



# **Large Group 4-Tier Formulary Prescription Drug List By Tier**

Last Updated: 12/27/2021

## Key Terms

### Formulary

A formulary is a list of prescription medications developed by a committee of practicing physicians and practicing pharmacists who represent a variety of specialty areas and who are knowledgeable in the diagnosis and treatment of disease.

### Brand-Name Drugs

Brand-name drugs are typically the first products to gain U.S. Food and Drug Administration (FDA) approval.

### Generic Drugs

Generic drugs have the same active ingredients and come in the same strengths and dosage forms as the equivalent brand-name drug. Multiple manufacturers may produce the same generic drug and the product may differ from its brand name counterpart in color, size or shape, but the differences do not alter the effectiveness. Generic versions of brand-name drugs are reviewed and approved by the FDA. The FDA works closely with all pharmaceutical companies to make sure that all drugs sold in the U.S. meet appropriate standards for strength, quality, and purity.

Note: With limited exceptions, when a generic launches the brand name drug will move to not covered immediately following the generic launch.

### 4-Tier Pharmacy Copayment Program (4-Tier Program)

To help maintain affordability in the pharmacy benefit, we encourage the use of cost-effective drugs and preferred brand names through the four-tier program. This program gives you and your doctor the opportunity to work together to find a prescription medication that's affordable and appropriate for you.

All covered drugs are placed into one of four tiers. Your physician may have the option to write you a prescription for a Tier 1, Tier 2, Tier 3 or Tier 4 drug (as defined below); however, there may be instances when only a Tier 4 drug is appropriate, which will require a higher copayment. The program features a high cost tier mostly inclusive of specialty drugs included in and obtained through the Designated Specialty Pharmacy (SP) program. Drugs subject to the SP program include but are not limited to medications used in the treatment of rare diseases, infertility, hepatitis C, growth hormone deficiency, multiple sclerosis, rheumatoid arthritis, and cancers treated with oral medications.

- **Tier 1:** Medications on this tier have the lowest cost sharing amount
- **Tier 2:** Medications on this tier have a higher cost sharing amount
- **Tier 3:** Medications on this tier have a higher cost sharing amount
- **Tier 4:** Medications on this tier have the highest cost sharing amount; limited to a 30 day supply

Please note that tier placement is subject to change throughout the year.

---

<b>CM</b> Cancer Mandate	<b>MM</b> Mandatory Mail	<b>NC</b> Non Covered Drugs
<b>NTM</b> New-to-Market	<b>PA</b> Prior Authorization	<b>QL</b> Quantity Limitation Program
<b>SI</b> Specialty Infusion	<b>SP</b> Designated Specialty Pharmacy	<b>STPA</b> Step Therapy Prior Authorization
<b>WH</b> Women's Health	<b>ACA</b> Preventive Service	<b>LCG</b> Low Cost Generic

## Copayment

A copayment is the fee a member pays for certain covered drugs. A member pays the copayment directly to the provider when he/she receives a covered drug, unless the provider arranges otherwise.

## Coinsurance

Coinsurance requires the member to pay a percentage of the total cost for certain covered drugs.

## Medical Review Process

Tufts Health Freedom Plan has pharmacy programs in place to help manage the pharmacy benefit. Requests for medically necessary review for coverage of drugs included in the New-to-Market Drug Evaluation Process (NTM), Prior Authorization Program (PA), Step Therapy Prior Authorization Program (STPA), Quantity Limitations Program (QL), Non-Covered Drugs (NC) With Suggested Alternatives Program should be completed by the physician and sent to Tufts Health Freedom Plan. Drugs excluded under your pharmacy benefit will not be covered through this process. The request must include clinical information that supports why the drug is medically necessary for you. Tufts Health Freedom Plan will approve the request if it meets coverage guidelines. If Tufts Health Freedom Plan does not approve the request, you have the right to appeal. The appeal process is described in your benefit document.

## Quantity Limitation (QL) Program

Because of potential safety and utilization concerns, Tufts Health Freedom Plan has placed quantity limitations on some prescription drugs. You are covered for up to the amount posted in our list of covered drugs. These quantities are based on recognized standards of care as well as from FDA-approved dosing guidelines. If your provider believes it is necessary for you to take more than the QL amount posted on the list, he or she may submit a request for coverage under the Medical Review Process.

## New-To-Market Drug Evaluation Process (NTM)

In an effort to make sure the new-to-market prescription drugs we cover are safe, effective and affordable, we delay coverage of many new drug products until the Plan's Pharmacy and Therapeutics Committee and physician specialists have reviewed them. This review process is usually completed within six months after a drug becomes available.

The review process enables us to learn a great deal about these new drugs, including how a physician can safely prescribe these new drugs and how physicians can choose the most appropriate patients for the new therapy. During the review process, if your physician believes you have a medical need for the New-To-Market drug, your doctor can submit a request for coverage to Tufts Health Freedom Plan under the Medical Review Process.

Note: Drugs approved through the Medical Review Process may be subject to the highest copayment.

## Non-Covered Drugs (NC)

There are thousands of drugs listed on the Tufts Health Freedom Plan covered drug list. In fact, most drugs are covered. There is, however, a list of drugs that Tufts Health Freedom Plan currently does not cover.

In many cases, these drugs are not covered by Tufts Health Freedom Plan because there are safe, comparably effective, and cost effective alternatives available. Our goal is to keep pharmacy benefits as affordable as possible.

---

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

If your doctor feels that one of the non-covered drugs is needed, your doctor can submit a request for coverage to Tufts Health Freedom Plan under the Medical Review Process.

Note: Drugs approved through the Medical Review Process may be subject to the highest copayment.

**Prior Authorization (PA) Program**

In order to ensure safety and affordability for everyone, some medications require prior authorization. This helps us work with your doctor to ensure that medications are prescribed appropriately.

If your doctor feels it is medically necessary for you to take one of the drugs listed below, he/she can submit a request for coverage to Tufts Health Freedom Plan under the Medical Review Process.

**Step Therapy Prior Authorization (STPA)**

Step Therapy is an automated form of Prior Authorization. It encourages the use of therapies that should be tried first, before other treatments are covered, based on clinical practice guidelines and cost-effectiveness. Some types of Step Therapy include requiring the use of generics before brand name drugs, preferred before non-preferred brand name drugs, and first-line before second-line therapies.

Medications included on step 1- the lowest step-are usually covered without authorization. We have noted the few exceptions, which may require your physician to submit a request to Tufts Health Freedom Plan for coverage. Medications on Step 2 or higher are automatically authorized at the point-of-sale if you have taken the required prerequisite drugs. However, if your physician prescribes a medication on a higher step, and you have not yet taken the required medication(s) on a lower step, or if you are a new Tufts Health Freedom Plan member and do not have any prescription drug claims history, the prescription will deny at the point-of-sale with a message indicating that a Prior Authorization (PA) is required. Physicians may submit requests for coverage to Tufts Health Freedom Plan for members who do not meet the Step Therapy criteria at the point of sale under the Medical Review process.

**Designated Specialty Pharmacy Program (SP)**

Tufts Health Freedom Plan's goal is to offer you the most clinically appropriate and cost-effective services.

As a result, we have designated special pharmacies to supply up to a 30-day supply of a select number of medications used in the treatment of complex diseases. These pharmacies are specialized in providing these medications and are staffed with nurses, coordinators and pharmacists to provide support services for members.

Other special designated pharmacies and medications may be identified and added to this program from time to time.

Benefits vary; some members may not participate in this program. Please see your benefit document for complete information.

Physicians may obtain a select number of specialty medications through a designated SP for administration in the office as an alternative to direct purchase. These medications are covered under the medical benefit, and will be shipped directly to and administered in the office by the member's provider. The designated pharmacy will bill Tufts Health Freedom Plan directly for the medication.

---

<b>CM</b> Cancer Mandate	<b>MM</b> Mandatory Mail	<b>NC</b> Non Covered Drugs
<b>NTM</b> New-to-Market	<b>PA</b> Prior Authorization	<b>QL</b> Quantity Limitation Program
<b>SI</b> Specialty Infusion	<b>SP</b> Designated Specialty Pharmacy	<b>STPA</b> Step Therapy Prior Authorization
<b>WH</b> Women's Health	<b>ACA</b> Preventive Service	<b>LCG</b> Low Cost Generic

Medications included in the Specialty Pharmacy Program must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767. For questions on the Specialty Pharmacy Program or to find out if your plan includes this program, please call us at the number listed on the back of your member identification card.

### **Designated Specialty Infusion Program for Drugs Covered Under the Medical Benefit (SI)**

Tufts Health Freedom Plan has designated home infusion providers for a select number of specialized pharmacy products and drug administration services.

