL (60 per 30 days)
VEMLIDY	5	MO
VIRACEPT ORAL TABLET	5	MO
VIREAD ORAL POWDER	5	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4	MO
VIREAD ORAL TABLET 300 MG	5	MO
VOSEVI	5	PA; MO; QL (28 per 28 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	3	MO
ZEPATIER	5	PA; MO; QL (28 per 28 days)
ZIAGEN ORAL SOLUTION	4	MO
<i>zidovudine</i>	2	MO
CEPHALOSPORINS		
AVYCAZ	5	PA; MO
<i>cefaclor oral capsule</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml</i>	2	
<i>cefaclor oral tablet extended release 12 hr</i>	2	MO
<i>cefadroxil oral capsule</i>	2	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	2	MO
<i>cefadroxil oral tablet</i>	2	MO
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	4	MO
<i>cefazolin injection recon soln 10 gram</i>	4	
<i>cefdinir</i>	2	MO
<i>cefepime injection</i>	4	MO
<i>cefixime</i>	4	MO
<i>cefotetan injection</i>	2	PA
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	4	PA; MO
<i>cefoxitin intravenous recon soln 10 gram</i>	4	PA
<i>cefpodoxime</i>	4	MO
<i>cefprozil</i>	2	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>ceftazidime injection recon soln 6 gram</i>	4	PA
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	4	MO
<i>ceftriaxone injection recon soln 10 gram</i>	4	
<i>cefuroxime axetil oral tablet</i>	2	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	4	PA; MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	4	PA; MO
<i>cephalexin</i>	2	MO
<i>tazicef injection</i>	4	PA; MO
TEFLARO	5	PA; MO
ZERBAXA	5	PA
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin intravenous</i>	4	PA; MO
<i>azithromycin oral packet</i>	2	MO
<i>azithromycin oral suspension for reconstitution</i>	2	MO
<i>azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	2	MO
<i>clarithromycin</i>	2	MO
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	5	QL (136 per 10 days)
DIFICID ORAL TABLET	5	MO; QL (20 per 10 days)
<i>e.e.s. 400 oral tablet</i>	2	MO
E.E.S. GRANULES	4	MO
ERYPED 200	4	MO
ERYPED 400	4	MO
<i>ery-tab oral tablet, delayed release (drlec) 250 mg, 333 mg</i>	4	MO
ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG	4	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	4	PA; MO
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>erythromycin ethylsuccinate oral tablet</i>	4	MO
<i>erythromycin oral</i>	4	MO
ZITHROMAX INTRAVENOUS	4	PA; MO
ZITHROMAX ORAL PACKET	4	MO
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	4	MO
ZITHROMAX ORAL TABLET 250 MG, 500 MG	4	MO
ZITHROMAX TRI-PAK	4	
ZITHROMAX Z-PAK	4	MO
MISCELLANEOUS ANTIINFECTIVES		
AEMCOLO	4	MO; QL (12 per 30 days)
<i>albendazole</i>	5	MO
<i>amikacin injection solution 500 mg/2 ml</i>	4	PA; MO
ARIKAYCE	5	PA; LA
<i>atovaquone</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>atovaquone-proguanil</i>	4	MO
AZACTAM	4	PA; MO
<i>aztreonam</i>	4	PA; MO
BETHKIS	5	PA; MO; QL (224 per 28 days)
BILTRICIDE	4	MO
CAYSTON	5	PA; MO; LA; QL (84 per 56 days)
<i>chloroquine phosphate</i>	2	MO
CLEOCIN HCL	4	MO
CLEOCIN INJECTION	4	PA; MO
CLEOCIN PEDIATRIC	4	MO
<i>clindamycin hcl</i>	2	MO
<i>clindamycin in 5 % dextrose</i>	4	PA; MO
<i>clindamycin pediatric</i>	2	MO
<i>clindamycin phosphate injection</i>	4	PA; MO
COARTEM	4	MO
<i>colistin (colistimethate na)</i>	5	PA; MO; QL (30 per 10 days)
CUBICIN RF	5	MO
<i>cycloserine</i>	2	MO
DALVANCE	5	PA; MO
<i>dapsone oral</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	5	MO
<i>daptomycin intravenous recon soln 500 mg</i>	5	MO
DARAPRIM	5	PA
EMVERM	5	MO
<i>ertapenem</i>	4	PA; MO; QL (14 per 14 days)
<i>ethambutol</i>	2	MO
FIRVANQ	4	QL (450 per 10 days)
FLAGYL ORAL CAPSULE	4	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>	4	PA; MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml</i>	4	PA
<i>gentamicin injection solution 40 mg/ml</i>	4	PA; MO
HUMATIN	4	MO
<i>hydroxychloroquine</i>	2	MO
<i>imipenem-cilastatin</i>	4	PA; MO
IMPAVIDO	5	PA; MO

Drug Name	Drug Tier	Requirements/Limits
INVANZ INJECTION	4	PA; QL (14 per 14 days)
<i>isoniazid oral</i>	2	MO
<i>ivermectin oral</i>	2	PA; MO; QL (20 per 30 days)
KITABIS PAK	5	PA; MO; QL (280 per 28 days)
KRINTAFEL	4	
LAMPIT	4	MO
<i>linezolid in dextrose 5%</i>	4	PA; MO
<i>linezolid oral suspension for reconstitution</i>	5	MO
<i>linezolid oral tablet</i>	4	MO
MALARONE	4	MO
MALARONE PEDIATRIC	4	MO
<i>mefloquine</i>	2	
MEPRON	5	MO
<i>meropenem intravenous recon soln 1 gram</i>	2	PA; QL (30 per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	2	PA; QL (10 per 10 days)
<i>metronidazole in nacl (iso-os)</i>	4	PA; MO
<i>metronidazole oral</i>	2	MO
MYAMBUTOL ORAL TABLET 400 MG	4	MO
MYCOBUTIN	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NEBUPENT	4	PA; MO; QL (1 per 28 days)
<i>neomycin</i>	2	MO
<i>nitazoxanide</i>	5	MO; QL (12 per 30 days)
PENTAM	4	MO
<i>pentamidine inhalation</i>	4	PA; MO; QL (1 per 28 days)
<i>pentamidine injection</i>	4	MO
PLAQUENIL	4	MO
<i>polymyxin b sulfate</i>	2	PA; MO
<i>praziquantel</i>	4	MO
PRETOMANID	4	PA
PRIFTIN	3	MO
PRIMAQUINE	4	MO
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	4	PA; MO
<i>pyrazinamide</i>	4	MO
<i>pyrimethamine</i>	5	PA; MO
QUALAQUIN	4	MO
<i>quinine sulfate</i>	4	MO
<i>rifabutin</i>	4	MO
<i>rifampin intravenous</i>	4	MO
<i>rifampin oral</i>	2	MO
SIRTURO	5	PA; LA
SIVEXTRO INTRAVENOUS	5	PA

Drug Name	Drug Tier	Requirements/Limits
SIVEXTRO ORAL	5	MO
SOLOSEC	4	MO
STREPTOMYCIN	5	PA; MO; QL (60 per 30 days)
STROMECTOL	4	PA; MO; QL (20 per 30 days)
<i>tigecycline</i>	5	PA; MO
<i>tinidazole</i>	2	MO
TOBI	5	PA; MO; QL (280 per 28 days)
TOBI PODHALER	5	MO; QL (224 per 56 days)
<i>tobramycin in 0.225 % nacl</i>	5	PA; MO; QL (280 per 28 days)
<i>tobramycin inhalation</i>	5	PA; MO; QL (224 per 28 days)
<i>tobramycin sulfate injection solution</i>	4	PA; MO
TRECTOR	4	MO
TYGACIL	5	PA; MO
VABOMERE	4	PA
VANCOCIN ORAL CAPSULE 125 MG	4	PA; MO; QL (40 per 10 days)
VANCOCIN ORAL CAPSULE 250 MG	5	PA; MO; QL (80 per 10 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>vancomycin intravenous recon soln 1,000 mg</i>	4	PA; MO; QL (20 per 10 days)
<i>vancomycin intravenous recon soln 10 gram</i>	4	PA; QL (2 per 10 days)
<i>vancomycin intravenous recon soln 500 mg</i>	4	PA; MO; QL (10 per 10 days)
<i>vancomycin intravenous recon soln 750 mg</i>	4	PA; MO; QL (27 per 10 days)
<i>vancomycin oral capsule 125 mg</i>	4	PA; MO; QL (40 per 10 days)
<i>vancomycin oral capsule 250 mg</i>	4	PA; MO; QL (80 per 10 days)
VANCOMYCIN ORAL RECON SOLN 25 MG/ML	4	QL (450 per 10 days)
<i>vancomycin oral recon soln 50 mg/ml</i>	2	MO; QL (450 per 10 days)
XIFAXAN ORAL TABLET 200 MG	3	PA; MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	5	PA; MO; QL (90 per 30 days)
ZEMDRI	5	PA
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	4	PA; MO
ZYVOX ORAL	5	MO

Drug Name	Drug Tier	Requirements/Limits
PENICILLINS		
<i>amoxicillin oral capsule</i>	2	MO
<i>amoxicillin oral suspension for reconstitution</i>	2	MO
<i>amoxicillin oral tablet</i>	2	MO
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	2	MO
<i>amoxicillin-pot clavulanate oral suspension for reconstitution</i>	2	MO
<i>amoxicillin-pot clavulanate oral tablet</i>	2	MO
<i>amoxicillin-pot clavulanate oral tablet extended release 12 hr</i>	4	MO
<i>amoxicillin-pot clavulanate oral tablet, chewable 200-28.5 mg</i>	2	MO
<i>amoxicillin-pot clavulanate oral tablet, chewable 400-57 mg</i>	2	
<i>ampicillin oral capsule 500 mg</i>	2	MO
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	4	PA; MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	4	PA
AUGMENTIN ES-600	4	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	4	MO
BICILLIN C-R	4	PA; MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 1,200,000 UNIT/2 ML, 2,400,000 UNIT/4 ML	4	PA; MO
BICILLIN L-A INTRAMUSCULAR SYRINGE 600,000 UNIT/ML	4	PA
<i>dicloxacillin</i>	2	MO
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	4	PA; MO
<i>nafcillin injection recon soln 10 gram</i>	5	PA
<i>oxacillin in dextrose(iso-osm)</i>	4	PA

Drug Name	Drug Tier	Requirements/Limits
<i>oxacillin injection recon soln 1 gram, 10 gram</i>	4	PA
<i>oxacillin injection recon soln 2 gram</i>	4	PA; MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	4	PA
<i>penicillin g potassium injection recon soln 20 million unit</i>	4	PA; MO
<i>penicillin g sodium</i>	4	PA; MO
<i>penicillin v potassium</i>	2	MO
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram</i>	4	MO
<i>piperacillin-tazobactam intravenous recon soln 40.5 gram</i>	4	
UNASYN INJECTION RECON SOLN 15 GRAM	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
UNASYN INJECTION RECON SOLN 3 GRAM	4	PA; MO
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	4	
QUINOLONES		
BAXDELA INTRAVENOUS	5	PA
BAXDELA ORAL	5	MO
CIPRO ORAL SUSPENSION, MICROCAPSULE RECON	4	
CIPRO ORAL TABLET 250 MG, 500 MG	4	MO
<i>ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg</i>	2	MO
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	4	PA; MO
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	4	PA; MO
<i>levofloxacin oral solution</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>levofloxacin oral tablet</i>	2	MO
<i>moxifloxacin oral</i>	2	MO
<i>moxifloxacin-sod.chloride(iso)</i>	4	PA; MO
<i>ofloxacin oral tablet 300 mg, 400 mg</i>	2	MO
SULFA'S / RELATED AGENTS		
BACTRIM	4	MO
BACTRIM DS	4	MO
<i>sulfadiazine</i>	4	MO
<i>sulfamethoxazole-trimethoprim oral suspension</i>	2	MO
<i>sulfamethoxazole-trimethoprim oral tablet</i>	1	MO
TETRACYCLINES		
<i>demeclocycline</i>	4	MO
DORYX MPC ORAL TABLET, DELAYED RELEASE (DR/EC) 60 MG	4	ST; MO
<i>doxy-100</i>	4	PA; MO
<i>doxycycline hyclate oral capsule</i>	2	MO
<i>doxycycline hyclate oral tablet</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline hyclate oral tablet, delayed release (drlec) 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	2	MO
DOXYCYCLINE HYCLATE ORAL TABLET, DELAYED RELEASE (DR/EC) 80 MG	4	ST; MO
<i>doxycycline monohydrate oral capsule</i>	2	MO
<i>doxycycline monohydrate oral capsule, ir - delay rel, biphasic</i>	2	MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	4	MO
<i>doxycycline monohydrate oral tablet</i>	2	MO
<i>minocycline oral capsule</i>	2	MO
<i>minocycline oral tablet</i>	4	MO
<i>minocycline oral tablet extended release 24 hr</i>	2	MO
NUZYRA INTRAVENOUS	5	PA
NUZYRA ORAL	5	
ORACEA	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
SEYSARA ORAL TABLET 100 MG, 60 MG	4	ST; MO
SEYSARA ORAL TABLET 150 MG	5	ST; MO
TARGADOX	4	ST; MO
<i>tetracycline oral capsule</i>	4	MO
VIBRAMYCIN ORAL CAPSULE 100 MG	4	ST; MO
URINARY TRACT AGENTS		
<i>fosfomycin tromethamine</i>	2	MO
HIPREX	4	
MACROBID	4	MO
MACRODANTIN	4	
<i>methenamine hippurate</i>	2	MO
<i>nitrofurantoin macrocrystal</i>	2	MO
<i>nitrofurantoin monohydrate-cryst</i>	2	MO
<i>nitrofurantoin oral suspension 25 mg/5 ml</i>	2	MO
NITROFURANTOIN ORAL SUSPENSION 50 MG/5 ML	5	MO
<i>trimethoprim</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>leucovorin calcium oral</i>	2	MO
MESNEX ORAL	5	MO
XGEVA	5	PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
<i>abiraterone oral tablet 250 mg</i>	5	PA; MO; QL (120 per 30 days)
<i>abiraterone oral tablet 500 mg</i>	5	PA; MO; QL (60 per 30 days)
AFINITOR	5	PA; MO; QL (30 per 30 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG	5	PA; MO; QL (330 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	5	PA; MO; QL (240 per 30 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 5 MG	5	PA; MO; QL (180 per 30 days)
AKEEGA	5	PA; LA; QL (60 per 30 days)
ALECENSA	5	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	5	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	5	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	5	PA; QL (30 per 180 days)
<i>anastrozole</i>	2	MO
ARIMIDEX	5	MO
AROMASIN	5	MO
ASTAGRAF XL	4	PA; MO
AUGTYRO	5	PA; MO; QL (240 per 30 days)
AYVAKIT	5	PA; LA; 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
AZASAN	4	PA; MO
<i>azathioprine</i>	2	PA; MO
BALVERSA	5	PA; LA
<i>bexarotene</i>	5	PA; MO
<i>bicalutamide</i>	2	MO
BOSULIF ORAL CAPSULE 100 MG	5	PA; MO; QL (180 per 30 days)
BOSULIF ORAL CAPSULE 50 MG	5	PA; MO; QL (330 per 30 days)
BOSULIF ORAL TABLET 100 MG	5	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	5	PA; MO; QL (30 per 30 days)
BRAFTOVI	5	PA; MO; LA; QL (180 per 30 days)
BRUKINSA	5	PA; LA; QL (120 per 30 days)
CABOMETYX	5	PA; MO; LA; QL (30 per 30 days)
CALQUENCE	5	PA; LA; QL (60 per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	5	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	5	PA; LA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
CAPRELSA ORAL TABLET 300 MG	5	PA; LA; QL (30 per 30 days)
CASODEX	4	MO
CELLCEPT ORAL CAPSULE	4	PA; MO
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	5	PA; MO
CELLCEPT ORAL TABLET	5	PA; MO
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	5	PA; MO; QL (56 per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	5	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	5	PA; MO; QL (84 per 28 days)
COPIKTRA	5	PA; LA; QL (60 per 30 days)
COTELLIC	5	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide oral capsule</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CYCLOPHOSPHAMIDE ORAL TABLET 25 MG	3	PA
CYCLOPHOSPHAMIDE ORAL TABLET 50 MG	3	PA; MO
<i>cyclosporine modified oral capsule</i>	2	PA; MO
<i>cyclosporine modified oral solution</i>	2	PA
<i>cyclosporine oral capsule</i>	2	PA; MO
DAURISMO ORAL TABLET 100 MG	5	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	5	PA; MO; QL (60 per 30 days)
DROXIA	3	MO
ELIGARD	3	PA; MO
ELIGARD (3 MONTH)	3	PA; MO
ELIGARD (4 MONTH)	3	PA; MO
ELIGARD (6 MONTH)	3	PA; MO
ENSPRYNG	5	PA; MO
ENVARUS XR	4	PA; MO
ERIVEDGE	5	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 240 MG	5	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ERLEADA ORAL TABLET 60 MG	5	PA; MO; QL (120 per 30 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	5	PA; MO; QL (30 per 30 days)
<i>erlotinib oral tablet 25 mg</i>	5	PA; MO; QL (60 per 30 days)
<i>everolimus (antineoplastic) oral tablet</i>	5	PA; MO; QL (30 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	5	PA; MO; QL (330 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	5	PA; MO; QL (240 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	5	PA; MO; QL (180 per 30 days)
<i>everolimus (immunosuppressive) oral tablet 0.25 mg</i>	2	PA; MO
<i>everolimus (immunosuppressive) oral tablet 0.5 mg, 0.75 mg, 1 mg</i>	5	PA; MO
<i>exemestane</i>	4	MO
FARESTON	5	MO
FEMARA	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	5	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	4	PA; MO
FOTIVDA	5	PA; LA; QL (21 per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	5	PA; QL (84 per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	5	PA; QL (21 per 28 days)
GAVRETO	5	PA; LA; QL (120 per 30 days)
<i>gefitinib</i>	5	PA; MO; QL (30 per 30 days)
<i>gengraf</i>	2	PA; MO
GILOTRIF	5	PA; MO; QL (30 per 30 days)
GLEEVEC ORAL TABLET 100 MG	5	PA; MO; QL (180 per 30 days)
GLEEVEC ORAL TABLET 400 MG	5	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
GLEOSTINE ORAL CAPSULE 10 MG	4	MO
GLEOSTINE ORAL CAPSULE 100 MG, 40 MG	5	MO
HYDREA	4	MO
<i>hydroxyurea</i>	2	MO
IBRANCE	5	PA; MO; QL (21 per 28 days)
ICLUSIG	5	PA; QL (30 per 30 days)
IDHIFA	5	PA; MO; LA; QL (30 per 30 days)
<i>imatinib oral tablet 100 mg</i>	5	PA; MO; QL (180 per 30 days)
<i>imatinib oral tablet 400 mg</i>	5	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	5	PA; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	5	PA; QL (30 per 30 days)
IMBRUVICA ORAL SUSPENSION	5	PA; QL (324 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	5	PA; QL (30 per 30 days)
IMURAN	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
INLYTA ORAL TABLET 1 MG	5	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	5	PA; MO; QL (120 per 30 days)
INQOVI	5	PA; MO; QL (5 per 28 days)
INREBIC	5	PA; MO; LA; QL (120 per 30 days)
IRESSA	5	PA; MO; QL (30 per 30 days)
IWILFIN	5	PA; LA; QL (240 per 30 days)
JAKAFI	5	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	5	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	5	PA; MO; QL (30 per 30 days)
JYLAMVO	4	PA
KANJINTI	5	PA; MO
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	5	PA; MO; QL (49 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	5	PA; MO; QL (70 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	5	PA; MO; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA; MO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	5	PA; MO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	5	PA; MO; QL (63 per 28 days)
KLISYRI	5	MO
KOSELUGO	5	PA
KRAZATI	5	PA; QL (180 per 30 days)
<i>lapatinib</i>	5	PA; MO; QL (180 per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	5	PA; MO; QL (28 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>lenalidomide oral capsule 2.5 mg, 20 mg</i>	5	PA; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	5	PA; MO; QL (30 per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X 2), 24 MG/DAY (10 MG X 2-4 MG X 1)	5	PA; MO; QL (90 per 30 days)
LENVIMA ORAL CAPSULE 14 MG/DAY (10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	5	PA; MO; QL (60 per 30 days)
<i>letrozole</i>	2	MO
LEUKERAN	5	MO
LEUPROLIDE (3 MONTH)	4	PA; MO
<i>leuprolide subcutaneous kit</i>	4	PA; MO
LONSURF	5	PA; MO
LORBRENA ORAL TABLET 100 MG	5	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	5	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
LUMAKRAS ORAL TABLET 120 MG	5	PA; MO; QL (240 per 30 days)
LUMAKRAS ORAL TABLET 320 MG	5	PA; MO; QL (90 per 30 days)
LUPKYNIS	5	PA; LA; QL (180 per 30 days)
LUPRON DEPOT	5	PA; MO
LUPRON DEPOT (3 MONTH)	5	PA; MO
LUPRON DEPOT (4 MONTH)	5	PA; MO
LUPRON DEPOT (6 MONTH)	5	PA; MO
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	5	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	5	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	5	PA; MO
LYNPARZA	5	PA; MO; QL (120 per 30 days)
LYSODREN	5	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
LYTGOBI ORAL TABLET 12 MG/DAY (4 MG X 3)	5	PA; LA; QL (84 per 28 days)
LYTGOBI ORAL TABLET 16 MG/DAY (4 MG X 4)	5	PA; LA; QL (112 per 28 days)
LYTGOBI ORAL TABLET 20 MG/DAY (4 MG X 5)	5	PA; LA; QL (140 per 28 days)
MATULANE	5	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml)</i>	2	PA; MO
<i>megestrol oral suspension 625 mg/5 ml (125 mg/ml)</i>	4	PA; MO
<i>megestrol oral tablet</i>	2	PA; MO
MEKINIST ORAL RECON SOLN	5	PA; MO; QL (1200 per 30 days)
MEKINIST ORAL TABLET 0.5 MG	5	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	5	PA; MO; QL (30 per 30 days)
MEKTOVI	5	PA; MO; LA; QL (180 per 30 days)
<i>mercaptopurine</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>methotrexate sodium (pf) injection solution</i>	2	PA; MO
<i>methotrexate sodium injection</i>	2	PA
<i>methotrexate sodium oral</i>	2	PA; MO
MVASI	5	PA; MO
MYCAPSSA	5	PA; LA
<i>mycophenolate mofetil oral capsule</i>	2	PA; MO
<i>mycophenolate mofetil oral suspension for reconstitution</i>	5	PA; MO
<i>mycophenolate mofetil oral tablet</i>	2	PA; MO
<i>mycophenolate sodium</i>	4	PA; MO
MYFORTIC	4	PA; MO
MYHIBBIN	5	PA
NEORAL	4	PA; MO
NERLYNX	5	PA; MO; LA
NEXAVAR	5	PA; MO; LA; QL (120 per 30 days)
NILANDRON	5	PA; MO
<i>nilutamide</i>	5	PA; MO
NINLARO	5	PA; MO; QL (3 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NUBEQA	5	PA; MO; LA; QL (120 per 30 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	5	PA; MO
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	4	PA; MO
ODOMZO	5	PA; MO; LA; QL (30 per 30 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	5	PA; QL (56 per 28 days)
OGSIVEO ORAL TABLET 50 MG	5	PA; QL (180 per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	5	PA; QL (96 per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	5	PA; QL (20 per 28 days)
OJJAARA	5	PA; QL (30 per 30 days)
ONTRUZANT	5	PA
ONUREG	5	PA; MO; QL (14 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ORGOVYX	5	PA; LA; QL (30 per 28 days)
ORSERDU ORAL TABLET 345 MG	5	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	5	PA; QL (90 per 30 days)
<i>pazopanib</i>	5	PA; MO; QL (120 per 30 days)
PEMAZYRE	5	PA; LA; QL (28 per 28 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	5	PA; MO; QL (28 per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	5	PA; MO; QL (56 per 28 days)
POMALYST	5	PA; MO; LA; QL (21 per 28 days)
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	4	PA; MO
PROGRAF ORAL CAPSULE 5 MG	5	PA; MO
PROGRAF ORAL GRANULES IN PACKET	4	PA; MO
PURIXAN	5	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
QINLOCK	5	PA; LA; QL (90 per 30 days)
RAPAMUNE ORAL TABLET 1 MG	5	PA; MO
RETEVMO ORAL CAPSULE 40 MG	5	PA; MO; LA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	5	PA; MO; LA; QL (120 per 30 days)
REVLIMID	5	PA; MO; LA; QL (28 per 28 days)
REZLIDHIA	5	PA; QL (60 per 30 days)
REZUROCK	5	PA; LA; QL (30 per 30 days)
RIABNI	5	PA; MO
ROZLYTREK ORAL CAPSULE 100 MG	5	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	5	PA; MO; QL (90 per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET	5	PA; MO; QL (336 per 28 days)
RUBRACA	5	PA; MO; LA; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
RUXIENCE	5	PA; MO
RYDAPT	5	PA; MO; QL (224 per 28 days)
SANDIMMUNE ORAL CAPSULE	4	PA; MO
SANDIMMUNE ORAL SOLUTION	4	PA
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	4	PA; MO
SCSEMBLIX ORAL TABLET 100 MG	5	PA; QL (120 per 30 days)
SCSEMBLIX ORAL TABLET 20 MG	5	PA; QL (600 per 30 days)
SCSEMBLIX ORAL TABLET 40 MG	5	PA; QL (300 per 30 days)
SIGNIFOR	5	PA
SIKLOS ORAL TABLET 1,000 MG	5	MO
SIKLOS ORAL TABLET 100 MG	4	MO
<i>sirolimus oral solution</i>	5	PA; MO
<i>sirolimus oral tablet</i>	4	PA; MO
SOLTAMOX	5	MO
SOMATULINE DEPOT	5	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>sorafenib</i>	5	PA; MO; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	5	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	5	PA; MO; QL (60 per 30 days)
STIVARGA	5	PA; MO; QL (84 per 28 days)
<i>sunitinib malate</i>	5	PA; MO; QL (30 per 30 days)
SUTENT	5	PA; MO; QL (30 per 30 days)
TABLOID	4	MO
TABRECTA	5	PA; MO
<i>tacrolimus oral capsule</i>	2	PA; MO
TAFINLAR ORAL CAPSULE	5	PA; MO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	5	PA; MO; QL (840 per 28 days)
TAGRISSO	5	PA; MO; LA; QL (30 per 30 days)
TALZENNA	5	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tamoxifen</i>	2	MO
TARGRETIN	5	PA; MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	5	PA; MO; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	5	PA; MO; QL (120 per 30 days)
TAZVERIK	5	PA; LA
TEPMETKO	5	PA; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	5	PA; MO; QL (28 per 28 days)
THALOMID ORAL CAPSULE 150 MG, 200 MG	5	PA; QL (56 per 28 days)
TIBSOVO	5	PA
<i>toremifene</i>	5	MO
TRAZIMERA	5	PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PA; MO
<i>tretinoin (antineoplastic)</i>	5	MO
TREXALL	4	PA; MO
TRUQAP	5	PA; QL (64 per 28 days)
TUKYSA ORAL TABLET 150 MG	5	PA; LA; 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TUKYSA ORAL TABLET 50 MG	5	PA; LA; QL (300 per 30 days)
TURALIO ORAL CAPSULE 125 MG	5	PA; LA; QL (120 per 30 days)
TYKERB	5	PA; MO; LA; QL (180 per 30 days)
VANFLYTA	5	PA; QL (56 per 28 days)
VENCLEXTA ORAL TABLET 10 MG	3	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	5	PA; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 50 MG	5	PA; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK	5	PA; LA; QL (42 per 180 days)
VERZENIO	5	PA; MO; LA; QL (60 per 30 days)
VIJOICE ORAL GRANULES IN PACKET	5	PA; QL (28 per 28 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	5	PA; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	5	PA; QL (56 per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	5	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	5	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	5	PA; MO; LA; QL (300 per 30 days)
VIZIMPRO	5	PA; MO; QL (30 per 30 days)
VONJO	5	PA; QL (120 per 30 days)
VOTRIENT	5	PA; MO; QL (120 per 30 days)
WELIREG	5	PA; LA
XALKORI ORAL CAPSULE	5	PA; MO; QL (60 per 30 days)
XALKORI ORAL PELLETT 150 MG	5	PA; MO; QL (180 per 30 days)
XALKORI ORAL PELLETT 20 MG, 50 MG	5	PA; MO; QL (120 per 30 days)
XATMEP	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
XERMELO	5	PA; LA; QL (84 per 28 days)
XOSPATA	5	PA; LA; QL (90 per 30 days)
XPOVIO	5	PA; LA
XTANDI ORAL CAPSULE	5	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	5	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	5	PA; MO; QL (60 per 30 days)
YONSA	5	PA; MO; QL (120 per 30 days)
ZEJULA ORAL TABLET	5	PA; MO; LA; QL (30 per 30 days)
ZELBORAF	5	PA; MO; QL (240 per 30 days)
ZIRABEV	5	PA; MO
ZOLINZA	5	PA; MO; QL (120 per 30 days)
ZORTRESS ORAL TABLET 0.25 MG	4	PA; MO
ZORTRESS ORAL TABLET 0.5 MG, 0.75 MG, 1 MG	5	PA; MO