The designated specialty infusion provider offers clinical management of drug therapies, nursing support, and care coordination to members with acute and chronic conditions. Place of service may be in the home or alternate infusion site based on availability of infusion centers and determination of the most clinically appropriate site for treatment. These medications are covered under the medical benefit (not the pharmacy benefit) and generally require support services, medication dose management, and special handling in addition to the drug administration services. Medications include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, and immune deficiency. Other specialty infusion providers and medications may be identified and added to this program from time to time.

### **Over-The-Counter Drugs (OTC)**

When a medication with the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent, becomes available over-the-counter, Tufts Health Freedom Plan may exclude coverage of the specific medication or all of the prescription drugs in the class. For more information, please call our Member Services Department at the number listed on the back of your member identification card.

### **Cancer Mandate (CM)**

Oral Cancer medications may have a cost share of up to \$0 for up to a 30 day supply under the New Hampshire oral cancer therapy mandate. Please check your benefit document.

### **Low Cost Generic (LCG)**

Certain medications may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.

### **Women's Health (WH)**

Certain medications may be covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

### **Affordable Care Act (ACA)**

Under the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or health care reform, these preventive medications may be covered at no cost (copay, coinsurance, or deductible) for Tufts Health Freedom Plan members, depending on their plan benefits. Please check the specific terms of your plan benefit document.

Note: A prescription is required for all listed medications, including over-the-counter (OTC) medications

---

<b>CM</b>	Cancer Mandate	<b>MM</b>	Mandatory Mail	<b>NC</b>	Non Covered Drugs
<b>NTM</b>	New-to-Market	<b>PA</b>	Prior Authorization	<b>QL</b>	Quantity Limitation Program
<b>SI</b>	Specialty Infusion	<b>SP</b>	Designated Specialty Pharmacy	<b>STPA</b>	Step Therapy Prior Authorization
<b>WH</b>	Women's Health	<b>ACA</b>	Preventive Service	<b>LCG</b>	Low Cost Generic

**Tufts Health Freedom Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Tufts Health Freedom Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.**

## Tufts Health Freedom Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Tufts Health Freedom Plan at 888.501.6048.

If you believe that Tufts Health Freedom Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### Tufts Health Freedom Plan, Attention:

Civil Rights Coordinator Legal Dept.  
705 Mount Auburn St. Watertown, MA 02472  
Phone: 888.880.8699 ext. 48000, [TTY number— 800.439.2370 or 711]  
Fax: 617.972.9048  
Email: OCRCoordinator@tufts-health.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Tufts Health Plan Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

### U.S. Department of Health and Human Services

200 Independence Avenue, SW  
Room 509F, HHH Building Washington, D.C. 20201  
800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

thfp.com | 888.501.6048

---

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

For no cost translation in English, call the number on your ID card.

**Arabic** للحصول على خدمة الترجمة المجانية باللغة العربية، يرجى الاتصال على الرقم المدون على بطاقة الهوية الخاصة بك.

**Chinese** 若需免費的中文版本，請撥打ID卡上的電話號碼。

**French** Pour demander une traduction gratuite en français, composez le numéro indiqué sur votre carte d'identité.

**German** Um eine kostenlose deutsche Übersetzung zu erhalten, rufen Sie bitte die Telefonnummer auf Ihrer Ausweiskarte an.

**Greek** Για δωρεάν μετάφραση στα Ελληνικά, καλέστε τον αριθμό που αναγράφεται στην αναγνωριστική κάρτας σας.

**Haitian Creole** Pou jwenn tradiksyon gratis nan lang Kreyòl Ayisyen, rele nimewo ki sou kat ID ou.

**Italian** Per la traduzione in italiano senza costi aggiuntivi, è possibile chiamare il numero indicato sulla tessera identificativa.

**Japanese** 日本語の無料翻訳についてはIDカードに書いてある番号に電話してください。

**Khmer (Cambodian)** សម្រាប់សេវាបកប្រែដោយឥតគិតថ្លៃជាភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់សមាជិករបស់អ្នក។

**Korean** 한국어로 무료 통역을 원하시면, ID 카드에 있는 번호로 연락하십시오.

**Navajo** Doo báąh ilíni da Diné k'ehjí álnéehgo, hodiilnih béésh bee hani'ée bee nées ho'dílingo nantinígíí bikáá'.

**Laotian** ສຳລັບການແປພາສາແບບພາສາລາວທີ່ໄດ້ສະໜອງໃຫ້ທ່ານ, ໃຫ້ໂທຫາເບທີອີເຊັບຕັດປະຈຳຕົວຂອງທ່ານ.

**Persian** برای ترجمه رایگا فارسی به شماره تلفن مندرج در کارت شناسائی تان زنگ بزنید.

**Polish** Aby uzyskać bezpłatne tłumaczenie w języku polskim, należy zadzwonić na numer znajdujący się na Pana/i dowodzie tożsamości.

**Portuguese** Para tradução grátis para português, ligue para o número no seu cartão de identificação.

**Russian** Для получения услуг бесплатного перевода на русский язык позвоните по номеру, указанному на идентификационной карточке.

**Spanish** Por servicio de traducción gratuito en español, llame al número de su tarjeta de miembro.

**Tagalog** Para sa walang bayad na pagsasalin sa Tagalog, tawagan ang numero na nasa inyong ID card.

**Vietnamese** Để có bản dịch tiếng Việt không phải trả phí, gọi theo số trên thẻ căn cước của bạn.

---

<b>CM</b> Cancer Mandate	<b>MM</b> Mandatory Mail	<b>NC</b> Non Covered Drugs	6
<b>NTM</b> New-to-Market	<b>PA</b> Prior Authorization	<b>QL</b> Quantity Limitation Program	
<b>SI</b> Specialty Infusion	<b>SP</b> Designated Specialty Pharmacy	<b>STPA</b> Step Therapy Prior Authorization	
<b>WH</b> Women's Health	<b>ACA</b> Preventive Service	<b>LCG</b> Low Cost Generic	

Drug Name	Tier	Pharmacy Program
abiraterone		SP
Accu-Chek test strips		OneTouch, OneTouch is the preferred, covered, test strip. Examples of non-covered test strips include, but are not limited to: Accu-Chek, Ascensia, BD, FreeStyle, Precision, TrueTrack test strips
<b>Afinitor</b>		SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., everolimus tablets, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Aldactone</b>		spironolactone
<b>Alkeran</b>		melphalan, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Altace</b>		ramipril
<b>Ambien</b>		QL 10 tablets/30 days, zolpidem tartrate tablets
apalutamide		SP
<b>Arimidex</b>		For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., anastrozole
<b>Aromasin</b>		exemestane, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Ativan</b>		lorazepam
Brineura		Covered under medical benefit with PA
<b>Casodex</b>		For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., bicalutamide
<b>Celexa</b>		citalopram
cerliponase alfa		
<b>Cozaar</b>		losartan
<b>Crestor 5 mg, 10 mg</b>		QL rosuvastatin, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater., 90 tablets/90 days
dexamethasone		
Diabetic Test Strips, Other		OneTouch is the preferred, covered, test strip. Examples of non-covered test strips include, but are not limited to: Accu-Chek, Ascensia, BD, FreeStyle, Precision, TrueTrack test strips, OneTouch Test Strips
Erleada		SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Xtandi

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



Ezallor Sprinkle	QL 30 capsules/30 days, rosuvastatin, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
Fareston	toremifene tablets, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Femara	letrozole, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Fosamax	alendronate
Gleevec	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., imatinib mesylate
Hemady	dexamethasone tablets, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
Hydrea	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., hydroxyurea
ibuprofen (Rx Only)	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
Ilumya	Covered under medical benefit with PA
Kisqali Femara Co-Pack	SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Kisqali, Femara/letrozole
Klonopin	clonazepam tablets
lapatinib	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
Lescol	QL Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater., simvastatin, atorvastatin, fluvastatin, 90 capsules/90 days
Lescol XL	QL 90 tablets/90 days, fluvastatin, simvastatin, atorvastatin, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
letermovir injection	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Levaquin</b>	ciprofloxacin, levofloxacin
<b>Lipitor 10 mg, 20 mg</b>	QL atorvastatin, 90 tablets/90 days, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
<b>Lopressor</b>	metoprolol tartrate tablets
<b>Mevacor</b>	QL Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater., 90 tablets/90 days, lovastatin tablets
<b>Moviprep</b>	PEG 3350 solution, Generics may be covered at no copayment for members age 45 through 74
<b>Naprosyn</b>	
<b>Nilandron</b>	nilutamide, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Norvasc</b>	amlodipine
<b>Pepcid</b>	cimetidine, famotidine, or ranitidine
<b>Pravachol</b>	QL 90 tablets/90 days, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater., pravastatin tablets
Prevymis injection	Covered under Medical Benefit with PA
<b>Pristiq</b>	PA STPA Prior Authorization applies to members through age 12., Step Therapy Prior Authorization required for members 13 years of age and older., Generic product covered only., desvenlafaxine succinate ext-rel
<b>Prozac</b>	fluoxetine
ribociclib and letrozole	SP
rosuvastatin capsules	QL
<b>sertraline</b>	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
<b>Tarceva</b>	SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., erlotinib, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Targretin capsules</b>	SP bexarotene capsules, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Temodar</b>	SP temozolomide, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Tenex</b>	guanfacine
<b>Tenormin</b>	atenolol
test strips	
tildrakizumab-asmn	
<b>Truvada</b>	May be covered at no cost share, emtricitabine/tenofovir disoproxil fumarate
Tykerb	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., lapatinib
<b>Valium</b>	diazepam tablets
<b>Xanax</b>	alprazolam tablets
<b>Xeloda</b>	SP capecitabine, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Yonsa	SP abiraterone, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Zocor 5 mg, 10 mg, 20 mg, 40 mg</b>	QL 90 tablets/90 days, simvastatin tablets, Low to moderate doses may be covered at no copayment for members aged 40 through 75 who are using for primary prevention of cardiovascular disease (CVD) with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
<b>Zoloft</b>	sertraline
<b>Zytiga 250 mg</b>	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., abiraterone, For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Zytiga 500 mg</b>	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., abiraterone, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