Drug Name	Drug Tier	Requirements/Limits
ZYDELIG	5	PA; MO; QL (60 per 30 days)
ZYKADIA	5	PA; MO; QL (90 per 30 days)
ZYTIGA ORAL TABLET 250 MG	5	PA; MO; QL (120 per 30 days)
ZYTIGA ORAL TABLET 500 MG	5	PA; MO; QL (60 per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG	5	MO; QL (180 per 30 days)
APTIOM ORAL TABLET 400 MG	5	MO; QL (90 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	5	MO; QL (60 per 30 days)
BANZEL	5	PA; MO
BRIVIACT INTRAVENOUS	4	MO; QL (600 per 30 days)
BRIVIACT ORAL SOLUTION	5	MO; QL (600 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
BRIVIACT ORAL TABLET	5	MO; QL (60 per 30 days)
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	2	MO
<i>carbamazepine oral suspension 100 mg/5 ml</i>	2	MO
<i>carbamazepine oral tablet</i>	2	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	2	MO
<i>carbamazepine oral tablet, chewable</i>	2	MO
CARBATROL	4	MO
CELONTIN ORAL CAPSULE 300 MG	4	MO
<i>clobazam oral suspension</i>	4	PA; MO; QL (480 per 30 days)
<i>clobazam oral tablet</i>	4	PA; MO; QL (60 per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	2	MO; QL (90 per 30 days)
<i>clonazepam oral tablet 2 mg</i>	2	MO; QL (300 per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	2	MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clonazepam oral tablet, disintegrating 2 mg</i>	2	MO; QL (300 per 30 days)
DEPAKOTE	4	MO
DEPAKOTE ER	4	MO
DEPAKOTE SPRINKLES	4	MO
DIACOMIT	5	PA; LA
<i>diazepam rectal</i>	4	MO
DILANTIN 30 MG	4	MO
DILANTIN EXTENDED 100 MG	4	MO
DILANTIN INFATABS	4	MO
DILANTIN-125	4	MO
<i>divalproex</i>	2	MO
EPIDIOLEX	5	PA; MO; LA
<i>epitol</i>	2	MO
EPRONTIA	4	PA; MO
EQUETRO	4	MO
<i>ethosuximide</i>	2	MO
<i>felbamate</i>	4	MO
FELBATOL ORAL TABLET	5	MO
FINTEPLA	5	PA; LA; QL (360 per 30 days)
FYCOMPA ORAL SUSPENSION	5	MO; QL (720 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	5	MO; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG	4	MO; QL (60 per 30 days)
FYCOMPA ORAL TABLET 4 MG, 6 MG	5	MO; QL (60 per 30 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	2	MO; QL (270 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	2	MO; QL (360 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	2	MO; QL (2160 per 30 days)
<i>gabapentin oral tablet 600 mg</i>	2	MO; QL (180 per 30 days)
<i>gabapentin oral tablet 800 mg</i>	2	MO; QL (120 per 30 days)
<i>gabapentin oral tablet extended release 24 hr 300 mg</i>	2	PA; MO; QL (30 per 30 days)
<i>gabapentin oral tablet extended release 24 hr 600 mg</i>	2	PA; MO; QL (90 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG, 750 MG, 900 MG	4	PA; MO; QL (60 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	4	PA; MO; QL (90 per 30 days)
KEPPRA ORAL	4	MO
KEPPRA XR	4	MO
KLONOPIN ORAL TABLET 0.5 MG, 1 MG	4	MO; QL (90 per 30 days)
KLONOPIN ORAL TABLET 2 MG	4	MO; QL (300 per 30 days)
<i>lacosamide oral solution</i>	4	MO; QL (1200 per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	4	MO; QL (60 per 30 days)
<i>lacosamide oral tablet 50 mg</i>	4	MO; QL (120 per 30 days)
LAMICTAL ODT	4	MO
LAMICTAL ORAL TABLET	4	MO
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL STARTER (BLUE) KIT	4	MO
LAMICTAL STARTER (GREEN) KIT	4	MO
LAMICTAL STARTER (ORANGE) KIT	4	MO
LAMICTAL XR	4	MO
LAMICTAL XR STARTER (BLUE)	4	MO
LAMICTAL XR STARTER (GREEN)	4	MO
LAMICTAL XR STARTER (ORANGE)	4	MO
<i>lamotrigine oral tablet</i>	1	MO
<i>lamotrigine oral tablet disintegrating, dose pk</i>	2	MO
<i>lamotrigine oral tablet extended release 24hr</i>	2	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	2	MO
<i>lamotrigine oral tablet, disintegrating</i>	4	MO
<i>lamotrigine oral tablets, dose pack</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>levetiracetam oral solution 100 mg/ml</i>	2	MO
<i>levetiracetam oral tablet</i>	2	MO
<i>levetiracetam oral tablet extended release 24 hr</i>	2	MO
LIBERVANT	5	PA; QL (10 per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG	4	PA; MO; QL (30 per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG	4	PA; MO; QL (60 per 30 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	4	MO; QL (90 per 30 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	4	MO; QL (60 per 30 days)
LYRICA ORAL SOLUTION	4	MO; QL (900 per 30 days)
<i>methsuximide</i>	4	MO
MOTPOLY XR ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG	4	ST; 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
MOTPOLY XR ORAL CAPSULE, EXTENDED RELEASE 24HR 150 MG, 200 MG	5	ST; MO; QL (60 per 30 days)
MYSOLINE	5	MO
NAYZILAM	3	PA; MO; QL (10 per 30 days)
NEURONTIN ORAL CAPSULE 100 MG, 400 MG	4	MO; QL (270 per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	4	MO; QL (360 per 30 days)
NEURONTIN ORAL SOLUTION	4	MO; QL (2160 per 30 days)
NEURONTIN ORAL TABLET 600 MG	4	MO; QL (180 per 30 days)
NEURONTIN ORAL TABLET 800 MG	4	MO; QL (120 per 30 days)
ONFI ORAL SUSPENSION	5	PA; MO; QL (480 per 30 days)
ONFI ORAL TABLET	5	PA; MO; QL (60 per 30 days)
<i>oxcarbazepine oral suspension</i>	4	MO
<i>oxcarbazepine oral tablet</i>	2	MO
OXTELLAR XR	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>phenobarbital oral elixir</i>	4	PA; MO
<i>phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg</i>	2	PA
<i>phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</i>	2	PA; MO
PHENYTEK	4	MO
<i>phenytoin oral suspension 125 mg/5 ml</i>	2	MO
<i>phenytoin oral tablet, chewable</i>	2	MO
<i>phenytoin sodium extended oral capsule 100 mg</i>	2	MO
<i>phenytoin sodium extended oral capsule 200 mg, 300 mg</i>	2	
<i>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	2	MO; QL (90 per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	2	MO; QL (60 per 30 days)
<i>pregabalin oral solution</i>	2	MO; QL (900 per 30 days)
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	2	PA; MO; QL (60 per 30 days)
PRIMIDONE ORAL TABLET 125 MG	4	MO
<i>primidone oral tablet 250 mg, 50 mg</i>	2	MO
QUDEXY XR	4	PA; MO
<i>roweepra oral tablet 500 mg</i>	2	MO
<i>rufinamide oral suspension</i>	5	PA; MO
<i>rufinamide oral tablet 200 mg</i>	4	PA; MO
<i>rufinamide oral tablet 400 mg</i>	5	PA; MO
SABRIL	5	PA; MO; LA
SPRITAM	4	MO
<i>subvenite</i>	1	MO
<i>subvenite starter (blue) kit</i>	2	MO
<i>subvenite starter (green) kit</i>	2	MO
<i>subvenite starter (orange) kit</i>	2	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	5	PA; MO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
TEGRETOL ORAL SUSPENSION	4	MO
TEGRETOL ORAL TABLET	4	MO
TEGRETOL XR	4	MO
<i>tiagabine</i>	4	MO
TOPAMAX	4	PA; MO
<i>topiramate oral capsule, sprinkle</i>	2	PA; MO
<i>topiramate oral capsule, extended release 24hr 100 mg, 25 mg, 50 mg</i>	2	PA; MO
<i>topiramate oral capsule, extended release 24hr 200 mg</i>	5	PA; MO
<i>topiramate oral capsule, sprinkle, er 24hr</i>	2	PA; MO
<i>topiramate oral tablet</i>	2	PA; MO
TRILEPTAL	4	MO
TROKENDI XR ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 25 MG, 50 MG	4	PA; MO
TROKENDI XR ORAL CAPSULE, EXTENDED RELEASE 24HR 200 MG	5	PA; MO
<i>valproic acid</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	2	MO
VALTOCO	3	PA; MO; QL (10 per 30 days)
<i>vigabatrin</i>	5	PA; MO; LA
<i>vigadrone</i>	5	PA; LA
<i>vigpoder</i>	5	PA; LA
VIMPAT ORAL SOLUTION	5	MO; QL (1200 per 30 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	5	MO; QL (60 per 30 days)
VIMPAT ORAL TABLET 50 MG	4	MO; QL (120 per 30 days)
XCOPRI MAINTENANCE PACK	5	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG, 25 MG, 50 MG	5	MO; QL (30 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	5	MO; QL (60 per 30 days)
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	4	MO; QL (28 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	5	MO; QL (28 per 180 days)
ZARONTIN	4	MO
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	4	PA; MO
ZONISADE	5	PA; MO
<i>zonisamide</i>	2	PA; MO
ZTALMY	5	PA; LA; QL (1100 per 30 days)
ANTIPARKINSONISM AGENTS		
APOKYN	5	PA; MO; LA; QL (90 per 30 days)
<i>apomorphine</i>	5	PA; QL (90 per 30 days)
AZILECT	4	MO
<i>benztropine oral</i>	2	PA; MO
<i>bromocriptine</i>	4	MO
<i>carbidopa</i>	4	MO
<i>carbidopa-levodopa oral tablet</i>	2	MO
<i>carbidopa-levodopa oral tablet extended release</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>carbidopa-levodopa oral tablet, disintegrating</i>	2	
<i>carbidopa-levodopa-entacapone</i>	4	MO
COMTAN	4	
DHIVY	4	MO
DUOPA	5	PA; MO
<i>entacapone</i>	4	MO
GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 137 MG	5	PA; QL (60 per 30 days)
GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 68.5 MG	5	PA; QL (30 per 30 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	5	PA; QL (300 per 30 days)
LODOSYN	4	MO
NEUPRO	4	MO
NOURIANZ	5	PA; MO; LA; QL (30 per 30 days)
ONGENTYS	4	PA; MO; QL (30 per 30 days)
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 129 MG, 193 MG	4	PA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
PARLODEL ORAL CAPSULE	4	MO
PARLODEL ORAL TABLET	4	
<i>pramipexole</i>	2	MO
<i>rasagiline</i>	4	MO
<i>ropinirole oral tablet</i>	2	MO
<i>ropinirole oral tablet extended release 24 hr</i>	4	MO
RYTARY	4	MO
<i>selegiline hcl</i>	2	MO
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	4	MO
STALEVO 100	4	MO
STALEVO 125	4	MO
STALEVO 150	4	MO
STALEVO 200	4	MO
STALEVO 50	4	MO
STALEVO 75	4	MO
TASMAR ORAL TABLET 100 MG	5	PA; MO
<i>tolcapone</i>	5	PA
<i>trihexyphenidyl oral tablet</i>	1	MO
XADAGO	5	MO
ZELAPAR	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR	3	PA; MO; QL (1 per 30 days)
AJOVY AUTOINJECTOR	4	PA; MO; QL (1.5 per 30 days)
AJOVY SYRINGE	4	PA; MO; QL (1.5 per 30 days)
<i>almotriptan malate</i>	2	MO; QL (16 per 28 days)
<i>dihydroergotamine nasal</i>	5	QL (8 per 28 days)
<i>eletriptan</i>	2	MO; QL (18 per 28 days)
ELYXYB	4	PA; MO; QL (57.6 per 28 days)
EMGALITY PEN	3	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	3	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	5	PA; MO; QL (3 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>ergotamine-caffeine</i>	2	MO
FROVA	4	MO; QL (27 per 28 days)
<i>frovatriptan</i>	2	MO; QL (27 per 28 days)
IMITREX ORAL TABLET 100 MG, 25 MG	4	MO; QL (18 per 28 days)
IMITREX ORAL TABLET 50 MG	4	QL (18 per 28 days)
IMITREX STATDOSE SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	4	MO; QL (8 per 28 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	4	MO; QL (8 per 28 days)
MAXALT ORAL TABLET 10 MG	4	MO; QL (24 per 28 days)
MAXALT-MLT ORAL TABLET, DISINTEGRATING 10 MG	4	MO; QL (24 per 28 days)
<i>migergot</i>	5	MO
MIGRANAL	5	QL (8 per 28 days)
<i>naratriptan</i>	2	MO; QL (18 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NURTEC ODT	3	PA; QL (16 per 30 days)
ONZETRA XSAIL	4	MO; QL (32 per 28 days)
QULIPTA	3	PA; MO; QL (30 per 30 days)
RELPAX	4	MO; QL (18 per 28 days)
REYVOW ORAL TABLET 100 MG	4	PA; QL (16 per 30 days)
REYVOW ORAL TABLET 50 MG	4	PA; QL (8 per 30 days)
<i>rizatriptan</i>	2	MO; QL (24 per 28 days)
<i>sumatriptan</i>	4	MO; QL (18 per 28 days)
<i>sumatriptan succinate oral</i>	2	MO; QL (18 per 28 days)
<i>sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml</i>	4	QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml</i>	4	QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml</i>	4	MO; QL (8 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate subcutaneous solution</i>	4	MO; QL (8 per 28 days)
<i>sumatriptan-naproxen</i>	2	MO; QL (18 per 28 days)
TOSYMRA	4	MO; QL (24 per 28 days)
TREXIMET	4	MO; QL (18 per 28 days)
UBRELVY	3	PA; QL (20 per 30 days)
ZAVZPRET	5	PA; MO; QL (6 per 28 days)
ZEMBRACE SYMTOUCH	5	MO; QL (8 per 28 days)
<i>zolmitriptan nasal spray, non-aerosol 5 mg</i>	2	MO; QL (18 per 28 days)
<i>zolmitriptan oral</i>	2	MO; QL (18 per 28 days)
ZOMIG NASAL SPRAY, NON-AEROSOL 5 MG	4	MO; QL (18 per 28 days)
MISCELLANEOUS NEUROLOGICAL THERAPY		
ADLARITY	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
AMPYRA	5	PA; MO; LA; QL (60 per 30 days)
ARICEPT	4	MO
AUBAGIO	5	PA; MO; QL (30 per 30 days)
AUSTEDO ORAL TABLET 12 MG, 9 MG	5	PA; MO; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG	5	PA; MO; QL (60 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	5	PA; MO; QL (90 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	5	PA; MO; QL (60 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 30 MG, 36 MG, 42 MG, 48 MG	5	PA; MO; QL (30 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	5	PA; MO; QL (210 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR TITRATION KT(WK1-4) ORAL TABLET, EXT REL 24HR DOSE PACK 6 MG (14)-12 MG (14)-24 MG (14)	5	PA; MO; QL (42 per 180 days)
BAFIERTAM	5	PA; MO; QL (120 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	5	PA; MO; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	5	PA; MO; QL (12 per 28 days)
<i>dalfampridine</i>	2	PA; MO; QL (60 per 30 days)
DAYBUE	5	PA; LA
<i>dimethyl fumarate oral capsule, delayed release(drlec) 120 mg</i>	5	PA; MO; QL (14 per 30 days)
<i>dimethyl fumarate oral capsule, delayed release(drlec) 120 mg (14)- 240 mg (46)</i>	5	PA; MO; QL (120 per 180 days)
<i>dimethyl fumarate oral capsule, delayed release(drlec) 240 mg</i>	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>donepezil oral tablet 10 mg, 5 mg</i>	1	MO
<i>donepezil oral tablet 23 mg</i>	4	MO
<i>donepezil oral tablet, disintegrating</i>	2	MO
EVRYSDI	5	PA; MO; LA; QL (240 per 30 days)
EXELON PATCH	4	MO
<i>fingolimod</i>	5	PA; MO; QL (30 per 30 days)
FIRDAPSE	5	PA; LA
<i>galantamine oral capsule, ext rel. pellets 24 hr</i>	2	MO
<i>galantamine oral solution</i>	4	MO
<i>galantamine oral tablet</i>	2	MO
GILENYA ORAL CAPSULE 0.25 MG	5	PA; QL (30 per 30 days)
GILENYA ORAL CAPSULE 0.5 MG	5	PA; MO; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	5	PA; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	5	PA; QL (12 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>glatopa subcutaneous syringe 20 mg/ml</i>	5	PA; MO; QL (30 per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	5	PA; MO; QL (12 per 28 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG	4	PA; MO; QL (30 per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	4	PA; MO; QL (60 per 30 days)
INGREZZA	5	PA; LA; QL (30 per 30 days)
INGREZZA INITIATION PK(TARDIV)	5	PA; LA; QL (28 per 180 days)
INGREZZA SPRINKLE	5	PA; LA; QL (30 per 30 days)
KESIMPTA PEN	5	PA; MO; QL (1.6 per 28 days)
KEVEYIS	5	PA
MAVENCLAD (10 TABLET PACK)	5	PA; MO; LA; QL (40 per 720 days)
MAVENCLAD (4 TABLET PACK)	5	PA; MO; LA; QL (16 per 720 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
MAVENCLAD (5 TABLET PACK)	5	PA; MO; LA; QL (20 per 720 days)
MAVENCLAD (6 TABLET PACK)	5	PA; MO; LA; QL (24 per 720 days)
MAVENCLAD (7 TABLET PACK)	5	PA; MO; LA; QL (28 per 720 days)
MAVENCLAD (8 TABLET PACK)	5	PA; MO; LA; QL (32 per 720 days)
MAVENCLAD (9 TABLET PACK)	5	PA; MO; LA; QL (36 per 720 days)
MAYZENT ORAL TABLET 0.25 MG	5	PA; MO; QL (120 per 30 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	5	PA; MO; QL (30 per 30 days)
MAYZENT STARTER(FOR 1MG MAINT)	4	PA; MO; QL (7 per 180 days)
MAYZENT STARTER(FOR 2MG MAINT)	5	PA; MO; QL (12 per 180 days)
<i>memantine oral capsule,sprinkle,er 24hr</i>	4	PA; MO
<i>memantine oral solution</i>	2	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>memantine oral tablet</i>	2	PA; MO
MEMANTINE ORAL TABLETS,DOSE PACK	4	PA; MO
NAMENDA TITRATION PAK	4	PA; MO
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 14 MG, 28 MG	4	PA
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR 21 MG	4	PA; MO
NAMZARIC ORAL CAP,SPRINKLE,ER 24HR DOSE PACK	3	PA
NAMZARIC ORAL CAPSULE,SPRINKLE,ER 24HR	3	PA; MO
NUEDEXTA	5	PA; MO
<i>ormalvi</i>	5	PA
PONVORY	5	PA; MO; QL (30 per 30 days)
PONVORY 14-DAY STARTER PACK	5	PA; MO; QL (14 per 180 days)
RADICAVA ORS	5	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
RADICAVA ORS STARTER KIT SUSP	5	PA; MO
<i>rivastigmine</i>	4	MO
<i>rivastigmine tartrate</i>	2	MO
SKYCLARYS	5	PA; LA
TASCENSO ODT	5	MO
TECFIDERA ORAL CAPSULE, DELAYED RELEASE (DR/EC) 120 MG	5	PA; MO; LA; QL (14 per 30 days)
TECFIDERA ORAL CAPSULE, DELAYED RELEASE (DR/EC) 120 MG (14)- 240 MG (46)	5	PA; MO; LA; QL (120 per 180 days)
TECFIDERA ORAL CAPSULE, DELAYED RELEASE (DR/EC) 240 MG	5	PA; MO; LA; QL (60 per 30 days)
TEGSEDI	5	PA; MO; LA
<i>teriflunomide</i>	5	PA; MO; QL (30 per 30 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	5	PA; MO; QL (240 per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	5	PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
VUMERITY	5	PA; MO; QL (120 per 30 days)
WAINUA	5	PA; LA; QL (0.8 per 28 days)
XENAZINE ORAL TABLET 12.5 MG	5	PA; MO; LA; QL (240 per 30 days)
XENAZINE ORAL TABLET 25 MG	5	PA; MO; LA; QL (120 per 30 days)
ZEPOSIA	5	PA; MO; QL (30 per 30 days)
ZEPOSIA STARTER KIT (28-DAY)	5	PA; MO; QL (28 per 180 days)
ZEPOSIA STARTER PACK (7-DAY)	5	PA; MO; QL (7 per 180 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
BACLOFEN ORAL SOLUTION 10 MG/5 ML (2 MG/ML)	4	MO
<i>baclofen oral suspension</i>	5	MO
<i>baclofen oral tablet 10 mg, 20 mg, 5 mg</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
BACLOFEN ORAL TABLET 15 MG	4	MO
<i>cyclobenzaprine oral tablet 10 mg, 5 mg</i>	4	PA; MO
<i>cyclobenzaprine oral tablet 7.5 mg</i>	2	PA; MO
DANTRIUM ORAL CAPSULE 25 MG	4	MO
<i>dantrolene oral</i>	4	MO
FEXMID	4	PA
FLEQSUVY	5	MO
LYVISPAH	4	MO
MESTINON ORAL	5	MO
MESTINON TIMESPAN	5	MO
OZOBAX DS	5	
<i>pyridostigmine bromide oral syrup</i>	2	MO
PYRIDOSTIGMINE BROMIDE ORAL TABLET 30 MG	4	MO
<i>pyridostigmine bromide oral tablet 60 mg</i>	2	MO
<i>pyridostigmine bromide oral tablet extended release</i>	2	
<i>tizanidine</i>	2	MO
ZANAFLEX	4	MO
ZILBRYSQ	5	PA; LA

Drug Name	Drug Tier	Requirements/Limits
NARCOTIC ANALGESICS		
<i>acetaminophen-caff-dihydrocod</i>	2	QL (300 per 30 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	2	MO; QL (4500 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	2	MO; QL (360 per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	2	MO; QL (180 per 30 days)
BELBUCA	3	PA; MO; QL (60 per 30 days)
<i>buprenorphine hcl sublingual</i>	2	MO
<i>buprenorphine transdermal patch</i>	4	PA; MO; QL (4 per 28 days)
BUTRANS	4	PA; MO; QL (4 per 28 days)
<i>codeine sulfate</i>	2	MO; QL (180 per 30 days)
DILAUDID ORAL LIQUID	4	MO; QL (2400 per 30 days)
DILAUDID ORAL TABLET	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>endocet</i>	2	MO; QL (360 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 1,200 mcg, 1,600 mcg, 400 mcg, 600 mcg, 800 mcg</i>	5	PA; MO; QL (120 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle 200 mcg</i>	4	PA; MO; QL (120 per 30 days)
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT 400 MCG, 800 MCG	5	PA; QL (120 per 30 days)
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT 600 MCG	5	PA; MO; QL (120 per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	4	PA; MO; QL (10 per 30 days)
<i>fentanyl transdermal patch 72 hour 37.5 mcg/hour, 62.5 mcg/hour, 87.5 mcg/hour</i>	2	PA; MO; QL (10 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FENTORA	5	PA; MO; QL (120 per 30 days)
<i>hydrocodone bitartrate, oral only, 12hr</i>	2	PA; MO; QL (90 per 30 days)
<i>hydrocodone bitartrate, oral only, ext. rel. 24 hr 100 mg, 120 mg</i>	5	PA; MO; QL (60 per 30 days)
<i>hydrocodone bitartrate, oral only, ext. rel. 24 hr 20 mg, 30 mg, 40 mg, 60 mg, 80 mg</i>	2	PA; MO; QL (60 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	2	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	2	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	MO; QL (360 per 30 days)
<i>hydrocodone-ibuprofen</i>	2	MO; QL (50 per 30 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	4	
<i>hydromorphone oral liquid</i>	4	MO; QL (2400 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone oral tablet</i>	2	MO; QL (180 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr</i>	4	PA; MO; QL (60 per 30 days)
HYSINGLA ER, ORAL ONLY, EXT. REL. 24 HR 100 MG, 120 MG, 80 MG	5	PA; MO; QL (60 per 30 days)
HYSINGLA ER, ORAL ONLY, EXT. REL. 24 HR 20 MG, 30 MG, 40 MG, 60 MG	4	PA; MO; QL (60 per 30 days)
<i>levorphanol tartrate</i>	5	MO; QL (120 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	2	PA; MO; QL (600 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	2	PA; MO; QL (1200 per 30 days)
<i>methadone oral tablet 10 mg</i>	2	PA; MO; QL (120 per 30 days)
<i>methadone oral tablet 5 mg</i>	2	PA; MO; QL (240 per 30 days)
<i>morphine concentrate oral solution</i>	2	MO; QL (900 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>morphine oral capsule, er multiphase 24 hr</i>	2	PA; MO; QL (60 per 30 days)
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	2	PA; MO; QL (90 per 30 days)
<i>morphine oral solution</i>	2	MO; QL (900 per 30 days)
<i>morphine oral tablet</i>	2	MO; QL (180 per 30 days)
<i>morphine oral tablet extended release</i>	2	PA; MO; QL (120 per 30 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG, 60 MG	5	PA; MO; QL (120 per 30 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG	4	PA; MO; QL (120 per 30 days)
NALOCET	4	MO; QL (390 per 30 days)
<i>oxycodone oral capsule</i>	2	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone oral concentrate</i>	4	MO; QL (180 per 30 days)
<i>oxycodone oral solution</i>	2	MO; QL (1200 per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	2	MO; QL (180 per 30 days)
<i>oxycodone oral tablet 5 mg</i>	2	MO; QL (360 per 30 days)
OXYCODONE ORAL TABLET, ORAL ONLY, EXT.REL. 12 HR 10 MG, 20 MG	4	PA; QL (90 per 30 days)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5 ml</i>	2	QL (1860 per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	5	QL (390 per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	2	MO; QL (360 per 30 days)
<i>oxycodone-acetaminophen oral tablet 2.5-325 mg</i>	2	QL (360 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	3	PA; MO; QL (90 per 30 days)
OXYCONTIN, ORAL ONLY, EXT.REL.12 HR 80 MG	5	PA; MO; QL (60 per 30 days)
<i>oxymorphone oral tablet 10 mg</i>	2	MO; QL (360 per 30 days)
<i>oxymorphone oral tablet 5 mg</i>	2	MO; QL (180 per 30 days)
<i>oxymorphone oral tablet extended release 12 hr 10 mg, 15 mg, 20 mg, 30 mg, 5 mg, 7.5 mg</i>	2	PA; MO; QL (90 per 30 days)
<i>oxymorphone oral tablet extended release 12 hr 40 mg</i>	5	PA; MO; QL (90 per 30 days)
PERCOCET	4	MO; QL (360 per 30 days)
PROLATE ORAL SOLUTION	5	MO; QL (2000 per 30 days)
<i>prolate oral tablet</i>	2	MO; QL (390 per 30 days)
ROXICODONE ORAL TABLET 15 MG, 30 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ROXYBOND ORAL TABLET, ORAL ONLY 15 MG, 30 MG	4	MO; QL (180 per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 5 MG	4	MO; QL (360 per 30 days)
SEGLENTIS	4	ST; MO; QL (120 per 30 days)
SUBLOCADE	5	MO
TREZIX	4	QL (300 per 30 days)
XTAMPZA ER	4	PA; MO; QL (90 per 30 days)

NON-NARCOTIC ANALGESICS

ARTHROTEC 50	4	ST; MO
ARTHROTEC 75	4	ST; MO
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	2	MO; QL (60 per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	2	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	2	MO; QL (90 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	2	MO; QL (360 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	2	MO; QL (90 per 30 days)
<i>butorphanol nasal</i>	4	MO; QL (10 per 28 days)
CAMBIA	4	ST; MO; QL (9 per 30 days)
CELEBREX	4	MO
<i>celecoxib</i>	2	MO
CONZIP	4	PA; MO; QL (30 per 30 days)
DAYPRO	4	ST; MO
DICLOFENAC EPOLAMINE	4	PA; QL (60 per 30 days)
<i>diclofenac potassium oral capsule</i>	2	MO
<i>diclofenac potassium oral powder in packet</i>	2	MO; QL (9 per 30 days)
<i>diclofenac potassium oral tablet 25 mg</i>	5	MO
<i>diclofenac potassium oral tablet 50 mg</i>	2	MO
<i>diclofenac sodium oral</i>	2	MO
<i>diclofenac sodium topical drops</i>	2	MO; QL (300 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>diclofenac sodium topical solution in metered-dose pump</i>	5	MO; QL (224 per 28 days)
<i>diclofenac-misoprostol</i>	4	MO
<i>diflunisal</i>	2	MO
<i>etodolac oral capsule</i>	2	MO
<i>etodolac oral tablet</i>	2	MO
<i>etodolac oral tablet extended release 24 hr</i>	4	MO
<i>fenoprofen oral tablet</i>	2	
FLECTOR	4	PA; MO; QL (60 per 30 days)
<i>flurbiprofen oral tablet 100 mg</i>	2	MO
<i>ibu oral tablet 600 mg, 800 mg</i>	1	MO
<i>ibuprofen oral suspension</i>	2	MO
<i>ibuprofen oral tablet 400 mg, 800 mg</i>	1	MO
<i>ibuprofen oral tablet 600 mg</i>	1	
<i>ibuprofen-famotidine</i>	2	MO
INDOCIN RECTAL	5	MO
<i>indomethacin rectal suppository 50 mg</i>	5	MO

Drug Name	Drug Tier	Requirements/Limits
<i>ketoprofen oral capsule 25 mg, 50 mg</i>	2	
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	2	MO
KLOXXADO	4	MO
LICART	4	PA; MO; QL (30 per 30 days)
LODINE ORAL TABLET	4	ST
<i>lofena</i>	5	MO
LUCEMYRA	5	PA; MO
<i>meclofenamate</i>	2	MO
<i>mefenamic acid</i>	2	MO
<i>meloxicam oral tablet</i>	1	MO; QL (30 per 30 days)
<i>meloxicam submicronized</i>	2	MO; QL (30 per 30 days)
<i>nabumetone</i>	2	MO
NALFON ORAL TABLET	4	ST; MO
<i>naloxone injection solution</i>	2	MO
<i>naloxone injection syringe</i>	2	MO
<i>naloxone nasal</i>	2	MO
<i>naltrexone</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 375 MG, 750 MG	4	ST; MO
NAPRELAN CR ORAL TABLET, ER MULTIPHASE 24 HR 500 MG	4	ST
NAPROSYN ORAL SUSPENSION	5	ST
<i>naproxen oral suspension</i>	2	MO
<i>naproxen oral tablet</i>	1	MO
<i>naproxen oral tablet, delayed release (drlec) 375 mg</i>	2	MO
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	2	MO
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	2	MO
<i>naproxen-esomeprazole</i>	5	MO
NUCYNTA ER	4	PA; MO; QL (60 per 30 days)
NUCYNTA ORAL TABLET 100 MG	4	MO; QL (181 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
NUCYNTA ORAL TABLET 50 MG	4	MO; QL (362 per 30 days)
NUCYNTA ORAL TABLET 75 MG	4	MO; QL (242 per 30 days)
OPVEE	4	
<i>oxaprozin oral tablet</i>	4	MO
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	5	ST; QL (224 per 28 days)
<i>piroxicam</i>	2	MO
QDOLO	5	QL (2400 per 30 days)
RELAFEN DS	5	ST; MO
SPRIX	5	ST
SUBOXONE SUBLINGUAL FILM 12-3 MG	4	MO; QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	4	MO; QL (360 per 30 days)
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	4	MO; QL (90 per 30 days)
<i>sulindac</i>	2	MO
TOLECTIN 600	5	ST
<i>tolmetin oral capsule</i>	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TRAMADOL ORAL CAPSULE, ER BIPHASE 24 HR 17-83	4	PA; MO; QL (30 per 30 days)
TRAMADOL ORAL CAPSULE, ER BIPHASE 24 HR 25-75 100 MG, 200 MG	4	PA; MO; QL (30 per 30 days)
TRAMADOL ORAL SOLUTION	4	MO; QL (2400 per 30 days)
TRAMADOL ORAL TABLET 100 MG, 25 MG	4	MO; QL (120 per 30 days)
<i>tramadol oral tablet 50 mg</i>	2	MO; QL (240 per 30 days)
<i>tramadol oral tablet extended release 24 hr</i>	2	PA; MO; QL (30 per 30 days)
<i>tramadol oral tablet, er multiphase 24 hr</i>	2	PA; QL (30 per 30 days)
<i>tramadol-acetaminophen</i>	2	MO; QL (240 per 30 days)
VIMOVO	5	ST; MO
VIVITROL	5	MO
ZIMHI	4	
ZIPSOR	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
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	3	MO; QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	3	MO; QL (60 per 30 days)
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING 720 MG/2.4 ML	5	MO; QL (2.4 per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING 960 MG/3.2 ML	5	MO; QL (3.2 per 56 days)
ABILIFY MAINTENA	5	MO; QL (1 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 15 MG, 2 MG, 20 MG, 30 MG, 5 MG	5	PA; QL (30 per 30 days)
ABILIFY MYCITE STARTER KIT ORAL TABLET WITH SENSOR, STRIP, POD 10 MG	5	PA; QL (30 per 30 days)
ABILIFY ORAL TABLET 10 MG, 15 MG, 30 MG, 5 MG	4	QL (30 per 30 days)
ABILIFY ORAL TABLET 2 MG, 20 MG	4	MO; QL (30 per 30 days)
ADDERALL ORAL TABLET 20 MG, 5 MG, 7.5 MG	4	MO
ADDERALL XR	4	ST; MO
ADZENYS XR-ODT	4	ST; MO
AMBIEN	4	MO; QL (30 per 30 days)
AMBIEN CR	4	MO; QL (30 per 30 days)
<i>amitriptyline</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>amoxapine</i>	2	MO
<i>amphetamine sulfate</i>	2	PA; MO
ANAFRANIL	4	MO
APLENZIN	5	MO; QL (30 per 30 days)
APTENSIO XR	4	ST; MO
<i>aripiprazole oral solution</i>	4	MO
<i>aripiprazole oral tablet</i>	2	MO; QL (30 per 30 days)
<i>aripiprazole oral tablet, disintegrating</i>	4	MO; QL (60 per 30 days)
ARISTADA INITIO	5	MO; QL (4.8 per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML	5	MO; QL (3.9 per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 441 MG/1.6 ML	5	MO; QL (1.6 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 662 MG/2.4 ML	5	MO; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 882 MG/3.2 ML	5	MO; QL (3.2 per 28 days)
<i>armodafinil</i>	4	PA; MO; QL (30 per 30 days)
<i>asenapine maleate</i>	4	MO; QL (60 per 30 days)
ATIVAN ORAL TABLET 0.5 MG, 1 MG	4	PA; MO; QL (90 per 30 days)
ATIVAN ORAL TABLET 2 MG	4	PA; MO; QL (150 per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	4	MO; QL (60 per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	4	MO; QL (30 per 30 days)
AUVELITY	5	ST; MO; QL (60 per 30 days)
AZSTARYS	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
BELSOMRA	4	PA; MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet</i>	2	MO
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	2	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	2	MO; QL (30 per 30 days)
BUPROPION HCL ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	4	MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	2	MO; QL (60 per 30 days)
<i>bupirone</i>	2	MO
CAPLYTA	4	MO; QL (30 per 30 days)
CELEXA ORAL TABLET	4	MO; QL (30 per 30 days)
<i>chlorpromazine oral</i>	4	MO
CITALOPRAM ORAL CAPSULE	4	MO; QL (30 per 30 days)
<i>citalopram oral solution</i>	2	MO
<i>citalopram oral tablet</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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>clomipramine</i>	4	MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	4	MO
<i>clorazepate dipotassium oral tablet 15 mg</i>	2	PA; MO; QL (180 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	2	PA; MO; QL (90 per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	2	PA; MO; QL (360 per 30 days)
<i>clozapine oral tablet</i>	2	
<i>clozapine oral tablet, disintegrating</i>	4	
CLOZARIL ORAL TABLET 100 MG	5	
CLOZARIL ORAL TABLET 200 MG, 25 MG, 50 MG	4	
CONCERTA	4	ST; MO
COTEMPLA XR-ODT	4	ST; MO
CYMBALTA	4	MO; QL (60 per 30 days)
DAYTRANA	4	ST; MO
DAYVIGO	4	PA; MO; QL (30 per 30 days)
<i>desipramine</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	4	MO; QL (120 per 30 days)
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	4	MO; QL (30 per 30 days)
<i>desvenlafaxine succinate</i>	2	MO; QL (30 per 30 days)
DEXEDRINE SPANSULE ORAL CAPSULE, EXTENDED RELEASE 10 MG	4	ST; MO
<i>dexmethylphenidate</i>	2	MO
<i>dextroamphetamine sulfate oral capsule, extended release</i>	2	MO
<i>dextroamphetamine sulfate oral solution</i>	2	MO
<i>dextroamphetamine sulfate oral tablet 10 mg, 15 mg, 20 mg, 30 mg, 5 mg</i>	2	MO
<i>dextroamphetamine -amphetamine oral capsule, er triphasic 24 hr</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>dextroamphetamine-amphetamine oral capsule, extended release 24hr</i>	4	MO
<i>dextroamphetamine-amphetamine oral tablet</i>	2	MO
<i>diazepam intensol</i>	2	PA; MO; QL (240 per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	2	PA; MO; QL (1200 per 30 days)
<i>diazepam oral tablet</i>	2	PA; MO; QL (120 per 30 days)
<i>doxepin oral capsule</i>	4	MO
<i>doxepin oral concentrate</i>	4	MO
<i>doxepin oral tablet</i>	2	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	4	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	4	MO; QL (90 per 30 days)
<i>duloxetine oral capsule, delayed release(drlec) 20 mg, 30 mg, 60 mg</i>	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>duloxetine oral capsule, delayed release(drlec) 40 mg</i>	2	MO; QL (90 per 30 days)
DYANAVEL XR	4	ST; MO
EFFEXOR XR ORAL CAPSULE, EXTENDED RELEASE 24HR 150 MG, 37.5 MG	4	MO; QL (30 per 30 days)
EFFEXOR XR ORAL CAPSULE, EXTENDED RELEASE 24HR 75 MG	4	MO; QL (90 per 30 days)
EMSAM	5	MO
<i>ergoloid</i>	2	
<i>escitalopram oxalate oral solution</i>	2	MO
<i>escitalopram oxalate oral tablet</i>	1	MO; QL (30 per 30 days)
<i>eszopiclone</i>	4	MO; QL (30 per 30 days)
EVEKEO	4	PA; MO
FANAPT ORAL TABLET	4	ST; MO; QL (60 per 30 days)
FANAPT ORAL TABLETS, DOSE PACK	4	ST; MO; QL (8 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)-40 MG (26)	3	MO; QL (28 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	3	MO; QL (30 per 30 days)
<i>fluoxetine (pmdd) oral tablet 10 mg</i>	2	QL (240 per 30 days)
<i>fluoxetine (pmdd) oral tablet 20 mg</i>	2	QL (120 per 30 days)
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 20 mg</i>	1	MO; QL (90 per 30 days)
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluoxetine oral capsule, delayed release(drlec)</i>	2	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	2	MO
<i>fluoxetine oral tablet 10 mg</i>	2	MO; QL (240 per 30 days)
<i>fluoxetine oral tablet 20 mg</i>	2	MO; QL (120 per 30 days)
<i>fluoxetine oral tablet 60 mg</i>	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>fluphenazine decanoate</i>	4	MO
<i>fluphenazine hcl</i>	4	MO
<i>fluvoxamine oral capsule, extended release 24hr</i>	2	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 100 mg</i>	2	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	2	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	2	MO; QL (60 per 30 days)
FOCALIN	4	MO
FOCALIN XR	4	ST; MO
FORFIVO XL	4	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	4	MO
GEODON ORAL CAPSULE 20 MG	4	MO; QL (60 per 30 days)
GEODON ORAL CAPSULE 40 MG, 60 MG, 80 MG	5	MO; QL (60 per 30 days)
HALDOL DECANOATE INTRAMUSCULAR SOLUTION 100 MG/ML	4	MO
<i>haloperidol</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>haloperidol decanoate intramuscular solution 100 mg/ml (1 ml)</i>	4	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml, 50 mg/ml (1ml)</i>	4	MO
<i>haloperidol lactate injection</i>	4	MO
<i>haloperidol lactate oral</i>	2	MO
HETLIOZ	5	PA; MO; QL (30 per 30 days)
HETLIOZ LQ	5	PA; MO; QL (158 per 30 days)
<i>imipramine hcl oral tablet 10 mg, 25 mg</i>	4	MO
<i>imipramine hcl oral tablet 50 mg</i>	2	MO
<i>imipramine pamoate</i>	2	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	5	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	5	MO; QL (5 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 3 MG, 9 MG	4	MO; QL (30 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	4	MO; QL (60 per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	5	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	5	MO; QL (1 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	5	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	5	MO; QL (0.5 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	5	MO; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	5	MO; QL (1.32 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	5	MO; QL (1.75 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	5	MO; QL (2.63 per 90 days)
JORNAY PM	4	ST; MO
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	5	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	5	MO; QL (60 per 30 days)
LEXAPRO ORAL TABLET	4	MO; QL (30 per 30 days)
<i>lisdexamfetamine</i>	2	MO
<i>lithium carbonate</i>	2	MO
<i>lithium citrate</i>	2	
LITHOBID	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>lorazepam intensol</i>	2	PA; QL (150 per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	2	PA; MO; QL (90 per 30 days)
<i>lorazepam oral tablet 2 mg</i>	2	PA; MO; QL (150 per 30 days)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 1 MG, 1.5 MG	4	PA; MO; QL (30 per 30 days)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 2 MG	4	PA; MO; QL (150 per 30 days)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 3 MG	4	PA; MO; QL (90 per 30 days)
<i>loxapine succinate</i>	2	MO
LUMRYZ	5	PA; MO; QL (30 per 30 days)
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	4	MO; QL (30 per 30 days)
<i>lurasidone oral tablet 80 mg</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
LYBALVI	5	ST; MO; QL (30 per 30 days)
MARPLAN	4	MO
METADATE CD	4	ST
<i>methamphetamine</i>	2	PA; MO
METHYLIN ORAL SOLUTION	4	MO
<i>methylphenidate</i>	2	MO
<i>methylphenidate hcl oral cap,er sprinkle,biphasic 40-60</i>	2	MO
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	2	MO
<i>methylphenidate hcl oral capsule,er biphasic 50-50</i>	4	MO
<i>methylphenidate hcl oral solution</i>	4	MO
<i>methylphenidate hcl oral tablet</i>	2	MO
<i>methylphenidate hcl oral tablet extended release</i>	4	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>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	2	MO
METHYLPHENIDATE HCL ORAL TABLET EXTENDED RELEASE 24HR 45 MG, 63 MG, 72 MG	4	ST; MO
<i>methylphenidate hcl oral tablet,chewable</i>	4	MO
<i>mirtazapine</i>	2	MO
<i>modafinil oral tablet 100 mg</i>	2	PA; MO; QL (30 per 30 days)
<i>modafinil oral tablet 200 mg</i>	2	PA; MO; QL (60 per 30 days)
<i>molindone oral tablet 10 mg, 25 mg</i>	4	
<i>molindone oral tablet 5 mg</i>	4	MO
MYDAYIS	4	ST; MO
NARDIL	4	MO
<i>nefazodone</i>	4	MO
NORPRAMIN ORAL TABLET 10 MG, 25 MG	4	
<i>nortriptyline oral capsule</i>	2	MO
<i>nortriptyline oral solution</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NUPLAZID	4	PA; MO; QL (30 per 30 days)
NUVIGIL	4	PA; MO; QL (30 per 30 days)
<i>olanzapine intramuscular</i>	4	MO
<i>olanzapine oral tablet</i>	2	MO; QL (30 per 30 days)
<i>olanzapine oral tablet, disintegrating</i>	4	MO; QL (30 per 30 days)
<i>olanzapine-fluoxetine</i>	2	MO
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg</i>	4	MO; QL (30 per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	4	MO; QL (60 per 30 days)
PAMELOR	4	MO
PARNATE	4	MO
<i>paroxetine hcl oral suspension</i>	4	MO
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	2	MO; QL (30 per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	2	MO; QL (60 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr</i>	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>paroxetine mesylate (menop. sym)</i>	2	MO; QL (30 per 30 days)
PAXIL CR	4	MO; QL (60 per 30 days)
PAXIL ORAL TABLET 10 MG, 20 MG, 40 MG	4	MO; QL (30 per 30 days)
PAXIL ORAL TABLET 30 MG	4	MO; QL (60 per 30 days)
<i>perphenazine</i>	4	MO
PERSERIS	5	ST; MO; QL (1 per 30 days)
<i>phenelzine</i>	2	MO
<i>pimozide</i>	4	MO
PRISTIQ	4	MO; QL (30 per 30 days)
<i>procentra</i>	2	MO
<i>protriptyline</i>	4	MO
PROVIGIL ORAL TABLET 100 MG	5	PA; MO; QL (30 per 30 days)
PROVIGIL ORAL TABLET 200 MG	5	PA; MO; QL (60 per 30 days)
PROZAC ORAL CAPSULE 10 MG	4	MO; QL (30 per 30 days)
PROZAC ORAL CAPSULE 20 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
PROZAC ORAL CAPSULE 40 MG	4	MO; QL (60 per 30 days)
QELBREE ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 150 MG	4	ST; MO; QL (30 per 30 days)
QELBREE ORAL CAPSULE, EXTENDED RELEASE 24HR 200 MG	4	ST; MO; QL (60 per 30 days)
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	2	MO; QL (90 per 30 days)
QUETIAPINE ORAL TABLET 150 MG	4	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	2	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	2	MO; QL (30 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	2	MO; QL (60 per 30 days)
QUILLICHEWER	4	ST; MO
QUILLIVANT XR	4	ST; MO
QUVIVIQ	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>ramelteon</i>	2	MO; QL (30 per 30 days)
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 18 MG, 27 MG, 36 MG	4	ST
RELEXXII ORAL TABLET EXTENDED RELEASE 24HR 45 MG, 63 MG	4	ST; MO
REMERON ORAL TABLET 15 MG, 30 MG	4	MO
REMERON SOLTAB	4	MO
REXULTI ORAL TABLET	4	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE RECON 12.5 MG/2 ML, 25 MG/2 ML	4	MO; QL (2 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	5	MO; QL (2 per 28 days)
RISPERDAL ORAL SOLUTION	4	MO
RISPERDAL ORAL TABLET 0.5 MG, 1 MG, 2 MG, 3 MG	4	MO; QL (60 per 30 days)
RISPERDAL ORAL TABLET 4 MG	4	MO; QL (120 per 30 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 12.5 mg/2 ml, 25 mg/2 ml</i>	2	MO; QL (2 per 28 days)
<i>risperidone microspheres intramuscular suspension,extended rel recon 37.5 mg/2 ml, 50 mg/2 ml</i>	5	MO; QL (2 per 28 days)
<i>risperidone oral solution</i>	2	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)