## No copayment

Drug Name	Tier	Pharmacy Program
nicotine gum	No copayment	Only generics are covered at no copayment.
Nicotine Lozenge	No copayment	Only generics are covered at no copayment.
nicotine patch	No copayment	Only generics are covered at no copayment.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

**NTM**

<b>Drug Name</b>	<b>Tier</b>	<b>Pharmacy Program</b>
Aduhelm	NTM	
Besremi	NTM	
Cablivi	NTM	
Carglumic	NTM	
Cocaine solution	NTM	
Elyxyb	NTM	
Epclusa pak	NTM	
Eprontia	NTM	
Ferrex 150	NTM	
Fyarro	NTM	
Gvoke kit injection	NTM	
Livtency	NTM	
Mavyret pak	NTM	
Opzelura	NTM	
oxycodone/acetaminophen 10/300 mg soln	NTM	
Prenatal Plus Multivitamin + DHA	NTM	
Qulipta	NTM	
Ryplazim	NTM	
Scemblix	NTM	
Skytrofa	NTM	
Susvimo implant	NTM	
Susvimo injection	NTM	
Tavneos	NTM	
Tramadol Cream 5%	NTM	
Triferic	NTM	
Voxzogo	NTM	
Vuity	NTM	
Xipere	NTM	

**Tier 1**

<b>Drug Name</b>	<b>Tier</b>	<b>Pharmacy Program</b>
abacavir/lamivudine/zidovudine	Tier 1	
acamprosate calcium	Tier 1	
acarbose	Tier 1	
acebutolol	Tier 1	
acetazolamide	Tier 1	
acetazolamide ext-rel	Tier 1	
acetic acid otic	Tier 1	
acetic acid/aluminum acetate otic	Tier 1	
acetic acid/hydrocortisone otic	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

acitretin	Tier 1	
acyclovir capsules, tablets	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
adefovir dipivoxil	Tier 1	
albuterol ext-rel	Tier 1	
albuterol sulfate nebulizer solution	Tier 1	QL 360 vials/90 days or 9 dropper bottles/90 days
albuterol sulfate, CFC-free aerosol	Tier 1	QL
albuterol syrup	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
albuterol tablets	Tier 1	
alclometasone	Tier 1	PA
alendronate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
alfuzosin ext-rel	Tier 1	
allopurinol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
alogliptin	Tier 1	
alogliptin/metformin	Tier 1	
alogliptin/pioglitazone	Tier 1	
alprazolam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
alprazolam ext-rel	Tier 1	
alprazolam orally disintegrating tablets	Tier 1	
amantadine	Tier 1	
Ambitussin	Tier 1	QL 60 mL/day
amcinonide cream, lotion	Tier 1	PA
amethia	Tier 1	PA
amethia lo	Tier 1	PA
amethyst	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
amiloride	Tier 1	
amiloride/hydrochlorothiazide	Tier 1	
amiodarone	Tier 1	
amitriptyline	Tier 1	PA Prior Authorization applies to members through age 12.
amitriptyline/perphenazine	Tier 1	PA Prior Authorization applies to members through age 12.
amlodipine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
amlodipine/benazepril	Tier 1	
amlodipine/valsartan	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

amlodipine/valsartan/hydrochlorothiazide	Tier 1	
ammonium lactate 12%	Tier 1	
amoxapine	Tier 1	PA Prior Authorization applies to members through age 12.
amoxicillin	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
amoxicillin/clavulanate	Tier 1	
amoxicillin/clavulanate ext-rel	Tier 1	
amphetamine/dextroamphetamine mixed salts	Tier 1	PA Prior Authorization applies to members 25 years of age or older.
ampicillin	Tier 1	
anagrelide	Tier 1	
anastrozole	Tier 1	
Anusol-HC 2.5%	Tier 1	
apraclonidine 0.5% eye drops	Tier 1	
apri	Tier 1	
aranelle	Tier 1	PA
aripiprazole tablets	Tier 1	
asenapine	Tier 1	
atenolol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
atenolol/chlorthalidone	Tier 1	
atorvastatin 10 mg, 20 mg	Tier 1	QL
atorvastatin 40 mg, 80 mg	Tier 1	
atropine eye drops	Tier 1	
aviane	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
azathioprine	Tier 1	
azelastine spray	Tier 1	QL 3 nasal spray units/90 days
azithromycin	Tier 1	
b complex + c/folic acid	Tier 1	
bacitracin eye ointment	Tier 1	
bacitracin/polymyxin B eye ointment	Tier 1	
baclofen	Tier 1	
balsalazide	Tier 1	
balziva	Tier 1	PA
benazepril	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
benazepril/hydrochlorothiazide	Tier 1	
benzonatate	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

benzonatate capsules	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
benzphetamine	Tier 1	
benztropine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
betamethasone dipropionate augmented cream	Tier 1	PA
betamethasone dipropionate augmented gel, ointment	Tier 1	
betamethasone dipropionate augmented lotion	Tier 1	
betamethasone dipropionate cream, lotion	Tier 1	
betamethasone valerate	Tier 1	
betaxolol	Tier 1	
bethanechol	Tier 1	
bicalutamide	Tier 1	
bisoprolol	Tier 1	
bisoprolol/hydrochlorothiazide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
brimonidine 0.2% eye drops	Tier 1	
bromocriptine	Tier 1	
budesonide delayed-release capsules	Tier 1	
budesonide inhalation suspension	Tier 1	QL 180 vials/90 days
bumetanide	Tier 1	
buprenorphine	Tier 1	QL 2 mg: 90 sublingual tablets/30 days; 8 mg: 120 sublingual tablets/30 days
buprenorphine/naloxone SL tablets	Tier 1	
bupropion	Tier 1	PA
bupropion ext-rel	Tier 1	PA
bupropion HCl SR	Tier 1	PA
buspiron	Tier 1	
butalbital/acetaminophen	Tier 1	
butalbital/aspirin/caffeine	Tier 1	
butorphanol nasal spray	Tier 1	QL 3 bottles (9 mL total)/30 days
cabergoline	Tier 1	
calcipotriene ointment, solution	Tier 1	
calcitonin-salmon injection	Tier 1	
calcitonin-salmon spray	Tier 1	
calcitriol	Tier 1	
calcium acetate	Tier 1	
camila	Tier 1	PA
camrese	Tier 1	PA
capecitabine	Tier 1	SP
captopril/hydrochlorothiazide	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

carbamazepine	Tier 1	
carbamazepine ext-rel	Tier 1	
carbidopa	Tier 1	
carbidopa/levodopa	Tier 1	
carbidopa/levodopa ext-rel	Tier 1	
carbidopa/levodopa orally disintegrating tablets	Tier 1	
carisoprodol 250 mg	Tier 1	
carisoprodol 350 mg	Tier 1	
carteolol eye drops	Tier 1	
carvedilol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
cefaclor	Tier 1	
cefadroxil	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
cefdinir	Tier 1	
cefprozil	Tier 1	
cefuroxime axetil	Tier 1	
CGU WC	Tier 1	QL 60 mL/day
chlordiazepoxide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
chlorhexidine gluconate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
chloroquine phosphate	Tier 1	
chlorthalidone	Tier 1	
chlorzoxazone	Tier 1	
cholestyramine	Tier 1	
chorionic gonadotropin	Tier 1	SP PA Please contact your sponsor / employer about applicability and effective date for your group., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
ciclopirox	Tier 1	
ciclopirox topical solution 8%	Tier 1	
cilostazol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
ciprofloxacin	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
ciprofloxacin eye drops	Tier 1	
ciprofloxacin otic	Tier 1	
citalopram	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



clarithromycin	Tier 1	
clarithromycin ext-rel	Tier 1	
clemastine 2.68 mg	Tier 1	
clindamycin	Tier 1	
clindamycin pads 1%	Tier 1	
clindamycin palmitate oral solution	Tier 1	
clindamycin vaginal cream	Tier 1	
clindamycin/benzoyl peroxide gel	Tier 1	
clindamycin/tretinoin gel	Tier 1	
clomiphene	Tier 1	Please contact your sponsor / employer about applicability and effective date for your group.
clonazepam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
clonidine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
clopidogrel	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
clotrimazole (Rx only)	Tier 1	
clotrimazole troches	Tier 1	
clozapine	Tier 1	
clozapine orally disintegrating tablets	Tier 1	
Codar GF	Tier 1	QL 60 mL/day
codeine sulfate	Tier 1	QL Solution: 60 mL/day; Tablets: 15 mg: 24 tablets/day, 30 mg: 12 tablets/day, 60 mg: 6 tablets/day
codeine/acetaminophen	Tier 1	QL
codeine/acetaminophen solution	Tier 1	QL 150 mL/day
codeine/chlorpheniramine	Tier 1	QL
codeine/chlorpheniramine/pseudoephedrine	Tier 1	
codeine/guaifenesin	Tier 1	QL
codeine/guaifenesin/pseudoephedrine	Tier 1	
codeine/promethazine	Tier 1	QL 30 mL/day
codeine/promethazine VC	Tier 1	QL 30 mL/day
codeine/promethazine/phenylephrine	Tier 1	QL
Coditussin AC	Tier 1	QL 60 mL/day
Coditussin DAC	Tier 1	QL 40 mL/day
colestipol	Tier 1	
constulose	Tier 1	
cortisone acetate	Tier 1	
cromolyn sodium nebulizer solution	Tier 1	QL 360 vials/90 days
Cryselle	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

cyanocobalamin injection	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
cyclobenzaprine	Tier 1	
cyclopentolate ophthalmic solution	Tier 1	
cyclosporine	Tier 1	
cyclosporine, modified	Tier 1	
cyproheptadine	Tier 1	
danazol	Tier 1	
dapsone	Tier 1	
deferiprone	Tier 1	QL
desmopressin	Tier 1	
desonide gel 0.05%	Tier 1	
dexamethasone	Tier 1	
dexamethasone sodium phosphate eye drops, eye ointment	Tier 1	
dexamethasone therapy pack	Tier 1	
dexmethylphenidate	Tier 1	PA Prior Authorization required for members 25 years of age and older.
dextroamphetamine	Tier 1	PA Prior Authorization required for members 25 years of age and older.
dextroamphetamine solution	Tier 1	PA Prior Authorization applies to members 25 years of age or older.
dextromethorphan/brompheniramine/pseudoephedrine syrup	Tier 1	
dextromethorphan/promethazine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
diazepam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
diclofenac potassium	Tier 1	
diclofenac sodium delayed-rel	Tier 1	
diclofenac sodium eye drops	Tier 1	
diclofenac sodium gel 1%	Tier 1	QL
diclofenac sodium solution	Tier 1	QL
dicloxacillin	Tier 1	
dicyclomine	Tier 1	
diethylpropion	Tier 1	
Differin 0.1% Gel OTC	Tier 1	PA Prior Authorization required for members 26 years of age and older.
diflunisal	Tier 1	
digoxin	Tier 1	
dihydroergotamine injection	Tier 1	
diltiazem	Tier 1	
diltiazem ext-rel	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

diphenhydramine 50 mg	Tier 1	
diphenoxylate/atropine	Tier 1	
dipyridamole	Tier 1	
disopyramide	Tier 1	
disulfiram	Tier 1	
divalproex sodium delayed-rel	Tier 1	
divalproex sodium ext-rel	Tier 1	
donepezil	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
dorzolamide HCl eye drops	Tier 1	
dorzolamide HCl/timolol maleate eye drops	Tier 1	
doxazosin	Tier 1	
doxepin	Tier 1	PA Prior Authorization applies to members through age 12.
doxepin oral concentrate	Tier 1	PA Prior Authorization applies to members through age 12.
doxycycline hyclate	Tier 1	
doxycycline hyclate 20 mg tablets	Tier 1	
doxycycline monohydrate	Tier 1	
drospirenone/EE/levomefolate and levomefolate	Tier 1	PA
Drysol	Tier 1	
duloxetine delayed-rel	Tier 1	QL
dutasteride	Tier 1	
dutasteride/tamsulosin	Tier 1	
econazole	Tier 1	
EE/norethindrone acetate	Tier 1	
Eluryng	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
enalapril	Tier 1	
enalapril/hydrochlorothiazide	Tier 1	
enoxaparin	Tier 1	
enpresse	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
entacapone	Tier 1	
enulose	Tier 1	
epinephrine (generic for Adrenaclick)	Tier 1	QL
ergocalciferol (D2)	Tier 1	
errin	Tier 1	PA
erythromycin eye ointment	Tier 1	
erythromycin solution	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

escitalopram	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
esomeprazole delayed-rel capsules	Tier 1	
estazolam	Tier 1	
estradiol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
estradiol transdermal	Tier 1	
estradiol vaginal cream	Tier 1	
estradiol vaginal tablets	Tier 1	
estradiol valerate	Tier 1	
estradiol/norethindrone acetate	Tier 1	
eszopiclone	Tier 1	QL
ethambutol	Tier 1	
ethosuximide	Tier 1	
ethynodiol diacetate/EE	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
etodolac	Tier 1	
etonogestrel/EE ring	Tier 1	PA
exemestane	Tier 1	
ezetimibe	Tier 1	
famciclovir	Tier 1	
famotidine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
fayosim	Tier 1	PA
felbamate	Tier 1	
felodipine ext-rel	Tier 1	
fenofibrate 43 mg, 130 mg	Tier 1	
fenofibrate 48 mg, 145 mg	Tier 1	
fenofibrate 54 mg, 67 mg, 134 mg, 160 mg, 200 mg	Tier 1	
fenofibric acid	Tier 1	
fenofibric acid delayed-rel	Tier 1	
fentanyl citrate lollipop	Tier 1	QL 120 units (lollipops)/30 days
fentanyl patch 50, 75, 100 mcg/hr	Tier 1	PA QL 10 patches/30 days
fentanyl transdermal	Tier 1	QL
finasteride 5 mg	Tier 1	
flavoxate hydrochloride	Tier 1	
flecainide	Tier 1	
fluconazole	Tier 1	
fludrocortisone	Tier 1	
fluocinolone acetonide oil	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

fluocinolone cream, ointment	Tier 1	PA
fluocinonide cream 0.05%	Tier 1	QL 60 grams/30 days
fluoride drops	Tier 1	No copayment required for children through age 6. Coverage is excluded for members age 16 and older.
fluoride tablets	Tier 1	No copayment required for children through age 6. Coverage is excluded for members age 16 and older.
fluorometholone eye drops, eye ointment	Tier 1	
fluoxetine	Tier 1	
fluoxetine capsules	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
fluoxetine solution	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
flurazepam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
flurbiprofen	Tier 1	
flutamide	Tier 1	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
fluticasone propionate cream, ointment	Tier 1	
fluticasone/salmeterol	Tier 1	QL
fluticasone/salmeterol - Wixela Inhub	Tier 1	QL 3 diskus/90 days
fluticasone/salmeterol (AirDuo RespiClick)	Tier 1	QL
fluvastatin	Tier 1	QL
fluvoxamine	Tier 1	
folic acid	Tier 1	No copayment required for members age 12 through age 52.
fosinopril	Tier 1	
fosinopril/hydrochlorothiazide	Tier 1	
furosemide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
gabapentin	Tier 1	
galantamine	Tier 1	
galantamine ext-rel	Tier 1	
Gavilyte-C	Tier 1	May be covered at no copayment for members age 45 through 74
Gavilyte-G	Tier 1	May be covered at no copayment for members age 45 through 74
gemfibrozil	Tier 1	
gentamicin	Tier 1	
gentamicin solution	Tier 1	
gianvi	Tier 1	PA
glimepiride	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