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)
<i>risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	4	MO; QL (60 per 30 days)
<i>risperidone oral tablet,disintegrating 4 mg</i>	4	MO; QL (120 per 30 days)
RITALIN	4	MO
RITALIN LA	4	ST; MO
ROZEREM	4	MO; QL (30 per 30 days)
SAPHRIS	4	MO; QL (60 per 30 days)
SECUADO	5	MO; QL (30 per 30 days)
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG	4	MO; QL (90 per 30 days)
SEROQUEL ORAL TABLET 300 MG, 400 MG	4	MO; QL (60 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 400 MG, 50 MG	4	MO; QL (60 per 30 days)
SERTRALINE ORAL CAPSULE	4	MO; QL (30 per 30 days)
<i>sertraline oral concentrate</i>	4	MO
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
SILENOR	4	MO; QL (30 per 30 days)
SODIUM OXYBATE (PREFERRED NDCS STARTING WITH 00054)	5	PA; LA; QL (540 per 30 days)
STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG	4	ST; MO; QL (60 per 30 days)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG	4	ST; MO; QL (30 per 30 days)
SUNOSI	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SYMBYAX ORAL CAPSULE 3-25 MG	4	
SYMBYAX ORAL CAPSULE 6-25 MG	4	MO
<i>tasimelteon</i>	5	PA; MO; QL (30 per 30 days)
<i>thioridazine</i>	2	MO
<i>thiothixene</i>	2	MO
<i>tranlycypromine</i>	4	MO
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	2	MO
<i>trimipramine</i>	4	MO
TRINTELLIX	3	MO; QL (30 per 30 days)
UZEDY SUBCUTANEOU S SUSPENSION,EX TENDED REL SYRING 100 MG/0.28 ML	5	MO; QL (0.28 per 28 days)
UZEDY SUBCUTANEOU S SUSPENSION,EX TENDED REL SYRING 125 MG/0.35 ML	5	MO; QL (0.35 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 150 MG/0.42 ML	5	MO; QL (0.42 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 200 MG/0.56 ML	5	MO; QL (0.56 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 250 MG/0.7 ML	5	MO; QL (0.7 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 50 MG/0.14 ML	5	MO; QL (0.14 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 75 MG/0.21 ML	5	MO; QL (0.21 per 28 days)
VENLAFAXINE BESYLATE	4	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	2	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	2	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet</i>	2	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet extended release 24hr</i>	2	MO; QL (30 per 30 days)
VERSACLOZ	5	
VIIBRYD ORAL TABLET	4	MO; QL (30 per 30 days)
<i>vilazodone</i>	2	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	4	MO; QL (30 per 30 days)
VYVANSE	4	ST; MO
WAKIX	5	PA; MO; LA; QL (60 per 30 days)
WELLBUTRIN SR	4	MO; QL (60 per 30 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	4	MO; QL (30 per 30 days)
XELSTRYM	4	ST; MO
XYREM	5	PA; LA; QL (540 per 30 days)
XYWAV	5	PA; LA; QL (540 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	4	MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 mg</i>	4	MO; QL (30 per 30 days)
<i>zenzedi oral tablet 10 mg, 5 mg</i>	2	MO
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	4	MO
<i>ziprasidone hcl</i>	2	MO; QL (60 per 30 days)
<i>ziprasidone mesylate</i>	4	MO
ZOLOFT ORAL CONCENTRATE	4	MO
ZOLOFT ORAL TABLET 100 MG, 50 MG	4	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ZOLOFT ORAL TABLET 25 MG	4	MO; QL (30 per 30 days)
<i>zolpidem oral tablet</i>	2	MO; QL (30 per 30 days)
<i>zolpidem oral tablet, ext release multiphase</i>	2	MO; QL (30 per 30 days)
ZURZUVAE ORAL CAPSULE 20 MG, 25 MG	5	PA; MO; QL (28 per 365 days)
ZURZUVAE ORAL CAPSULE 30 MG	5	PA; MO; QL (14 per 365 days)
ZYPREXA INTRAMUSCULAR	4	MO
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	4	MO; QL (30 per 30 days)
ZYPREXA ORAL TABLET 15 MG, 20 MG	5	MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	4	MO; QL (2 per 28 days)
ZYPREXA ZYDIS ORAL TABLET, DISINTEGRATING 10 MG, 5 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA ZYDIS ORAL TABLET, DISINTEGRATING 15 MG, 20 MG	5	MO; QL (30 per 30 days)

CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

<i>amiodarone oral tablet 100 mg, 200 mg</i>	2	MO
<i>amiodarone oral tablet 400 mg</i>	2	
BETAPACE AF	4	MO
<i>dofetilide</i>	4	MO
<i>flecainide</i>	2	MO
<i>mexiletine</i>	2	MO
MULTAQ	3	MO
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	2	MO
<i>propafenone oral capsule, extended release 12 hr</i>	4	MO
<i>propafenone oral tablet</i>	2	MO
<i>quinidine gluconate oral</i>	2	MO
<i>quinidine sulfate oral tablet</i>	2	MO
RYTHMOL SR	4	

Drug Name	Drug Tier	Requirements/Limits
<i>sotalol af</i>	2	
<i>sotalol oral</i>	2	MO
SOTYLIZE	4	MO
TIKOSYN	4	MO

ANTI-HYPERTENSIVE THERAPY

<i>acebutolol</i>	2	MO
ALDACTONE	4	MO
<i>aliskiren</i>	4	MO
ALTACE ORAL CAPSULE 1.25 MG, 10 MG, 2.5 MG	4	MO
ALTACE ORAL CAPSULE 5 MG	4	
<i>amiloride</i>	2	MO
<i>amiloride-hydrochlorothiazide</i>	2	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthid</i>	2	MO
ATACAND	4	ST; MO
ATACAND HCT	4	ST; MO
<i>atenolol</i>	1	MO
<i>atenolol-chlorthalidone</i>	1	MO
AVALIDE	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
AVAPRO	4	ST; MO
AZOR	4	ST; MO
<i>benazepril</i>	1	MO
<i>benazepril-hydrochlorothiazide</i>	1	MO
BENICAR	4	ST; MO
BENICAR HCT	4	ST; MO
<i>betaxolol oral</i>	2	MO
BIDIL	4	MO; QL (180 per 30 days)
<i>bisoprolol fumarate</i>	2	MO
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide injection</i>	4	MO
<i>bumetanide oral</i>	2	MO
BYSTOLIC ORAL TABLET 10 MG	4	
BYSTOLIC ORAL TABLET 2.5 MG, 20 MG, 5 MG	4	MO
<i>candesartan</i>	1	MO
<i>candesartan-hydrochlorothiazid</i>	2	MO
<i>captopril</i>	1	MO
CARDIZEM CD	4	MO
CARDIZEM LA	4	MO
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	4	MO

Drug Name	Drug Tier	Requirements/Limits
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG	4	MO; QL (30 per 30 days)
CARDURA ORAL TABLET 8 MG	4	MO; QL (60 per 30 days)
CARDURA XL	4	MO; QL (30 per 30 days)
CAROSPIR	4	MO
<i>cartia xt</i>	2	MO
<i>carvedilol</i>	1	MO
<i>carvedilol phosphate</i>	2	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	2	MO
<i>clonidine</i>	4	MO; QL (4 per 28 days)
<i>clonidine hcl oral tablet</i>	1	MO
CLONIDINE HCL ORAL TABLET EXTENDED RELEASE 24 HR	5	MO
COZAAR	4	ST; MO
DEMSEER	5	PA; MO
DIBENZYLINE	5	PA; MO
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	2	MO
<i>diltiazem hcl oral capsule, extended release 24 hr 360 mg, 420 mg</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg</i>	2	
<i>diltiazem hcl oral capsule, extended release 24hr 180 mg, 240 mg, 300 mg</i>	2	MO
<i>diltiazem hcl oral tablet</i>	2	MO
<i>diltiazem hcl oral tablet extended release 24 hr</i>	2	MO
<i>dilt-xr</i>	2	MO
DIOVAN	4	ST; MO
DIOVAN HCT	4	ST; MO
DIURIL	4	MO
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	2	MO; QL (30 per 30 days)
<i>doxazosin oral tablet 8 mg</i>	2	MO; QL (60 per 30 days)
DYRENIUM	4	MO
EDARBI	3	MO
EDARBYCLOR	3	MO
EDECIN	4	MO
<i>enalapril maleate oral solution</i>	2	MO
<i>enalapril maleate oral tablet</i>	1	MO
<i>enalapril-hydrochlorothiazide oral tablet 5-12.5 mg</i>	1	MO
<i>eplerenone</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>ethacrynic acid</i>	2	MO
EXFORGE	4	ST; MO
EXFORGE HCT	4	ST; MO
<i>felodipine</i>	2	MO
<i>fosinopril</i>	1	MO
<i>fosinopril-hydrochlorothiazide</i>	1	MO
FUROSIX	5	ST
<i>furosemide injection solution</i>	4	MO
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	2	MO
<i>furosemide oral tablet</i>	1	MO
<i>hydralazine oral</i>	2	MO
<i>hydrochlorothiazide</i>	1	MO
HYZAAR	4	ST; MO
<i>indapamide</i>	1	MO
INDERAL LA	4	MO
INNOPRAN XL	4	MO
INSPIRA	4	MO
<i>irbesartan</i>	1	MO
<i>irbesartan-hydrochlorothiazide</i>	1	MO
<i>isosorbide-hydralazine</i>	2	MO; QL (180 per 30 days)
<i>isradipine</i>	2	MO
KAPSPARGO SPRINKLE	4	MO
KATERZIA	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
KERENDIA	3	PA; QL (30 per 30 days)
<i>labetalol oral</i>	2	MO
LASIX ORAL TABLET 20 MG, 40 MG	4	MO
LASIX ORAL TABLET 80 MG	4	
<i>lisinopril</i>	1	MO
<i>lisinopril-hydrochlorothiazide</i>	1	MO
LOPRESSOR ORAL	4	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	4	
LOTREL	4	MO
<i>matzim la</i>	2	MO
<i>metolazone</i>	2	MO
<i>metoprolol succinate</i>	1	MO
<i>metoprolol tartrate hydrochlorothiazide</i>	2	MO
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	MO
<i>metoprolol tartrate oral tablet 37.5 mg, 75 mg</i>	2	MO
<i>metirosine</i>	5	PA; MO
MICARDIS HCT	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
<i>minoxidil oral</i>	2	MO
<i>moexipril oral tablet 15 mg</i>	1	
<i>moexipril oral tablet 7.5 mg</i>	1	MO
<i>nadolol</i>	4	MO
<i>nebivolol</i>	2	MO
NEXICLON XR	5	
<i>nicardipine oral</i>	4	MO
<i>nifedipine oral tablet extended release</i>	2	MO
<i>nifedipine oral tablet extended release 24hr</i>	2	MO
<i>nimodipine</i>	4	MO
<i>nisoldipine</i>	2	MO
NORLIQVA	4	MO
NORVASC	4	MO
NYMALIZE ORAL SYRINGE 60 MG/10 ML	5	
<i>olmesartan</i>	1	MO
<i>olmesartan-amlodipin-hcthiacid</i>	2	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO
ORENITRAM MONTH 1 TITRATION KT	5	PA; MO; QL (168 per 180 days)
ORENITRAM MONTH 2 TITRATION KT	5	PA; MO; QL (336 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM MONTH 3 TITRATION KT	5	PA; MO; QL (252 per 180 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	4	PA; MO; QL (90 per 30 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG	5	PA; MO; QL (90 per 30 days)
ORENITRAM ORAL TABLET EXTENDED RELEASE 5 MG	5	PA; MO; QL (720 per 30 days)
<i>perindopril erbumine</i>	1	MO
<i>phenoxybenzamine</i>	5	PA; MO
<i>pindolol</i>	2	MO
<i>prazosin</i>	2	MO
PROCARDIA XL	4	MO
<i>propranolol oral capsule, extended release 24 hr</i>	2	MO
<i>propranolol oral solution</i>	2	MO
<i>propranolol oral tablet</i>	1	MO
QBRELIS	4	MO
<i>quinapril</i>	1	
<i>ramipril</i>	1	MO
SOAANZ	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
<i>spironolactone oral suspension</i>	2	MO
<i>spironolactone oral tablet</i>	1	MO
<i>spironolactone-hydrochlorothiaz</i>	2	MO
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	4	MO
TEKTURNA	4	MO
<i>telmisartan</i>	1	MO
<i>telmisartan-amlodipine</i>	2	MO
<i>telmisartan-hydrochlorothiazid</i>	2	MO
TENORETIC 100	4	MO
TENORETIC 50	4	MO
TENORMIN	4	MO
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
THALITONE	4	MO
<i>tiadylt er</i>	2	MO
THIAZAC	4	MO
<i>timolol maleate oral</i>	4	MO
TOPROL XL	4	MO
<i>toremide oral</i>	2	MO
<i>trandolapril</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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>trandolapril-verapamil</i>	2	MO
<i>treprostinil sodium</i>	5	PA; MO
<i>triamterene</i>	2	MO
<i>triamterene-hydrochlorothiazid</i>	1	MO
TRIBENZOR	4	ST; MO
UPTRAVI ORAL TABLET	5	PA; MO; LA; QL (60 per 30 days)
UPTRAVI ORAL TABLETS,DOSE PACK	5	PA; MO; LA; QL (200 per 180 days)
VALSARTAN ORAL SOLUTION	5	ST; MO
<i>valsartan oral tablet</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
VASERETIC	4	MO
VASOTEC	4	MO
<i>verapamil oral capsule, 24 hr er pellet ct</i>	2	MO
<i>verapamil oral capsule,ext rel. pellets 24 hr</i>	2	MO
<i>verapamil oral tablet</i>	1	MO
<i>verapamil oral tablet extended release</i>	2	MO
VERELAN	4	
VERELAN PM	4	MO

Drug Name	Drug Tier	Requirements/Limits
ZESTORETIC	4	MO
ZESTRIL	4	MO
COAGULATION THERAPY		
ALVAIZ	5	PA; MO
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	5	MO
ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	4	MO
<i>aspirin-dipyridamole</i>	4	MO
BRILINTA	3	MO
CABLIVI INJECTION KIT	5	PA; LA
<i>cilostazol</i>	2	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
<i>dabigatran etexilate</i>	4	MO; QL (60 per 30 days)
<i>dipyridamole oral</i>	4	MO
DOPTelet (10 TAB PACK)	5	PA; MO; LA
DOPTelet (15 TAB PACK)	5	PA; MO; LA
DOPTelet (30 TAB PACK)	5	PA; MO; LA
EFFIENT	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ELIQUIS	3	MO; QL (60 per 30 days)
ELIQUIS DVT-PE TREAT 30D START	3	MO; QL (74 per 180 days)
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	4	MO; QL (28 per 28 days)
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	4	MO; QL (22.4 per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	4	MO; QL (16.8 per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	4	MO; QL (11.2 per 28 days)
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	5	MO
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	4	MO
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	5	MO

FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI-XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	5	MO
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI-XA UNIT/0.2 ML	4	MO
<i>heparin (porcine) injection solution</i>	2	MO
<i>jantoven</i>	1	MO
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML, 150 MG/ML	4	MO; QL (28 per 28 days)
LOVENOX SUBCUTANEOUS SYRINGE 120 MG/0.8 ML, 80 MG/0.8 ML	4	MO; QL (22.4 per 28 days)
LOVENOX SUBCUTANEOUS SYRINGE 30 MG/0.3 ML, 60 MG/0.6 ML	4	MO; QL (16.8 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
LOVENOX SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	4	MO; QL (11.2 per 28 days)
MULPLETA	5	PA; MO
<i>pentoxifylline</i>	2	MO
PLAVIX ORAL TABLET 75 MG	4	MO; QL (30 per 30 days)
PRADAXA ORAL CAPSULE	4	PA; MO; QL (60 per 30 days)
PRADAXA ORAL PELLETS IN PACKET 110 MG, 30 MG, 40 MG, 50 MG	5	PA; QL (120 per 30 days)
PRADAXA ORAL PELLETS IN PACKET 150 MG, 20 MG	5	PA; QL (60 per 30 days)
<i>prasugrel</i>	2	MO
PROMACTA	5	PA; MO; LA
SAVAYSA	4	PA; MO; QL (30 per 30 days)
TAVALISSE	5	PA; LA; QL (60 per 30 days)
<i>warfarin</i>	1	MO
XARELTO DVT-PE TREAT 30D START	3	MO; QL (51 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	3	MO; QL (775 per 28 days)
XARELTO ORAL TABLET 10 MG, 15 MG, 20 MG	3	MO; QL (30 per 30 days)
XARELTO ORAL TABLET 2.5 MG	3	MO; QL (60 per 30 days)
LIPID/CHOLESTEROL LOWERING AGENTS		
ALTOPREV	5	ST; MO; QL (30 per 30 days)
<i>amlodipine-atorvastatin</i>	2	MO; QL (30 per 30 days)
ATORVALIQ	4	ST; MO; QL (600 per 30 days)
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)
CADUET	4	ST; MO; QL (30 per 30 days)
<i>cholestyramine (with sugar) oral powder in packet</i>	2	MO
<i>cholestyramine light oral powder in packet</i>	2	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>colesevelam</i>	4	MO
COLESTID ORAL TABLET	4	
<i>colestipol oral packet</i>	4	
<i>colestipol oral tablet</i>	4	MO
CRESTOR	4	ST; MO; QL (30 per 30 days)
EZALLOR SPRINKLE	4	ST; QL (30 per 30 days)
<i>ezetimibe</i>	2	MO
<i>ezetimibe-simvastatin</i>	2	MO; QL (30 per 30 days)
<i>fenofibrate micronized oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	2	MO
<i>fenofibrate nanocrystallized</i>	2	MO
FENOFIBRATE ORAL CAPSULE	4	MO
<i>fenofibrate oral tablet</i>	2	MO
<i>fenofibric acid (choline)</i>	4	MO
FENOGLIDE	4	MO
FLOLIPID	4	ST; QL (300 per 30 days)
<i>fluvastatin oral capsule 20 mg</i>	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>fluvastatin oral capsule 40 mg</i>	2	MO; QL (60 per 30 days)
<i>fluvastatin oral tablet extended release 24 hr</i>	2	MO; QL (30 per 30 days)
<i>gemfibrozil</i>	1	MO
<i>icosapent ethyl</i>	2	MO
JUXTAPID	5	PA; MO; LA
LESCOL XL	4	ST; MO; QL (30 per 30 days)
LIPITOR	4	ST; MO; QL (30 per 30 days)
LIPOFEN	4	MO
LIVALO	4	ST; MO; QL (30 per 30 days)
LOPID	4	
<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	4	ST; MO
NEXLETOL	3	PA; MO
NEXLIZET	3	PA; MO
<i>niacin oral tablet 500 mg</i>	2	MO
<i>niacin oral tablet extended release 24 hr</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NIACOR	4	MO
<i>omega-3 acid ethyl esters</i>	2	MO
<i>pitavastatin calcium</i>	1	MO; QL (30 per 30 days)
PRALUENT PEN	4	PA; QL (2 per 28 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite oral powder in packet</i>	2	MO
QUESTRAN LIGHT	4	
QUESTRAN ORAL POWDER	4	MO
REPATHA	3	PA; QL (6 per 28 days)
REPATHA PUSHTRONEX	3	PA; QL (7 per 28 days)
REPATHA SURECLICK	3	PA; QL (6 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin</i>	1	MO; QL (30 per 30 days)
TRICOR	4	MO
TRILIPIX	4	MO
VASCEPA	4	ST; MO
VYTORIN 10-10	4	ST; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
VYTORIN 10-20	4	ST; MO; QL (30 per 30 days)
VYTORIN 10-40	4	ST; MO; QL (30 per 30 days)
VYTORIN 10-80	4	ST; MO; QL (30 per 30 days)
WELCHOL	4	MO
ZETIA	4	MO
ZOCOR ORAL TABLET 10 MG, 20 MG, 40 MG	4	ST; MO; QL (30 per 30 days)
ZYPITAMAG	4	ST; MO; QL (30 per 30 days)

MISCELLANEOUS CARDIOVASCULAR AGENTS

ASPRUZYO SPRINKLE ORAL EXTEND RELEASE GRANULES, PACKET 1,000 MG	4	MO
ASPRUZYO SPRINKLE ORAL EXTEND RELEASE GRANULES, PACKET 500 MG	4	
CAMZYOS	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CORLANOR ORAL SOLUTION	4	QL (450 per 30 days)
CORLANOR ORAL TABLET	3	MO; QL (60 per 30 days)
<i>digoxin oral</i>	2	MO
ENTRESTO	3	MO; QL (60 per 30 days)
FILSPARI	5	PA; QL (30 per 30 days)
LANOXIN ORAL	4	MO
LODOCO	4	PA; MO
<i>ranolazine</i>	2	MO
VECAMYL	5	
VERQUVO	3	MO; QL (30 per 30 days)
VYNDAMAX	5	PA; MO
VYNDAQEL	4	PA; MO
NITRATES		
ISORDIL	5	MO
ISORDIL TITRADOSE ORAL TABLET 5 MG	4	MO
<i>isosorbide dinitrate oral tablet</i>	2	MO
<i>isosorbide mononitrate</i>	1	MO
<i>nitro-bid</i>	2	MO
NITRO-DUR	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>nitroglycerin sublingual</i>	2	MO
<i>nitroglycerin transdermal patch 24 hour</i>	2	MO
<i>nitroglycerin translingual</i>	4	MO
NITROLINGUAL	4	MO
NITROSTAT	4	MO
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATICS / ANTISEBORRHOEIC		
<i>acitretin</i>	4	MO
BIMZELX	5	PA; MO; QL (2 per 21 days)
BIMZELX AUTOINJECTOR	5	PA; MO; QL (2 per 21 days)
<i>calcipotriene scalp</i>	2	MO; QL (120 per 30 days)
<i>calcipotriene topical cream</i>	4	MO; QL (120 per 30 days)
CALCIPOTRIENE TOPICAL FOAM	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>calcipotriene topical ointment</i>	4	MO; QL (120 per 30 days)
<i>calcipotriene-betamethasone</i>	2	MO; QL (400 per 30 days)
<i>calcitriol topical</i>	2	
COSENTYX (2 SYRINGES)	5	PA; MO; QL (10 per 28 days)
COSENTYX PEN (2 PENS)	5	PA; MO; QL (10 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; MO; QL (2.5 per 28 days)
COSENTYX UNOREADY PEN	5	PA; MO; QL (10 per 28 days)
ENSTILAR	5	MO; QL (400 per 30 days)
ILUMYA	5	PA; MO; QL (2 per 28 days)
<i>selenium sulfide topical lotion</i>	2	MO
SILIQ	5	PA; MO; QL (6 per 28 days)
SKYRIZI SUBCUTANEOUS PEN INJECTOR	5	PA; MO; QL (2 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	5	PA; MO; QL (2 per 28 days)
SORILUX	4	QL (120 per 30 days)
SOTYKTU	5	PA; MO; QL (30 per 30 days)
SPEVIGO SUBCUTANEOUS	5	PA; MO; QL (4 per 28 days)
STELARA INTRAVENOUS	5	PA; MO; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	5	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	5	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	5	PA; MO; QL (1 per 28 days)
TACLONEX TOPICAL SUSPENSION	5	MO; QL (400 per 30 days)
TALTZ AUTOINJECTOR	5	PA; MO; QL (1 per 28 days)
TALTZ SUBCUTANEOUS SYRINGE 80 MG/ML	5	PA; MO; QL (1 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TREMFYA	5	PA; MO; QL (2 per 28 days)
VECTICAL	4	
VTAMA	5	PA; MO; QL (60 per 30 days)
ZORYVE TOPICAL CREAM 0.3 %	4	PA; MO; QL (60 per 30 days)
ZORYVE TOPICAL FOAM	4	PA; MO; QL (60 per 30 days)
MISCELLANEOUS DERMATOLOGICALS		
ADBRY SUBCUTANEOUS AUTO-INJECTOR	5	PA; QL (6 per 28 days)
ADBRY SUBCUTANEOUS SYRINGE	5	PA; MO; QL (6 per 28 days)
<i>ammonium lactate</i>	2	MO
CARAC	5	
CIBINQO	5	PA; MO; QL (30 per 30 days)
CONDYLOX TOPICAL GEL	4	MO
<i>diclofenac sodium topical gel 3 %</i>	4	PA; MO; QL (100 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>doxepin topical</i>	2	MO; QL (45 per 30 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	5	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	5	PA; MO; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	5	PA; QL (1.34 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	5	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	5	PA; MO; QL (8 per 28 days)
EFUDEX TOPICAL CREAM	4	MO
ELIDEL	4	PA; MO; QL (100 per 30 days)
EUCRISA	4	PA; MO; QL (120 per 30 days)
FILSUEVZ	5	PA; LA
FLUOROURACIL TOPICAL CREAM 0.5 %	5	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>fluorouracil topical cream 5 %</i>	2	MO
<i>fluorouracil topical solution</i>	2	MO
HYFTOR	5	PA
<i>imiquimod topical cream in metered-dose pump</i>	2	MO
<i>imiquimod topical cream in packet 5 %</i>	2	MO
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	2	MO
<i>lidocaine topical adhesive patch, medicated 5 %</i>	4	PA; MO; QL (90 per 30 days)
<i>lidocaine topical ointment</i>	4	MO; QL (36 per 30 days)
<i>lidocaine viscous</i>	2	
<i>lidocaine-prilocaine topical cream</i>	2	MO; QL (30 per 30 days)
<i>lidocan iii</i>	4	PA; QL (90 per 30 days)
<i>methoxsalen</i>	5	MO
OPZELURA	5	PA; MO; QL (240 per 28 days)
PANRETIN	5	PA; MO
<i>pimecrolimus</i>	4	PA; MO; QL (100 per 30 days)
PLIAGLIS	4	PA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>podofilox</i>	2	MO
<i>prudoxin</i>	2	MO; QL (45 per 30 days)
REGRANEX	5	QL (15 per 30 days)
SANTYL	3	MO; QL (180 per 30 days)
SILVADENE	4	MO
<i>silver sulfadiazine</i>	2	MO
<i>ssd</i>	2	MO
<i>tacrolimus topical</i>	4	PA; MO; QL (100 per 30 days)
VALCHLOR	5	PA; MO
VEREGEN	4	MO; QL (30 per 30 days)
ZONALON	4	MO; QL (45 per 30 days)
ZTLIDO	4	PA; MO; QL (90 per 30 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	5	MO
THERAPY FOR ACNE		
ABSORICA	5	
ABSORICA LD	5	

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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ACANYA TOPICAL GEL WITH PUMP	4	MO
<i>accutane oral capsule 10 mg, 20 mg, 40 mg</i>	4	
ACZONE	4	MO
<i>adapalene topical cream</i>	2	PA; MO
<i>adapalene topical gel 0.3 %</i>	2	PA; MO
<i>adapalene topical swab</i>	2	PA
<i>adapalene-benzoyl peroxide</i>	2	MO
AKLIEF	4	PA; MO
ALTRENO	4	PA; MO
<i>amnestem</i>	4	
ARAZLO	4	PA; MO
ATRALIN	4	PA; MO
<i>azelaic acid</i>	4	MO
AZELEX	4	MO
BENZAMYCIN	4	MO
<i>brimonidine topical</i>	2	PA; MO
CABTREO	4	MO
<i>claravis</i>	4	
CLEOCIN T TOPICAL LOTION	4	MO; QL (120 per 30 days)
<i>clindacin</i>	2	QL (100 per 30 days)
<i>clindacin etz topical swab</i>	2	MO; QL (69 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
CLINDAGEL	5	QL (150 per 30 days)
<i>clindamycin phosphate topical foam</i>	2	QL (100 per 30 days)
<i>clindamycin phosphate topical gel</i>	2	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical gel, once daily</i>	2	MO; QL (150 per 30 days)
<i>clindamycin phosphate topical lotion</i>	2	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical solution</i>	2	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical swab</i>	2	MO; QL (60 per 30 days)
<i>clindamycin-benzoyl peroxide topical gel</i>	2	MO
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2 % (1 % base) -3.75 %, 1.2-2.5 %</i>	2	MO
<i>clindamycin-tretinoin</i>	2	MO
<i>dapsone topical</i>	2	MO
DIFFERIN TOPICAL CREAM	4	PA; MO
DIFFERIN TOPICAL GEL WITH PUMP	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DIFFERIN TOPICAL LOTION	4	PA; MO
EPIDUO FORTE	4	MO
EPIDUO TOPICAL GEL WITH PUMP	4	
EPSOLAY	4	ST; MO
<i>ery pads</i>	2	MO
<i>erygel</i>	2	MO
<i>erythromycin with ethanol topical gel</i>	2	MO
<i>erythromycin with ethanol topical solution</i>	2	MO
<i>erythromycin-benzoyl peroxide</i>	2	MO
FABIOR	4	PA; MO
FINACEA TOPICAL FOAM	4	ST; MO
FINACEA TOPICAL GEL	4	ST
<i>isotretinoin oral capsule 10 mg, 20 mg, 30 mg, 40 mg</i>	4	
<i>isotretinoin oral capsule 25 mg, 35 mg</i>	2	
<i>ivermectin topical cream</i>	2	MO; QL (90 per 30 days)
METROCREAM	4	ST
METROGEL TOPICAL GEL 1 %	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
METROLOTION	4	ST
<i>metronidazole topical cream</i>	4	MO
<i>metronidazole topical gel</i>	4	MO
<i>metronidazole topical lotion</i>	4	MO
MIRVASO	4	PA; MO
<i>neuac</i>	2	MO
NORITATE	5	ST; MO
ONEXTON TOPICAL GEL WITH PUMP	4	MO
RETIN-A	4	PA; MO
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 %	4	PA; MO
RETIN-A MICRO TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	4	PA; MO
SOOLANTRA	4	ST; MO; QL (90 per 30 days)
<i>tazarotene topical cream</i>	4	PA; MO
TAZAROTENE TOPICAL FOAM	4	PA
<i>tazarotene topical gel</i>	4	PA; MO
TAZORAC	4	PA; MO
<i>tretinoin microspheres topical gel</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>tretinoin microspheres topical gel with pump 0.08 %</i>	2	PA; MO
<i>tretinoin topical cream 0.025 %, 0.05 %, 0.1 %</i>	4	PA; MO
<i>tretinoin topical gel 0.01 %, 0.025 %, 0.05 %</i>	2	PA; MO
TWYNEO	4	MO
VELTIN	4	
WINLEVI	4	PA; MO
<i>zenatane</i>	4	
ZIANA	4	
TOPICAL ANTIBACTERIALS		
ALTABAX	4	QL (30 per 30 days)
<i>gentamicin topical</i>	2	MO; QL (60 per 30 days)
KLARON	4	MO
<i>mupirocin</i>	2	MO; QL (44 per 30 days)
<i>mupirocin calcium</i>	2	MO; QL (30 per 30 days)
NEO-SYNALAR	4	MO
<i>sulfacetamide sodium (acne)</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
SULFAMYLON TOPICAL CREAM	4	MO
TOPICAL ANTIFUNGALS		
<i>ciclopirox topical cream</i>	2	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	2	MO; QL (100 per 28 days)
<i>ciclopirox topical shampoo</i>	2	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	2	MO; QL (6.6 per 28 days)
<i>ciclopirox topical suspension</i>	2	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	2	MO; QL (45 per 28 days)
<i>clotrimazole topical solution</i>	2	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	2	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	4	MO; QL (60 per 28 days)
<i>econazole</i>	4	MO; QL (85 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ERTACZO	4	QL (60 per 28 days)
JUBLIA	4	MO; QL (8 per 30 days)
<i>ketconazole topical cream</i>	2	MO; QL (60 per 28 days)
<i>ketconazole topical foam</i>	2	MO; QL (100 per 28 days)
<i>ketconazole topical shampoo</i>	2	MO; QL (120 per 28 days)
<i>ketodan</i>	2	QL (100 per 28 days)
LOPROX TOPICAL SHAMPOO	4	QL (120 per 28 days)
LULICONAZOLE	4	MO; QL (60 per 28 days)
LUZU	4	MO; QL (60 per 28 days)
<i>naftifine topical cream</i>	2	MO; QL (60 per 28 days)
<i>naftifine topical gel 2 %</i>	4	MO; QL (60 per 28 days)
NAFTIN TOPICAL GEL	4	MO; QL (60 per 28 days)
<i>nyamyc</i>	2	MO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>nystatin topical cream</i>	2	MO; QL (30 per 28 days)
<i>nystatin topical ointment</i>	2	MO; QL (30 per 28 days)
<i>nystatin topical powder</i>	2	MO; QL (180 per 30 days)
<i>nystatin-triamcinolone</i>	2	MO; QL (60 per 28 days)
<i>nystop</i>	2	MO; QL (180 per 30 days)
<i>oxiconazole</i>	2	MO; QL (90 per 28 days)
OXISTAT TOPICAL CREAM	4	QL (90 per 28 days)
OXISTAT TOPICAL LOTION	4	MO; QL (60 per 28 days)
<i>tavaborole</i>	2	MO; QL (10 per 30 days)

TOPICAL ANTIVIRALS

<i>acyclovir topical cream</i>	2	PA; MO; QL (5 per 30 days)
<i>acyclovir topical ointment</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DENAVIR	4	MO; QL (5 per 30 days)
<i>penciclovir</i>	4	MO; QL (5 per 30 days)
XERESE	5	MO
ZOVIRAX TOPICAL CREAM	4	PA; MO; QL (5 per 30 days)
ZOVIRAX TOPICAL OINTMENT	4	PA; MO; QL (30 per 30 days)
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream 1 %</i>	2	MO
<i>ala-cort topical cream 2.5 %</i>	2	
ALA-SCALP	4	MO
<i>alclometasone</i>	2	MO
<i>amcinonide topical cream</i>	2	
<i>amcinonide topical ointment</i>	2	
<i>apexicon e</i>	2	MO; QL (120 per 30 days)
<i>betamethasone dipropionate</i>	2	MO
<i>betamethasone valerate</i>	2	MO
<i>betamethasone, augmented</i>	2	MO
BRYHALI	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>clobetasol scalp</i>	4	MO; QL (100 per 28 days)
<i>clobetasol topical cream</i>	4	MO; QL (120 per 28 days)
<i>clobetasol topical foam</i>	4	MO; QL (100 per 28 days)
<i>clobetasol topical gel</i>	4	MO; QL (120 per 28 days)
<i>clobetasol topical lotion</i>	4	MO; QL (118 per 28 days)
<i>clobetasol topical ointment</i>	4	MO; QL (120 per 28 days)
<i>clobetasol topical shampoo</i>	4	MO; QL (236 per 28 days)
<i>clobetasol topical spray, non-aerosol</i>	2	MO; QL (125 per 28 days)
<i>clobetasol-emollient topical cream</i>	4	MO; QL (120 per 28 days)
<i>clobetasol-emollient topical foam</i>	2	MO; QL (100 per 28 days)
CLOBEX TOPICAL LOTION	4	QL (118 per 28 days)
CLOBEX TOPICAL SHAMPOO	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CLOBEX TOPICAL SPRAY, NON-AEROSOL	4	QL (125 per 28 days)
<i>clocortolone pivalate</i>	2	MO
<i>clodan</i>	2	MO; QL (236 per 28 days)
CORDRAN TAPE LARGE ROLL	4	MO
CORDRAN TOPICAL CREAM 0.05 %	4	QL (120 per 30 days)
CORDRAN TOPICAL LOTION	4	QL (120 per 30 days)
DERMA-SMOOTH/FS SCALP OIL	4	MO
<i>desonide topical cream</i>	4	MO
<i>desonide topical gel</i>	2	MO
<i>desonide topical lotion</i>	2	MO
<i>desonide topical ointment</i>	4	MO
DESOWEN TOPICAL CREAM	4	
<i>desoximetasone</i>	2	MO
<i>diflorasone</i>	2	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	4	MO
DUOBRII	4	MO; QL (200 per 30 days)
<i>fluocinolone and shower cap</i>	4	MO
<i>fluocinolone topical cream</i>	4	MO
<i>fluocinolone topical ointment</i>	4	MO
<i>fluocinolone topical solution</i>	4	MO
<i>fluocinonide topical cream 0.05 %</i>	4	MO; QL (120 per 30 days)
<i>fluocinonide topical cream 0.1 %</i>	2	MO; QL (120 per 30 days)
<i>fluocinonide topical gel</i>	4	MO; QL (120 per 30 days)
<i>fluocinonide topical ointment</i>	4	MO; QL (120 per 30 days)
<i>fluocinonide topical solution</i>	4	MO; QL (120 per 30 days)
<i>fluocinonide-emollient</i>	4	MO; QL (120 per 30 days)
<i>flurandrenolide topical cream</i>	2	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>flurandrenolide topical lotion</i>	2	MO; QL (120 per 30 days)
<i>fluticasone propionate topical</i>	2	MO
<i>halcinonide topical cream</i>	2	MO
<i>halobetasol propionate topical cream</i>	4	MO
<i>halobetasol propionate topical foam</i>	2	
<i>halobetasol propionate topical ointment</i>	4	MO
HALOG TOPICAL CREAM	4	MO
HALOG TOPICAL OINTMENT	4	
HALOG TOPICAL SOLUTION	4	
<i>hydrocortisone butyrate topical cream</i>	2	MO; QL (120 per 30 days)
<i>hydrocortisone butyrate topical lotion</i>	2	MO; QL (118 per 30 days)
<i>hydrocortisone butyrate topical ointment</i>	2	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone butyrate topical solution</i>	2	MO; QL (120 per 30 days)
<i>hydrocortisone topical cream 1 %</i>	2	MO
<i>hydrocortisone topical lotion 2.5 %</i>	2	MO
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	2	MO
<i>hydrocortisone valerate</i>	2	MO
KENALOG TOPICAL	4	QL (126 per 28 days)
LEXETTE	4	
LOCOID LIPOCREAM	4	MO; QL (120 per 30 days)
LOCOID TOPICAL LOTION	4	MO; QL (118 per 30 days)
<i>mometasone topical</i>	2	MO
PANDEL	4	MO
SYNALAR TOPICAL CREAM	4	MO
SYNALAR TOPICAL OINTMENT	4	MO
TEXACORT	4	MO
TOPICORT TOPICAL CREAM	4	
TOPICORT TOPICAL GEL	4	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TOPICORT TOPICAL OINTMENT 0.05 %	4	
TOPICORT TOPICAL SPRAY, NON- AEROSOL	4	
<i>tovet emollient</i>	2	MO; QL (100 per 28 days)
<i>triamcinolone acetonide topical cream</i>	2	MO
<i>triamcinolone acetonide topical lotion</i>	2	MO
<i>triamcinolone acetonide topical ointment</i>	2	MO
<i>triderm topical cream</i>	2	
ULTRAVATE TOPICAL LOTION	5	
VANOS	5	MO; QL (120 per 30 days)
VERDESO	4	MO
TOPICAL SCABICIDES / PEDICULICIDES		
<i>crotan</i>	2	
<i>malathion</i>	4	MO
NATROBA	4	MO

Drug Name	Drug Tier	Requirements/Limits
OVIDE	4	MO
<i>permethrin</i>	2	MO; QL (60 per 30 days)
<i>spinosad</i>	2	MO
DIAGNOSTIC S / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
<i>acamprosate</i>	4	MO
AGRYLIN	4	MO
<i>anagrelide</i>	2	MO
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	5	PA; MO; LA
BUPHENYL	5	PA
CARBAGLU	5	PA; MO; LA
<i>carglumic acid</i>	5	PA; MO
CARNITOR ORAL	4	MO
<i>cevimeline</i>	4	MO
CHEMET	3	PA
CLINIMIX 4.25%/D5W SULFIT FREE	4	PA
CLINIMIX E 2.75%/D5W SULF FREE	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CUVROR	5	PA; LA
<i>d10 %-0.45 % sodium chloride</i>	4	
<i>d2.5 %-0.45 % sodium chloride</i>	4	
<i>d5 % and 0.9 % sodium chloride</i>	4	MO
<i>d5 %-0.45 % sodium chloride</i>	4	MO
<i>deferasirox oral granules in packet</i>	5	PA; MO
<i>deferasirox oral tablet</i>	2	PA; MO
<i>deferasirox oral tablet, dispersible 125 mg</i>	2	PA; MO
<i>deferasirox oral tablet, dispersible 250 mg, 500 mg</i>	5	PA; MO
<i>deferiprone</i>	5	PA; MO
<i>dextrose 10 % and 0.2 % nacl</i>	4	
<i>dextrose 10 % in water (d10w)</i>	4	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	4	MO
<i>dextrose 5%-0.2 % sod chloride</i>	4	
<i>disulfiram oral tablet 250 mg</i>	2	MO
<i>disulfiram oral tablet 500 mg</i>	2	
<i>droxidopa</i>	5	PA; MO

Drug Name	Drug Tier	Requirements/Limits
ENDARI	5	PA; MO
EVOXAC	4	MO
EXJADE	5	PA; MO; LA
EXSERVAN	5	PA
FABHALTA	5	PA
FERRIPROX	5	PA
FERRIPROX (2 TIMES A DAY)	5	PA
GLASSIA	5	PA; MO; LA
INCRELEX	5	MO; LA
JADENU	5	PA; MO
JADENU SPRINKLE	5	PA; MO
JOENJA	5	PA; LA; QL (60 per 30 days)
<i>kionex (with sorbitol)</i>	2	
<i>levocarnitine (with sugar)</i>	4	MO
<i>levocarnitine oral tablet</i>	4	MO
LITFULO	5	PA; MO; QL (28 per 28 days)
LITHOSTAT	4	
LOKELMA	3	MO
<i>midodrine</i>	2	MO
<i>nitisinone</i>	5	PA; MO
NITYR	4	PA; MO; LA
NORTHERA	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
OLPRUVA	5	PA; LA
ORFADIN	5	PA; LA
OXBRYTA ORAL TABLET 300 MG	5	PA; MO; LA; QL (150 per 30 days)
OXBRYTA ORAL TABLET 500 MG	5	PA; MO; LA; QL (90 per 30 days)
OXBRYTA ORAL TABLET FOR SUSPENSION	5	PA; MO; LA; QL (150 per 30 days)
PHEBURANE	5	PA; MO
<i>pilocarpine hcl oral</i>	4	MO
PROLASTIN-C INTRAVENOUS SOLUTION	5	PA; MO; LA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	5	PA; LA; QL (56 per 28 days)
PYRUKYND ORAL TABLET 5 MG	5	PA; LA; QL (7 per 180 days)
PYRUKYND ORAL TABLETS, DOSE PACK	5	PA; LA; QL (14 per 180 days)
RAVICTI	5	PA; MO
REVCovi	5	PA; LA
REZDIFFRA	5	PA; MO; QL (30 per 30 days)
<i>riluzole</i>	2	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>risedronate oral tablet 30 mg</i>	2	MO; QL (30 per 30 days)
SALAGEN (PILOCARPINE) ORAL TABLET 5 MG	4	MO
SALAGEN (PILOCARPINE) ORAL TABLET 7.5 MG	4	
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	4	MO
<i>sodium chloride irrigation</i>	4	MO
<i>sodium phenylbutyrate oral powder</i>	5	PA; MO
<i>sodium phenylbutyrate oral tablet</i>	5	PA
<i>sodium polystyrene sulfonate oral powder</i>	2	MO
SOHONOS ORAL CAPSULE 1 MG, 1.5 MG	5	PA; LA; QL (112 per 28 days)
SOHONOS ORAL CAPSULE 10 MG	5	PA; LA; QL (56 per 28 days)
SOHONOS ORAL CAPSULE 2.5 MG	5	PA; LA; QL (140 per 28 days)
SOHONOS ORAL CAPSULE 5 MG	5	PA; LA; QL (84 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>sps (with sorbitol) oral</i>	2	MO
SYPRINE	5	PA; MO
TAVNEOS	5	PA; LA; QL (180 per 30 days)
TEGLUTIK	5	PA
THIOLA	5	PA
THIOLA EC	5	PA
TIGLUTIK	5	PA
<i>tiopronin oral tablet</i>	5	PA; MO
<i>trientine oral capsule 250 mg</i>	5	PA; MO
TRIENTINE ORAL CAPSULE 500 MG	5	PA; MO
VELTASSA ORAL POWDER IN PACKET 16.8 GRAM, 8.4 GRAM	3	MO
VELTASSA ORAL POWDER IN PACKET 25.2 GRAM	3	
ZEMAIRA INTRAVENOUS RECON SOLN 1,000 MG	5	PA; MO; LA

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS CARDIOVASCULAR AGENTS		
WEGOVY SUBCUTANEOUS PEN INJECTOR 0.25 MG/0.5 ML, 0.5 MG/0.5 ML, 1 MG/0.5 ML	5	PA; MO; QL (4 per 365 days)
WEGOVY SUBCUTANEOUS PEN INJECTOR 1.7 MG/0.75 ML, 2.4 MG/0.75 ML	5	PA; MO; QL (3 per 28 days)
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter)</i>	2	MO
NICOTROL	4	
NICOTROL NS	4	MO
<i>varenicline oral tablet 0.5 mg, 1 mg</i>	4	MO
<i>varenicline oral tablet 1 mg (56 pack)</i>	4	
<i>varenicline oral tablets, dose pack</i>	4	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
<i>azelastine nasal spray, non-aerosol 137 mcg (0.1 %)</i>	2	MO; QL (60 per 30 days)
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>ipratropium bromide nasal</i>	2	MO; QL (30 per 30 days)
<i>kourzeq</i>	2	
<i>olopatadine nasal</i>	2	MO; QL (30.5 per 30 days)
<i>periogard</i>	2	MO
<i>triamcinolone acetonide dental</i>	2	MO
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear)</i>	2	MO
DERMOTIC OIL	4	MO
<i>flac otic oil</i>	4	
<i>fluocinolone acetonide oil</i>	4	MO
<i>hydrocortisone-acetic acid</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>ofloxacin otic (ear)</i>	2	MO
OTIC STEROID / ANTIBIOTIC		
CIPRO HC	4	MO
<i>ciprofloxacin-dexamethasone</i>	2	MO; QL (7.5 per 7 days)
<i>neomycin-polymyxin-hc otic (ear)</i>	2	MO
ENDOCRINE/ DIABETES		
ADRENAL HORMONES		
ACTHAR	5	PA; MO
AGAMREE	5	PA; LA
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 0.5 MG, 1 MG	4	
ALKINDI SPRINKLE ORAL CAPSULE, SPRINKLE 2 MG, 5 MG	5	
CORTEF	4	MO
CORTROPHIN GEL	5	PA; MO
<i>deflazacort oral suspension</i>	5	PA
<i>deflazacort oral tablet</i>	5	PA; MO
<i>dexabliss</i>	2	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>dexamethasone oral solution</i>	2	MO
<i>dexamethasone oral tablet</i>	2	MO
<i>dexamethasone oral tablets, dose pack</i>	2	MO
EMFLAZA	5	PA; MO; LA
<i>fludrocortisone</i>	2	MO
HEMADY	4	
<i>hydrocortisone oral</i>	2	MO
MEDROL (PAK)	4	MO
MEDROL ORAL TABLET 16 MG, 4 MG, 8 MG	4	PA; MO
MEDROL ORAL TABLET 2 MG	4	PA
<i>methylprednisolone oral tablet</i>	2	PA; MO
<i>methylprednisolone oral tablets, dose pack</i>	2	MO
ORAPRED ODT	4	PA; MO
<i>prednisolone oral solution</i>	2	MO
<i>prednisolone oral tablet</i>	2	PA; 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>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone sodium phosphate oral tablet, disintegrating 10 mg</i>	2	PA
<i>prednisolone sodium phosphate oral tablet, disintegrating 15 mg, 30 mg</i>	2	PA; MO
<i>prednisone intensol</i>	4	MO
<i>prednisone oral solution</i>	2	MO
<i>prednisone oral tablet</i>	1	MO
<i>prednisone oral tablets, dose pack</i>	1	MO
RAYOS	5	MO
TAPERDEX ORAL TABLETS, DOSE PACK 1.5 MG (21 TABS)	4	MO
TAPERDEX ORAL TABLETS, DOSE PACK 1.5 MG (27 TABS), 1.5 MG (49 TABS)	4	
TARPEYO	5	PA; QL (120 per 30 days)

ANTITHYROID AGENTS

<i>methimazole oral tablet 10 mg, 5 mg</i>	2	MO
<i>propylthiouracil</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DIABETES THERAPY		
<i>acarbose oral tablet 100 mg</i>	2	MO; QL (90 per 30 days)
<i>acarbose oral tablet 25 mg</i>	2	MO; QL (360 per 30 days)
<i>acarbose oral tablet 50 mg</i>	2	MO; QL (180 per 30 days)
ACTOPLUS MET ORAL TABLET 15-850 MG	4	MO; QL (90 per 30 days)
ACTOS	4	MO; QL (30 per 30 days)
ADMELOG SOLOSTAR U-100 INSULIN	4	ST; MO
ADMELOG U-100 INSULIN LISPRO	4	ST; MO
AFREZZA	4	MO
<i>alcohol pads</i>	2	PA
ALOGLIPTIN	4	ST; MO; QL (30 per 30 days)
ALOGLIPTIN-METFORMIN	4	ST; MO; QL (60 per 30 days)
ALOGLIPTIN-PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	4	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
APIDRA SOLOSTAR U-100 INSULIN	4	ST; MO
APIDRA U-100 INSULIN	4	ST; MO
BAQSIMI	3	MO
BASAGLAR KWIKPEN U-100 INSULIN	4	ST; MO
BASAGLAR TEMPO PEN(U-100)INSLN	4	ST; MO
BYDUREON BCISE	3	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	3	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	3	PA; MO; QL (1.2 per 30 days)
CYCLOSET	4	MO; QL (180 per 30 days)
DAPAGLIFLOZ PROPANED-METFORMIN ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG	4	ST; 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DAPAGLIFLOZIN PROPANEDIMOL ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	4	ST; MO; QL (60 per 30 days)
DAPAGLIFLOZIN PROPANEDIOL ORAL TABLET 10 MG	4	ST; MO; QL (30 per 30 days)
DAPAGLIFLOZIN PROPANEDIOL ORAL TABLET 5 MG	4	ST; MO; QL (60 per 30 days)
<i>diazoxide</i>	5	MO
DROPSAFE ALCOHOL PREP PADS	3	PA
DUETACT	4	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 10 MG	3	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	3	MO; QL (60 per 30 days)
FIASP FLEXTOUCH U- 100 INSULIN	4	ST
FIASP PENFILL U-100 INSULIN	4	ST; MO
FIASP U-100 INSULIN	4	ST

Drug Name	Drug Tier	Requirements/Limits
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)
<i>glimepiride oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)
<i>glimepiride oral tablet 4 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)
GLIPIZIDE ORAL TABLET 2.5 MG	4	MO; QL (30 per 30 days)
<i>glipizide oral tablet 5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	MO; QL (120 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)
GLUCAGON EMERGENCY KIT (HUMAN)	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG	4	MO; QL (60 per 30 days)
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 5 MG	4	MO; QL (120 per 30 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTIO N 24 HR 1,000 MG	5	ST; MO; QL (60 per 30 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTIO N 24 HR 500 MG	5	ST; MO; QL (120 per 30 days)
GLYXAMBI	3	MO; QL (30 per 30 days)
GVOKE	3	MO
GVOKE HYOPEN 2- PACK	3	MO
GVOKE PFS 1- PACK SYRINGE SUBCUTANEOU S SYRINGE 1 MG/0.2 ML	3	MO
HUMALOG JUNIOR KWIKPEN U-100	3	MO

Drug Name	Drug Tier	Requirements/Limits
HUMALOG KWIKPEN INSULIN	3	MO
HUMALOG MIX 50-50 KWIKPEN	3	MO
HUMALOG MIX 75-25 KWIKPEN	3	MO
HUMALOG MIX 75-25(U- 100)INSULN	3	MO
HUMALOG TEMPO PEN(U- 100)INSULN	4	ST; MO
HUMALOG U- 100 INSULIN	3	MO
HUMULIN 70/30 U-100 INSULIN	3	MO
HUMULIN 70/30 U-100 KWIKPEN	3	MO
HUMULIN N NPH INSULIN KWIKPEN	3	MO
HUMULIN N NPH U-100 INSULIN	3	MO
HUMULIN R REGULAR U-100 INSULN	3	MO
HUMULIN R U- 500 (CONC) INSULIN	3	MO
HUMULIN R U- 500 (CONC) KWIKPEN	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
INPEFA	3	PA; MO; QL (30 per 30 days)
INSULIN ASP PRT-INSULIN ASPART	4	ST; MO
INSULIN ASPART U-100	4	ST; MO
INSULIN DEGLUDEC	4	ST; MO
INSULIN GLARGINE U-300 CONC	4	ST; MO
INSULIN GLARGINE-YFGN	4	ST; MO
INSULIN LISPRO PROTAMIN-LISPRO	4	ST; MO
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN	4	ST; MO
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN, HALF-UNIT	4	ST; MO
INSULIN LISPRO SUBCUTANEOUS SOLUTION	3	MO
INVOKAMET	4	ST; MO; QL (60 per 30 days)
INVOKAMET XR	4	ST; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
INVOKANA	4	ST; MO; QL (30 per 30 days)
JANUMET	3	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	3	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	3	MO; QL (60 per 30 days)
JANUVIA	3	MO; QL (30 per 30 days)
JARDIANCE	3	MO; QL (30 per 30 days)
JENTADUETO	3	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
KAZANO ORAL TABLET 12.5-1,000 MG	4	ST; MO; QL (60 per 30 days)
KAZANO ORAL TABLET 12.5-500 MG	4	ST; QL (60 per 30 days)
LANTUS SOLOSTAR U-100 INSULIN	3	MO
LANTUS U-100 INSULIN	3	MO
LYUMJEV KWIKPEN U-100 INSULIN	3	MO
LYUMJEV KWIKPEN U-200 INSULIN	3	MO
LYUMJEV TEMPO PEN(U-100)INSULIN	4	ST; MO
LYUMJEV U-100 INSULIN	3	MO
<i>metformin oral solution</i>	2	MO; QL (765 per 30 days)
<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)
<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
METFORMIN ORAL TABLET 625 MG	5	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>metformin oral tablet 850 mg</i>	1	MO; QL (90 per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	MO; QL (120 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>	2	ST; MO; QL (60 per 30 days)
<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	2	ST; MO; QL (150 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg</i>	2	ST; MO; QL (60 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 500 mg</i>	2	ST; MO; QL (120 per 30 days)
<i>miglitol oral tablet 100 mg</i>	2	MO; QL (90 per 30 days)
<i>miglitol oral tablet 25 mg</i>	2	MO; QL (360 per 30 days)
<i>miglitol oral tablet 50 mg</i>	2	MO; QL (180 per 30 days)
MOUNJARO	3	PA; MO; QL (2 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>nateglinide oral tablet 120 mg</i>	2	MO; QL (90 per 30 days)
<i>nateglinide oral tablet 60 mg</i>	2	MO; QL (180 per 30 days)
NESINA	4	ST; QL (30 per 30 days)
NOVOLIN 70/30 U-100 INSULIN	4	ST; MO
NOVOLIN 70-30 FLEXPEN U-100	4	ST; MO
NOVOLIN N FLEXPEN	4	ST; MO
NOVOLIN N NPH U-100 INSULIN	4	ST; MO
NOVOLIN R FLEXPEN	4	ST; MO
NOVOLIN R REGULAR U100 INSULIN	4	ST; MO
NOVOLOG FLEXPEN U-100 INSULIN	4	ST; MO
NOVOLOG MIX 70-30 U-100 INSULIN	4	ST; MO
NOVOLOG MIX 70-30FLEXPEN U-100	4	ST; MO
NOVOLOG PENFILL U-100 INSULIN	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG U-100 INSULIN ASPART	4	ST; MO
OSENI ORAL TABLET 12.5-30 MG	4	MO; QL (30 per 30 days)
OSENI ORAL TABLET 25-15 MG, 25-30 MG, 25-45 MG	4	QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	3	PA; MO; QL (3 per 28 days)
<i>pioglitazone</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-glimepiride</i>	2	MO; QL (30 per 30 days)
<i>pioglitazone-metformin</i>	2	MO; QL (90 per 30 days)
PROGLYCEM	4	MO
QTERN	4	ST; MO; QL (30 per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	2	MO; QL (960 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>repaglinide oral tablet 1 mg</i>	2	MO; QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	2	MO; QL (240 per 30 days)
REZVOGLAR KWIKPEN	4	ST; MO
RYBELSUS	3	PA; MO; QL (30 per 30 days)
<i>saxagliptin</i>	2	MO; QL (30 per 30 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg</i>	2	MO; QL (60 per 30 days)
<i>saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg</i>	2	MO; QL (30 per 30 days)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	3	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	3	MO; QL (120 per 30 days)
SEMGLEE(INSULIN GLARGINE-YFGN)	4	ST; MO
SEMGLEE(INSULIN GLARG-YFGN)PEN	4	ST; MO

Drug Name	Drug Tier	Requirements/Limits
SITAGLIPTIN	4	ST; QL (30 per 30 days)
SOLQUA 100/33	3	MO; QL (90 per 30 days)
STEGLATRO	3	MO; QL (30 per 30 days)
STEGLUJAN	4	ST; MO; QL (30 per 30 days)
SYMLINPEN 120	5	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	5	PA; MO; QL (6 per 30 days)
SYNJARDY	3	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	3	MO; QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	3	MO; QL (60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	3	MO
TOUJEO SOLOSTAR U-300 INSULIN	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TRADJENTA	3	MO; QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100	4	ST; MO
TRESIBA FLEXTOUCH U-200	4	ST; MO
TRESIBA U-100 INSULIN	4	ST; MO
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	3	MO; QL (30 per 30 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	3	MO; QL (60 per 30 days)
TRULICITY	3	PA; MO; QL (2 per 28 days)
VICTOZA 3-PAK	4	PA; MO; QL (9 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	3	MO; QL (60 per 30 days)
XULTOPHY 100/3.6	4	ST; MO; QL (15 per 30 days)
ZEGALOGUE AUTOINJECTOR	4	ST; MO
ZEGALOGUE SYRINGE	4	ST; MO
ZITUVIO	4	ST; QL (30 per 30 days)
MISCELLANEOUS HORMONES		
AVEED	4	PA; LA
<i>cabergoline</i>	2	MO
<i>calcitonin (salmon) nasal</i>	2	MO
<i>calcitriol oral capsule</i>	2	MO
<i>calcitriol oral solution</i>	4	
CERDELGA	5	PA; MO
<i>cinacalcet oral tablet 30 mg, 60 mg</i>	4	PA; MO
<i>cinacalcet oral tablet 90 mg</i>	5	PA; MO
<i>danazol</i>	4	MO
DDAVP ORAL	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DEPO-TESTOSTERONE INTRAMUSCULAR OIL 100 MG/ML	4	PA; MO
DEPO-TESTOSTERONE INTRAMUSCULAR OIL 200 MG/ML	4	PA
<i>desmopressin nasal spray, non-aerosol 10 mcg/spray (0.1 ml)</i>	4	
<i>desmopressin oral</i>	2	MO
<i>doxercalciferol oral</i>	4	MO
ELFABRIO	5	PA
GALAFOLD	5	PA; MO; LA; QL (15 per 30 days)
ISTURISA ORAL TABLET 1 MG	5	PA; LA; QL (240 per 30 days)
ISTURISA ORAL TABLET 5 MG	5	PA; LA; QL (360 per 30 days)
JATENZO ORAL CAPSULE 158 MG, 198 MG	4	PA; MO; QL (120 per 30 days)
JATENZO ORAL CAPSULE 237 MG	5	PA; MO; QL (60 per 30 days)
<i>javygtor oral powder in packet 100 mg</i>	2	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>javygtor oral powder in packet 500 mg</i>	5	PA; MO
<i>javygtor oral tablet, soluble</i>	5	PA; MO
JYNARQUE	5	PA; LA
KORLYM	5	PA
KUVAN	5	PA; MO
METHITEST	4	MO
<i>methyltestosterone oral capsule</i>	5	MO
<i>mifepristone oral tablet 300 mg</i>	5	PA; MO
<i>miglustat</i>	5	PA; MO; LA
MYALEPT	5	PA; MO; LA
ORILISSA	5	MO
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	5	PA; MO; LA; QL (15 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	5	PA; MO; LA; QL (4 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	5	PA; MO; LA; QL (60 per 30 days)
<i>paricalcitol oral</i>	4	MO
RAYALDEE	5	MO
RECORLEV	5	PA
ROCALTROL	4	
SAMSCA	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>sapropterin</i>	5	PA; MO
SENSIPAR ORAL TABLET 30 MG	4	PA; MO
SENSIPAR ORAL TABLET 60 MG, 90 MG	5	PA; MO
SOMAVERT	5	PA; MO
STRENSIQ SUBCUTANEOUS SOLUTION 28 MG/0.7 ML, 40 MG/ML, 80 MG/0.8 ML	5	PA
SYNAREL	5	PA; MO
TESTIM	4	PA; MO; QL (300 per 30 days)
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	2	PA; MO
<i>testosterone cypionate intramuscular oil 200 mg/ml (1 ml)</i>	2	PA
<i>testosterone enanthate</i>	2	PA; MO
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram lactuation</i>	2	PA; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/1.25 gram (1 %)</i>	2	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	4	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5 gram), 1 % (50 mg/5 gram)</i>	4	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	4	PA; MO; QL (37.5 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	4	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal solution in metered pump w/lapp</i>	4	PA; MO; QL (180 per 30 days)
TLANDO	4	PA; MO; QL (120 per 30 days)
<i>tolvaptan</i>	5	PA; MO
VOGELXO TRANSDERMAL GEL	4	PA; 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	4	PA; QL (300 per 30 days)
VOXZOGO	5	PA; MO
XYOSTED	4	PA; MO; QL (2 per 28 days)
<i>yargesa</i>	5	PA; LA
ZAVESCA	5	PA; MO; LA
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	4	MO
THYROID HORMONES		
CYTOMEL	4	MO
ERMEZA	4	
<i>euthyrox</i>	1	MO
LEVOTHYROXINE ORAL CAPSULE	4	MO
<i>levothyroxine oral tablet</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
<i>liothyronine oral</i>	2	MO
SYNTHROID	4	ST; MO
THYQUIDITY	4	MO

Drug Name	Drug Tier	Requirements/Limits
TIROSINT	4	MO
TIROSINT-SOL	4	MO
<i>unithroid</i>	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
CUVPOSA	4	MO
<i>dicyclomine oral capsule</i>	2	MO
<i>dicyclomine oral solution</i>	4	MO
<i>dicyclomine oral tablet</i>	2	MO
<i>diphenoxylate-atropine oral liquid</i>	4	MO
<i>diphenoxylate-atropine oral tablet</i>	2	MO
GLYCATE	4	
<i>glycopyrrolate oral solution</i>	2	MO
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	2	MO
<i>glycopyrrolate oral tablet 1.5 mg</i>	2	
LOMOTIL	4	MO
<i>loperamide oral capsule</i>	2	MO
<i>methscopolamine</i>	2	MO
MOTOFEN	4	MO
MYTESI	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ROBINUL FORTE	4	MO
ROBINUL ORAL	4	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron oral tablet 0.5 mg</i>	4	PA; MO
<i>alosetron oral tablet 1 mg</i>	5	PA; MO
AMITIZA	4	ST; MO; QL (60 per 30 days)
ANTIVERT ORAL TABLET 50 MG	4	
ANTIVERT ORAL TABLET, CHEWABLE	4	
ANUSOL-HC TOPICAL	4	MO
ANZEMET ORAL TABLET 50 MG	4	PA; MO
<i>aprepitant</i>	4	PA; MO
APRISO	4	MO
AZULFIDINE	4	MO
AZULFIDINE EN-TABS	4	MO
<i>balsalazide</i>	2	MO
<i>betaine</i>	5	MO
BONJESTA	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide oral capsule, delayed, extended release</i>	4	MO
<i>budesonide oral tablet, delayed and extended release</i>	5	MO
<i>budesonide rectal</i>	2	MO
BYLVAY	5	PA; MO; LA
CANASA	4	MO
CHENODAL	5	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	5	PA
CHOLBAM ORAL CAPSULE 50 MG	5	PA; QL (120 per 30 days)
CIMZIA	5	PA; MO; QL (2 per 28 days)
CIMZIA POWDER FOR RECONST	5	PA; MO; QL (2 per 28 days)
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM-12 GRAM/160 ML	4	ST
CLENPIQ ORAL SOLUTION 10 MG-3.5 GRAM-12 GRAM/175 ML	4	ST; MO
COLAZAL	5	MO
<i>compro</i>	4	MO
<i>constulose</i>	2	MO
CORTIFOAM	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CREON	3	MO
<i>cromolyn oral</i>	4	MO
CYSTADANE	5	
DELZICOL	4	
DICLEGIS	4	MO
DIPENTUM	5	MO
<i>doxylamine-pyridoxine (vit b6)</i>	2	MO
<i>dronabinol</i>	4	PA
EMEND ORAL CAPSULE 80 MG	4	PA; MO
EMEND ORAL CAPSULE,DOSE PACK	4	PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	4	PA
ENTYVIO PEN	5	PA; MO; QL (1.36 per 28 days)
<i>enulose</i>	2	MO
GASTROCROM	4	MO
GATTEX 30-VIAL	5	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>generlac</i>	2	
GIMOTI	5	
GOLYTELY	4	ST; MO
<i>granisetron hcl oral</i>	2	PA; MO
<i>hydrocortisone rectal</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	2	MO
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	2	MO
IBSRELA	5	PA; MO; QL (60 per 30 days)
INFLECTRA	5	PA; MO; QL (20 per 28 days)
KRISTALOSE	4	MO
<i>lactulose oral packet</i>	2	
<i>lactulose oral solution 10 gram/15 ml</i>	2	MO
LIALDA	4	MO
LINZESS	3	MO; QL (30 per 30 days)
LIVMARLI ORAL SOLUTION 9.5 MG/ML	5	PA; LA
LOTRONEX	5	PA; MO
<i>lubiprostone</i>	4	MO; QL (60 per 30 days)
MARINOL ORAL CAPSULE 10 MG, 5 MG	5	PA
MARINOL ORAL CAPSULE 2.5 MG	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	2	MO
<i>mesalamine oral capsule (with del rel tablets)</i>	4	MO
<i>mesalamine oral capsule, extended release</i>	4	
<i>mesalamine oral capsule, extended release 24hr</i>	4	MO
<i>mesalamine oral tablet, delayed release (drlec)</i>	4	MO
<i>mesalamine rectal</i>	4	MO
<i>metoclopramide hcl oral solution</i>	2	MO
<i>metoclopramide hcl oral tablet</i>	2	MO
<i>metoclopramide hcl oral tablet, disintegrating 5 mg</i>	2	
MOTEGRITY	4	ST; MO; QL (30 per 30 days)
MOVANTIK	4	ST; MO; QL (30 per 30 days)
MOVIPREP	4	ST; MO
<i>nitroglycerin rectal</i>	2	MO
OICALIVA	5	PA; MO; LA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
OMVOH PEN	5	PA; MO; QL (2 per 28 days)
OMVOH SUBCUTANEOUS	5	PA; QL (2 per 28 days)
<i>ondansetron hcl oral solution</i>	4	PA; MO
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	2	PA; MO
<i>ondansetron oral tablet, disintegrating 4 mg, 8 mg</i>	2	PA; MO
PANCREAZE ORAL CAPSULE, DELAYED RELEASE (DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-8,800-15,200 UNIT, 21,000-54,700-83,900 UNIT, 4,200-14,200-24,600 UNIT	4	ST; MO
PANCREAZE ORAL CAPSULE, DELAYED RELEASE (DR/EC) 37,000-97,300-149,900 UNIT	5	ST; MO
<i>peg 3350-electrolytes</i>	1	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	2	MO
<i>peg-electrolyte</i>	1	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	4	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	5	MO
PERTZYE ORAL CAPSULE, DELAYED RELEASE (DR/EC) 16,000-57,500-60,500 UNIT, 4,000-14,375-15,125 UNIT, 8,000-28,750-30,250 UNIT	4	ST; MO
PERTZYE ORAL CAPSULE, DELAYED RELEASE (DR/EC) 24,000-86,250-90,750 UNIT	5	ST; MO
PLENVU	4	ST; MO
<i>prochlorperazine</i>	4	MO
<i>prochlorperazine maleate</i>	2	MO
PROCTOFOAM HC	4	MO
<i>procto-med hc</i>	2	MO
<i>proctosol hc topical</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>proctozone-hc</i>	2	MO
RECTIV	4	MO
REGLAN ORAL	4	MO
RELISTOR ORAL	5	ST; MO; QL (90 per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION	5	ST; MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	5	ST; MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	5	ST; MO; QL (12 per 30 days)
RELTONE	5	
REMICADE	5	PA; MO; QL (20 per 28 days)
RENFLEXIS	5	PA; MO; QL (20 per 28 days)
ROWASA RECTAL ENEMA KIT	4	MO
SANCUSO	5	MO
<i>scopolamine base</i>	4	MO
SKYRIZI INTRAVENOUS	5	PA; MO; QL (30 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	5	PA; MO; QL (1.2 per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	5	PA; MO; QL (2.4 per 56 days)
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram</i>	4	MO
<i>sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram 2 pack (480ml)</i>	4	
SUCRAID	5	PA
SUFLAVE	4	ST; MO
<i>sulfasalazine</i>	2	MO
SUPREP BOWEL PREP KIT	4	ST; MO
SUTAB	4	ST; MO
SYMPROIC	3	MO; QL (30 per 30 days)
TRULANCE	3	MO; QL (30 per 30 days)
UCERIS ORAL	5	MO
UCERIS RECTAL	4	MO
URSO 250	4	

Drug Name	Drug Tier	Requirements/Limits
URSO FORTE	4	
<i>ursodiol oral capsule 200 mg, 400 mg</i>	5	
<i>ursodiol oral capsule 300 mg</i>	2	MO
<i>ursodiol oral tablet</i>	2	MO
VARUBI	3	PA
VELSIPITY	5	PA; MO; QL (30 per 30 days)
VIBERZI	5	MO; QL (60 per 30 days)
VIOKACE	4	MO
VOWST	5	PA; LA
ZENPEP ORAL CAPSULE, DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000-168,000 UNIT, 5,000-17,000-24,000 UNIT	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ZENPEP ORAL CAPSULE, DELAYED RELEASE (DR/EC) 60,000-189,600-252,600 UNIT	5	MO
ZYMFENTRA	5	PA; MO; QL (2 per 28 days)

ULCER THERAPY

<i>amoxicillin-clarithromycin-lansoprazole</i>	2	MO; QL (112 per 180 days)
<i>bismuth subcitrate-k-metronidazole</i>	2	MO; QL (120 per 180 days)
CARAFATE ORAL SUSPENSION	4	
CARAFATE ORAL TABLET	4	MO
<i>cimetidine</i>	2	MO
CYTOTEC	4	MO
DEXILANT	4	MO; QL (30 per 30 days)
<i>dexlansoprazole</i>	2	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule, delayed release (drlec) 20 mg</i>	2	MO; QL (30 per 30 days)

<i>esomeprazole magnesium oral capsule, delayed release (drlec) 40 mg</i>	2	MO; QL (60 per 30 days)
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg</i>	2	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</i>	2	MO; QL (60 per 30 days)
<i>famotidine oral suspension for reconstitution</i>	2	MO
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO
KONVOMEPR	4	QL (600 per 30 days)
<i>lansoprazole oral capsule, delayed release (drlec) 15 mg</i>	2	MO; QL (30 per 30 days)
<i>lansoprazole oral capsule, delayed release (drlec) 30 mg</i>	2	MO; QL (60 per 30 days)
<i>lansoprazole oral tablet, disintegrates, delay rel 15 mg</i>	2	MO; QL (30 per 30 days)
<i>lansoprazole oral tablet, disintegrates, delay rel 30 mg</i>	2	MO; QL (60 per 30 days)
<i>misoprostol</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NEXIUM ORAL CAPSULE, DELAYED RELEASE (DR/EC) 20 MG	4	MO; QL (30 per 30 days)
NEXIUM ORAL CAPSULE, DELAYED RELEASE (DR/EC) 40 MG	4	MO; QL (60 per 30 days)
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	4	MO; QL (30 per 30 days)
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	4	MO; QL (60 per 30 days)
nizatidine oral capsule	2	MO
OMECLAMOX-PAK	4	QL (80 per 180 days)
omeprazole oral capsule, delayed release (drlec) 10 mg, 20 mg	1	MO; QL (30 per 30 days)
omeprazole oral capsule, delayed release (drlec) 40 mg	1	MO; QL (60 per 30 days)
omeprazole-sodium bicarbonate oral capsule	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
omeprazole-sodium bicarbonate oral packet	5	MO; QL (30 per 30 days)
pantoprazole oral granules dr for susp in packet	2	MO; QL (60 per 30 days)
pantoprazole oral tablet, delayed release (drlec) 20 mg	1	MO; QL (30 per 30 days)
pantoprazole oral tablet, delayed release (drlec) 40 mg	1	MO; QL (60 per 30 days)
PEPCID ORAL TABLET	4	MO
PREVACID	4	MO; QL (60 per 30 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 15 MG	4	MO; QL (30 per 30 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 30 MG	4	MO; QL (60 per 30 days)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 10 MG	4	MO; QL (120 per 30 days)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 2.5 MG	4	MO; QL (480 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	4	MO; QL (60 per 30 days)
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 20 MG	4	MO; QL (30 per 30 days)
PROTONIX ORAL TABLET,DELAYED RELEASE (DR/EC) 40 MG	4	MO; QL (60 per 30 days)
PYLERA	4	MO; QL (120 per 180 days)
<i>rabeprazole oral tablet, delayed release (drlec)</i>	2	MO; QL (60 per 30 days)
<i>sucralfate oral suspension</i>	4	MO
<i>sucralfate oral tablet</i>	2	MO
TALICIA	4	MO; QL (168 per 180 days)
VOQUEZNA	4	ST; MO; QL (30 per 30 days)
VOQUEZNA DUAL PAK	4	MO; QL (112 per 180 days)
VOQUEZNA TRIPLE PAK	4	MO; QL (112 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
ZEGERID ORAL CAPSULE 20-1.1 MG-GRAM	5	MO; QL (30 per 30 days)
ZEGERID ORAL CAPSULE 40-1.1 MG-GRAM	5	QL (30 per 30 days)
IMMUNOLOGY, VACCINES / BIOTECHNOLOGY		
BIOTECHNOLOGY DRUGS		
ACTIMMUNE	5	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML	5	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 100 MCG/0.5 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML, 60 MCG/0.3 ML	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML	5	PA; MO
ARCALYST	5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	5	PA; MO; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	5	PA; MO; QL (1 per 28 days)
BESREMI	5	PA; LA
BETASERON SUBCUTANEOUS KIT	5	PA; MO; QL (14 per 28 days)
EGRIFTA SV	5	PA; 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	4	PA; MO
FULPHILA	5	PA; MO
FYLNETRA	5	PA
GENOTROPIN	5	PA; MO