glipizide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
glipizide ext-rel	Tier 1	
glipizide/metformin	Tier 1	
glyburide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
glyburide, micronized	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
glyburide/metformin	Tier 1	
guaifenesin/pseudoephedrine/codeine	Tier 1	QL
guanfacine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
guanfacine ext-rel	Tier 1	
guanidine	Tier 1	
Guiatuss AC	Tier 1	
Guiatuss DAC	Tier 1	
haloperidol	Tier 1	
hydralazine	Tier 1	
hydrochlorothiazide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
hydrocodone polistirex/chlorpheniramine polistirex	Tier 1	QL 10 mL/day
hydrocodone/acetaminophen	Tier 1	QL 2.5/325 mg: 12 tablets/day; 2.5/500, 5/300, 5/400, and 5/500 mg: 8 tablets/day; 7.5/400, 7.5/500, 7.5/650, 10/300, 10/400, 10/500, and 10/650 mg: 6 tablets/day; 7.5/750, 10/660, and 10/750 mg: 5 tablets/day. Quantity Limitation applies to brand and generic products.
hydrocodone/acetaminophen 5/300, 7.5/300	Tier 1	QL
hydrocodone/acetaminophen solution	Tier 1	QL 90 mL/day
hydrocodone/homatropine syrup	Tier 1	QL
hydrocodone/homatropine tabs	Tier 1	QL
hydrocodone/ibuprofen	Tier 1	QL
hydrocortisone	Tier 1	
hydrocortisone (prescription only)	Tier 1	
hydrocortisone butyrate ointment	Tier 1	PA
hydrocortisone cream	Tier 1	
hydrocortisone enema	Tier 1	
Hydromet	Tier 1	QL 30 mL/day
hydromorphone suppository	Tier 1	QL 4 suppositories/day
hydromorphone tablets, liquid	Tier 1	QL
hydroxychloroquine	Tier 1	
hydroxyurea	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

hydroxyzine HCl	Tier 1	
hydroxyzine pamoate	Tier 1	
hyoscyamine sulfate	Tier 1	
hyoscyamine sulfate ext-rel	Tier 1	
ibandronate 150 mg	Tier 1	
ibuprofen (Rx Only)	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
imatinib mesylate	Tier 1	SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
imipramine HCl	Tier 1	
imiquimod	Tier 1	
indapamide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
ipratropium nasal spray	Tier 1	QL 6 nasal spray units/90 days
ipratropium nebulizer solution	Tier 1	QL 360 vials/90 days
ipratropium/albuterol nebulizer solution	Tier 1	QL 360 vials/90 days
irbesartan	Tier 1	
irbesartan/hydrochlorothiazide	Tier 1	
isoniazid	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
isosorbide mononitrate ext-rel	Tier 1	
isradipine	Tier 1	
ivermectin	Tier 1	QL
ivermectin lotion	Tier 1	
Jinteli	Tier 1	
jolessa	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
jolivet	Tier 1	PA
junel	Tier 1	PA
junel fe	Tier 1	PA
kariva	Tier 1	PA
Kelnor	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
ketoconazole	Tier 1	
ketoconazole 2%	Tier 1	
ketorolac 0.4% eye drops	Tier 1	
ketorolac 0.5% eye drops	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

ketorolac tablets	Tier 1	
Krintafel	Tier 1	QL 2 tablets/fill
labetalol	Tier 1	
lactulose	Tier 1	
lamivudine	Tier 1	
lamivudine tablets	Tier 1	
lamivudine/zidovudine	Tier 1	
lamotrigine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
lansoprazole + amoxicillin + clarithromycin	Tier 1	
latanoprost	Tier 1	
latanoprost eye drops	Tier 1	
layolis fe	Tier 1	PA
leena	Tier 1	PA
Lessina	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
letrozole	Tier 1	
leucovorin calcium	Tier 1	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
leuprolide acetate 1 mg kit	Tier 1	Lupron Depot and Lupron Depot-Ped are covered under the medical benefit
levalbuterol inhalation solution	Tier 1	
levalbuterol tartrate, CFC-free aerosol	Tier 1	QL
levetiracetam	Tier 1	
levetiracetam ext-rel	Tier 1	
levobunolol eye drops	Tier 1	
levofloxacin	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
levofloxacin eye drops	Tier 1	
levora	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Levothroid	Tier 1	
levothyroxine	Tier 1	
Levoxyl	Tier 1	
lidocaine gel 2%	Tier 1	
lidocaine viscous	Tier 1	
lidocaine/prilocaine cream	Tier 1	QL 1 tube/30 days
Lidocort Rectal kit	Tier 1	
lindane	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



linezolid 600 mg tablets	Tier 1	
liothyronine	Tier 1	
lisinopril	Tier 1	
lisinopril/hydrochlorothiazide	Tier 1	
lithium carbonate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
lithium carbonate ext-rel tablets 300 mg	Tier 1	
lithium carbonate ext-rel tablets 450 mg	Tier 1	
Lomedia 24 Fe	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
loperamide	Tier 1	
lorazepam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
Lortuss EX	Tier 1	QL 40 mL/day
losartan	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
losartan/hydrochlorothiazide	Tier 1	
lovastatin	Tier 1	QL
low-ogestrel	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
loxapine	Tier 1	
Luride drops	Tier 1	No copayment required for children through age 6. Coverage is excluded for members age 16 and older.
Lutera	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
maprotiline	Tier 1	PA Prior Authorization applies to members through age 12.
MAR-COF CG	Tier 1	QL 45 mL/day
meclizine 12.5 mg, 25 mg	Tier 1	
medroxyprogesterone acetate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
mefloquine	Tier 1	
megestrol acetate	Tier 1	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
meloxicam	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
memantine	Tier 1	
meperidine oral solution	Tier 1	QL Solution: 90 mL/day

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

meperidine tablets	Tier 1	QL 50 mg: 18 tablets/day; 100 mg: 8 tablets/day
mercaptapurine	Tier 1	
mesalamine rectal suspension	Tier 1	
Metadate ER 20 mg	Tier 1	PA QL 30 tablets/30 days, Prior Authorization required for members 25 years of age and older.
metaproterenol syrup	Tier 1	
metformin	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
metformin ext-rel	Tier 1	
methadone	Tier 1	PA QL Solution: 5 mg/5 mL: 20 mL/day; 10 mg/5 mL: 10 mL/day; Tablets: 5 mg: 4 tablets/day; 10 mg: 2 tablets/day
methadone injection	Tier 1	PA QL 2 mL/day
methadone intensol concentrate 10 mg/mL	Tier 1	PA QL 2 mL/day
methazolamide	Tier 1	
methenamine hippurate	Tier 1	
methimazole	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
methocarbamol	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
methotrexate	Tier 1	
methoxsalen	Tier 1	
methyl dopa	Tier 1	
methylphenidate	Tier 1	PA Prior Authorization required for members 25 years of age and older.
methylphenidate chewable tablets	Tier 1	PA Prior Authorization required for members 25 years of age and older., Prior Authorization required for members 25 years of age and older.
methylphenidate ext-rel	Tier 1	QL
methylprednisolone	Tier 1	
metoclopramide	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
metoclopramide orally disintegrating tablets 5 mg	Tier 1	QL 120 tablets/30 days
metolazone	Tier 1	
metoprolol succinate ext-rel	Tier 1	
metoprolol tartrate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
metoprolol/hydrochlorothiazide	Tier 1	
metronidazole	Tier 1	
metronidazole cream	Tier 1	
metronidazole tablets	Tier 1	
mexiletine	Tier 1	
microgestin	Tier 1	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

microgestin fe	Tier 1	PA
midodrine	Tier 1	
minocycline capsules	Tier 1	
minocycline ext-rel	Tier 1	
mirtazapine	Tier 1	PA Prior Authorization applies to members through age 12.
mirtazapine orally disintegrating tablets	Tier 1	PA
misoprostol	Tier 1	
moexipril	Tier 1	
molindone	Tier 1	
mometasone	Tier 1	
mometasone 0.1% lotion	Tier 1	PA This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
mometasone lotion 0.1%	Tier 1	PA
mononessa	Tier 1	PA
montelukast	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
montelukast chewable tablets	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
montelukast chewable tabs	Tier 1	
morphine	Tier 1	QL Solution: 100 mg/5 mL: 4.5 mL/day, 10 mg/5 mL: 45 mL/day, 20 mg/5 mL: 22.5 mL/day; Tablets: 15 mg: 6 tablets/day, 30 mg: 3 tablets/day
morphine ext-rel	Tier 1	QL 90 tablets/30 days
morphine ext-rel 60, 100, 200 mg	Tier 1	PA QL
morphine sulfate beads	Tier 1	QL 1 capsule/day
morphine sulfate beads 120 mg	Tier 1	PA QL 1 capsule/day
morphine sulfate ext-rel 10, 20, 30, 40 mg	Tier 1	QL 60 capsules/30 days
morphine sulfate ext-rel 50, 60, 80, 100 mg	Tier 1	PA QL 60 capsules/30 days
morphine suppositories 5 mg, 10 mg, 20 mg	Tier 1	QL 5 and 10 mg: 6 suppositories/day; 20 mg: 4 suppositories/day
moxifloxacin	Tier 1	
mycophenolate mofetil	Tier 1	
mycophenolate sodium	Tier 1	
nabumetone	Tier 1	
naltrexone	Tier 1	
naphazoline eye drops	Tier 1	
naproxen	Tier 1	
naproxen delayed-rel	Tier 1	
naratriptan	Tier 1	QL
nateglinide	Tier 1	
necon 0.5/35	Tier 1	PA
necon 1/35	Tier 1	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