Drug Name	Drug Tier	Requirements/Limits
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	4	PA; MO
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	5	PA; MO
GRANIX	5	PA; MO
HUMATROPE INJECTION CARTRIDGE	5	PA; MO
LEUKINE INJECTION RECON SOLN	5	PA; MO
NEULASTA	5	PA; MO
NEULASTA ONPRO	5	PA; MO
NEUPOGEN	5	PA; MO
NGENLA	5	PA; MO
NIVESTYM	5	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 10 MG/1.5 ML (6.7 MG/ML), 15 MG/1.5 ML (10 MG/ML), 5 MG/1.5 ML (3.3 MG/ML)	5	PA; MO
NORDITROPIN FLEXPRO SUBCUTANEOUS PEN INJECTOR 30 MG/3 ML (10 MG/ML)	5	PA
NUTROPIN AQ NUSPIN	5	PA; MO
NYVEPRIA	5	PA; MO
OMNITROPE	5	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION	5	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	5	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	5	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; MO; QL (1 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	5	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	5	PA; MO; QL (1 per 180 days)
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	5	PA; MO
REBIF (WITH ALBUMIN)	5	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	5	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	5	PA; MO; QL (4.2 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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
REBIF TITRATION PACK	5	PA; MO; QL (4.2 per 180 days)
RELEUKO SUBCUTANEOUS	4	PA; MO
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	5	PA; MO
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	5	PA; MO
SKYTROFA	5	PA; MO
SOGROYA	5	PA; MO
STIMUFEND	5	PA; MO
UDENYCA	5	PA; MO
UDENYCA AUTOINJECTOR	5	PA; MO
UDENYCA ONBODY	5	PA; MO
XOLREMDI	5	PA; LA
ZARXIO	5	PA; MO
ZIEXTENZO	5	PA; MO
ZOMACTON	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ABRYSVO (PF)	1	V
ACTHIB (PF)	3	
ADACEL(TDAP ADOLESN/ADULT)(PF)	1	V
AREXVY (PF)	1	V
BCG VACCINE, LIVE (PF)	1	V
BEXSERO	1	V
BIVIGAM	5	PA; MO
BOOSTRIX TDAP	1	V
DAPTACEL (DTAP PEDIATRIC) (PF)	3	
DYSPORT	4	PA; MO
ENGRIX-B (PF)	1	PA; V
ENGRIX-B PEDIATRIC (PF)	1	PA; V
GAMMAGARD LIQUID	5	PA; MO
GAMMAGARD S-D (IGA < 1 MCG/ML)	5	PA; MO
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	5	PA; MO
GAMMAPLEX	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
GAMMAPLEX (WITH SORBITOL)	5	PA; MO
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	5	PA; MO
GARDASIL 9 (PF)	1	V
GRASTEK	4	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	3	
HEPLISAV-B (PF)	1	PA; V
HIBERIX (PF)	3	
IMOVAX RABIES VACCINE (PF)	1	V
INFANRIX (DTAP) (PF)	3	
IPOL	1	V
IXCHIQ (PF)	1	V
IXIARO (PF)	1	V
JYNNEOS (PF)	1	PA; V
KINRIX (PF)	3	
MENACTRA (PF) INTRAMUSCULAR SOLUTION	1	V

Drug Name	Drug Tier	Requirements/Limits
MENQUADFI (PF)	1	V
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1	V
M-M-R II (PF)	1	V
OCTAGAM	5	PA; MO
ODACTRA	4	PA; MO
PANZYGA	5	PA; MO
PEDIARIX (PF)	3	
PEDVAX HIB (PF)	3	
PENBRAYA (PF)	1	V
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	3	
PREHEVBRIO (PF)	1	PA; V
PRIORIX (PF)	1	V
PRIVIGEN	5	PA; MO
PROQUAD (PF)	3	
QUADRACEL (PF)	3	
RABAVERT (PF)	1	V
RAGWITEK	4	MO
RECOMBIVAX HB (PF)	1	PA; V
ROTARIX ORAL SUSPENSION	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ROTARIX ORAL SUSPENSION FOR RECONSTITUTION	1	
ROTATEQ VACCINE	3	
SHINGRIX (PF)	1	V; QL (2 per 720 days)
TDVAX	1	V
TENIVAC (PF)	1	V
TETANUS,DIPHTHERIA TOX PED(PF)	3	
TICOVAC INTRAMUSCULAR SYRINGE 1.2 MCG/0.25 ML	3	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	3	V
TRUMENBA	1	V
TWINRIX (PF)	1	V
TYPHIM VI	1	V
VAQTA (PF) INTRAMUSCULAR SUSPENSION 25 UNIT/0.5 ML	3	
VAQTA (PF) INTRAMUSCULAR SUSPENSION 50 UNIT/ML	1	V

Drug Name	Drug Tier	Requirements/Limits
VAQTA (PF) INTRAMUSCULAR SYRINGE 25 UNIT/0.5 ML	3	
VAQTA (PF) INTRAMUSCULAR SYRINGE 50 UNIT/ML	1	V
VARIVAX (PF)	1	V
YF-VAX (PF)	1	V
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
NOVO PEN NEEDLE	3	PA; MO
BD AUTOSHIELD DUO PEN NEEDLE	3	PA; MO
BD INSULIN SYRINGE (HALF UNIT)	3	PA; MO
BD INSULIN SYRINGE 1 ML 25 GAUGE X 5/8", 1 ML 25 X 1"	3	PA
BD INSULIN SYRINGE U-500	3	PA; MO
BD INSULIN SYRINGE	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
BD NANO 2ND GEN PEN NEEDLE	3	PA; MO
BD ULTRA-FINE MICRO PEN NEEDLE	3	PA; MO
BD ULTRA-FINE MINI PEN NEEDLE	3	PA; MO
BD ULTRA-FINE NANO PEN NEEDLE	3	PA
BD ULTRA-FINE SHORT PEN NEEDLE	3	PA; MO
BD VEO INSULIN SYR (HALF UNIT)	3	PA; MO
BD VEO INSULIN SYRINGE UF	3	PA; MO
CEQR SIMPLICITY	3	MO
CEQR SIMPLICITY INSERTER	3	MO
PEN NEEDLES (NON-PREFERRED BRANDS)	4	PA

Drug Name	Drug Tier	Requirements/Limits
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5ML 30 GAUGE X 15/64"	4	PA
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16"	4	PA; MO
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64"	4	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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DROPLET INSULIN SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16	4	PA; MO
DROPLET MICRON PEN NEEDLE	4	PA; MO
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32"	4	PA; MO
DROPLET PEN NEEDLE 29 GAUGE X 3/8", 30 GAUGE X 5/16", 32 GAUGE X 5/16"	4	PA
DROPSAFE PEN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16"	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
DROPSAFE PEN NEEDLE 31 GAUGE X 3/16"	4	PA
GAUZE PADS 2 X 2	3	PA
INPEN (FOR HUMALOG) BLUE	4	
INPEN (FOR HUMALOG) GREY	4	
INPEN (FOR HUMALOG) PINK	4	
INPEN (NOVOLOG OR FIASP) BLUE	4	
INPEN (NOVOLOG OR FIASP) GREY	4	
INPEN (NOVOLOG OR FIASP) PINK	4	
BD INSULIN SYRINGE	3	PA
BD INSULIN SYRINGE	3	PA; MO
NOVO PEN NEEDLE 32 GAUGE X 1/4"	3	PA; MO
NOVO PEN NEEDLE 32 GAUGE X 1/5", 32 GAUGE X 1/6"	3	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD 5 G6 INTRO KIT (GEN 5)	3	MO; QL (1 per 720 days)
OMNIPOD 5 G6 PODS (GEN 5)	3	MO
OMNIPOD 5 G6-G7 INTRO KT(GEN5)	3	QL (1 per 720 days)
OMNIPOD 5 G6-G7 PODS (GEN 5)	3	
OMNIPOD DASH INTRO KIT (GEN 4)	3	QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	3	MO
OMNIPOD GO PODS	3	
OMNIPOD GO PODS 10 UNITS/DAY	3	
OMNIPOD GO PODS 15 UNITS/DAY	3	
OMNIPOD GO PODS 20 UNITS/DAY	3	
OMNIPOD GO PODS 25 UNITS/DAY	3	
OMNIPOD GO PODS 30 UNITS/DAY	3	
OMNIPOD GO PODS 40 UNITS/DAY	3	
BD PEN NEEDLE	3	PA

Drug Name	Drug Tier	Requirements/Limits
PEN NEEDLES (NON-PREFERRED BRANDS)	4	PA
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 29 GAUGE X 1/2"	4	PA
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	4	PA; MO
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16"	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TECHLITE INSULIN SYRINGE (HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16"	4	PA; MO
TECHLITE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32"	4	PA; MO
TECHLITE PEN NEEDLE NEEDLE 29 GAUGE X 3/8", 31 GAUGE X 1/4", 32 GAUGE X 5/16"	4	PA
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	4	PA

Drug Name	Drug Tier	Requirements/Limits
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 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16"	4	PA; MO
TRUEPLUS PEN NEEDLE NEEDLE 29 GAUGE X 1/2"	4	PA
TRUEPLUS PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32"	4	PA; MO
UNIFINE PENTIPS MAXFLOW	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32"	4	PA; MO
UNIFINE PENTIPS PLUS	4	PA; MO
UNIFINE PENTIPS PLUS MAXFLOW	4	PA
UNIFINE SAFECONTROL NEEDLE 30 GAUGE X 3/16", 32 GAUGE X 5/32"	4	PA
UNIFINE SAFECONTROL NEEDLE 30 GAUGE X 5/16"	4	PA; MO
UNIFINE SAFECONTROL PEN NEEDLE	4	PA
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 5/32"	4	PA

Drug Name	Drug Tier	Requirements/Limits
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 3/16"	4	PA; MO
INSULIN SYRINGES (NON-PREFERRED BRANDS)	4	PA
V-GO 20	4	MO
V-GO 30	4	MO
V-GO 40	4	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	MO
ALLOPURINOL ORAL TABLET 200 MG	4	
<i>colchicine</i>	2	MO
COLCRYS	4	ST; MO
<i>febuxostat</i>	2	MO
GLOPERBA	4	ST
MITIGARE	4	ST; MO
<i>probenecid</i>	2	MO
<i>probenecid-colchicine</i>	2	MO
ULORIC	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
OSTEOPOROSIS THERAPY		
ACTONEL ORAL TABLET 150 MG	4	ST; MO; QL (1 per 30 days)
ACTONEL ORAL TABLET 35 MG	4	ST; MO; QL (4 per 28 days)
<i>alendronate oral solution</i>	2	MO; QL (300 per 28 days)
<i>alendronate oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
ATELVIA	4	ST; MO; QL (4 per 28 days)
BINOSTO	4	ST; MO; QL (4 per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	5	PA; MO; QL (2.34 per 30 days)
EVISTA	4	MO
FORTEO	5	PA; MO; QL (2.4 per 28 days)
FOSAMAX ORAL TABLET 70 MG	4	ST; MO; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
FOSAMAX PLUS D	4	ST; MO; QL (4 per 28 days)
<i>ibandronate oral</i>	2	MO; QL (1 per 30 days)
PROLIA	4	PA; MO; QL (1 per 180 days)
<i>raloxifene</i>	2	MO
<i>risedronate oral tablet 150 mg</i>	2	MO; QL (1 per 30 days)
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	2	MO; QL (4 per 28 days)
<i>risedronate oral tablet 5 mg</i>	2	MO; QL (30 per 30 days)
<i>risedronate oral tablet, delayed release (drlec)</i>	4	MO; QL (4 per 28 days)
TERIPARATIDE SUBCUTANEOUS PEN INJECTOR 20 MCG/DOSE (620MCG/2.48ML)	5	PA; QL (2.48 per 28 days)
TYMLOS	5	PA; MO; QL (1.56 per 30 days)
OTHER RHEUMATOLOGICALS		
ABRILADA(CF) PEN	5	PA; QL (6 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ABRILADA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	5	PA; QL (2 per 28 days)
ABRILADA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (6 per 28 days)
ACTEMRA ACTPEN	5	PA; MO; QL (3.6 per 28 days)
ACTEMRA SUBCUTANEOUS	5	PA; MO; QL (3.6 per 28 days)
ADALIMUMAB-AACF	5	PA; MO; QL (6 per 28 days)
ADALIMUMAB-AATY SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days)
ADALIMUMAB-AATY SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	5	PA; QL (3 per 28 days)
ADALIMUMAB-AATY SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	5	PA; QL (2 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ADALIMUMAB-AATY SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (6 per 28 days)
ADALIMUMAB-ADAZ	5	PA; MO; QL (2.4 per 28 days)
ADALIMUMAB-ADBM (PREFERRED NDCS STARTING WITH 00597) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML, 40 MG/0.8 ML	5	PA; MO; QL (4 per 28 days)
ADALIMUMAB-ADBM (PREFERRED NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5	PA; MO; QL (2 per 28 days)
ADALIMUMAB-ADBM (PREFERRED NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ADALIMUMAB-ADBM (PREFERRED NDCS STARTING WITH 00597) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; MO; QL (4 per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS (PREFERRED NDCS STARTING WITH 00597)	5	PA; QL (6 per 180 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV (PREFERRED NDCS STARTING WITH 00597)	5	PA; QL (4 per 180 days)
ADALIMUMAB-FKJP SUBCUTANEOUS PEN INJECTOR KIT	5	PA; QL (6 per 28 days)
ADALIMUMAB-FKJP SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	5	PA; QL (2 per 28 days)
ADALIMUMAB-FKJP SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (6 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ADALIMUMAB-RYVK SUBCUTANEOUS AUTO-INJECTOR, KIT	5	PA; MO; QL (6 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.4 ML, 80 MG/0.8 ML	5	PA; MO; QL (2.4 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	5	PA; MO; QL (4.8 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML, 20 MG/0.2 ML	5	PA; MO; QL (0.4 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 20 MG/0.4 ML	5	PA; MO; QL (0.8 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA; MO; QL (2.4 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	5	PA; MO; QL (4.8 per 28 days)
ARAVA	5	MO; QL (30 per 30 days)
BENLYSTA SUBCUTANEOUS	5	PA; MO
CUPRIMINE	5	PA; MO
CYLTEZO(CF) PEN	5	PA; MO; QL (4 per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	5	PA; QL (6 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
CYLTEZO(CF) PEN PSORIASIS-UV	5	PA; QL (4 per 180 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	5	PA; MO; QL (2 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; MO; QL (4 per 28 days)
DEPEN TITRATABS	5	PA; MO
ENBREL MINI	5	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	5	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	5	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	5	PA; MO; QL (8 per 28 days)
HADLIMA	5	PA; MO; QL (4.8 per 28 days)
HADLIMA PUSHTOUCH	5	PA; MO; QL (4.8 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
HADLIMA(CF)	5	PA; MO; QL (2.4 per 28 days)
HADLIMA(CF) PUSHTOUCH	5	PA; MO; QL (2.4 per 28 days)
HULIO(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT	5	PA; QL (6 per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	5	PA; QL (2 per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; QL (6 per 28 days)
HUMIRA (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	5	PA; MO; QL (4 per 28 days)
HUMIRA PEN (PREFERRED NDCS STARTING WITH 00074)	5	PA; MO; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	5	PA; MO; QL (2 per 28 days)
HUMIRA(CF) (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	5	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEN (PREFERRED NDCS STARTING WITH 00074) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	5	PA; MO; QL (2 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) PEN CROHNS-UC-HS (PREFERRED NDCS STARTING WITH 00074)	5	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC (PREFERRED NDCS STARTING WITH 00074)	5	PA; MO; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS (PREFERRED NDCS STARTING WITH 00074)	5	PA; MO; QL (3 per 180 days)
HYRIMOZ (PREFERRED NDCS STARTING WITH 61314)	5	PA; QL (3.2 per 28 days)
HYRIMOZ PEN (PREFERRED NDCS STARTING WITH 61314)	5	PA; QL (3.2 per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER (PREFERRED NDCS STARTING WITH 61314)	5	PA; MO; QL (2.4 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ PEN PSORIASIS STARTER (PREFERRED NDCS STARTING WITH 61314)	5	PA; MO; QL (1.6 per 180 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	5	PA; MO; QL (0.2 per 28 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	5	PA; MO; QL (0.4 per 28 days)
HYRIMOZ(CF) (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	5	PA; QL (1.6 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ(CF) PEDI CROHN STARTER (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOU S SYRINGE 80 MG/0.8 ML	5	PA; MO; QL (2.4 per 180 days)
HYRIMOZ(CF) PEDI CROHN STARTER (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOU S SYRINGE 80 MG/0.8 ML- 40 MG/0.4 ML	5	PA; MO; QL (1.2 per 180 days)
HYRIMOZ(CF) PEN (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOU S PEN INJECTOR 40 MG/0.4 ML	5	PA; QL (1.6 per 28 days)
HYRIMOZ(CF) PEN (PREFERRED NDCS STARTING WITH 61314) SUBCUTANEOU S PEN INJECTOR 80 MG/0.8 ML	5	PA; MO; QL (1.6 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
IDACIO(CF)	5	PA; MO; QL (4 per 28 days)
IDACIO(CF) PEN	5	PA; MO; QL (4 per 28 days)
IDACIO(CF) PEN CROHN-UC STARTR	5	PA; MO; QL (6 per 180 days)
IDACIO(CF) PEN PSORIASIS START	5	PA; MO; QL (4 per 180 days)
KEVZARA SUBCUTANEOU S PEN INJECTOR 150 MG/1.14 ML	5	PA; QL (2.28 per 28 days)
KEVZARA SUBCUTANEOU S PEN INJECTOR 200 MG/1.14 ML	5	PA; MO; QL (2.28 per 28 days)
KEVZARA SUBCUTANEOU S SYRINGE	5	PA; MO; QL (2.28 per 28 days)
KINERET	5	PA; QL (20.1 per 30 days)
<i>leflunomide</i>	2	MO; QL (30 per 30 days)
OLUMIANT	5	PA; MO; QL (30 per 30 days)
ORENCIA CLICKJECT	5	PA; MO; QL (4 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	5	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	5	PA; MO; QL (1.6 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	5	PA; MO; QL (2.8 per 28 days)
OTEZLA ORAL TABLET 30 MG	5	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	5	PA; MO; QL (55 per 180 days)
OTREXUP (PF)	4	MO
<i>penicillamine</i>	5	PA; MO
RASUVO (PF)	4	MO
RIDAURA	5	MO
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	5	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	5	PA; MO; QL (84 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
SAVELLA ORAL TABLET	3	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	3	MO; QL (55 per 180 days)
SIMLANDI(CF) AUTOINJECTOR	5	PA; MO; QL (6 per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	5	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	5	PA; MO; QL (0.5 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	5	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	5	PA; MO; QL (0.5 per 28 days)
TOFIDENCE	5	PA; QL (160 per 28 days)
XELJANZ ORAL SOLUTION	5	PA; MO; QL (480 per 24 days)
XELJANZ ORAL TABLET	5	PA; MO; QL (60 per 30 days)
XELJANZ XR	5	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
YUFLYMA(CF) AI CROHN'S-UC-HS	5	PA; QL (3 per 180 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 40 MG/0.4 ML	5	PA; QL (4 per 28 days)
YUFLYMA(CF) AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR, KIT 80 MG/0.8 ML	5	PA; QL (2 per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.2 ML	5	PA; QL (2 per 28 days)
YUFLYMA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	5	PA; QL (4 per 28 days)
YUSIMRY(CF) PEN	5	PA; QL (4.8 per 28 days)

OBSTETRICS / GYNECOLOGY

ESTROGENS / PROGESTINS

ACTIVELLA	4	PA; MO
ANGELIQ	4	PA; MO
BIJUVA	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>camila</i>	2	MO
CLIMARA	4	PA; MO; QL (4 per 28 days)
CLIMARA PRO	4	PA; MO
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.14 MG/24 HR	4	PA; MO
COMBIPATCH TRANSDERMAL PATCH SEMIWEEKLY 0.05-0.25 MG/24 HR	4	PA
CRINONE VAGINAL GEL 4 %	4	MO
CRINONE VAGINAL GEL 8 %	4	PA; MO
<i>deblitane</i>	2	MO
DELESTROGEN INTRAMUSCULAR OIL 10 MG/ML, 20 MG/ML	4	MO
DEPO-ESTRADIOL	4	
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 150 MG/ML	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
DEPO-PROVERA INTRAMUSCULAR SYRINGE	4	MO
DEPO-SUBQ PROVERA 104	3	MO
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %)	4	PA; MO; QL (30 per 30 days)
DIVIGEL TRANSDERMAL GEL IN PACKET 1.25 MG/1.25 GRAM (0.1 %)	4	PA; MO; QL (37.5 per 30 days)
<i>dotti</i>	2	PA; MO; QL (8 per 28 days)
DUAVEE	3	MO
ELESTRIN	4	PA; MO; QL (70 per 30 days)
<i>errin</i>	2	MO
ESTRACE VAGINAL	4	ST; MO
<i>estradiol oral</i>	4	PA; MO
<i>estradiol transdermal gel in metered-dose pump</i>	2	PA; MO; QL (50 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>estradiol transdermal gel in packet 0.25 mg/0.25 gram (0.1 %), 0.5 mg/0.5 gram (0.1 %), 0.75 mg/0.75 gram (0.1%), 1 mg/gram (0.1 %)</i>	2	PA; MO; QL (30 per 30 days)
<i>estradiol transdermal gel in packet 1.25 mg/1.25 gram (0.1 %)</i>	2	PA; MO; QL (37.5 per 30 days)
<i>estradiol transdermal patch semiweekly</i>	2	PA; MO; QL (8 per 28 days)
<i>estradiol transdermal patch weekly</i>	2	PA; MO; QL (4 per 28 days)
<i>estradiol vaginal</i>	4	MO
<i>estradiol valerate</i>	4	MO
<i>estradiol-norethindrone acet</i>	2	PA; MO
ESTRING	4	ST; MO
EVAMIST	4	PA; MO; QL (16.2 per 30 days)
FEMRING	4	ST; MO
<i>fyavolv</i>	4	PA; MO
<i>heather</i>	2	MO
IMVEXXY MAINTENANCE PACK	3	MO
IMVEXXY STARTER PACK	3	MO
<i>incassia</i>	2	MO
<i>jinteli</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>lyleq</i>	2	MO
<i>lyllana</i>	2	PA; MO; QL (8 per 28 days)
<i>lyza</i>	2	
<i>medroxyprogesterone</i>	2	MO
MENEST	4	PA; MO
MENOSTAR	4	PA; MO; QL (4 per 28 days)
<i>mimvey</i>	2	PA; MO
MINIVELLE	4	PA; MO; QL (8 per 28 days)
<i>nora-be</i>	2	MO
<i>norethindrone (contraceptive)</i>	2	
<i>norethindrone acetate</i>	2	MO
<i>norethindrone aceth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	4	PA; MO
PREMARIN ORAL	3	MO
PREMARIN VAGINAL	3	MO
PREMPHASE	3	MO
PREMPRO	3	MO
<i>progesterone micronized</i>	2	MO
PROMETRIUM	4	MO
PROVERA	4	MO
<i>sharobel</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
VAGIFEM	4	ST; MO
VIVELLE-DOT	4	PA; MO; QL (8 per 28 days)
<i>yuvafem</i>	4	MO
MISCELLANEOUS OB/GYN		
ANNOVERA	4	MO
CLEOCIN VAGINAL	4	MO
<i>clindamycin phosphate vaginal</i>	2	MO
CLINDESSE	4	MO
<i>eluryng</i>	2	MO
<i>enilloring</i>	2	MO
<i>etonogestrel-ethinyl estradiol</i>	2	
GYNAZOLE-1	4	MO
<i>haloette</i>	2	MO
INTRAROSA	4	MO
KYLEENA	4	
LILETTA	3	MO
<i>metronidazole vaginal gel 0.75 % (37.5mg/5 gram)</i>	2	MO
<i>miconazole-3 vaginal suppository</i>	2	MO
MIRENA	4	
MYFEMBREE	5	PA; MO
NEXPLANON	3	
<i>norelgestromin-ethin.estradiol</i>	2	
NUVARING	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ORIAHNN	5	PA; MO
OSPHENA	4	MO
PHEXXI	4	MO
SKYLA	4	
terconazole	2	MO
tranexamic acid oral	2	MO
vandazole	2	MO
VEOZAH	4	PA; MO
XACIATO	4	ST; MO
xulane	2	MO
zafemy	2	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
altavera (28)	2	MO
alyacen 1/35 (28)	2	MO
amethia	2	
apri	2	MO
aranelle (28)	2	MO
ashlyna	2	MO
aubra eq	2	MO
aviane	2	MO
BALCOLTRA	4	MO
balziva (28)	2	MO
BEYAZ	4	MO
blisovi 24 fe	2	MO
blisovi fe 1.5/30 (28)	2	MO
briellyn	2	MO
camrese lo	2	MO

Drug Name	Drug Tier	Requirements/Limits
cryselle (28)	2	MO
cyred eq	2	MO
desog-e.estradiol/e.estradiol	2	
desogestrel-ethinyl estradiol	2	
dolishale	2	MO
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)	2	MO
drospirenone-ethinyl estradiol oral tablet 3-0.02 mg	2	
drospirenone-ethinyl estradiol oral tablet 3-0.03 mg	2	
enpresse	2	MO
enskyce	2	MO
estarylla	2	MO
ethynodiol diac-eth estradiol	2	
falmina (28)	2	MO
finzala	2	MO
gemmily	2	MO
hailey 24 fe	2	MO
iclevia	2	
introvale	2	
isibloom	2	MO
jasmie (28)	2	MO
joyeaux	2	MO
juleber	2	MO
june 1.5/30 (21)	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>junel 1/20 (21)</i>	2	MO
<i>junel fe 1.5/30 (28)</i>	2	MO
<i>junel fe 1/20 (28)</i>	2	MO
<i>junel fe 24</i>	2	MO
<i>kaitlib fe</i>	2	MO
<i>kariva (28)</i>	2	MO
<i>kelnor 1/35 (28)</i>	2	MO
<i>kelnor 1-50 (28)</i>	2	MO
<i>kurvelo (28)</i>	2	MO
<i>l norgestle.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	2	
<i>l norgestle.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	2	MO
<i>larin 1.5/30 (21)</i>	2	MO
<i>larin 1/20 (21)</i>	2	MO
<i>larin fe 1.5/30 (28)</i>	2	MO
<i>larin fe 1/20 (28)</i>	2	MO
<i>layolis fe</i>	2	MO
<i>lessina</i>	2	MO
<i>levonest (28)</i>	2	MO
<i>levonorgestrel-ethinyl estradiol oral tablet 0.1-20 mg-mcg</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>levonorgestrel-ethinyl estradiol oral tablet 0.15-0.03 mg, 90-20 mcg (28)</i>	2	
<i>levonorgestrel-ethinyl estradiol oral tablets,dose pack,3 month</i>	2	
<i>levonorg-eth estradiol triphasic</i>	2	
<i>levora-28</i>	2	MO
LO LOESTRIN FE	4	MO
LOESTRIN 1.5/30 (21)	4	MO
LOESTRIN 1/20 (21)	4	MO
LOESTRIN FE 1.5/30 (28-DAY)	4	MO
LOESTRIN FE 1/20 (28-DAY)	4	MO
<i>loryna (28)</i>	2	MO
<i>low-ogestrel (28)</i>	2	MO
<i>luteria (28)</i>	2	MO
<i>marlissa (28)</i>	2	MO
<i>merzee</i>	2	MO
<i>mibelas 24 fe</i>	2	MO
<i>microgestin 1.5/30 (21)</i>	2	MO
<i>microgestin 1/20 (21)</i>	2	MO
<i>microgestin 24 fe</i>	2	
<i>microgestin fe 1.5/30 (28)</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>microgestin fe 1/20 (28)</i>	2	MO
<i>mili</i>	2	MO
NATAZIA	4	MO
<i>necon 0.5/35 (28)</i>	2	MO
NEXTSTELLIS	4	MO
<i>nikki (28)</i>	2	MO
<i>noreth-ethinyl estradiol-iron</i>	2	
<i>norethindrone acetate estradiol oral tablet 1-20 mg-mcg</i>	2	MO
<i>norethindrone-estradiol-iron oral capsule</i>	2	
<i>norethindrone-estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1-20(5)/1-30(7) /1mg-35mcg (9)</i>	2	
<i>norethindrone-estradiol-iron oral tablet, chewable</i>	2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg</i>	2	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)</i>	2	MO
<i>nortrel 0.5/35 (28)</i>	2	MO
<i>nortrel 1/35 (21)</i>	2	MO
<i>nortrel 1/35 (28)</i>	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>nortrel 7/7/7 (28)</i>	2	MO
<i>nylia 1/35 (28)</i>	2	MO
<i>nylia 7/7/7 (28)</i>	2	MO
<i>nymyo</i>	2	
<i>ocella</i>	2	MO
<i>pimtrea (28)</i>	2	MO
<i>portia 28</i>	2	MO
<i>reclipsen (28)</i>	2	MO
<i>rivelsa</i>	2	MO
SAFYRAL	4	MO
<i>setlakin</i>	2	MO
<i>sprintec (28)</i>	2	MO
<i>sronyx</i>	2	MO
<i>syeda</i>	2	MO
<i>tarina 24 fe</i>	2	MO
<i>tarina fe 1-20 eq (28)</i>	2	MO
<i>tilia fe</i>	4	MO
<i>tri-estarylla</i>	2	MO
<i>tri-legest fe</i>	4	MO
<i>tri-lo-estarylla</i>	2	MO
<i>tri-lo-sprintec</i>	2	
<i>tri-mili</i>	2	
<i>tri-nymyo</i>	2	
<i>tri-sprintec (28)</i>	2	MO
<i>trivora (28)</i>	2	MO
<i>tri-vylibra</i>	2	MO
<i>tri-vylibra lo</i>	2	MO
<i>turqoz (28)</i>	2	MO
<i>tydemy</i>	2	
<i>velivet triphasic regimen (28)</i>	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>vestura (28)</i>	2	MO
<i>vienva</i>	2	MO
<i>vyfemla (28)</i>	2	MO
<i>vylibra</i>	2	MO
<i>wymzya fe</i>	2	MO
YASMIN (28)	4	MO
YAZ (28)	4	MO
<i>zovia 1-35 (28)</i>	2	MO

OPHTHALM OLOGY

ANTIBIOTICS

AZASITE	4	MO
<i>bacitracin ophthalmic (eye)</i>	2	MO
<i>bacitracin- polymyxin b</i>	2	MO
BESIVANCE	4	MO
CILOXAN OPHTHALMIC (EYE) OINTMENT	4	MO
<i>ciprofloxacin hcl ophthalmic (eye)</i>	2	MO
<i>erythromycin ophthalmic (eye)</i>	2	MO; QL (3.5 per 14 days)
<i>gatifloxacin</i>	4	MO
<i>gentamicin ophthalmic (eye) drops</i>	2	MO; QL (70 per 30 days)
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>moxifloxacin ophthalmic (eye) drops</i>	2	MO
NATACYN	4	
<i>neomycin- bacitracin- polymyxin</i>	2	MO
<i>neomycin- polymyxin- gramicidin</i>	2	MO
<i>neo-polycin</i>	2	
OCUFLOX	4	MO
<i>ofloxacin ophthalmic (eye)</i>	2	MO
<i>polycin</i>	2	
<i>polymyxin b sulf- trimethoprim</i>	2	MO
<i>tobramycin ophthalmic (eye)</i>	2	MO; QL (10 per 14 days)
TOBREX OPHTHALMIC (EYE) OINTMENT	4	MO; QL (3.5 per 14 days)
VIGAMOX	4	MO
ANTIVIRALS		
<i>trifluridine</i>	2	MO
ZIRGAN	4	MO
BETA- BLOCKERS		
<i>betaxolol ophthalmic (eye)</i>	2	MO
BETIMOL	4	MO
BETOPTIC S	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>carteolol</i>	2	MO
ISTALOL	4	MO
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	2	MO
<i>timolol maleate (pf)</i>	2	MO
<i>timolol maleate ophthalmic (eye) drops</i>	1	MO
<i>timolol maleate ophthalmic (eye) drops, once daily</i>	2	MO
<i>timolol maleate ophthalmic (eye) gel forming solution</i>	4	MO
TIMOPTIC OCUDOSE (PF)	4	MO
MISCELLANEOUS OPHTHALMOLOGICS		
ALOMIDE	4	MO
<i>atropine ophthalmic (eye) drops 1 %</i>	2	MO
<i>azelastine ophthalmic (eye)</i>	2	MO
<i>bepotastine besilate</i>	2	MO
BEPREVE	4	MO
BYOOVIZ	5	PA; MO
CEQUA	4	MO; QL (60 per 30 days)
<i>cromolyn ophthalmic (eye)</i>	2	

Drug Name	Drug Tier	Requirements/Limits
<i>cyclosporine ophthalmic (eye)</i>	2	MO; QL (60 per 30 days)
CYSTADROPS	5	PA
CYSTARAN	5	PA
<i>epinastine</i>	2	MO
LACRISERT	4	PA
MIEBO (PF)	3	MO; QL (12 per 30 days)
OXERVATE	5	PA; MO
PHOSPHOLINE IODIDE	4	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	2	MO
RESTASIS	4	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	4	MO; QL (5.5 per 30 days)
<i>sulfacetamide sodium ophthalmic (eye) drops</i>	2	MO
<i>sulfacetamide sodium ophthalmic (eye) ointment</i>	2	
<i>sulfacetamide-prednisolone</i>	2	MO
TYRVAYA	4	MO; QL (8.4 per 30 days)
VEVYE	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
VUITY	4	PA; MO
XDEMVEY	5	PA; QL (10 per 42 days)
XIIDRA	3	MO; QL (60 per 30 days)

NON-STEROIDAL ANTI-INFLAMMATORY AGENTS

ACULAR	4	MO
ACULAR LS	4	MO
ACUVAIL (PF)	4	MO
<i>bromfenac</i>	2	MO
BROMSITE	4	MO
<i>diclofenac sodium ophthalmic (eye)</i>	2	MO
<i>flurbiprofen sodium</i>	2	MO
ILEVRO	4	MO
<i>ketorolac ophthalmic (eye)</i>	2	MO
NEVANAC	4	MO
PROLENSA	4	MO

ORAL DRUGS FOR GLAUCOMA

<i>acetazolamide</i>	2	MO
<i>methazolamide</i>	4	MO

OTHER GLAUCOMA DRUGS

AZOPT	4	MO
-------	---	----

Drug Name	Drug Tier	Requirements/Limits
<i>bimatoprost ophthalmic (eye)</i>	2	MO
<i>brimonidine-timolol</i>	2	MO
<i>brinzolamide</i>	2	MO
COMBIGAN	4	MO
COSOPT	4	MO
COSOPT (PF)	4	MO
<i>dorzolamide</i>	2	
<i>dorzolamide-timolol</i>	2	MO
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	2	MO
IYUZEH (PF)	4	ST; MO
<i>latanoprost</i>	1	MO
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	3	MO
RHOPRESSA	3	MO
ROCKLATAN	3	MO
SIMBRINZA	3	MO
<i>tafluprost (pf)</i>	2	MO
TRAVATAN Z	4	ST; MO
<i>travoprost</i>	2	MO
VYZULTA	4	ST; MO
XALATAN	4	ST; MO
XELPROS	4	ST
ZIOPTAN (PF)	4	ST; MO

STEROID-ANTIBIOTIC COMBINATIONS

MAXITROL	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-bacitracin-poly-hc</i>	2	MO
<i>neomycin-polymyxin b-dexameth</i>	2	MO
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	4	MO
<i>neo-polycin hc</i>	2	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	3	MO; QL (3.5 per 14 days)
<i>tobramycin-dexamethasone</i>	2	MO; QL (10 per 14 days)
ZYLET	4	MO; QL (10 per 14 days)
STEROIDS		
ALREX	4	MO
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	2	MO
<i>difluprednate</i>	2	MO
DUREZOL	4	MO
EYSUVIS	4	PA; MO; QL (8.3 per 14 days)
<i>fluorometholone</i>	2	MO
FML FORTE	4	MO
FML LIQUIFILM	4	MO
INVELTYS	3	MO
LOTEMAX	4	MO
LOTEMAX SM	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>loteprednol etabonate</i>	2	MO
MAXIDEX	4	MO
PRED FORTE	4	MO
PRED MILD	4	MO
<i>prednisolone acetate</i>	2	MO
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	2	MO
SYMPATHOMIMETICS		
ALPHAGAN P	4	MO
<i>apraclonidine</i>	2	MO
<i>brimonidine ophthalmic (eye)</i>	2	MO
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	4	MO
RESPIRATORY AND ALLERGY		
ANTI-HISTAMINE / ANTI-ALLERGIC AGENTS		
AUVI-Q	4	QL (2 per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	2	MO
CLARINEX ORAL TABLET	4	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
CLARINEX-D 12 HOUR	4	QL (60 per 30 days)
<i>desloratadine</i>	2	MO; QL (30 per 30 days)
EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.15 ML	4	MO; QL (2 per 30 days)
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	2	MO; QL (2 per 30 days)
EPINEPHRINE INJECTION AUTO-INJECTOR 0.3 MG/0.3 ML (MANUFACTURED BY MYLAN SPECIALTY)	4	QL (2 per 30 days)
EPIPEN 2-PAK	4	QL (2 per 30 days)
EPIPEN JR 2-PAK	4	QL (2 per 30 days)
<i>hydroxyzine hcl oral tablet</i>	2	PA; MO
<i>levocetirizine oral solution</i>	4	MO
<i>levocetirizine oral tablet</i>	2	MO; QL (30 per 30 days)
<i>promethazine oral</i>	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
PULMONARY AGENTS		
<i>acetylcysteine</i>	2	PA; MO
ADCIRCA	5	PA; MO; QL (60 per 30 days)
ADEMPAS	5	PA; MO; LA; QL (90 per 30 days)
ADVAIR DISKUS	4	MO; QL (60 per 30 days)
ADVAIR HFA	3	MO; QL (12 per 30 days)
AIRDUO DIGIHALER	4	ST; QL (1 per 30 days)
AIRDUO RESPICLICK	4	ST; MO; QL (1 per 30 days)
AIRSUPRA	4	ST; MO; QL (32.1 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcglactuation</i>	2	MO; QL (17 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcglactuation package size 6.7 gm</i>	2	QL (13.4 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (NDA020983)	4	ST; QL (36 per 30 days)
<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>	2	PA; MO
<i>albuterol sulfate oral syrup</i>	2	MO
<i>albuterol sulfate oral tablet</i>	4	MO
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)
<i>alyq</i>	5	PA; QL (60 per 30 days)
<i>ambrisentan</i>	5	PA; MO; LA; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ANORO ELLIPTA	4	ST; MO; QL (60 per 30 days)
<i>arformoterol</i>	4	PA; MO; QL (120 per 30 days)
ARMONAIR DIGIHALER	4	ST; QL (1 per 30 days)
ARNUITY ELLIPTA	4	ST; MO; QL (30 per 30 days)
ASMANEX HFA	3	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ACTUATION (30), 220 MCG/ACTUATION (30)	3	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ACTUATION (120)	3	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (60)	3	QL (1 per 30 days)
ATROVENT HFA	4	MO; QL (25.8 per 30 days)
<i>azelastine-fluticasone</i>	2	MO; QL (23 per 30 days)
BERINERT INTRAVENOUS KIT	5	PA; MO
BEVESPI AEROSPHERE	3	MO; QL (10.7 per 30 days)
<i>bosentan</i>	5	PA; MO; LA; QL (60 per 30 days)
BREO ELLIPTA	3	MO; QL (60 per 30 days)
<i>breyna</i>	2	MO; QL (10.3 per 30 days)
BREZTRI AEROSPHERE	3	MO; QL (10.7 per 30 days)
BROVANA	5	PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	4	PA; MO; QL (120 per 30 days)
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	4	PA; MO; QL (60 per 30 days)
<i>budesonide-formoterol</i>	2	QL (10.2 per 30 days)
CINRYZE	5	PA; MO
COMBIVENT RESPIMAT	3	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	2	PA; MO
DALIRESP	4	PA; MO; QL (30 per 30 days)
DUAKLIR PRESSAIR	5	ST; MO; QL (1 per 30 days)
DULERA	3	MO; QL (13 per 30 days)
DYMISTA	4	MO; QL (23 per 30 days)
ESBRIET ORAL CAPSULE	5	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 267 MG	5	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 viii. 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 drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ESBRIET ORAL TABLET 801 MG	5	PA; MO; QL (90 per 30 days)
FASENRA PEN	5	PA; MO; QL (1 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	5	PA; MO; QL (0.5 per 28 days)
FASENRA SUBCUTANEOUS SYRINGE 30 MG/ML	5	PA; MO; QL (1 per 28 days)
FIRAZYR	5	PA; MO
<i>flunisolide</i>	2	MO; QL (50 per 30 days)
FLUTICASONE FUROATE-VILANTEROL	4	ST; MO; QL (60 per 30 days)
FLUTICASONE PROPIONATE INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	4	ST; MO; QL (60 per 30 days)
FLUTICASONE PROPIONATE INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	4	ST; MO; QL (240 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	4	ST; MO; QL (12 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	4	ST; MO; QL (24 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	4	ST; MO; QL (10.6 per 30 days)
<i>fluticasone propionate nasal</i>	2	MO; QL (16 per 30 days)
FLUTICASONE PROPION-SALMETEROL INHALATION AEROSOL POWDER BREATH ACTIVATED	4	ST; MO; QL (1 per 30 days)
<i>fluticasone propionate-salmeterol inhalation blister with device</i>	2	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
FLUTICASONE PROPION- SALMETEROL INHALATION HFA AEROSOL INHALER	4	ST; MO; QL (12 per 30 days)
<i>formoterol fumarate</i>	4	PA; MO; QL (120 per 30 days)
HAEGARDA	5	PA; MO; LA
<i>icatibant</i>	5	PA; MO
INCRUSE ELLIPTA	4	ST; MO; QL (30 per 30 days)
<i>ipratropium bromide inhalation</i>	2	PA; MO
<i>ipratropium- albuterol</i>	2	PA; MO
KALYDECO	5	PA; MO; QL (56 per 28 days)
LETAIRIS	5	PA; MO; LA; QL (30 per 30 days)
<i>levalbuterol hcl</i>	2	PA; MO
LEVALBUTERO L TARTRATE	4	ST; MO; QL (30 per 30 days)
LIQREV	5	PA; MO; QL (244 per 30 days)
<i>mometasone nasal</i>	2	MO; QL (34 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>montelukast oral granules in packet</i>	4	MO
<i>montelukast oral tablet</i>	1	MO
<i>montelukast oral tablet, chewable</i>	2	MO
NUCALA SUBCUTANEOU S AUTO- INJECTOR	5	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOU S RECON SOLN	5	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOU S SYRINGE 100 MG/ML	5	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOU S SYRINGE 40 MG/0.4 ML	5	PA; MO; LA; QL (0.4 per 28 days)
OFEV	5	PA; MO; QL (60 per 30 days)
OMNARIS	4	ST; MO; QL (12.5 per 30 days)
OPSUMIT	5	PA; MO; LA; QL (30 per 30 days)
OPSYNVI	5	PA; MO; QL (30 per 30 days)
ORKAMBI ORAL GRANULES IN PACKET	5	PA; MO; QL (56 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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI ORAL TABLET	5	PA; MO; QL (112 per 28 days)
ORLADEYO	5	PA; LA
PERFOROMIST	5	PA; MO; QL (120 per 30 days)
<i>pirfenidone oral capsule</i>	5	PA; MO; QL (270 per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	5	PA; MO; QL (270 per 30 days)
PIRFENIDONE ORAL TABLET 534 MG	5	PA; QL (90 per 30 days)
<i>pirfenidone oral tablet 801 mg</i>	5	PA; MO; QL (90 per 30 days)
PROAIR DIGIHALER	4	ST; QL (2 per 30 days)
PROAIR RESPICLICK	4	ST; MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	3	MO; QL (2 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	3	MO; QL (1 per 30 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML	4	PA; MO; QL (120 per 30 days)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 1 MG/2 ML	4	PA; MO; QL (60 per 30 days)
PULMOZYME	5	PA; MO
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	4	ST; MO; QL (6.8 per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	4	ST; MO; QL (10.6 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	3	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	3	MO; QL (21.2 per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	5	PA; MO; QL (224 per 30 days)
REVATIO ORAL TABLET	5	PA; MO; QL (90 per 30 days)
<i>roflumilast</i>	4	PA; MO; QL (30 per 30 days)
RUCONEST	5	PA; MO
RYALTRIS	4	ST; MO; QL (29 per 30 days)
<i>sajazir</i>	5	PA; MO
SEREVENT DISKUS	4	ST; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>sildenafil</i> (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml	5	PA; MO; QL (224 per 30 days)
<i>sildenafil</i> (pulmonary arterial hypertension) oral tablet 20 mg	2	PA; MO; QL (90 per 30 days)
SINGULAIR	4	MO
SPIRIVA RESPIMAT	3	MO; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER	4	ST; MO; QL (90 per 90 days)
STIOLTO RESPIMAT	3	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	3	MO; QL (4 per 30 days)
SYMBICORT	4	ST; MO; QL (10.2 per 30 days)
SYMDEKO	5	PA; MO; QL (56 per 28 days)
<i>tadalafil</i> (pulmonary arterial hypertension) oral tablet 20 mg	5	PA; QL (60 per 30 days)
TADLIQ	5	PA; MO; QL (300 per 30 days)
TAKHZYRO	5	PA; MO; LA
<i>terbutaline oral</i>	4	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
TEZSPIRE	5	PA; MO; QL (1.91 per 30 days)
THEO-24	4	MO
<i>theophylline oral solution</i>	4	
<i>theophylline oral tablet extended release 12 hr</i>	2	MO
<i>theophylline oral tablet extended release 24 hr</i>	2	MO
<i>tiotropium bromide</i>	2	QL (90 per 90 days)
TRACLEER ORAL TABLET	5	PA; MO; LA; QL (60 per 30 days)
TRACLEER ORAL TABLET FOR SUSPENSION	5	PA; MO; LA; QL (112 per 28 days)
TRELEGY ELLIPTA	3	MO; QL (60 per 30 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	5	PA; MO; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	5	PA; MO; QL (84 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION	4	ST; MO; QL (1 per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATION (30 ACTUAT)	4	ST; QL (1 per 30 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16 MCG, 32 MCG, 48 MCG, 64 MCG	5	PA; MO; QL (112 per 28 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 16(112)-32(112) - 48(28) MCG	5	PA; MO; QL (252 per 180 days)
TYVASO DPI INHALATION CARTRIDGE WITH INHALER 32-48 MCG	5	PA; MO; QL (224 per 28 days)
VENTOLIN HFA	4	ST; MO; QL (36 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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>wixela inhub</i>	2	QL (60 per 30 days)
XHANCE	4	ST; MO; QL (32 per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	5	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	5	PA; MO; LA; QL (1 per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN	5	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	5	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	5	PA; MO; LA; QL (1 per 28 days)
XOPENEX HFA	4	ST; MO; QL (30 per 30 days)
YUPELRI	5	PA; MO; QL (90 per 30 days)
<i>zafirlukast</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
ZETONNA	4	ST; MO; QL (6.1 per 30 days)
<i>zileuton</i>	5	MO
ZYFLO	5	MO

UROLOGICALS

ANTICHOLINERGICS / ANTISPASMODICS

<i>darifenacin</i>	2	MO
DETROL	4	MO
DETROL LA	4	MO
<i>fesoterodine</i>	2	MO
<i>flavoxate</i>	2	MO
GEMTESA	4	MO
<i>mirabegron</i>	2	MO
MYRBETRIQ ORAL SUSPENSION, EXTENDED RELEASE	3	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	3	MO
<i>oxybutynin chloride oral syrup</i>	2	MO
<i>oxybutynin chloride oral tablet 5 mg</i>	2	MO
<i>oxybutynin chloride oral tablet extended release 24hr</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
OXYTROL	4	MO; QL (8 per 28 days)
<i>solifenacin</i>	2	MO
<i>tolterodine</i>	2	MO
TOVIAZ	4	MO
<i>tropium</i>	2	MO
VESICARE	4	MO
VESICARE LS	4	MO
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY		
<i>alfuzosin</i>	2	MO
<i>dutasteride</i>	2	MO
<i>dutasteride-tamsulosin</i>	4	MO
ENTADFI	4	PA; QL (30 per 30 days)
<i>finasteride oral tablet 5 mg</i>	1	MO
FLOMAX	4	MO
PROSCAR	4	MO
RAPAFLO	4	MO
<i>silodosin</i>	2	MO
<i>tamsulosin</i>	1	MO
UROXATRAL	4	MO
MISCELLANEOUS UROLOGICALS		
<i>bethanechol chloride</i>	2	MO
CIALIS ORAL TABLET 2.5 MG	4	PA; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
CIALIS ORAL TABLET 5 MG	4	PA; MO; QL (30 per 30 days)
CYSTAGON	4	PA; LA
ELMIRON	3	MO
<i>potassium citrate oral tablet extended release</i>	2	MO
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	5	PA; MO
RIVFLOZA	5	PA
<i>tadalafil oral tablet 2.5 mg</i>	4	PA; MO; QL (60 per 30 days)
<i>tadalafil oral tablet 5 mg</i>	4	PA; MO; QL (30 per 30 days)
UROCIT-K 10	4	MO
UROCIT-K 15	4	MO
UROCIT-K 5	4	MO
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
<i>klor-con 10</i>	2	MO
<i>klor-con 8</i>	2	MO
<i>klor-con m10</i>	2	MO
<i>klor-con m15</i>	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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
<i>klor-con m20</i>	2	MO
<i>klor-con oral packet 20</i>	4	MO
<i>magnesium sulfate injection solution</i>	4	MO
<i>magnesium sulfate injection syringe</i>	4	
<i>potassium chloride-d5-0.45%nacl</i>	4	
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	4	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	4	
<i>potassium chloride intravenous</i>	4	
<i>potassium chloride oral capsule, extended release</i>	2	MO
<i>potassium chloride oral liquid</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride oral packet</i>	4	
<i>potassium chloride oral tablet extended release 10 meq, 8 meq</i>	2	MO
<i>potassium chloride oral tablet extended release 20 meq</i>	2	
<i>potassium chloride oral tablet,er particles/crystals 10 meq</i>	2	MO
<i>potassium chloride oral tablet,er particles/crystals 15 meq, 20 meq</i>	2	
<i>potassium chloride-0.45 % nacl</i>	4	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	4	
<i>potassium chloride-d5-0.9%nacl</i>	4	
<i>sodium chloride 0.45 % intravenous</i>	4	MO
<i>sodium chloride 3 % hypertonic</i>	4	
<i>sodium chloride 5 % hypertonic</i>	4	MO
TPN ELECTROLYTES	4	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE	4	PA
CLINIMIX 4.25%/D10W SULF FREE	4	PA
CLINIMIX 5%-D20W(SULFITE-FREE)	4	PA
CLINIMIX E 4.25%/D10W SULF FREE	4	PA
CLINIMIX E 4.25%/D5W SULF FREE	4	PA
CLINIMIX E 5%/D15W SULFIT FREE	4	PA
CLINIMIX E 5%/D20W SULFIT FREE	4	PA
CLINISOL SF 15 %	4	PA
DOJOLVI	5	PA; MO; LA
<i>electrolyte-148</i>	2	
<i>intralipid intravenous emulsion 20 %</i>	4	PA
INTRALIPID INTRAVENOUS EMULSION 30 %	4	PA
ISOLYTE S PH 7.4	4	

Drug Name	Drug Tier	Requirements/Limits
ISOLYTE-P IN 5 % DEXTROSE	4	
NUTRILIPID	4	PA
PLASMA-LYTE 148	4	
PLASMA-LYTE A	4	
PLENAMINE	4	PA
<i>premasol 10 %</i>	4	PA
PROSOL 20 %	4	PA
<i>travasol 10 %</i>	4	PA
TROPHAMINE 10 %	4	PA
VITAMINS / HEMATINICS		
<i>fluoride (sodium) oral tablet</i>	2	
<i>prenatal vitamin oral tablet</i>	2	

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 viii. 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](https://www.express-scripts.com).

This drug list was updated in August 2024.

Index

<i>abacavir</i>	2	ACZONE.....	76	AIMOVIG	
<i>abacavir-lamivudine</i>	2	ADACEL(TDAP		AUTOINJECTOR.....	34
ABELCET.....	1	ADOLESN/ADULT)(PF)...	110	AIRDUO DIGIHALER....	136
ABILIFY.....	48	ADALIMUMAB-AACF....	119	AIRDUO RESPICLICK....	136
ABILIFY ASIMTUFII.....	47	ADALIMUMAB-AATY....	119	AIRSUPRA.....	136
ABILIFY MAINTENA.....	47	ADALIMUMAB-ADAZ....	119	AJOVY AUTOINJECTOR..	34
ABILIFY MYCITE		ADALIMUMAB-ADB		AJOVY SYRINGE.....	34
MAINTENANCE KIT.....	48	(PREFERRED NDCS		AKEEGA.....	15
ABILIFY MYCITE		STARTING WITH 00597)		AKLIEF.....	76
STARTER KIT.....	48		119, 120	<i>ala-cort</i>	80
<i>abiraterone</i>	15	ADALIMUMAB-		ALA-SCALP.....	80
ABRILADA(CF).....	119	ADB(M(CF) PEN CROHNS		<i>albendazole</i>	8
ABRILADA(CF) PEN.....	118	(PREFERRED NDCS		<i>albuterol sulfate</i>	136, 137
ABRYSVO (PF).....	110	STARTING WITH 00597).	120	ALBUTEROL SULFATE..	137
ABSORICA.....	75	ADALIMUMAB-		<i>alclometasone</i>	80
ABSORICA LD.....	75	ADB(M(CF) PEN PS-UV		<i>alcohol pads</i>	89
<i>acamprosate</i>	83	(PREFERRED NDCS		ALDACTONE.....	62
ACANYA.....	76	STARTING WITH 00597).	120	ALECENSA.....	15
<i>acarbose</i>	89	ADALIMUMAB-FKJP.....	120	<i>alendronate</i>	118
<i>accutane</i>	76	ADALIMUMAB-RYVK....	120	<i>alfuzosin</i>	145
<i>acebutolol</i>	62	<i>adapalene</i>	76	<i>aliskiren</i>	62
<i>acetaminophen-caff-</i>		<i>adapalene-benzoyl peroxide</i>	76	ALKINDI SPRINKLE.....	87
<i>dihydrocod</i>	40	ADBRY.....	74	<i>allopurinol</i>	117
<i>acetaminophen-codeine</i>	40	ADCIRCA.....	136	ALLOPURINOL.....	117
<i>acetazolamide</i>	134	ADDERALL.....	48	<i>almotriptan malate</i>	34
<i>acetic acid</i>	87	ADDERALL XR.....	48	ALOGLIPTIN.....	89
<i>acetylcysteine</i>	136	<i>adefovir</i>	2	ALOGLIPTIN-	
<i>acitretin</i>	72	ADEMPAS.....	136	METFORMIN.....	89
ACTEMRA.....	119	ADLARITY.....	35	ALOGLIPTIN-	
ACTEMRA ACTPEN.....	119	ADMELOG SOLOSTAR		PIOGLITAZONE.....	89
ACTHAR.....	87	U-100 INSULIN.....	89	ALOMIDE.....	133
ACTHIB (PF).....	110	ADMELOG U-100		<i>alosetron</i>	100
ACTIMMUNE.....	107	INSULIN LISPRO.....	89	ALPHAGAN P.....	135
ACTIVELLA.....	126	ADVAIR DISKUS.....	136	ALREX.....	135
ACTONEL.....	118	ADVAIR HFA.....	136	ALTABAX.....	78
ACTOPLUS MET.....	89	ADZENYS XR-ODT.....	48	ALTACE.....	62
ACTOS.....	89	AEMCOLO.....	8	<i>altavera (28)</i>	129
ACULAR.....	134	AFINITOR.....	15	ALTOPREV.....	69
ACULAR LS.....	134	AFINITOR DISPERZ.....	15	ALTRENO.....	76
ACUVAIL (PF).....	134	AFREZZA.....	89	ALUNBRIG.....	15
<i>acyclovir</i>	2, 79	AGAMREE.....	87	ALVAIZ.....	67
<i>acyclovir sodium</i>	2	AGRYLIN.....	83	ALVESCO.....	137

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 viii. 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 drug list was updated in August 2024.

<i>alyacen 1/35 (28)</i>	129	ANGELIQ.....	126	<i>asenapine maleate</i>	49
<i>alyq</i>	137	ANNOVERA.....	128	<i>ashlyna</i>	129
<i>amantadine hcl</i>	2	ANORO ELLIPTA.....	137	ASMANEX HFA.....	137
AMBIEN.....	48	ANTIVERT.....	100	ASMANEX	
AMBIEN CR.....	48	ANUSOL-HC.....	100	TWISTHALER.....	137, 138
AMBISOME.....	1	ANZEMET.....	100	<i>aspirin-dipyridamole</i>	67
<i>ambrisentan</i>	137	<i>apexicon e</i>	80	ASPRUZYO SPRINKLE.....	71
<i>amcinonide</i>	80	APIDRA SOLOSTAR U-		ASSURE ID INSULIN	
<i>amethia</i>	129	100 INSULIN.....	89	SAFETY.....	112
<i>amikacin</i>	8	APIDRA U-100 INSULIN..	89	ASTAGRAF XL.....	15
<i>amiloride</i>	62	APLENZIN.....	48	ATACAND.....	62
<i>amiloride-hydrochlorothiazide</i>	62	APOKYN.....	32	ATACAND HCT.....	62
<i>amiodarone</i>	62	<i>apomorphine</i>	32	<i>atazanavir</i>	2
AMITIZA.....	100	<i>apraclonidine</i>	135	ATELVIA.....	118
<i>amitriptyline</i>	48	<i>aprepitant</i>	100	<i>atenolol</i>	62
AMJEVITA (PREFERRED		<i>apri</i>	129	<i>atenolol-chlorthalidone</i>	62
NDCS STARTING WITH		APRISO.....	100	ATIVAN.....	49
55513).....	120, 121	APTENSIO XR.....	48	<i>atomoxetine</i>	49
<i>amlodipine</i>	62	APTIOM.....	26	ATORVALIQ.....	69
<i>amlodipine-atorvastatin</i>	69	APTIVUS.....	2	<i>atorvastatin</i>	69
<i>amlodipine-benazepril</i>	62	ARALAST NP.....	83	<i>atovaquone</i>	8
<i>amlodipine-olmesartan</i>	62	<i>aranelle (28)</i>	129	<i>atovaquone-proguanil</i>	8
<i>amlodipine-valsartan</i>	62	ARANESP (IN		ATRALIN.....	76
<i>amlodipine-valsartan-</i>		POLYSORBATE).....	107, 108	<i>atropine</i>	133
<i>hcthiacid</i>	62	ARAVA.....	121	ATROVENT HFA.....	138
<i>ammonium lactate</i>	74	ARAZLO.....	76	AUBAGIO.....	36
<i>amnesteem</i>	76	ARCALYST.....	108	<i>aubra eq</i>	129
<i>amoxapine</i>	48	AREXVY (PF).....	110	AUGMENTIN.....	12
<i>amoxicil-clarithromy-</i>		<i>arformoterol</i>	137	AUGMENTIN ES-600.....	12
<i>lansopraz</i>	105	ARICEPT.....	36	AUGTYRO.....	15
<i>amoxicillin</i>	11	ARIKAYCE.....	8	AUSTEDO.....	36
<i>amoxicillin-pot clavulanate</i>	11	ARIMIDEX.....	15	AUSTEDO XR.....	36
<i>amphetamine sulfate</i>	48	<i>aripiprazole</i>	48	AUSTEDO XR	
<i>amphotericin b</i>	1	ARISTADA.....	48, 49	TITRATION KT(WK1-4)....	36
<i>amphotericin b liposome</i>	1	ARISTADA INITIO.....	48	AUVELITY.....	49
<i>ampicillin</i>	11	ARIXTRA.....	67	AUVI-Q.....	135
<i>ampicillin sodium</i>	11	<i>armodafinil</i>	49	AVALIDE.....	62
<i>ampicillin-sulbactam</i>	12	ARMONAIR DIGIHALER		AVAPRO.....	63
AMPYRA.....	36		137	AVEED.....	96
ANAFRANIL.....	48	ARNUITY ELLIPTA.....	137	<i>aviane</i>	129
<i>anagrelide</i>	83	AROMASIN.....	15	AVONEX.....	108
<i>anastrozole</i>	15	ARTHROTEC 50.....	44	AVYCAZ.....	6
ANCOBON.....	1	ARTHROTEC 75.....	44	AYVAKIT.....	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 viii. 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 drug list was updated in August 2024.

AZACTAM.....	8	BD INSULIN SYRINGE		BETOPTIC S.....	132
AZASAN.....	16	U-500.....	112	BEVESPI AEROSPHERE..	138
AZASITE.....	132	BD INSULIN SYRINGE		<i>bexarotene</i>	16
<i>azathioprine</i>	16	ULTRA-FINE.....	112	BEXSERO.....	110
<i>azelaic acid</i>	76	BD NANO 2ND GEN PEN		BEYAZ.....	129
<i>azelastine</i>	87, 133	NEEDLE.....	113	<i>bicalutamide</i>	16
<i>azelastine-fluticasone</i>	138	BD ULTRA-FINE MICRO		BICILLIN C-R.....	12
AZELEX.....	76	PEN NEEDLE.....	113	BICILLIN L-A.....	12
AZILECT.....	32	BD ULTRA-FINE MINI		BIDIL.....	63
<i>azithromycin</i>	7	PEN NEEDLE.....	113	BIJUVA.....	126
AZOPT.....	134	BD ULTRA-FINE NANO		BIKTARVY.....	2
AZOR.....	63	PEN NEEDLE.....	113	BILTRICIDE.....	8
AZSTARYS.....	49	BD ULTRA-FINE SHORT		<i>bimatoprost</i>	134
<i>aztreonam</i>	8	PEN NEEDLE.....	113	BIMZELX.....	72
AZULFIDINE.....	100	BD VEO INSULIN SYR		BIMZELX	
AZULFIDINE EN-TABS..	100	(HALF UNIT).....	113	AUTOINJECTOR.....	72
<i>bacitracin</i>	132	BD VEO INSULIN		BINOSTO.....	118
<i>bacitracin-polymyxin b</i>	132	SYRINGE UF.....	113	<i>bismuth subcit k-metronidz-</i>	
BACLOFEN.....	39, 40	BELBUCA.....	40	<i>tcn</i>	105
<i>baclofen</i>	39	BELSOMRA.....	49	<i>bisoprolol fumarate</i>	63
BACTRIM.....	13	<i>benazepril</i>	63	<i>bisoprolol-</i>	
BACTRIM DS.....	13	<i>benazepril-</i>		<i>hydrochlorothiazide</i>	63
BAFIERTAM.....	36	<i>hydrochlorothiazide</i>	63	BIVIGAM.....	110
BALCOLTRA.....	129	BENICAR.....	63	<i>blisovi 24 fe</i>	129
<i>balsalazide</i>	100	BENICAR HCT.....	63	<i>blisovi fe 1.5/30 (28)</i>	129
BALVERSA.....	16	BENLYSTA.....	121	BONJESTA.....	100
<i>balziva (28)</i>	129	BENZAMYCIN.....	76	BOOSTRIX TDAP.....	110
BANZEL.....	26	<i>benztropine</i>	32	<i>bosentan</i>	138
BAQSIMI.....	89	<i>bepotastine besilate</i>	133	BOSULIF.....	16
BARACLUDE.....	2	BEPREVE.....	133	BRAFTOVI.....	16
BASAGLAR KWIKPEN		BERINERT.....	138	BREO ELLIPTA.....	138
U-100 INSULIN.....	89	BESIVANCE.....	132	<i>breyana</i>	138
BASAGLAR TEMPO		BESREMI.....	108	BREZTRI AEROSPHERE..	138
PEN(U-100)INSLN.....	89	<i>betaine</i>	100	<i>briellyn</i>	129
BAXDELA.....	13	<i>betamethasone dipropionate</i>	80	BRILINTA.....	67
BCG VACCINE, LIVE (PF)		<i>betamethasone valerate</i>	80	<i>brimonidine</i>	76, 135
.....	110	<i>betamethasone, augmented</i>	80	<i>brimonidine-timolol</i>	134
BD AUTOSHIELD DUO		BETAPACE AF.....	62	<i>brinzolamide</i>	134
PEN NEEDLE.....	112	BETASERON.....	108	BRIVIACT.....	26, 27
BD INSULIN SYRINGE... 112		<i>betaxolol</i>	63, 132	<i>bromfenac</i>	134
BD INSULIN SYRINGE		<i>bethanechol chloride</i>	145	<i>bromocriptine</i>	32
(HALF UNIT).....	112	BETHKIS.....	8	BROMSITE.....	134
		BETIMOL.....	132	BROVANA.....	138

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 viii. 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 drug list was updated in August 2024.

BRUKINSA.....	16	candesartan-	CELEBREX.....	44
BRYHALI.....	80	hydrochlorothiazid.....	celecoxib.....	44
budesonide.....	100, 138	CAPLYTA.....	CELEXA.....	49
budesonide-formoterol.....	138	CAPRELSA.....	CELLCEPT.....	16
bumetanide.....	63	captopril.....	CELONTIN.....	27
BUPHENYL.....	83	CARAC.....	cephalexin.....	7
buprenorphine hcl.....	40	CARAFATE.....	CEQUA.....	133
buprenorphine transdermal		CARBAGLU.....	CEQUR SIMPLICITY.....	113
patch.....	40	carbamazepine.....	CEQUR SIMPLICITY	
buprenorphine-naloxone.....	44	CARBATROL.....	INSERTER.....	113
bupropion hcl.....	49	carbidopa.....	CERDELGA.....	96
BUPROPION HCL.....	49	carbidopa-levodopa.....	cetirizine.....	135
bupropion hcl (smoking		carbidopa-levodopa-	cevimeline.....	83
deter).....	86	entacapone.....	CHEMET.....	83
buspirone.....	49	CARDIZEM.....	CHENODAL.....	100
butorphanol.....	44	CARDIZEM CD.....	chlorhexidine gluconate.....	87
BUTRANS.....	40	CARDIZEM LA.....	chloroquine phosphate.....	8
BYDUREON BCISE.....	89	CARDURA.....	chlorpromazine.....	49
BYETTA.....	89	CARDURA XL.....	chlorthalidone.....	63
BYLVAY.....	100	carglumic acid.....	CHOLBAM.....	100
BYOOVIZ.....	133	CARNITOR.....	cholestyramine (with sugar)...	69
BYSTOLIC.....	63	CAROSPIR.....	cholestyramine light.....	69
cabergoline.....	96	carteolol.....	CIALIS.....	145
CABLIVI.....	67	cartia xt.....	CIBINQO.....	74
CABOMETYX.....	16	carvedilol.....	ciclopirox.....	78
CABTREO.....	76	carvedilol phosphate.....	cilostazol.....	67
CADUET.....	69	CASODEX.....	CILOXAN.....	132
calcipotriene.....	72, 73	caspofungin.....	CIMDUO.....	2
CALCIPOTRIENE.....	72	CAYSTON.....	cimetidine.....	105
calcipotriene-betamethasone...	73	cefaclor.....	CIMZIA.....	100
calcitonin (salmon).....	96	cefadroxil.....	CIMZIA POWDER FOR	
calcitriol.....	73, 96	cefazolin.....	RECONST.....	100
CALQUENCE.....	16	cefdinir.....	cinacalcet.....	96
CALQUENCE		cefepime.....	CINRYZE.....	138
(ACALABRUTINIB MAL). 16		cefixime.....	CIPRO.....	13
CAMBIA.....	44	cefotetan.....	CIPRO HC.....	87
camila.....	126	cefoxitin.....	ciprofloxacin hcl.....	13, 132
camrese lo.....	129	cefpodoxime.....	ciprofloxacin in 5 % dextrose..	13
CAMZYOS.....	71	cefprozil.....	ciprofloxacin-dexamethasone..	87
CANASA.....	100	ceftazidime.....	CITALOPRAM.....	49
CANCIDAS.....	1	ceftriaxone.....	italopram.....	49
candesartan.....	63	cefuroxime axetil.....	claravis.....	76
		cefuroxime sodium.....	CLARINEX.....	135

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 viii. 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 drug list was updated in August 2024.

CLARINEX-D 12 HOUR.. 136	<i>clodan</i> 81	CORTROPHIN GEL..... 87
<i>clarithromycin</i> 7	<i>clomipramine</i> 50	COSENTYX..... 73
CLENPIQ..... 100	<i>clonazepam</i> 27	COSENTYX (2
CLEOCIN..... 8, 128	<i>clonidine</i> 63	SYRINGES)..... 73
CLEOCIN HCL..... 8	<i>clonidine hcl</i> 50, 63	COSENTYX PEN (2 PENS). 73
CLEOCIN PEDIATRIC..... 8	CLONIDINE HCL..... 63	COSENTYX UNOREADY
CLEOCIN T..... 76	<i>clopidogrel</i> 67	PEN..... 73
CLIMARA..... 126	<i>clorazepate dipotassium</i> 50	COSOPT..... 134
CLIMARA PRO..... 126	<i>clotrimazole</i> 1, 78	COSOPT (PF)..... 134
<i>clindacin</i> 76	<i>clotrimazole-betamethasone</i> 78	COTELLIC..... 16
<i>clindacin etz</i> 76	<i>clozapine</i> 50	COTEMPLA XR-ODT..... 50
CLINDAGEL..... 76	CLOZARIL..... 50	COZAAR..... 63
<i>clindamycin hcl</i> 8	COARTEM..... 8	CREON..... 101
<i>clindamycin in 5 % dextrose</i> 8	<i>codeine sulfate</i> 40	CRESEMBA..... 1
<i>clindamycin pediatric</i> 8	COLAZAL..... 100	CRESTOR..... 70
<i>clindamycin phosphate</i> . 8, 76, 128	<i>colchicine</i> 117	CRINONE..... 126
<i>clindamycin-benzoyl peroxide</i> . 76	COLCRYS..... 117	<i>cromolyn</i> 101, 133, 138
<i>clindamycin-tretinoin</i> 76	<i>colesevelam</i> 70	<i>crotan</i> 83
CLINDESSE..... 128	COLESTID..... 70	<i>cryselle (28)</i> 129
CLINIMIX 5%/D15W	<i>colestipol</i> 70	CUBICIN RF..... 8
SULFITE FREE..... 147	<i>colistin (colistimethate na)</i> 8	CUPRIMINE..... 121
CLINIMIX 4.25%/D10W	COMBIGAN..... 134	CUVPOSA..... 99
SULF FREE..... 147	COMBIPATCH..... 126	CUVRIOR..... 84
CLINIMIX 4.25%/D5W	COMBIVENT RESPIMAT 138	<i>cyclobenzaprine</i> 40
SULFIT FREE..... 83	COMBIVIR..... 2	<i>cyclophosphamide</i> 16
CLINIMIX 5%-	COMETRIQ..... 16	CYCLOPHOSPHAMIDE.... 17
D20W(SULFITE-FREE).... 147	COMFORT EZ PRO	<i>cycloserine</i> 8
CLINIMIX E 2.75%/D5W	SAFETY PEN NDL..... 113	CYCLOSET..... 89
SULF FREE..... 83	COMPLERA..... 2	<i>cyclosporine</i> 17, 133
CLINIMIX E 4.25%/D10W	<i>compro</i> 100	<i>cyclosporine modified</i> 17
SUL FREE..... 147	COMTAN..... 33	CYLTEZO(CF)..... 121
CLINIMIX E 4.25%/D5W	CONCERTA..... 50	CYLTEZO(CF) PEN..... 121
SULF FREE..... 147	CONDYLOX..... 74	CYLTEZO(CF) PEN
CLINIMIX E 5%/D15W	<i>constulose</i> 100	CROHN'S-UC-HS..... 121
SULFIT FREE..... 147	CONZIP..... 44	CYLTEZO(CF) PEN
CLINIMIX E 5%/D20W	COPAXONE..... 36	PSORIASIS-UV..... 121
SULFIT FREE..... 147	COPIKTRA..... 16	CYMBALTA..... 50
CLINISOL SF 15 %..... 147	CORDRAN..... 81	<i>cyred eq</i> 129
<i>clobazam</i> 27	CORDRAN TAPE LARGE	CYSTADANE..... 101
<i>clobetasol</i> 80	ROLL..... 81	CYSTADROPS..... 133
<i>clobetasol-emollient</i> 80	CORLANOR..... 72	CYSTAGON..... 145
CLOBEX..... 80, 81	CORTEF..... 87	CYSTARAN..... 133
<i>clocortolone pivalate</i> 81	CORTIFOAM..... 100	CYTOMEL..... 99

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 viii. 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 drug list was updated in August 2024.

CYTOTEC.....	105	DEPAKOTE.....	27	DIACOMIT.....	27
d10 %-0.45 % sodium chloride	84	DEPAKOTE ER.....	27	diazepam.....	27, 51
d2.5 %-0.45 % sodium chloride.....	84	DEPAKOTE SPRINKLES..	27	diazepam intensol.....	51
d5 % and 0.9 % sodium chloride.....	84	DEPEN TITRATABS.....	121	diazoxide.....	90
d5 %-0.45 % sodium chloride..	84	DEPO-ESTRADIOL.....	126	DIBENZYLINE.....	63
dabigatran etexilate.....	67	DEPO-PROVERA.....	126, 127	DICLEGIS.....	101
dalfampridine.....	36	DEPO-SUBQ PROVERA		DICLOFENAC	
DALIRESP.....	138	104.....	127	EPOLAMINE.....	44
DALVANCE.....	8	DEPO-TESTOSTERONE....	97	diclofenac potassium.....	44
danazol.....	96	DERMA-SMOOTH/FS		diclofenac sodium	44, 45, 74, 134
DANTRIUM.....	40	SCALP OIL.....	81	diclofenac-misoprostol.....	45
dantrolene.....	40	DERMOTIC OIL.....	87	dicloxacillin.....	12
DAPAGLIFLOZ		DESCOVY.....	2	dicyclomine.....	99
PROPANED-		desipramine.....	50	DIFFERIN.....	76, 77
METFORMIN.....	89, 90	desloratadine.....	136	DIFICID.....	7
DAPAGLIFLOZIN		desmopressin.....	97	diflorasone.....	81
PROPANEDIOL.....	90	desog-e.estradiolle.estradiol..	129	DIFLUCAN.....	1
dapsone.....	8, 76	desogestrel-ethinyl estradiol..	129	diflunisal.....	45
DAPTACEL (DTAP		desonide.....	81	difluprednate.....	135
PEDIATRIC) (PF).....	110	DESOWEN.....	81	digoxin.....	72
DAPTOMYCIN.....	9	desoximetasone.....	81	dihydroergotamine.....	34
daptomycin.....	9	DESVENLAFAXINE.....	50	DILANTIN 30 MG.....	27
DARAPRIM.....	9	desvenlafaxine succinate.....	50	DILANTIN EXTENDED	
darifenacin.....	144	DETROL.....	144	100 MG.....	27
darunavir.....	2	DETROL LA.....	144	DILANTIN INFATABS.....	27
DAURISMO.....	17	dexabliss.....	87	DILANTIN-125.....	27
DAYBUE.....	36	dexamethasone.....	88	DILAUDID.....	40
DAYPRO.....	44	dexamethasone sodium		diltiazem hcl.....	63, 64
DAYTRANA.....	50	phosphate.....	135	dilt-xr.....	64
DAYVIGO.....	50	DEXEDRINE SPANSULE..	50	dimethyl fumarate.....	36
DDAVP.....	96	DEXILANT.....	105	DIOVAN.....	64
deblitane.....	126	dexlansoprazole.....	105	DIOVAN HCT.....	64
deferasirox.....	84	dexmethylphenidate.....	50	DIPENTUM.....	101
deferiprone.....	84	dextroamphetamine sulfate.....	50	diphenoxylate-atropine.....	99
deflazacort.....	87	dextroamphetamine-		DIPROLENE	
DELESTROGEN.....	126	amphetamine.....	50, 51	(AUGMENTED).....	81
DELSTRIGO.....	2	dextrose 10 % and 0.2 % nacl.	84	dipyridamole.....	67
DELZICOL.....	101	dextrose 10 % in water		disulfiram.....	84
demeclocycline.....	13	(d10w).....	84	DIURIL.....	64
DEMSEER.....	63	dextrose 5 % in water (d5w) ..	84	divalproex.....	27
DENAVIR.....	80	dextrose 5%-0.2 % sod		DIVIGEL.....	127
		chloride.....	84	dofetilide.....	62
		DHIVY.....	33	DOJOLVI.....	147

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 viii. 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 drug list was updated in August 2024.