necon 1/50	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
necon 7/7/7	Tier 1	PA
neomycin/polymyxin B/bacitracin/hydrocortisone eye ointment	Tier 1	
neomycin/polymyxin B/dexamethasone eye drops, eye ointment	Tier 1	
neomycin/polymyxin B/gramicidin eye drops	Tier 1	
neomycin/polymyxin B/hydrocortisone otic	Tier 1	
nevirapine	Tier 1	
nevirapine ext-rel	Tier 1	
next choice one dose	Tier 1	
nicardipine	Tier 1	
nifedipine 10 mg	Tier 1	
nifedipine ext-rel	Tier 1	
nimodipine	Tier 1	
nisoldipine ext-rel	Tier 1	
nitazoxanide	Tier 1	
nitrofurantoin ext-rel	Tier 1	
nitrofurantoin macrocrystals	Tier 1	
nitroglycerin lingual spray	Tier 1	
nitroglycerin sublingual	Tier 1	
nitroglycerin transdermal	Tier 1	
norethindrone acetate	Tier 1	
norethindrone acetate/EE 1/20 and iron	Tier 1	PA
norethindrone acetate/EE 1/20 and iron chewable	Tier 1	PA
norethindrone/EE 0.4/35 and iron chewable	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
nortrel 0.5/35	Tier 1	PA
nortrel 1/35	Tier 1	PA
nortrel 7/7/7	Tier 1	PA
nortriptyline	Tier 1	PA
nystatin	Tier 1	
nystatin/triamcinolone	Tier 1	
ocella	Tier 1	PA
ofloxacin	Tier 1	
ofloxacin eye drops	Tier 1	
ofloxacin otic	Tier 1	
Ogestrel	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

olanzapine	Tier 1	
olanzapine orally disintegrating tablets	Tier 1	Step Therapy Prior Authorization applies to both brand and generic drug.
olanzapine/fluoxetine	Tier 1	
omeprazole delayed-rel	Tier 1	PA QL
ondansetron	Tier 1	QL oral solution: 90 mL/7 days; tablets/ODT tablets: 4 mg: 9 tablets/7 days; 8 mg: 9 tablets/7 days; 24 mg: 1 tablet/7 days
orphenadrine ext-rel	Tier 1	
oxazepam	Tier 1	
oxcarbazepine	Tier 1	
oxybutynin	Tier 1	
oxybutynin ext-rel	Tier 1	
oxycodone	Tier 1	QL 5 mg capsules: 12 capsules/day; Tablets: 10 mg: 6 tablets/day; 20 mg: 3 tablets/day; Solution: 100 mg/5 mL: 3 mL/day; 5 mg/5 mL: 60 mL/day
oxycodone/acetaminophen	Tier 1	QL
oxycodone/aspirin	Tier 1	QL
oxycodone/ibuprofen	Tier 1	QL 4 tablets/day
oxymorphone	Tier 1	QL
pantoprazole delayed-rel	Tier 1	PA QL
paricalcitol capsules	Tier 1	
paroxetine HCl	Tier 1	PA This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document., Prior Authorization applies to members through age 12.
peg 3350/electrolytes	Tier 1	Generics may be covered at no copayment for members age 45 through 74
peg 3350/electrolytes disposable jug	Tier 1	
Peg-prep	Tier 1	May be covered at no copayment for members age 45 through 74
penicillin VK	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
pentazocine/naloxone	Tier 1	QL 4 tablets/day
pentoxifylline ext-rel	Tier 1	
perindopril	Tier 1	
permethrin 5%	Tier 1	
perphenazine	Tier 1	
phendimetrazine	Tier 1	
phendimetrazine ext-rel	Tier 1	PA
phenelzine	Tier 1	PA Prior Authorization applies to members through age 12.
phenobarbital	Tier 1	
phenoxybenzamine	Tier 1	
phentermine	Tier 1	PA
phenytoin sodium	Tier 1	
phenytoin sodium ext-rel	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

pilocarpine	Tier 1	
pimozide	Tier 1	
pindolol	Tier 1	
pioglitazone	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
pioglitazone/glimepiride	Tier 1	
pioglitazone/metformin	Tier 1	
piroxicam	Tier 1	
podofilox	Tier 1	
polymyxin B/trimethoprim eye drops	Tier 1	
Portia	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
potassium chloride ext-rel	Tier 1	
potassium chloride/potassium bicarbonate/citric acid effervescent tablets 25 mE	Tier 1	
pramipexole	Tier 1	
pravastatin	Tier 1	QL
prazosin	Tier 1	
prednicarbate ointment	Tier 1	
prednisolone acetate 1% eye drops	Tier 1	
prednisolone sodium phosphate	Tier 1	
prednisolone sodium phosphate 5 mg/5 mL	Tier 1	
prednisolone syrup	Tier 1	
prednisone	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
pregabalin	Tier 1	
pregabalin ext-rel	Tier 1	
prenatal vitamins w/folic acid	Tier 1	
previfem	Tier 1	PA
primidone	Tier 1	
probenecid	Tier 1	
prochlorperazine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
progesterone, micronized	Tier 1	
promethazine	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
propafenone	Tier 1	
propantheline 15 mg	Tier 1	
propranolol	Tier 1	
propranolol ext-rel	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

propylthiouracil	Tier 1	
protriptyline	Tier 1	PA Prior Authorization applies to members through age 12.
pyrazinamide	Tier 1	
pyridostigmine	Tier 1	
pyrimethamine	Tier 1	
Quasense	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
quetiapine	Tier 1	
quinapril	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
quinapril/hydrochlorothiazide	Tier 1	
quinine sulfate	Tier 1	
raloxifene	Tier 1	No copayment required for women under Preventive Services
ramipril	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
Reclipsen	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
repaglinide	Tier 1	
ribavirin 200 mg capsules	Tier 1	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
ribavirin 200 mg tablets	Tier 1	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
rifampin	Tier 1	
riluzole	Tier 1	
rimantadine	Tier 1	
risperidone	Tier 1	
risperidone orally disintegrating tablets	Tier 1	
rivastigmine capsules	Tier 1	
rizatriptan	Tier 1	QL
ropinirole	Tier 1	
ropinirole ext-rel	Tier 1	
salicylic acid liquid 27.5%	Tier 1	
selegiline capsules	Tier 1	
selegiline tablets	Tier 1	
selenium sulfide lotion, shampoo 2.5%	Tier 1	
sertraline	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
sildenafil 20 mg	Tier 1	SP PA
sildenafil oral suspension	Tier 1	SP PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

silver sulfadiazine	Tier 1	
simvastatin 5 mg, 10 mg, 20 mg, 40 mg	Tier 1	QL
simvastatin 80 mg	Tier 1	
sirolimus	Tier 1	
sotalol	Tier 1	
sotalol AF	Tier 1	
spironolactone	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
spironolactone/hydrochlorothiazide	Tier 1	
sprintec	Tier 1	PA
stavudine	Tier 1	
sucrafate tablets	Tier 1	
sulfacetamide 10% eye drops	Tier 1	
sulfacetamide sodium 10%	Tier 1	
sulfacetamide/prednisolone phosphate eye drops, eye ointment	Tier 1	
sulfamethoxazole/trimethoprim	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
sulfasalazine	Tier 1	
sulfasalazine delayed-rel	Tier 1	
sulindac	Tier 1	
sumatriptan tablets	Tier 1	QL
Suttar-2	Tier 1	QL 40 mL/day
tacrolimus capsules	Tier 1	
tamoxifen	Tier 1	No copayment required for women under Preventive Services.
tamsulosin	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
telmisartan	Tier 1	
temazepam	Tier 1	
terazosin	Tier 1	
terbinafine tablets	Tier 1	
terbutaline tablets	Tier 1	
terconazole cream	Tier 1	
testosterone cypionate	Tier 1	
testosterone enanthate	Tier 1	
theophylline ext-rel tablets	Tier 1	
thioridazine	Tier 1	
thiothixene	Tier 1	
tiagabine 2 mg, 4 mg	Tier 1	
tilia fe	Tier 1	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



timolol maleate eye drops	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
timolol maleate gel forming solution	Tier 1	
tinidazole	Tier 1	
tiopronin	Tier 1	
tobramycin eye drops, eye ointment	Tier 1	
tolcapone	Tier 1	
tolterodine	Tier 1	
topiramate	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
torseamide	Tier 1	
tramadol	Tier 1	QL
tramadol ext-rel	Tier 1	QL 1 tablet or capsule/day
tramadol/acetaminophen	Tier 1	QL
trandolapril	Tier 1	
trandolapril/verapamil ext-rel	Tier 1	
tranexamic acid	Tier 1	QL 30 tablets/28 days
trazodone	Tier 1	PA This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document., Prior Authorization applies to members through age 12.
tretinoin	Tier 1	PA
tretinoin gel 0.01%, 0.025%	Tier 1	PA
triamcinolone acetonide	Tier 1	
triamcinolone paste	Tier 1	
triamterene/hydrochlorothiazide capsules 37.5/25	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
triamterene/hydrochlorothiazide capsules 50/25	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
triamterene/hydrochlorothiazide tablets 37.5/25	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
triamterene/hydrochlorothiazide tablets 75/50	Tier 1	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.
triazolam	Tier 1	
trifluoperazine	Tier 1	
trihexyphenidyl	Tier 1	
tri-legest fe	Tier 1	PA
trimethobenzamide capsules	Tier 1	
trimethoprim	Tier 1	
trinessa	Tier 1	PA
trinessa lo	Tier 1	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