<i>dolishale</i>	129	DUAVEE.....	127	<i>eluryng</i>	128
<i>donepezil</i>	37	DUETACT.....	90	ELYXYB.....	34
DOPTELET (10 TAB PACK).....	67	DULERA.....	138	EMEND.....	101
DOPTELET (15 TAB PACK).....	67	<i>duloxetine</i>	51	EMFLAZA.....	88
DOPTELET (30 TAB PACK).....	67	DUOBRII.....	81	EMGALITY PEN.....	34
DORYX MPC.....	13	DUOPA.....	33	EMGALITY SYRINGE.....	34
<i>dorzolamide</i>	134	DUPIXENT PEN.....	74	EMSAM.....	51
<i>dorzolamide-timolol</i>	134	DUPIXENT SYRINGE.....	74	<i>emtricitabine</i>	2
<i>dorzolamide-timolol (pf)</i>	134	DUREZOL.....	135	<i>emtricitabine-tenofovir (tdf)</i>	3
<i>dotti</i>	127	<i>dutasteride</i>	145	EMTRIVA.....	3
DOVATO.....	2	<i>dutasteride-tamsulosin</i>	145	EMVERM.....	9
<i>doxazosin</i>	64	DYANAVEL XR.....	51	<i>enalapril maleate</i>	64
<i>doxepin</i>	51, 74	DYMISTA.....	138	<i>enalapril-hydrochlorothiazide</i> ..	64
<i>doxercalciferol</i>	97	DYRENIUM.....	64	ENBREL.....	121
<i>doxy-100</i>	13	DYSPORT.....	110	ENBREL MINI.....	121
<i>doxycycline hyclate</i>	13, 14	<i>e.e.s. 400</i>	7	ENBREL SURECLICK.....	121
DOXYCYCLINE HYCLATE.....	14	E.E.S. GRANULES.....	7	ENDARI.....	84
<i>doxycycline monohydrate</i>	14	<i>econazole</i>	78	<i>endocet</i>	41
<i>doxylamine-pyridoxine (vit b6)</i>	101	EDARBI.....	64	ENGERIX-B (PF).....	110
DRIZALMA SPRINKLE....	51	EDARBYCLOR.....	64	ENGERIX-B PEDIATRIC (PF).....	110
<i>dronabinol</i>	101	EDECRIIN.....	64	<i>enilloring</i>	128
DROPLET INSULIN SYR(HALF UNIT).....	113	EDURANT.....	2	<i>enoxaparin</i>	68
DROPLET INSULIN SYRINGE.....	113, 114	<i>efavirenz</i>	2	<i>enpresse</i>	129
DROPLET MICRON PEN NEEDLE.....	114	<i>efavirenz-emtricitabin-tenofov</i> ..	2	<i>enskyce</i>	129
DROPLET PEN NEEDLE.....	114	<i>efavirenz-lamivu-tenofov</i>	2	ENSPRYNG.....	17
DROPSAFE ALCOHOL PREP PADS.....	90	<i>disop</i>	2	ENSTILAR.....	73
DROPSAFE PEN NEEDLE	114	EFFEXOR XR.....	51	<i>entacapone</i>	33
<i>drospirenone-e.estradiol-lm.fa</i>	129	EFFIENT.....	67	ENTADFI.....	145
<i>drospirenone-ethinyl estradiol</i>	129	EFUDEX.....	74	<i>entecavir</i>	3
DROXIA.....	17	EGRIFTA SV.....	108	ENTRESTO.....	72
<i>droxidopa</i>	84	<i>electrolyte-148</i>	147	ENTYVIO PEN.....	101
DUAKLIR PRESSAIR.....	138	ELESTRIN.....	127	<i>enulose</i>	101
		<i>eletriptan</i>	34	ENVARUSUS XR.....	17
		ELFABRIO.....	97	EPCLUSA.....	3
		ELIDEL.....	74	EPIDIOLEX.....	27
		ELIGARD.....	17	EPIDUO.....	77
		ELIGARD (3 MONTH).....	17	EPIDUO FORTE.....	77
		ELIGARD (4 MONTH).....	17	<i>epinastine</i>	133
		ELIGARD (6 MONTH).....	17	EPINEPHRINE.....	136
		ELIQUIS.....	68	<i>epinephrine</i>	136
		ELIQUIS DVT-PE TREAT 30D START.....	68	EPIPEN 2-PAK.....	136
		ELMIRON.....	145	EPIPEN JR 2-PAK.....	136

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 viii. 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 drug list was updated in August 2024.

<i>epitol</i>	27	<i>ethambutol</i>	9	FEMRING.....	127
EPIVIR.....	3	<i>ethosuximide</i>	27	FENOFIBRATE.....	70
<i>eplerenone</i>	64	<i>ethynodiol diac-eth estradiol</i>	129	<i>fenofibrate</i>	70
EPOGEN.....	108	<i>etodolac</i>	45	<i>fenofibrate micronized</i>	70
EPRONTIA.....	27	<i>etonogestrel-ethinyl estradiol</i>	128	<i>fenofibrate nanocrystallized</i>	70
EPSOLAY.....	77	<i>etravirine</i>	3	<i>fenofibric acid (choline)</i>	70
EPZICOM.....	3	EUCRISA.....	74	FENOGLIDE.....	70
EQUETRO.....	27	<i>euthyrox</i>	99	<i>fenoprofen</i>	45
ERAXIS(WATER		EVAMIST.....	127	<i>fentanyl</i>	41
DILUENT).....	1	EVEKEO.....	51	<i>fentanyl citrate</i>	41
<i>ergoloid</i>	51	EVENITY.....	118	FENTANYL CITRATE.....	41
<i>ergotamine-caffeine</i>	34	<i>everolimus (antineoplastic)</i>	17	FENTORA.....	41
ERIVEDGE.....	17	<i>everolimus</i>		FERRIPROX.....	84
ERLEADA.....	17	<i>(immunosuppressive)</i>	17	FERRIPROX (2 TIMES A	
<i>erlotinib</i>	17	EVISTA.....	118	DAY).....	84
ERMEZA.....	99	EVOTAZ.....	3	<i>fesoterodine</i>	144
<i>errin</i>	127	EVOXAC.....	84	FETZIMA.....	52
ERTACZO.....	79	EVRYSDI.....	37	FEXMID.....	40
<i>ertapenem</i>	9	EXELON PATCH.....	37	FIASP FLEXTOUCH U-	
<i>ery pads</i>	77	<i>exemestane</i>	17	100 INSULIN.....	90
<i>erygel</i>	77	EXFORGE.....	64	FIASP PENFILL U-100	
ERYPED 200.....	7	EXFORGE HCT.....	64	INSULIN.....	90
ERYPED 400.....	7	EXJADE.....	84	FIASP U-100 INSULIN.....	90
<i>ery-tab</i>	7	EXSERVAN.....	84	FILSPARI.....	72
ERY-TAB.....	7	EYSUVIS.....	135	FILSUVEZ.....	74
ERYTHROCIN.....	7	EZALLOR SPRINKLE.....	70	FINACEA.....	77
<i>erythrocine (as stearate)</i>	7	<i>ezetimibe</i>	70	<i>finasteride</i>	145
<i>erythromycin</i>	8, 132	<i>ezetimibe-simvastatin</i>	70	<i>ingolimod</i>	37
<i>erythromycin ethylsuccinate</i> ..	7, 8	FABHALTA.....	84	FINTEPLA.....	27
<i>erythromycin with ethanol</i>	77	FABIOR.....	77	<i>finzala</i>	129
<i>erythromycin-benzoyl</i>		<i>falmina (28)</i>	129	FIRAZYR.....	139
<i>peroxide</i>	77	<i>famciclovir</i>	3	FIRDAPSE.....	37
ESBRIET.....	138, 139	<i>famotidine</i>	105	FIRMAGON KIT W	
<i>escitalopram oxalate</i>	51	FANAPT.....	51	DILUENT SYRINGE.....	18
<i>esomeprazole magnesium</i>	105	FARESTON.....	17	FIRVANQ.....	9
<i>estarylla</i>	129	FARXIGA.....	90	<i>flac otic oil</i>	87
ESTRACE.....	127	FASENRA.....	139	FLAGYL.....	9
<i>estradiol</i>	127	FASENRA PEN.....	139	<i>flavoxate</i>	144
<i>estradiol valerate</i>	127	<i>febuxostat</i>	117	<i>flecainide</i>	62
<i>estradiol-norethindrone acet</i> ..	127	<i>felbamate</i>	27	FLECTOR.....	45
ESTRING.....	127	FELBATOL.....	27	FLEQSUVY.....	40
<i>eszopiclone</i>	51	<i>felodipine</i>	64	FLOLIPID.....	70
<i>ethacrynic acid</i>	64	FEMARA.....	17	FLOMAX.....	145

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 viii. 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 drug list was updated in August 2024.

<i>fluconazole</i>	1	FOSAMAX PLUS D.....	118	GENOTROPIN	
<i>fluconazole in nacl (iso-osm)</i>	1	<i>fosamprenavir</i>	3	MINIQUICK.....	108
<i>flucytosine</i>	1	<i>fosfomycin tromethamine</i>	14	<i>gentamicin</i>	9, 78, 132
<i>fludrocortisone</i>	88	<i>fosinopril</i>	64	<i>gentamicin in nacl (iso-osm)</i>	9
<i>flunisolide</i>	139	<i>fosinopril-hydrochlorothiazide</i>	64	GENVOYA.....	3
<i>fluocinolone</i>	81	FOTIVDA.....	18	GEODON.....	52
<i>fluocinolone acetone oil</i>	87	FRAGMIN.....	68	GILENYA.....	37
<i>fluocinolone and shower cap</i>	81	FROVA.....	34	GILOTRIF.....	18
<i>fluocinonide</i>	81	<i>frovatriptan</i>	34	GIMOTI.....	101
<i>fluocinonide-emollient</i>	81	FRUZAQLA.....	18	GLASSIA.....	84
<i>fluoride (sodium)</i>	147	FULPHILA.....	108	<i>glatiramer</i>	37
<i>fluorometholone</i>	135	FUROSCIX.....	64	<i>glatopa</i>	37
FLUOROURACIL.....	74	<i>furosemide</i>	64	GLEEVEC.....	18
<i>fluorouracil</i>	75	FUZEON.....	3	GLEOSTINE.....	18
<i>fluoxetine</i>	52	<i>fyavolv</i>	127	<i>glimepiride</i>	90
<i>fluoxetine (pmdd)</i>	52	FYCOMPA.....	27, 28	<i>glipizide</i>	90
<i>fluphenazine decanoate</i>	52	FYLNETRA.....	108	GLIPIZIDE.....	90
<i>fluphenazine hcl</i>	52	<i>gabapentin</i>	28	<i>glipizide-metformin</i>	90
<i>flurandrenolide</i>	81, 82	GALAFOLD.....	97	GLOPERBA.....	117
<i>flurbiprofen</i>	45	<i>galantamine</i>	37	GLUCAGON	
<i>flurbiprofen sodium</i>	134	GAMMAGARD LIQUID ..	110	EMERGENCY KIT	
FLUTICASONE		GAMMAGARD S-D (IGA		(HUMAN).....	90
FUOATE-VILANTEROL		< 1 MCG/ML)	110	GLUCOTROL XL.....	91
.....	139	GAMMAKED.....	110	GLUMETZA.....	91
<i>fluticasone propionate</i>	82, 139	GAMMAPLEX.....	110	GLYCATÉ.....	99
FLUTICASONE		GAMMAPLEX (WITH		<i>glycopyrrolate</i>	99
PROPIONATE.....	139	SORBITOL).....	111	GLYXAMBI.....	91
FLUTICASONE		GAMUNEX-C.....	111	GOCOVRI.....	33
PROPION-SALMETEROL		GARDASIL 9 (PF).....	111	GOLYTELY.....	101
.....	139, 140	GASTROCROM.....	101	GRALISE.....	28
<i>fluticasone propion-salmeterol</i>		<i>gatifloxacin</i>	132	<i>granisetron hcl</i>	101
.....	139	GATTEX 30-VIAL.....	101	GRANIX.....	108
<i>fluvastatin</i>	70	GAUZE PAD.....	114	GRASTEK.....	111
<i>fluvoxamine</i>	52	<i>gavilyte-c</i>	101	<i>griseofulvin microsize</i>	1
FML FORTE.....	135	<i>gavilyte-g</i>	101	<i>griseofulvin ultramicrosize</i>	1
FML LIQUIFILM.....	135	GAVRETO.....	18	GVOKE.....	91
FOCALIN.....	52	<i>gefitinib</i>	18	GVOKE HYPOPEN 2-	
FOCALIN XR.....	52	<i>gemfibrozil</i>	70	PACK.....	91
<i>fondaparinux</i>	68	<i>gemmily</i>	129	GVOKE PFS 1-PACK	
FORFIVO XL.....	52	GEMTESA.....	144	SYRINGE.....	91
<i>formoterol fumarate</i>	140	<i>generlac</i>	101	GYNAZOLE-1.....	128
FORTEO.....	118	<i>gengraf</i>	18	HADLIMA.....	121
FOSAMAX.....	118	GENOTROPIN.....	108	HADLIMA PUSHTOUCH	121

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 viii. 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 drug list was updated in August 2024.

HADLIMA(CF).....	122	HUMIRA (PREFERRED	<i>hydrocodone-ibuprofen</i>	41
HADLIMA(CF)		NDCS STARTING WITH	<i>hydrocortisone</i>	82, 88, 101
PUSHTOUCH.....	122	00074).....	<i>hydrocortisone butyrate</i>	82
HAEGARDA.....	140	HUMIRA PEN	<i>hydrocortisone valerate</i>	82
<i>hailey 24 fe</i>	129	(PREFERRED NDCS	<i>hydrocortisone-acetic acid</i>	87
<i>halcinonide</i>	82	STARTING WITH 00074). 122	<i>hydrocortisone-pramoxine</i>	101
HALDOL DECANOATE....	52	HUMIRA(CF)	<i>hydromorphone</i>	41, 42
<i>halobetasol propionate</i>	82	(PREFERRED NDCS	<i>hydromorphone (pf)</i>	41
<i>haloette</i>	128	STARTING WITH 00074). 122	<i>hydroxychloroquine</i>	9
HALOG.....	82	HUMIRA(CF) PEN	<i>hydroxyurea</i>	18
<i>haloperidol</i>	52	(PREFERRED NDCS	<i>hydroxyzine hcl</i>	136
<i>haloperidol decanoate</i>	53	STARTING WITH 00074). 122	HYFTOR.....	75
<i>haloperidol lactate</i>	53	HUMIRA(CF) PEN	HYRIMOZ (PREFERRED	
HARVONI.....	3	CROHNS-UC-HS	NDCS STARTING WITH	
HAVRIX (PF).....	111	(PREFERRED NDCS	61314).....	123
<i>heather</i>	127	STARTING WITH 00074). 123	HYRIMOZ PEN	
HEMADY.....	88	HUMIRA(CF) PEN	(PREFERRED NDCS	
<i>heparin (porcine)</i>	68	PEDIATRIC UC	STARTING WITH 61314). 123	
HEPLISAV-B (PF).....	111	(PREFERRED NDCS	HYRIMOZ PEN	
HETLIOZ.....	53	STARTING WITH 00074). 123	CROHN'S-UC STARTER	
HETLIOZ LQ.....	53	HUMIRA(CF) PEN PSOR-	(PREFERRED NDCS	
HIBERIX (PF).....	111	UV-ADOL HS	STARTING WITH 61314). 123	
HIPREX.....	14	(PREFERRED NDCS	HYRIMOZ PEN	
HORIZANT.....	37	STARTING WITH 00074). 123	PSORIASIS STARTER	
HULIO(CF).....	122	HUMULIN 70/30 U-100	(PREFERRED NDCS	
HULIO(CF) PEN.....	122	INSULIN.....	STARTING WITH 61314). 123	
HUMALOG JUNIOR		HUMULIN 70/30 U-100	HYRIMOZ(CF)	
KWIKPEN U-100.....	91	KWIKPEN.....	(PREFERRED NDCS	
HUMALOG KWIKPEN		HUMULIN N NPH	STARTING WITH 61314). 123	
INSULIN.....	91	INSULIN KWIKPEN.....	HYRIMOZ(CF) PEDI	
HUMALOG MIX 50-50		HUMULIN N NPH U-100	CROHN STARTER	
KWIKPEN.....	91	INSULIN.....	(PREFERRED NDCS	
HUMALOG MIX 75-25		HUMULIN R REGULAR	STARTING WITH 61314). 124	
KWIKPEN.....	91	U-100 INSULN.....	HYRIMOZ(CF) PEN	
HUMALOG MIX 75-25(U-		HUMULIN R U-500	(PREFERRED NDCS	
100)INSULN.....	91	(CONC) INSULIN.....	STARTING WITH 61314). 124	
HUMALOG TEMPO		HUMULIN R U-500	HYSINGLA ER.....	42
PEN(U-100)INSULN.....	91	(CONC) KWIKPEN.....	HYZAAR.....	64
HUMALOG U-100		<i>hydralazine</i>	<i>ibandronate</i>	118
INSULIN.....	91	HYDREA.....	IBRANCE.....	18
HUMATIN.....	9	<i>hydrochlorothiazide</i>	IBSRELA.....	101
HUMATROPE.....	108	<i>hydrocodone bitartrate</i>	<i>ibu</i>	45
		<i>hydrocodone-acetaminophen</i> ...	<i>ibuprofen</i>	45

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 viii. 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 drug list was updated in August 2024.

<i>ibuprofen-famotidine</i>	45	INGREZZA.....	37	INVEGA SUSTENNA.....	53
<i>icatibant</i>	140	INGREZZA INITIATION		INVEGA TRINZA.....	54
<i>iclevia</i>	129	PK(TARDIV).....	37	INVELTYS.....	135
ICLUSIG.....	18	INGREZZA SPRINKLE.....	37	INVOKAMET.....	92
<i>icosapent ethyl</i>	70	INLYTA.....	19	INVOKAMET XR.....	92
IDACIO(CF).....	124	INNOPRAN XL.....	64	INVOKANA.....	92
IDACIO(CF) PEN.....	124	INPEFA.....	92	IOPIDINE.....	135
IDACIO(CF) PEN		INPEN (FOR HUMALOG)		IPOL.....	111
CROHN-UC STARTR.....	124	BLUE.....	114	<i>ipratropium bromide</i>	87, 140
IDACIO(CF) PEN		INPEN (FOR HUMALOG)		<i>ipratropium-albuterol</i>	140
PSORIASIS START.....	124	GREY.....	114	<i>irbesartan</i>	64
IDHIFA.....	18	INPEN (FOR HUMALOG)		<i>irbesartan-</i>	
ILEVRO.....	134	PINK.....	114	<i>hydrochlorothiazide</i>	64
ILUMYA.....	73	INPEN (NOVOLOG OR		IRESSA.....	19
<i>imatinib</i>	18	FIASP) BLUE.....	114	ISENTRESS.....	3
IMBRUVICA.....	18	INPEN (NOVOLOG OR		ISENTRESS HD.....	3
<i>imipenem-cilastatin</i>	9	FIASP) GREY.....	114	<i>isibloom</i>	129
<i>imipramine hcl</i>	53	INPEN (NOVOLOG OR		ISOLYTE S PH 7.4.....	147
<i>imipramine pamoate</i>	53	FIASP) PINK.....	114	ISOLYTE-P IN 5 %	
<i>imiquimod</i>	75	INQOVI.....	19	DEXTROSE.....	147
IMITREX.....	34	INREBIC.....	19	<i>isoniazid</i>	9
IMITREX STATDOSE		INSPIRA.....	64	ISORDIL.....	72
PEN.....	34	INSULIN ASP PRT-		ISORDIL TITRADOSE.....	72
IMITREX STATDOSE		INSULIN ASPART.....	92	<i>isosorbide dinitrate</i>	72
REFILL.....	34	INSULIN ASPART U-100..	92	<i>isosorbide mononitrate</i>	72
IMOVAX RABIES		INSULIN DEGLUDEC.....	92	<i>isosorbide-hydralazine</i>	64
VACCINE (PF).....	111	INSULIN GLARGINE U-		<i>isotretinoin</i>	77
IMPAVIDO.....	9	300 CONC.....	92	<i>isradipine</i>	64
IMURAN.....	18	INSULIN GLARGINE-		ISTALOL.....	133
IMVEXXY		YFGN.....	92	ISTURISA.....	97
MAINTENANCE PACK... 127		INSULIN LISPRO.....	92	<i>itraconazole</i>	1
IMVEXXY STARTER		INSULIN LISPRO		<i>ivermectin</i>	9, 77
PACK.....	127	PROTAMIN-LISPRO.....	92	IWILFIN.....	19
INBRIJA.....	33	INSULIN SYRINGE-		IXCHIQ (PF).....	111
<i>incassia</i>	127	NEEDLE U-100.....	114	IXIARO (PF).....	111
INCRELEX.....	84	INTELENCE.....	3	IYUZEH (PF).....	134
INCRUSE ELLIPTA.....	140	<i>intralipid</i>	147	JADENU.....	84
<i>indapamide</i>	64	INTRALIPID.....	147	JADENU SPRINKLE.....	84
INDERAL LA.....	64	INTRAROSA.....	128	JAKAFI.....	19
INDOCIN.....	45	<i>introvale</i>	129	<i>jantoven</i>	68
<i>indomethacin</i>	45	INVANZ.....	9	JANUMET.....	92
INFANRIX (DTAP) (PF)...111		INVEGA.....	53	JANUMET XR.....	92
INFLECTRA.....	101	INVEGA HAFYERA.....	53	JANUVIA.....	92

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 viii. 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 drug list was updated in August 2024.

JARDIANCE.....	92	KEVZARA.....	124	LAMICTAL XR STARTER	
<i>jasmiel (28)</i>	129	KINERET.....	124	(BLUE).....	29
JATENZO.....	97	KINRIX (PF).....	111	LAMICTAL XR STARTER	
<i>javygtor</i>	97	<i>kionex (with sorbitol)</i>	84	(GREEN).....	29
JAYPIRCA.....	19	KISQALI.....	19	LAMICTAL XR STARTER	
JENTADUETO.....	92	KISQALI FEMARA CO-		(ORANGE).....	29
JENTADUETO XR.....	92	PACK.....	19	<i>lamivudine</i>	4
<i>jinteli</i>	127	KITABIS PAK.....	9	<i>lamivudine-zidovudine</i>	4
JOENJA.....	84	KLARON.....	78	<i>lamotrigine</i>	29
JORNAY PM.....	54	KLISYRI.....	19	LAMPIT.....	9
<i>joyeaux</i>	129	KLONOPIN.....	28	LANOXIN.....	72
JUBLIA.....	79	<i>klor-con 10</i>	145	<i>lansoprazole</i>	105
<i>juleber</i>	129	<i>klor-con 8</i>	145	LANTUS SOLOSTAR U-	
JULUCA.....	3	<i>klor-con m10</i>	145	100 INSULIN.....	93
<i>junel 1.5/30 (21)</i>	129	<i>klor-con m15</i>	145	LANTUS U-100 INSULIN..	93
<i>junel 1/20 (21)</i>	130	<i>klor-con m20</i>	146	<i>lapatinib</i>	19
<i>junel fe 1.5/30 (28)</i>	130	<i>klor-con oral packet 20</i>	146	<i>larin 1.5/30 (21)</i>	130
<i>junel fe 1/20 (28)</i>	130	KLOXXADO.....	45	<i>larin 1/20 (21)</i>	130
<i>junel fe 24</i>	130	KONVOMEF.....	105	<i>larin fe 1.5/30 (28)</i>	130
JUXTAPID.....	70	KORLYM.....	97	<i>larin fe 1/20 (28)</i>	130
JYLAMVO.....	19	KOSELUGO.....	19	LASIX.....	65
JYNARQUE.....	97	<i>kourzeq</i>	87	<i>latanoprost</i>	134
JYNNEOS (PF).....	111	KRAZATI.....	19	LATUDA.....	54
<i>kaitlib fe</i>	130	KRINTAFEL.....	9	<i>layolis fe</i>	130
KALETRA.....	4	KRISTALOSE.....	101	LEDIPASVIR-	
KALYDECO.....	140	<i>kurvelo (28)</i>	130	SOFOSBUVIR.....	4
KANJINTI.....	19	KUVAN.....	97	<i>leflunomide</i>	124
KAPSPARGO SPRINKLE..	64	KYLEENA.....	128	<i>lenalidomide</i>	19, 20
<i>kariva (28)</i>	130	<i>l norgestle.estradiol-e.estrad.</i>	130	LENVIMA.....	20
KATERZIA.....	64	<i>labetalol</i>	65	LESCOL XL.....	70
KAZANO.....	93	<i>lacosamide</i>	28	<i>lessina</i>	130
<i>kelnor 1/35 (28)</i>	130	LACRISERT.....	133	LETAIRIS.....	140
<i>kelnor 1-50 (28)</i>	130	<i>lactulose</i>	101	<i>letrozole</i>	20
KENALOG.....	82	LAMICTAL.....	28	<i>leucovorin calcium</i>	15
KEPPRA.....	28	LAMICTAL ODT.....	28	LEUKERAN.....	20
KEPPRA XR.....	28	LAMICTAL STARTER		LEUKINE.....	108
KERENDIA.....	65	(BLUE) KIT.....	29	<i>leuprolide</i>	20
KESIMPTA PEN.....	37	LAMICTAL STARTER		LEUPROLIDE (3	
<i>ketoconazole</i>	1, 79	(GREEN) KIT.....	29	MONTH).....	20
<i>ketodan</i>	79	LAMICTAL STARTER		<i>levalbuterol hcl</i>	140
<i>ketoprofen</i>	45	(ORANGE) KIT.....	29	LEVALBUTEROL	
<i>ketorolac</i>	134	LAMICTAL XR.....	29	TARTRATE.....	140
KEVEYIS.....	37			<i>levetiracetam</i>	29

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 viii. 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 drug list was updated in August 2024.

<i>levobunolol</i>	133	LIVTENCITY.....	4	LUMAKRAS.....	20
<i>levocarnitine</i>	84	LO LOESTRIN FE.....	130	LUMIGAN.....	134
<i>levocarnitine (with sugar)</i>	84	LOCOID.....	82	LUMRYZ.....	54
<i>levocetirizine</i>	136	LOCOID LIPOCREAM.....	82	LUPKYNIS.....	20
<i>levofloxacin</i>	13, 132	LODINE.....	45	LUPRON DEPOT.....	20
<i>levofloxacin in d5w</i>	13	LODOCO.....	72	LUPRON DEPOT (3	
<i>levonest (28)</i>	130	LODOSYN.....	33	MONTH).....	20
<i>levonorgestrel-ethinyl estrad.</i>	130	LOESTRIN 1.5/30 (21).....	130	LUPRON DEPOT (4	
<i>levonorg-eth estrad triphasic.</i>	130	LOESTRIN 1/20 (21).....	130	MONTH).....	20
<i>levora-28</i>	130	LOESTRIN FE 1.5/30 (28-		LUPRON DEPOT (6	
<i>levorphanol tartrate</i>	42	DAY).....	130	MONTH).....	20
LEVOTHYROXINE.....	99	LOESTRIN FE 1/20 (28-		LUPRON DEPOT-PED.....	20
<i>levothyroxine</i>	99	DAY).....	130	LUPRON DEPOT-PED (3	
<i>levoxyl</i>	99	<i>lofena</i>	45	MONTH).....	20
LEXAPRO.....	54	LOKELMA.....	84	<i>lurasidone</i>	54
LEXETTE.....	82	LOMOTIL.....	99	<i>lutra (28)</i>	130
LEXIVA.....	4	LONSURF.....	20	LUZU.....	79
LIALDA.....	101	<i>loperamide</i>	99	LYBALVI.....	55
LIBERVANT.....	29	LOPID.....	70	<i>lyleq</i>	128
LICART.....	45	<i>lopinavir-ritonavir</i>	4	<i>lyllana</i>	128
<i>lidocaine</i>	75	LOPRESSOR.....	65	LYNPARZA.....	20
<i>lidocaine hcl</i>	75	LOPROX.....	79	LYRICA.....	29
<i>lidocaine viscous</i>	75	<i>lorazepam</i>	54	LYRICA CR.....	29
<i>lidocaine-prilocaine</i>	75	<i>lorazepam intensol</i>	54	LYSODREN.....	20
<i>lidocan iii</i>	75	LORBRENA.....	20	LYTGOBI.....	21
LILETTA.....	128	LOREEV XR.....	54	LYUMJEV KWIKPEN U-	
<i>linezolid</i>	9	<i>loryna (28)</i>	130	100 INSULIN.....	93
<i>linezolid in dextrose 5%</i>	9	<i>losartan</i>	65	LYUMJEV KWIKPEN U-	
LINZESS.....	101	<i>losartan-hydrochlorothiazide</i> ..	65	200 INSULIN.....	93
<i>liothyronine</i>	99	LOTEMAX.....	135	LYUMJEV TEMPO	
LIPITOR.....	70	LOTEMAX SM.....	135	PEN(U-100)INSULN.....	93
LIPOFEN.....	70	LOTENSIN.....	65	LYUMJEV U-100	
LIQREV.....	140	<i>loteprednol etabonate</i>	135	INSULIN.....	93
<i>lisdexamfetamine</i>	54	LOTREL.....	65	LYVISPAH.....	40
<i>lisinopril</i>	65	LOTRONEX.....	101	<i>lyza</i>	128
<i>lisinopril-hydrochlorothiazide</i> ..	65	<i>lovastatin</i>	70	MACROBID.....	14
LITFULO.....	84	LOVAZA.....	70	MACRODANTIN.....	14
<i>lithium carbonate</i>	54	LOVENOX.....	68, 69	<i>magnesium sulfate</i>	146
<i>lithium citrate</i>	54	<i>low-ogestrel (28)</i>	130	MALARONE.....	9
LITHOBID.....	54	<i>loxapine succinate</i>	54	MALARONE PEDIATRIC...9	
LITHOSTAT.....	84	<i>lubiprostone</i>	101	<i>malathion</i>	83
LIVALO.....	70	LUCEMYRA.....	45	<i>maraviroc</i>	4
LIVMARLI.....	101	LULICONAZOLE.....	79	MARINOL.....	101

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 viii. 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 drug list was updated in August 2024.

<i>marlissa</i> (28).....	130	MEMANTINE.....	38	METROGEL.....	77
MARPLAN.....	55	MENACTRA (PF).....	111	METROLOTION.....	77
MATULANE.....	21	MENEST.....	128	<i>metronidazole</i>	9, 77, 128
<i>matzim la</i>	65	MENOSTAR.....	128	<i>metronidazole in nacl (iso-os)</i> ..	9
MAVENCLAD (10		MENQUADFI (PF).....	111	<i>metyrosine</i>	65
TABLET PACK).....	37	MENVEO A-C-Y-W-135-		<i>mexiletine</i>	62
MAVENCLAD (4 TABLET		DIP (PF).....	111	<i>mibelas 24 fe</i>	130
PACK).....	37	MEPRON.....	9	<i>micafungin</i>	1
MAVENCLAD (5 TABLET		<i>mercaptopurine</i>	21	MICARDIS HCT.....	65
PACK).....	38	<i>meropenem</i>	9	<i>miconazole-3</i>	128
MAVENCLAD (6 TABLET		<i>merzee</i>	130	<i>microgestin 1.5/30 (21)</i>	130
PACK).....	38	<i>mesalamine</i>	102	<i>microgestin 1/20 (21)</i>	130
MAVENCLAD (7 TABLET		MESNEX.....	15	<i>microgestin 24 fe</i>	130
PACK).....	38	MESTINON.....	40	<i>microgestin fe 1.5/30 (28)</i>	130
MAVENCLAD (8 TABLET		MESTINON TIMESPAN...	40	<i>microgestin fe 1/20 (28)</i>	131
PACK).....	38	METADATE CD.....	55	<i>midodrine</i>	84
MAVENCLAD (9 TABLET		<i>metformin</i>	93	MIEBO (PF).....	133
PACK).....	38	METFORMIN.....	93	<i>mifepristone</i>	97
MAVYRET.....	4	<i>methadone</i>	42	<i>migergot</i>	34
MAXALT.....	34	<i>methamphetamine</i>	55	<i>miglitol</i>	93
MAXALT-MLT.....	34	<i>methazolamide</i>	134	<i>miglustat</i>	97
MAXIDEX.....	135	<i>methenamine hippurate</i>	14	MIGRANAL.....	34
MAXITROL.....	134	<i>methimazole</i>	88	<i>mili</i>	131
MAYZENT.....	38	METHITEST.....	97	<i>mimvey</i>	128
MAYZENT		<i>methotrexate sodium</i>	21	MINIVELLE.....	128
STARTER(FOR 1MG		<i>methotrexate sodium (pf)</i>	21	<i>minocycline</i>	14
MAINT).....	38	<i>methoxsalen</i>	75	<i>minoxidil</i>	65
MAYZENT		<i>methscopolamine</i>	99	<i>mirabegron</i>	144
STARTER(FOR 2MG		<i>methsuximide</i>	29	MIRENA.....	128
MAINT).....	38	METHYLIN.....	55	<i>mirtazapine</i>	55
<i>meclizine</i>	102	<i>methylphenidate</i>	55	MIRVASO.....	77
<i>meclofenamate</i>	45	<i>methylphenidate hcl</i>	55	<i>misoprostol</i>	105
MEDROL.....	88	METHYLPHENIDATE		MITIGARE.....	117
MEDROL (PAK).....	88	HCL.....	55	M-M-R II (PF).....	111
<i>medroxyprogesterone</i>	128	<i>methylprednisolone</i>	88	<i>modafinil</i>	55
<i>mefenamic acid</i>	45	<i>methyltestosterone</i>	97	<i>moexipril</i>	65
<i>mefloquine</i>	9	<i>metoclopramide hcl</i>	102	<i>molindone</i>	55
<i>megestrol</i>	21	<i>metolazone</i>	65	<i>mometasone</i>	82, 140
MEKINIST.....	21	<i>metoprolol succinate</i>	65	<i>montelukast</i>	140
MEKTOVI.....	21	<i>metoprolol ta-</i>		<i>morphine</i>	42
<i>meloxicam</i>	45	<i>hydrochlorothiaz</i>	65	<i>morphine concentrate</i>	42
<i>meloxicam submicronized</i>	45	<i>metoprolol tartrate</i>	65	MOTEGRITY.....	102
<i>memantine</i>	38	METROCREAM.....	77	MOTOFEN.....	99

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 viii. 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 drug list was updated in August 2024.

MOTPOLY XR.....	29, 30	<i>naproxen sodium</i>	46	NEXTSTELLIS.....	131
MOUNJARO.....	93	<i>naproxen-esomeprazole</i>	46	NGENLA.....	108
MOVANTIK.....	102	<i>naratriptan</i>	34	<i>niacin</i>	70
MOVIPREP.....	102	NARDIL.....	55	NIACOR.....	71
<i>moxifloxacin</i>	13, 132	NATACYN.....	132	<i>nicardipine</i>	65
<i>moxifloxacin-sod.chloride(isa.)</i>	13	NATAZIA.....	131	NICOTROL.....	86
MS CONTIN.....	42	<i>nateglinide</i>	94	NICOTROL NS.....	86
MULPLETA.....	69	NATROBA.....	83	<i>nifedipine</i>	65
MULTAQ.....	62	NAYZILAM.....	30	<i>nikki (28)</i>	131
<i>mupirocin</i>	78	<i>nebivolol</i>	65	NILANDRON.....	21
<i>mupirocin calcium</i>	78	NEBUPENT.....	10	<i>nilutamide</i>	21
MVASI.....	21	<i>necon 0.5/35 (28)</i>	131	<i>nimodipine</i>	65
MYALEPT.....	97	<i>nefazodone</i>	55	NINLARO.....	21
MYAMBUTOL.....	9	<i>neomycin</i>	10	<i>nisoldipine</i>	65
MYCAMINE.....	1	<i>neomycin-bacitracin-poly-hc</i>	135	<i>nitazoxanide</i>	10
MYCAPSSA.....	21	<i>neomycin-bacitracin-polymyxin</i>	132	<i>nitisinone</i>	84
MYCOBUTIN.....	9	<i>neomycin-polymyxin b-dexameth</i>	135	<i>nitro-bid</i>	72
<i>mycophenolate mofetil</i>	21	<i>neomycin-polymyxin-gramicidin</i>	132	NITRO-DUR.....	72
<i>mycophenolate sodium</i>	21	<i>neomycin-polymyxin-hc</i>	87, 135	<i>nitrofurantoin</i>	14
MYDAYIS.....	55	<i>neo-polycin</i>	132	NITROFURANTOIN.....	14
MYFEMBREE.....	128	<i>neo-polycin hc</i>	135	<i>nitrofurantoin macrocrystal</i>	14
MYFORTIC.....	21	NEORAL.....	21	<i>nitrofurantoin monohydrate</i>	14
MYHIBBIN.....	21	NEO-SYNALAR.....	78	<i>nitroglycerin</i>	72, 102
MYRBETRIQ.....	144	NERLYNX.....	21	NITROLINGUAL.....	72
MYSOLINE.....	30	NESINA.....	94	NITROSTAT.....	72
MYTESI.....	99	<i>neuac</i>	77	NITYR.....	84
<i>nabumetone</i>	45	NEULASTA.....	108	NIVESTYM.....	108
<i>nadolol</i>	65	NEULASTA ONPRO.....	108	<i>nizatidine</i>	106
<i>nafcillin</i>	12	NEUPOGEN.....	108	<i>nora-be</i>	128
<i>naftifine</i>	79	NEUPRO.....	33	NORDITROPIN.....	
NAFTIN.....	79	NEURONTIN.....	30	FLEXPRO.....	109
NALFON.....	45	NEVANAC.....	134	<i>norelgestromin-ethin.estradiol</i>	128
NALOCET.....	42	<i>nevirapine</i>	4	<i>noreth-ethinyl estradiol-iron</i>	131
<i>naloxone</i>	45	NEXAVAR.....	21	<i>norethindrone (contraceptive)</i>	128
<i>naltrexone</i>	45	NEXICLON XR.....	65	<i>norethindrone acetate</i>	128
NAMENDA TITRATION PAK.....	38	NEXIUM.....	106	<i>norethindrone ac-eth estradiol</i>	128, 131
NAMENDA XR.....	38	NEXIUM PACKET.....	106	<i>norethindrone-e.estradiol-iron</i>	131
NAMZARIC.....	38	NEXLETOL.....	70		
NAPRELAN CR.....	46	NEXLIZET.....	70		
NAPROSYN.....	46	NEXPLANON.....	128		
<i>naproxen</i>	46				

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 viii. 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 drug list was updated in August 2024.