tri-previfem	Tier 1	PA
tri-sprintec	Tier 1	PA
Trivora	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
trospium	Tier 1	
Tussigon	Tier 1	QL 6 tablets/day
ubidecarenone	Tier 1	PA
Unithroid	Tier 1	
Uribel	Tier 1	
ursodiol	Tier 1	
valacyclovir	Tier 1	
valproic acid	Tier 1	
valsartan	Tier 1	
valsartan/hydrochlorothiazide	Tier 1	
Vandazole	Tier 1	
velivet	Tier 1	PA
venlafaxine	Tier 1	
venlafaxine ext-rel capsules	Tier 1	
verapamil	Tier 1	
verapamil ext-rel	Tier 1	
Virtussin DAC	Tier 1	QL 40 mL/day
vitamin B-12	Tier 1	
voriconazole suspension 40 mg/mL	Tier 1	
warfarin	Tier 1	
Wymzya Fe	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Xulane	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
zafirlukast	Tier 1	
zaleplon	Tier 1	QL 10 capsules/30 days
Zamicet	Tier 1	
zidovudine	Tier 1	
ziprasidone HCl	Tier 1	
zolpidem	Tier 1	QL This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document., 10 tablets/30 days
zolpidem tartrate CR	Tier 1	QL 10 tablets/30 days
zonisamide	Tier 1	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Zovia	Tier 1	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
-------	--------	---