<i>norgestimate-ethinyl estradiol</i>	131	NUTRILIPID.....	147	OMNIPOD 5 G6 INTRO KIT (GEN 5).....	115
NORITATE.....	77	NUTROPIN AQ NUSPIN.....	109	OMNIPOD 5 G6 PODS (GEN 5).....	115
NORLIQVA.....	65	NUVARING.....	128	OMNIPOD 5 G6-G7 INTRO KT(GEN5).....	115
NORPRAMIN.....	55	NUVIGIL.....	56	OMNIPOD 5 G6-G7 PODS (GEN 5).....	115
NORTHERA.....	84	NUZYRA.....	14	OMNIPOD DASH INTRO KIT (GEN 4).....	115
<i>nortrel 0.5/35 (28)</i>	131	<i>nyamyc</i>	79	OMNIPOD DASH PODS (GEN 4).....	115
<i>nortrel 1/35 (21)</i>	131	<i>nylia 1/35 (28)</i>	131	OMNIPOD GO PODS.....	115
<i>nortrel 1/35 (28)</i>	131	<i>nylia 7/7/7 (28)</i>	131	OMNIPOD GO PODS 10 UNITS/DAY.....	115
<i>nortrel 7/7/7 (28)</i>	131	NYMALIZE.....	65	OMNIPOD GO PODS 15 UNITS/DAY.....	115
<i>nortriptyline</i>	55	<i>nymyo</i>	131	OMNIPOD GO PODS 20 UNITS/DAY.....	115
NORVASC.....	65	<i>nystatin</i>	2, 79	OMNIPOD GO PODS 25 UNITS/DAY.....	115
NORVIR.....	4	<i>nystatin-triamcinolone</i>	79	OMNIPOD GO PODS 30 UNITS/DAY.....	115
NOURIANZ.....	33	<i>nystop</i>	79	OMNIPOD GO PODS 40 UNITS/DAY.....	115
NOVO PEN NEEDLE.....	114	NYVEPRIA.....	109	OMNITROPE.....	109
NOVOLIN 70/30 U-100 INSULIN.....	94	OCALIVA.....	102	OMVOH.....	102
NOVOLIN 70-30 FLEXPEN U-100.....	94	<i>ocella</i>	131	OMVOH PEN.....	102
NOVOLIN N FLEXPEN.....	94	OCTAGAM.....	111	<i>ondansetron</i>	102
NOVOLIN N NPH U-100 INSULIN.....	94	<i>octreotide acetate</i>	22	<i>ondansetron hcl</i>	102
NOVOLIN R FLEXPEN.....	94	OCUFLOX.....	132	ONEXTON.....	77
NOVOLIN R REGULAR U100 INSULIN.....	94	ODACTRA.....	111	ONFI.....	30
NOVOLOG FLEXPEN U-100 INSULIN.....	94	ODEFSEY.....	4	ONGENTYS.....	33
NOVOLOG MIX 70-30 U-100 INSULN.....	94	ODOMZO.....	22	ONTRUZANT.....	22
NOVOLOG MIX 70-30FLEXPEN U-100.....	94	OFEV.....	140	ONUREG.....	22
NOVOLOG PENFILL U-100 INSULIN.....	94	<i>ofloxacin</i>	13, 87, 132	ONZETRA XSAIL.....	35
NOVOLOG U-100 INSULIN ASPART.....	94	OGSIVEO.....	22	OPSUMIT.....	140
NOXAFIL.....	1, 2	OJEMDA.....	22	OPSYNVI.....	140
NUBEQA.....	22	OJJAARA.....	22	OPVEE.....	46
NUCALA.....	140	<i>olanzapine</i>	56	OPZELURA.....	75
NUCYNTA.....	46	<i>olanzapine-fluoxetine</i>	56	ORACEA.....	14
NUCYNTA ER.....	46	<i>olmesartan</i>	65	ORAPRED ODT.....	88
NUDEXTA.....	38	<i>olmesartan-amlodipin-hcthiacid</i>	65	ORENCIA.....	125
NUPLAZID.....	56	<i>olmesartan-hydrochlorothiazide</i>	65		
NURTEC ODT.....	35	<i>olopatadine</i>	87		
		OLPRUVA.....	85		
		OLUMIANT.....	124		
		OMECLAMOX-PAK.....	106		
		<i>omega-3 acid ethyl esters</i>	71		
		<i>omeprazole</i>	106		
		<i>omeprazole-sodium bicarbonate</i>	106		
		OMNARIS.....	140		

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 viii. 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 drug list was updated in August 2024.

ORENCIA CLICKJECT	124	<i>paliperidone</i>	56	PEPCID	106
ORENITRAM	66	PALYNZIQ	97	PERCOCET	43
ORENITRAM MONTH 1		PAMELOR	56	PERFOROMIST	141
TITRATION KT	65	PANCREAZE	102	<i>perindopril erbumine</i>	66
ORENITRAM MONTH 2		PANDEL	82	<i>periogard</i>	87
TITRATION KT	65	PANRETIN	75	<i>permethrin</i>	83
ORENITRAM MONTH 3		<i>pantoprazole</i>	106	<i>perphenazine</i>	56
TITRATION KT	66	PANZYGA	111	PERSERIS	56
ORFADIN	85	<i>paricalcitol</i>	97	PERTZYE	103
ORGOVYX	22	PARLODEL	33	PHEBURANE	85
ORIAHNN	129	PARNATE	56	<i>phenelzine</i>	56
ORILISSA	97	<i>paroxetine hcl</i>	56	<i>phenobarbital</i>	30
ORKAMBI	140, 141	<i>paroxetine</i>		<i>phenoxybenzamine</i>	66
ORLADEYO	141	<i>mesylate(.menop.sym.)</i>	56	PHENYTEK	30
<i>ormalvi</i>	38	PAXIL	56	<i>phenytoin</i>	30
ORSERDU	22	PAXIL CR	56	<i>phenytoin sodium extended</i>	30
<i>oseltamivir</i>	4	PAXLOVID	4	PHEXXI	129
OSENI	94	<i>pazopanib</i>	22	PHOSPHOLINE IODIDE ..	133
OSMOLEX ER	33	PEDIARIX (PF)	111	PIFELTRO	4
OSPHENA	129	PEDVAX HIB (PF)	111	<i>pilocarpine hcl</i>	85, 133
OTEZLA	125	<i>peg 3350-electrolytes</i>	102	<i>pimecrolimus</i>	75
OTEZLA STARTER	125	<i>peg3350-sod sul-nacl-kcl-asb-</i>		<i>pimozide</i>	56
OTREXUP (PF)	125	<i>c</i>	103	<i>pimtrea (28)</i>	131
OVIDE	83	PEGASYS	109	<i>pindolol</i>	66
<i>oxacillin</i>	12	<i>peg-electrolyte</i>	103	<i>pioglitazone</i>	94
<i>oxacillin in dextrose(iso-osm)</i>	12	PEMAZYRE	22	<i>pioglitazone-glimepiride</i>	94
<i>oxaprozin</i>	46	PEN NEEDLE, DIABETIC	115	<i>pioglitazone-metformin</i>	94
OXBRYTA	85	PEN NEEDLES (NON-		<i>piperacillin-tazobactam</i>	12
<i>oxcarbazepine</i>	30	PREFERRED BRANDS) ..	115	PIQRAY	22
OXERVATE	133	PENBRAYA (PF)	111	<i>pirfenidone</i>	141
<i>oxiconazole</i>	79	<i>penciclovir</i>	80	PIRFENIDONE	141
OXISTAT	79	<i>penicillamine</i>	125	<i>piroxicam</i>	46
OXTELLAR XR	30	PENICILLIN G POT IN		<i>pitavastatin calcium</i>	71
<i>oxybutynin chloride</i>	144	DEXTROSE	12	PLAQUENIL	10
<i>oxycodone</i>	42, 43	<i>penicillin g potassium</i>	12	PLASMA-LYTE 148	147
OXYCODONE	43	<i>penicillin g sodium</i>	12	PLASMA-LYTE A	147
<i>oxycodone-acetaminophen</i>	43	<i>penicillin v potassium</i>	12	PLAVIX	69
OXYCONTIN	43	PENNSAID	46	PLEGRIDY	109
<i>oxymorphone</i>	43	PENTACEL (PF)	111	PLENAMINE	147
OXYTROL	145	PENTAM	10	PLENVU	103
OZEMPIC	94	<i>pentamidine</i>	10	PLIAGLIS	75
OZOBAX DS	40	PENTASA	103	<i>podofilox</i>	75
<i>pacerone</i>	62	<i>pentoxifylline</i>	69	<i>polycin</i>	132

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 viii. 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 drug list was updated in August 2024.

<i>polymyxin b sulfate</i>	10	PREMPHASE.....	128	PROMETRIUM.....	128
<i>polymyxin b sulf-</i>		PREMPRO.....	128	<i>propafenone</i>	62
<i>trimethoprim</i>	132	<i>prenatal vitamin oral tablet</i> ...	147	<i>propranolol</i>	66
POMALYST.....	22	PRETOMANID.....	10	<i>propylthiouracil</i>	88
PONVORY.....	38	PREVACID.....	106	PROQUAD (PF).....	111
PONVORY 14-DAY		PREVACID SOLUTAB.....	106	PROSCAR.....	145
STARTER PACK.....	38	<i>prevalite</i>	71	PROSOL 20 %.....	147
<i>portia 28</i>	131	PREVYMIS.....	4	PROTONIX.....	107
<i>posaconazole</i>	2	PREZCOBIX.....	4	<i>protriptyline</i>	56
<i>potassium chlorid-d5-</i>		PREZISTA.....	4	PROVERA.....	128
<i>0.45%nacl</i>	146	PRIFTIN.....	10	PROVIGIL.....	56
<i>potassium chloride</i>	146	PRILOSEC.....	106	PROZAC.....	56, 57
<i>potassium chloride in</i>		PRIMAQUINE.....	10	<i>prudoxin</i>	75
<i>0.9%nacl</i>	146	PRIMAXIN IV.....	10	PULMICORT.....	141
<i>potassium chloride in 5 % dex</i>	146	PRIMIDONE.....	31	PULMICORT	
<i>potassium chloride in lr-d5</i> ...	146	<i>primidone</i>	31	FLEXHALER.....	141
<i>potassium chloride in water</i> ...	146	PRIORIX (PF).....	111	PULMOZYME.....	141
<i>potassium chloride-0.45 %</i>		PRISTIQ.....	56	PURIXAN.....	22
<i>nacl</i>	146	PRIVIGEN.....	111	PYLERA.....	107
<i>potassium chloride-d5-</i>		PROAIR DIGIHALER.....	141	<i>pyrazinamide</i>	10
<i>0.2%nacl</i>	146	PROAIR RESPICLICK.....	141	<i>pyridostigmine bromide</i>	40
<i>potassium chloride-d5-</i>		<i>probenecid</i>	117	PYRIDOSTIGMINE	
<i>0.9%nacl</i>	146	<i>probenecid-colchicine</i>	117	BROMIDE.....	40
<i>potassium citrate</i>	145	PROCARDIA XL.....	66	<i>pyrimethamine</i>	10
PRADAXA.....	69	<i>procentra</i>	56	PYRUKYND.....	85
PRALUENT PEN.....	71	<i>prochlorperazine</i>	103	QBRELIS.....	66
<i>pramipexole</i>	33	<i>prochlorperazine maleate</i>	103	QDOLO.....	46
<i>prasugrel</i>	69	PROCRIT.....	109	QELBREE.....	57
<i>pravastatin</i>	71	PROCTOFOAM HC.....	103	QINLOCK.....	23
<i>praziquantel</i>	10	<i>procto-med hc</i>	103	QNASL.....	141
<i>prazosin</i>	66	<i>proctosol hc</i>	103	QTERN.....	94
PRED FORTE.....	135	<i>proctozone-hc</i>	103	QUADRACEL (PF).....	111
PRED MILD.....	135	PROCYSBI.....	145	QUALAQUIN.....	10
<i>prednisolone</i>	88	<i>progesterone micronized</i>	128	QUDEXY XR.....	31
<i>prednisolone acetate</i>	135	PROGLYCEM.....	94	QUESTRAN.....	71
<i>prednisolone sodium</i>		PROGRAF.....	22	QUESTRAN LIGHT.....	71
<i>phosphate</i>	88, 135	PROLASTIN-C.....	85	<i>quetiapine</i>	57
<i>prednisone</i>	88	PROLATE.....	43	QUETIAPINE.....	57
<i>prednisone intensol</i>	88	<i>prolate</i>	43	QUILLICHEW ER.....	57
<i>pregabalin</i>	30, 31	PROLENSA.....	134	QUILLIVANT XR.....	57
PREHEVBRIO (PF).....	111	PROLIA.....	118	<i>quinapril</i>	66
PREMARIN.....	128	PROMACTA.....	69	<i>quinidine gluconate</i>	62
<i>premasol 10 %</i>	147	<i>promethazine</i>	136	<i>quinidine sulfate</i>	62

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 viii. 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 drug list was updated in August 2024.

<i>quinine sulfate</i>	10	<i>repaglinide</i>	94, 95	<i>rizatriptan</i>	35
QULIPTA.....	35	REPATHA.....	71	ROBINUL.....	100
QUVIVIQ.....	57	REPATHA.....		ROBINUL FORTE.....	100
QVAR REDHALER.....	142	PUSHTRONEX.....	71	ROCALTROL.....	97
RABAVERT (PF).....	111	REPATHA SURECLICK...	71	ROCKLATAN.....	134
<i>rabeprazole</i>	107	RESTASIS.....	133	<i>roflumilast</i>	142
RADICAVA ORS.....	38	RESTASIS MULTIDOSE..	133	<i>ropinirole</i>	33
RADICAVA ORS.....		RETACRIT.....	110	<i>rosuvastatin</i>	71
STARTER KIT SUSP.....	39	RETEVMO.....	23	ROTARIX.....	111, 112
RAGWITEK.....	111	RETIN-A.....	77	ROTATEQ VACCINE.....	112
<i>raloxifene</i>	118	RETIN-A MICRO.....	77	ROWASA.....	103
<i>ramelteon</i>	57	RETROVIR.....	5	<i>roweepra</i>	31
<i>ramipril</i>	66	REVATIO.....	142	ROXICODONE.....	43
<i>ranolazine</i>	72	REVCovi.....	85	ROXYBOND.....	44
RAPAFLO.....	145	REVLIMID.....	23	ROZEREM.....	58
RAPAMUNE.....	23	REXULTI.....	57	ROZLYTREK.....	23
<i>rasagiline</i>	33	REYATAZ.....	5	RUBRACA.....	23
RASUVO (PF).....	125	REYVOW.....	35	RUCONEST.....	142
RAVICTI.....	85	REZDIFFRA.....	85	<i>rufinamide</i>	31
RAYALDEE.....	97	REZLIDHIA.....	23	RUKOBIA.....	5
RAYOS.....	88	REZUROCK.....	23	RUXIENCE.....	23
REBIF (WITH ALBUMIN)		REZVOGLAR KWIKPEN..	95	RYALTRIS.....	142
.....	109	RHOPRESSA.....	134	RYBELSUS.....	95
REBIF REBIDOSE.....	109	RIABNI.....	23	RYDAPT.....	23
REBIF TITRATION PACK		<i>ribavirin</i>	5	RYTARY.....	33
.....	110	RIDAURA.....	125	RYTHMOL SR.....	62
<i>reclipsen (28)</i>	131	<i>rifabutin</i>	10	SABRIL.....	31
RECOMBIVAX HB (PF)...	111	<i>rifampin</i>	10	SAFYRAL.....	131
RECORLEV.....	97	<i>riluzole</i>	85	<i>sajazir</i>	142
RECTIV.....	103	<i>rimantadine</i>	5	SALAGEN	
REGLAN.....	103	RINVOQ.....	125	(PILOCARPINE).....	85
REGRANEX.....	75	<i>risedronate</i>	85, 118	SAMSCA.....	97
RELAFEN DS.....	46	RISPERDAL.....	58	SANCUSO.....	103
RELENZA DISKHALER.....	4	RISPERDAL CONSTA..	57, 58	SANDIMMUNE.....	23
RELEUKO.....	110	<i>risperidone</i>	58	SANDOSTATIN.....	23
RELEXXII.....	57	<i>risperidone microspheres</i>	58	SANTYL.....	75
RELISTOR.....	103	RITALIN.....	58	SAPHRIS.....	58
RELPAK.....	35	RITALIN LA.....	58	<i>sapropterin</i>	98
RELTONE.....	103	<i>ritonavir</i>	5	SAVAYSA.....	69
REMERON.....	57	<i>rivastigmine</i>	39	SAVELLA.....	125
REMERON SOLTAB.....	57	<i>rivastigmine tartrate</i>	39	<i>saxagliptin</i>	95
REMICADE.....	103	<i>rivelsa</i>	131	<i>saxagliptin-metformin</i>	95
RENFLEXIS.....	103	RIVFLOZA.....	145	SCEMBLIX.....	23

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 viii. 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 drug list was updated in August 2024.

<i>scopolamine base</i>	103	SKYLA.....	129	<i>spironolacton-</i>	
SECUADO.....	58	SKYRIZI.....	73, 103, 104	<i>hydrochlorothiaz</i>	66
SEGLENTIS.....	44	SKYTROFA.....	110	SPORANOX.....	2
SEGLUROMET.....	95	SOAAZ.....	66	<i>sprintec (28)</i>	131
<i>selegiline hcl</i>	33	<i>sodium chloride</i>	85	SPRITAM.....	31
<i>selenium sulfide</i>	73	<i>sodium chloride 0.45 %</i>	146	SPRIX.....	46
SELZENTRY.....	5	<i>sodium chloride 0.9 %</i>	85	SPRYCEL.....	24
SEMGLEE(INSULIN		<i>sodium chloride 3 %</i>		<i>sps (with sorbitol)</i>	86
GLARGINE-YFGN).....	95	<i>hypertonic</i>	146	<i>sronyx</i>	131
SEMGLEE(INSULIN		<i>sodium chloride 5 %</i>		<i>ssd</i>	75
GLARG-YFGN)PEN.....	95	<i>hypertonic</i>	146	STALEVO 100.....	33
SENSIPAR.....	98	SODIUM OXYBATE		STALEVO 125.....	33
SEREVENT DISKUS.....	142	(PREFERRED NDCS		STALEVO 150.....	33
SEROQUEL.....	58	STARTING WITH 00054)...	59	STALEVO 200.....	33
SEROQUEL XR.....	58, 59	<i>sodium phenylbutyrate</i>	85	STALEVO 50.....	33
SEROSTIM.....	110	<i>sodium polystyrene sulfonate</i> ..	85	STALEVO 75.....	33
SERTRALINE.....	59	<i>sodium,potassium,mag</i>		STEGLATRO.....	95
<i>sertraline</i>	59	<i>sulfates</i>	104	STEGLUJAN.....	95
<i>setlakin</i>	131	SOFOSBUVIR-		STELARA.....	73
SEYSARA.....	14	VELPATASVIR.....	5	STIMUFEND.....	110
<i>sharobel</i>	128	SOGROYA.....	110	STIOLTO RESPIMAT.....	142
SHINGRIX (PF).....	112	SOHONOS.....	85	STIVARGA.....	24
SIGNIFOR.....	23	<i>solifenacin</i>	145	STRATTERA.....	59
SIKLOS.....	23	SOLQUA 100/33.....	95	STRENSIQ.....	98
<i>sildenafil (pulmonary arterial</i>		SOLOSEC.....	10	STREPTOMYCIN.....	10
<i>hypertension)</i>	142	SOLTAMOX.....	23	STRIBILD.....	5
SILENOR.....	59	SOMATULINE DEPOT.....	23	STRIVERDI RESPIMAT..	142
SILIQ.....	73	SOMAVERT.....	98	STROMECTOL.....	10
<i>silodosin</i>	145	SOOLANTRA.....	77	SUBLOCADE.....	44
SILVADENE.....	75	<i>sorafenib</i>	24	SUBOXONE.....	46
<i>silver sulfadiazine</i>	75	SORILUX.....	73	<i>subvenite</i>	31
SIMBRINZA.....	134	<i>sotalol</i>	62	<i>subvenite starter (blue) kit</i>	31
SIMLANDI(CF)		<i>sotalol af</i>	62	<i>subvenite starter (green) kit</i> ...	31
AUTOINJECTOR.....	125	SOTYKTU.....	73	<i>subvenite starter (orange) kit</i> .	31
SIMPONI.....	125	SOTYLIZE.....	62	SUCRAID.....	104
<i>simvastatin</i>	71	SOVALDI.....	5	<i>sucralfate</i>	107
SINEMET.....	33	SPEVIGO.....	73	SUFLAVE.....	104
SINGULAIR.....	142	<i>spinosad</i>	83	SULAR.....	66
<i>sirolimus</i>	23	SPIRIVA RESPIMAT.....	142	<i>sulfacetamide sodium</i>	133
SIRTURO.....	10	SPIRIVA WITH		<i>sulfacetamide sodium (acne)</i> ..	78
SITAGLIPTIN.....	95	HANDIHALER.....	142	<i>sulfacetamide-prednisolone</i> ...	133
SIVEXTRO.....	10	<i>spironolactone</i>	66	<i>sulfadiazine</i>	13
SKYCLARYS.....	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 viii. 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 drug list was updated in August 2024.

<i>sulfamethoxazole-</i>		<i>telmisartan-</i>	
<i>trimethoprim</i>	13	<i>hydrochlorothiazid</i>	66
SULFAMYLOX.....	78	TENIVAC (PF).....	112
<i>sulfasalazine</i>	104	<i>tenofovir disoproxil fumarate</i>	5
<i>sulindac</i>	46	TENORETIC 100.....	66
<i>sumatriptan</i>	35	TENORETIC 50.....	66
<i>sumatriptan succinate</i>	35	TENORMIN.....	66
<i>sumatriptan-naproxen</i>	35	TEPMETKO.....	24
<i>sunitinib malate</i>	24	<i>terazosin</i>	66
SUNLENCA.....	5	<i>terbinafine hcl</i>	2
SUNOSI.....	59	<i>terbutaline</i>	142
SUPREP BOWEL PREP		<i>terconazole</i>	129
KIT.....	104	<i>teriflunomide</i>	39
SUTAB.....	104	TERIPARATIDE.....	118
SUTENT.....	24	TESTIM.....	98
<i>syeda</i>	131	<i>testosterone</i>	98
SYMBICORT.....	142	<i>testosterone cypionate</i>	98
SYMBYAX.....	59	<i>testosterone enanthate</i>	98
SYMDEKO.....	142	TETANUS,DIPHThERIA	
SYMFI.....	5	TOX PED(PF).....	112
SYMFI LO.....	5	<i>tetrabenazine</i>	39
SYMLINPEN 120.....	95	<i>tetracycline</i>	14
SYMLINPEN 60.....	95	TEXACORT.....	82
SYMPAZAN.....	31	TEZSPIRE.....	143
SYMPROIC.....	104	THALITONE.....	66
SYMTUZA.....	5	THALOMID.....	24
SYNALAR.....	82	THEO-24.....	143
SYNAREL.....	98	<i>theophylline</i>	143
SYNJARDY.....	95	THIOLA.....	86
SYNJARDY XR.....	95	THIOLA EC.....	86
SYNTHROID.....	99	<i>thioridazine</i>	59
SYPRINE.....	86	<i>thiothixene</i>	59
TABLOID.....	24	THYQUIDITY.....	99
TABRECTA.....	24	<i>tiadylt er</i>	66
TACLONEX.....	73	<i>tiagabine</i>	31
<i>tacrolimus</i>	24, 75	TIAZAC.....	66
<i>tadalafil</i>	145	TIBSOVO.....	24
<i>tadalafil (pulmonary arterial</i>		TICOVAC.....	112
<i>hypertension) oral tablet 20</i>		<i>tigecycline</i>	10
<i>mg</i>	142	TIGLUTIK.....	86
TADLIQ.....	142	TIKOSYN.....	62
TAFINLAR.....	24	<i>tilia fe</i>	131
<i>tafluprost (pf)</i>	134	<i>timolol maleate</i>	66, 133

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 viii. 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 drug list was updated in August 2024.

<i>timolol maleate (pf)</i>	133	TRAMADOL.....	47	<i>tri-legest fe</i>	131
TIMOPTIC OCUDOSE		<i>tramadol</i>	47	TRILEPTAL.....	31
(PF).....	133	<i>tramadol-acetaminophen</i>	47	TRILIPIX.....	71
<i>tinidazole</i>	10	<i>trandolapril</i>	66	<i>tri-lo-estarylla</i>	131
<i>tiopronin</i>	86	<i>trandolapril-verapamil</i>	67	<i>tri-lo-sprintec</i>	131
<i>tiotropium bromide</i>	143	<i>tranexamic acid</i>	129	<i>trimethoprim</i>	14
TIROSINT.....	99	<i>tranylcypromine</i>	59	<i>tri-mili</i>	131
TIROSINT-SOL.....	99	<i>travasol 10 %</i>	147	<i>trimipramine</i>	59
TIVICAY.....	5	TRAVATAN Z.....	134	TRINTELLIX.....	59
TIVICAY PD.....	5	<i>travoprost</i>	134	<i>tri-nymyo</i>	131
<i>tizanidine</i>	40	TRAZIMERA.....	24	<i>tri-sprintec (28)</i>	131
TLANDO.....	98	<i>trazodone</i>	59	TRIUMEQ.....	5
TOBI.....	10	TRECATOR.....	10	TRIUMEQ PD.....	5
TOBI PODHALER.....	10	TRELEGY ELLIPTA.....	143	<i>trivora (28)</i>	131
TOBRADEX.....	135	TRELSTAR.....	24	<i>tri-vylibra</i>	131
<i>tobramycin</i>	10, 132	TREMFYA.....	74	<i>tri-vylibra lo</i>	131
<i>tobramycin in 0.225 % nacl</i>	10	<i>treprostinil sodium</i>	67	TROKENDI XR.....	31
<i>tobramycin sulfate</i>	10	TRESIBA FLEXTOUCH		TROPHAMINE 10 %.....	147
<i>tobramycin-dexamethasone</i> ..	135	U-100.....	96	<i>trospium</i>	145
TOBREX.....	132	TRESIBA FLEXTOUCH		TRUEPLUS INSULIN.....	116
TOFIDENCE.....	125	U-200.....	96	TRUEPLUS PEN NEEDLE	
<i>tolcapone</i>	33	TRESIBA U-100 INSULIN..	96		116
TOLECTIN 600.....	46	<i>tretinoin (antineoplastic)</i>	24	TRULANCE.....	104
<i>tolmetin</i>	46	<i>tretinoin microspheres</i>	77, 78	TRULICITY.....	96
TOLSURA.....	2	<i>tretinoin topical</i>	78	TRUMENBA.....	112
<i>tolterodine</i>	145	TREXALL.....	24	TRUQAP.....	24
<i>tolvaptan</i>	98	TREXIMET.....	35	TRUVADA.....	5
TOPAMAX.....	31	TREZIX.....	44	TUDORZA PRESSAIR.....	143
TOPICORT.....	82, 83	<i>triamcinolone acetonide</i>	83, 87	TUKYSA.....	24, 25
<i>topiramate</i>	31	<i>triamterene</i>	67	TURALIO.....	25
TOPROL XL.....	66	<i>triamterene-</i>		<i>turqoz (28)</i>	131
<i>toremifene</i>	24	<i>hydrochlorothiazid</i>	67	TWINRIX (PF).....	112
<i>toremide</i>	66	TRIBENZOR.....	67	TWYNEO.....	78
TOSYMRA.....	35	TRICOR.....	71	TYBOST.....	5
TOUJEO MAX U-300		<i>triderm</i>	83	<i>tydemy</i>	131
SOLOSTAR.....	95	<i>trientine</i>	86	TYGACIL.....	10
TOUJEO SOLOSTAR U-		TRIENTINE.....	86	TYKERB.....	25
300 INSULIN.....	95	<i>tri-estarylla</i>	131	TYMLOS.....	118
<i>tovet emollient</i>	83	<i>trifluoperazine</i>	59	TYPHIM VI.....	112
TOVIAZ.....	145	<i>trifluridine</i>	132	TYRVAYA.....	133
TPN ELECTROLYTES.....	146	<i>trihexyphenidyl</i>	33	TYVASO DPI.....	143
TRACLEER.....	143	TRIJARDY XR.....	96	UBRELVY.....	35
TRADJENTA.....	96	TRIKAFTA.....	143	UCERIS.....	104

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 viii. 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 drug list was updated in August 2024.

UDENYCA.....	110	VANCOCIN.....	10	VFEND IV.....	2
UDENYCA		<i>vancomycin</i>	11	V-GO 20.....	117
AUTOINJECTOR.....	110	VANCOMYCIN.....	11	V-GO 30.....	117
UDENYCA ONBODY.....	110	<i>vandazole</i>	129	V-GO 40.....	117
ULORIC.....	117	VANFLYTA.....	25	VIBERZI.....	104
ULTRAVATE.....	83	VANOS.....	83	VIBRAMYCIN.....	14
UNASYN.....	12, 13	VAQTA (PF).....	112	VICTOZA 3-PAK.....	96
UNIFINE PENTIPS.....	117	<i>varenicline</i>	86	<i>vienva</i>	132
UNIFINE PENTIPS		VARIVAX (PF).....	112	<i>vigabatrin</i>	32
MAXFLOW.....	116	VARUBI.....	104	<i>vigadrone</i>	32
UNIFINE PENTIPS PLUS	117	VASCEPA.....	71	VIGAMOX.....	132
UNIFINE PENTIPS PLUS		VASERETIC.....	67	<i>vigpoder</i>	32
MAXFLOW.....	117	VASOTEC.....	67	VIIBRYD.....	60
UNIFINE		VECAMYL.....	72	VIJOICE.....	25
SAFECONTROL.....	117	VECTICAL.....	74	<i>vilazodone</i>	60
UNIFINE		<i>velivet triphasic regimen (28)</i>	131	VIMOVO.....	47
SAFECONTROL PEN		VELSIPITY.....	104	VIMPAT.....	32
NEEDLE.....	117	VELTASSA.....	86	VIOKACE.....	104
UNIFINE ULTRA PEN		VELTIN.....	78	VIRACEPT.....	6
NEEDLE.....	117	VEMLIDY.....	6	VIREAD.....	6
<i>unithroid</i>	99	VENCLEXTA.....	25	VITRAKVI.....	25
UPTRAVI.....	67	VENCLEXTA STARTING		VIVELLE-DOT.....	128
UROCIT-K 10.....	145	PACK.....	25	VIVITROL.....	47
UROCIT-K 15.....	145	<i>venlafaxine</i>	60	VIVJOA.....	2
UROCIT-K 5.....	145	VENLAFAXINE		VIZIMPRO.....	25
UROXATRAL.....	145	BESYLATE.....	60	VOGELXO.....	98, 99
URSO 250.....	104	VENTOLIN HFA.....	143	VONJO.....	25
URSO FORTE.....	104	VEOZAH.....	129	VOQUEZNA.....	107
<i>ursodiol</i>	104	<i>verapamil</i>	67	VOQUEZNA DUAL PAK	
UZEDY.....	59, 60	VERDESO.....	83	VOQUEZNA TRIPLE PAK	
VABOMERE.....	10	VEREGEN.....	75		107
VAGIFEM.....	128	VERELAN.....	67	<i>voriconazole</i>	2
<i>valacyclovir</i>	5	VERELAN PM.....	67	VOSEVI.....	6
VALCHLOR.....	75	VERIFINE INSULIN		VOTRIENT.....	25
VALCYTE.....	5	SYRINGE.....	117	VOWST.....	104
<i>valganciclovir</i>	5, 6	VERQUVO.....	72	VOXZOGO.....	99
<i>valproic acid</i>	31	VERSACLOZ.....	60	VRAYLAR.....	60
<i>valproic acid (as sodium salt)</i>	32	VERZENIO.....	25	VTAMA.....	74
VALSARTAN.....	67	VESICARE.....	145	VUITY.....	134
<i>valsartan</i>	67	VESICARE LS.....	145	VUMERITY.....	39
<i>valsartan-hydrochlorothiazide</i>	67	<i>vestura (28)</i>	132	<i>vyfemla (28)</i>	132
VALTOCO.....	32	VEVYE.....	133	<i>vylibra</i>	132
VALTREX.....	6	VFEND.....	2	VYNDAMAX.....	72

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 viii. 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 drug list was updated in August 2024.

VYNDAQEL.....	72	XIIDRA.....	134	ZEMBRACE SYMTOUCH.....	35
VYTORIN 10-10.....	71	XOFLUZA.....	6	ZEMDRI.....	11
VYTORIN 10-20.....	71	XOLAIR.....	144	ZEMPLAR.....	99
VYTORIN 10-40.....	71	XOLREMDI.....	110	<i>zenatane</i>	78
VYTORIN 10-80.....	71	XOPENEX HFA.....	144	ZENPEP.....	104, 105
VYVANSE.....	60	XOSPATA.....	26	<i>zenzedi</i>	61
VYZULTA.....	134	XPOVIO.....	26	ZENZEDI.....	61
WAINUA.....	39	XTAMPZA ER.....	44	ZEPATIER.....	6
WAKIX.....	60	XTANDI.....	26	ZEPOSIA.....	39
<i>warfarin</i>	69	<i>xulane</i>	129	ZEPOSIA STARTER KIT	
WEGOVY.....	86	XULTOPHY 100/3.6.....	96	(28-DAY).....	39
WELCHOL.....	71	XYOSTED.....	99	ZEPOSIA STARTER	
WELIREG.....	25	XYREM.....	61	PACK (7-DAY).....	39
WELLBUTRIN SR.....	60	XYWAV.....	61	ZERBAXA.....	7
WELLBUTRIN XL.....	60, 61	<i>yargesa</i>	99	ZESTORETIC.....	67
WINLEVI.....	78	YASMIN (28).....	132	ZESTRIL.....	67
<i>wixela inhub</i>	144	YAZ (28).....	132	ZETIA.....	71
<i>wymzya fe</i>	132	YF-VAX (PF).....	112	ZETONNA.....	144
XACIATO.....	129	YONSA.....	26	ZIAGEN.....	6
XADAGO.....	33	YUFLYMA(CF).....	126	ZIANA.....	78
XALATAN.....	134	YUFLYMA(CF) AI		<i>zidovudine</i>	6
XALKORI.....	25	CROHN'S-UC-HS.....	126	ZIEXTENZO.....	110
XARELTO.....	69	YUFLYMA(CF)		ZILBRYSQ.....	40
XARELTO DVT-PE		AUTOINJECTOR.....	126	<i>zileuton</i>	144
TREAT 30D START.....	69	YUPELRI.....	144	ZIMHI.....	47
XATMEP.....	25	YUSIMRY(CF) PEN.....	126	ZIOPTAN (PF).....	134
XCOPRI.....	32	<i>yuvaferm</i>	128	<i>ziprasidone hcl</i>	61
XCOPRI MAINTENANCE		<i>zafemy</i>	129	<i>ziprasidone mesylate</i>	61
PACK.....	32	<i>zafirlukast</i>	144	ZIPSOR.....	47
XCOPRI TITRATION		<i>zaleplon</i>	61	ZIRABEV.....	26
PACK.....	32	ZANAFLEX.....	40	ZIRGAN.....	132
XDEMVI.....	134	ZARONTIN.....	32	ZITHROMAX.....	8
XELJANZ.....	125	ZARXIO.....	110	ZITHROMAX TRI-PAK.....	8
XELJANZ XR.....	125	ZAVESCA.....	99	ZITHROMAX Z-PAK.....	8
XELPROS.....	134	ZAVZPRET.....	35	ZITUVIO.....	96
XELSTRYM.....	61	ZEGALOGUE		ZOCOR.....	71
XENAZINE.....	39	AUTOINJECTOR.....	96	ZOLINZA.....	26
XERESE.....	80	ZEGALOGUE SYRINGE...	96	<i>zolmitriptan</i>	35
XERMELO.....	26	ZEGERID.....	107	ZOLOFT.....	61
XGEVA.....	15	ZEJULA.....	26	<i>zolpidem</i>	61
XHANCE.....	144	ZELAPAR.....	33	ZOMACTON.....	110
XIFAXAN.....	11	ZELBORAF.....	26	ZOMIG.....	35
XIGDUO XR.....	96	ZEMAIRA.....	86	ZONALON.....	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 viii. 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 drug list was updated in August 2024.

ZONEGRAN.....	32
ZONISADE.....	32
<i>zonisamide</i>	32
ZORTRESS.....	26
ZORYVE.....	74
ZOSYN IN DEXTROSE (ISO-OSM).....	13
<i>zovia 1-35 (28)</i>	132
ZOVIRAX.....	80
ZTALMY.....	32
ZTLIDO.....	75
ZUBSOLV.....	47
ZURZUVAE.....	61
ZYCLARA.....	75
ZYDELIG.....	26
ZYFLO.....	144
ZYKADIA.....	26
ZYLET.....	135
ZYMFENTRA.....	105
ZYPITAMAG.....	71
ZYPREXA.....	61
ZYPREXA RELPREVV.....	61
ZYPREXA ZYDIS.....	61, 62
ZYTIGA.....	26
ZYVOX.....	11

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 viii. 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](https://www.express-scripts.com)**.

This drug list was updated in August 2024.

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 08/26/2024. 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.

© 2024 Express Scripts. All Rights Reserved.

F0PA5O5A

This drug list was updated in August 2024.