Z-tuss AC	Tier 1	QL 60 mL/day
-----------	--------	--------------

## Tier 2

Drug Name	Tier	Pharmacy Program
<b>abacavir</b>	Tier 2	
<b>abacavir/lamivudine</b>	Tier 2	
<b>acetaminophen/caffeine/dihydrocodeine capsules</b>	Tier 2	QL
<b>acetaminophen/caffeine/dihydrocodeine tablets</b>	Tier 2	QL 325/30/16 mg: 10 tablets/day
Actimmune	Tier 2	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>acyclovir cream 5%</b>	Tier 2	QL
<b>acyclovir ointment 5%</b>	Tier 2	QL
<b>acyclovir suspension</b>	Tier 2	
<b>adapalene/benzoyl peroxide gel 0.1%-2.5%</b>	Tier 2	
Advair HFA	Tier 2	QL 6 inhalers/90 days
Aimovig	Tier 2	PA QL 70 mg/mL & 140 mg/mL pen: 1 pen per 30 days; 140 mg/mL (2 x 70 mg/mL) pen pack: 1 pack (2 pens) per 30 days
Ajovy	Tier 2	PA QL 3 pens/90 days
Ajovy Auto-injector	Tier 2	PA QL 3 pens/90 days
<b>albendazole</b>	Tier 2	
<b>aliskiren</b>	Tier 2	
<b>almotriptan</b>	Tier 2	QL 6 tablets/30 days
<b>alosetron</b>	Tier 2	
Alrex	Tier 2	
<b>amcinonide cream, lotion</b>	Tier 2	PA
Amcinonide ointment	Tier 2	PA
<b>aminocaproic acid oral solution</b>	Tier 2	
<b>aminocaproic acid tablets</b>	Tier 2	
<b>amlodipine/atorvastatin</b>	Tier 2	
<b>amlodipine/olmesartan</b>	Tier 2	
<b>amphetamine/dextroamphetamine mixed salts ext-rel</b>	Tier 2	PA QL Prior Authorization applies to members 25 years of age or older., 5, 10, 15 mg: 30 capsules/30 days; 20, 25, 30 mg: 60 capsules/30 days
Anoro Ellipta	Tier 2	QL 3 inhalers, 180 blister packs/90 days
Apokyn	Tier 2	
<b>aprepitant capsules</b>	Tier 2	QL
Aptiom	Tier 2	
Aptivus	Tier 2	
Aranesp	Tier 2	SP QL 4 mL/30 days; Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>arformoterol tartrate nebulizer solution</b>	Tier 2	
<b>aripiprazole oral solution</b>	Tier 2	
<b>aripiprazole orally disintegrating tablets</b>	Tier 2	
Armour Thyroid	Tier 2	
Arnuity Ellipta	Tier 2	QL 3 inhalers/90 days
Asthma Supplies	Tier 2	QL 2 spacers/year; 1 peak flow meter/year
<b>atazanavir</b>	Tier 2	
<b>atomoxetine</b>	Tier 2	QL
<b>atovaquone</b>	Tier 2	
<b>atovaquone/proguanil</b>	Tier 2	
Atrovent HFA	Tier 2	QL 6 inhalers/90 days
<b>azelaic acid gel</b>	Tier 2	
Baqsimi	Tier 2	QL 2 devices/fill
B-D Insulin syringes	Tier 2	
B-D Pen needles	Tier 2	
Benznidazole	Tier 2	
<b>betamethasone dipropionate ointment 0.05%</b>	Tier 2	PA
<b>betamethasone valerate foam</b>	Tier 2	PA
Betimol	Tier 2	
BiDil	Tier 2	
Biktarvy	Tier 2	
<b>bimatoprost 0.03%</b>	Tier 2	
Breo Ellipta	Tier 2	QL 3 inhalers/90 days
<b>brimonidine 0.15% eye drops</b>	Tier 2	
<b>brinzolamide suspension 1%</b>	Tier 2	
<b>bromfenac sodium eye drops</b>	Tier 2	
<b>budesonide ext-rel</b>	Tier 2	
<b>buprenorphine transdermal</b>	Tier 2	PA QL
<b>buprenorphine/naloxone film</b>	Tier 2	
<b>bupropion ext-rel</b>	Tier 2	PA
<b>butalbital/acetaminophen/caffeine/codeine</b>	Tier 2	QL
<b>calcipotriene cream</b>	Tier 2	
<b>calcipotriene/betamethasone dipropionate ointment</b>	Tier 2	
<b>calcitriol ointment</b>	Tier 2	
<b>calcium acetate</b>	Tier 2	
<b>candesartan</b>	Tier 2	
<b>candesartan/hydrochlorothiazide</b>	Tier 2	
<b>captopril</b>	Tier 2	
Carbaglu	Tier 2	
<b>carbidopa/levodopa/entacapone</b>	Tier 2	
<b>carvedilol phosphate ext-rel</b>	Tier 2	
Cefaclor ER	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>ceffixime capsules, suspension</b>	Tier 2	
<b>cefpodoxime</b>	Tier 2	
<b>celecoxib</b>	Tier 2	
<b>cephalexin</b>	Tier 2	
<b>cevimeline</b>	Tier 2	
<b>chlorpromazine</b>	Tier 2	
Cholbam	Tier 2	
choriogonadotropin alfa	Tier 2	SP
<b>ciclopirox shampoo 1%</b>	Tier 2	
Cimduo	Tier 2	
<b>cimetidine</b>	Tier 2	
<b>cinacalcet</b>	Tier 2	
<b>ciprofloxacin-dexamethasone otic suspension</b>	Tier 2	
<b>clarithromycin suspension</b>	Tier 2	
Climara Pro	Tier 2	
<b>clindamycin gel, lotion</b>	Tier 2	
<b>clindamycin phosphate gel 1%</b>	Tier 2	
<b>clobazam</b>	Tier 2	
<b>clobetasol propionate</b>	Tier 2	PA
<b>clobetasol propionate 0.05%</b>	Tier 2	PA
<b>clobetasol propionate emollient cream</b>	Tier 2	PA
<b>clobetasol propionate foam</b>	Tier 2	PA
<b>clobetasol propionate spray 0.05%</b>	Tier 2	PA
<b>clobetasol propionate/emollient foam</b>	Tier 2	PA
<b>clocortolone</b>	Tier 2	PA
<b>clomipramine</b>	Tier 2	
<b>clonidine ext-rel</b>	Tier 2	
<b>clonidine transdermal</b>	Tier 2	
<b>clorazepate</b>	Tier 2	
<b>clotrimazole/betamethasone</b>	Tier 2	
Coartem	Tier 2	QL 24 tablets/90 days
<b>colchicine capsules</b>	Tier 2	
<b>colchicine tablets</b>	Tier 2	
<b>colesevelam</b>	Tier 2	
Combigan	Tier 2	
CombiPatch	Tier 2	
Combivent Respimat	Tier 2	QL 6 inhalers/90 days
Complera	Tier 2	
Corlanor	Tier 2	
Cortifoam	Tier 2	
Creon	Tier 2	
Crinone	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Crixivan	Tier 2	
<b>cromolyn sodium oral concentrate</b>	Tier 2	
<b>crotamiton</b>	Tier 2	
cyclophosphamide	Tier 2	SP
Cyclophosphamide Capsules	Tier 2	SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Cycloset	Tier 2	
Daliresp	Tier 2	
<b>dantrolene</b>	Tier 2	
<b>dapsone gel 5%</b>	Tier 2	
<b>darifenacin</b>	Tier 2	
<b>deferasirox</b>	Tier 2	
<b>deferasirox 180 mg tablets</b>	Tier 2	
<b>deferasirox granules</b>	Tier 2	
<b>deferasirox tablets</b>	Tier 2	
Delstrigo	Tier 2	
Descovy	Tier 2	PA
<b>desipramine</b>	Tier 2	PA
<b>desonide cream</b>	Tier 2	PA
<b>desonide lotion</b>	Tier 2	PA
<b>desonide ointment</b>	Tier 2	
<b>desoximetasone cream, gel, ointment</b>	Tier 2	PA
<b>desvenlafaxine succinate ext-rel</b>	Tier 2	PA
<b>dexmethylphenidate ext-rel</b>	Tier 2	PA QL Prior Authorization applies to members 25 years of age or older., 30 capsules/30 days
<b>dextroamphetamine ext-rel</b>	Tier 2	PA QL
<b>diazepam rectal gel</b>	Tier 2	QL 1 kit (2 units)/fill
<b>diazoxide suspension</b>	Tier 2	
<b>diclofenac sodium delayed-rel/misoprostol</b>	Tier 2	
<b>diflorasone diacetate</b>	Tier 2	PA
Dipentum	Tier 2	
<b>dipyridamole ext-rel/aspirin</b>	Tier 2	
<b>divalproex sodium sprinkle</b>	Tier 2	
<b>dofetilide</b>	Tier 2	
<b>dorzolamide/timolol/preservative-free</b>	Tier 2	
Dovato	Tier 2	
<b>doxepin cream</b>	Tier 2	
<b>doxepin cream 5%</b>	Tier 2	
<b>doxercalciferol</b>	Tier 2	
<b>doxycycline hyclate 75 mg tablets</b>	Tier 2	
<b>dronabinol capsule</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Droxia	Tier 2	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Duavee	Tier 2	
Duopa	Tier 2	
Edurant	Tier 2	
<b>efavirenz</b>	Tier 2	
<b>efavirenz/emtricitabine/tenofovir</b>	Tier 2	
<b>efavirenz/lamivudine/tenofovir disoproxil fumarate</b>	Tier 2	
<b>eletriptan</b>	Tier 2	QL
Eliquis	Tier 2	
Elixophyllin	Tier 2	
Emgality	Tier 2	PA QL 100 mg prefilled syringe: 3 syringes per 30 days. 120 mg auto-injector/prefilled syringe: 2 auto-injectors/syringes (240 mg) as a single loading dose, followed by 1 auto-injector or syringe (120 mg)/30 days.
<b>emtricitabine</b>	Tier 2	
<b>emtricitabine/tenofovir</b>	Tier 2	May be covered at no cost share
<b>enalapril maleate solution</b>	Tier 2	
Endometrin	Tier 2	
<b>entecavir</b>	Tier 2	
Entresto	Tier 2	
<b>epinephrine (generic for Epipen Jr.)</b>	Tier 2	QL
<b>epinephrine (generic for Epipen)</b>	Tier 2	QL
Episil	Tier 2	QL 4 bottles/30 days
Epivir-HBV solution	Tier 2	
<b>eplerenone</b>	Tier 2	
Epogen	Tier 2	SP QL 10 vials/14 days; Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>ergotamine/caffeine tablets</b>	Tier 2	
Ery-Tab	Tier 2	
<b>erythromycin delayed-rel</b>	Tier 2	
<b>erythromycin ethylsuccinate</b>	Tier 2	
<b>erythromycin ethylsuccinate susp 400 mg/5 mL</b>	Tier 2	
<b>erythromycin ethylsuccinate tablets</b>	Tier 2	
<b>erythromycin gel</b>	Tier 2	
<b>erythromycin stearate</b>	Tier 2	
<b>erythromycin tablets</b>	Tier 2	
<b>erythromycin/benzoyl peroxide</b>	Tier 2	
<b>esomeprazole delayed-rel oral suspension</b>	Tier 2	PA QL 90 packets/90 days, Prior Authorization required for members older than 12 years of age.
<b>estradiol</b>	Tier 2	This drug may be included in the Low Cost Generic program and be subject to a \$5 copay for a 30-day supply rather than the tier 1 copay. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>estradiol transdermal</b>	Tier 2	
estradiol valerate and dienogest/estradiol valerat	Tier 2	
Estring	Tier 2	
<b>etodolac ext-rel</b>	Tier 2	
<b>etravirine</b>	Tier 2	
evolocumab	Tier 2	PA QL
Evotaz	Tier 2	
<b>ezetimibe/simvastatin</b>	Tier 2	
<b>famotidine suspension</b>	Tier 2	
Farxiga	Tier 2	
<b>febuxostat</b>	Tier 2	
Femring	Tier 2	
<b>fenofibrate 120 mg</b>	Tier 2	
<b>fenofibrate 40 mg, 120 mg</b>	Tier 2	
<b>fenofibrate 50 mg, 150 mg</b>	Tier 2	
<b>fenofibrate micronized capsule 130 mg</b>	Tier 2	
<b>fentanyl citrate buccal</b>	Tier 2	QL
<b>fentanyl patch 37.5 mcg/hr</b>	Tier 2	QL 10 patches/30 days
<b>fentanyl patch 62.5 mcg/hr, 87.5 mcg/hr</b>	Tier 2	PA QL
<b>fentanyl patch 62.5, 87.5 mcg/hr</b>	Tier 2	PA QL 10 patches/30 days
Ferriprox oral solution	Tier 2	QL 150 mL/30 days
<b>Ferriprox tablets</b>	Tier 2	QL 30 tablets/30 days
Finacea Aerosol	Tier 2	
First-Progesterone VGS	Tier 2	
Flovent Diskus	Tier 2	QL 6 diskus/90 days
Flovent HFA	Tier 2	QL 6 inhalers/90 days
<b>fluocinolone oil, body or scalp 0.01%</b>	Tier 2	PA
<b>fluocinolone solution 0.01%</b>	Tier 2	PA
<b>fluocinonide</b>	Tier 2	PA QL 60 units/30 days
<b>fluocinonide cream 0.1%</b>	Tier 2	PA QL
Fluoxetine 60 mg	Tier 2	PA
<b>fluoxetine tablets 10 mg, 20 mg</b>	Tier 2	PA
<b>fluphenazine</b>	Tier 2	
<b>flurandrenolide cream, lotion, ointment</b>	Tier 2	PA
<b>fluticasone propionate lotion</b>	Tier 2	PA
<b>fluvastatin ext-rel</b>	Tier 2	QL
<b>fondaparinux sodium</b>	Tier 2	
<b>fosamprenavir tablet 700 mg</b>	Tier 2	
<b>fosfomycin tromethamine</b>	Tier 2	
Fycompa	Tier 2	
Galzin	Tier 2	
<b>gatifloxacin eye drops</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



gefitinib	Tier 2	PA
Gelclair	Tier 2	
Genvoya	Tier 2	
Glucagen	Tier 2	
Glucagon Emergency Kit	Tier 2	
Glyxambi	Tier 2	
Golytely packets	Tier 2	May be covered at no copayment for members age 45 through 74
<b>granisetron tablets</b>	Tier 2	QL 6 tablets/7 days
<b>griseofulvin microsize</b>	Tier 2	
<b>griseofulvin microsize suspension</b>	Tier 2	
<b>griseofulvin ultramicrosize</b>	Tier 2	
<b>halcinonide</b>	Tier 2	PA
<b>halobetasol propionate</b>	Tier 2	PA
Humalog	Tier 2	Generic formulations are non-covered and are subject to non-covered cost share.
Humulin	Tier 2	
<b>hydrocortisone butyrate cream, solution</b>	Tier 2	PA
<b>hydrocortisone butyrate lipid cream 0.1%</b>	Tier 2	PA
<b>hydrocortisone butyrate lotion 0.1%</b>	Tier 2	PA
<b>hydrocortisone valerate</b>	Tier 2	PA
<b>hydromorphone ext-rel</b>	Tier 2	QL 30 tablets/30 days
<b>hydromorphone ext-rel 32 mg</b>	Tier 2	PA QL 30 tablets/30 days
hydroxyurea	Tier 2	PA
Ibrance	Tier 2	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767. For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>imipramine pamoate</b>	Tier 2	
<b>imiquimod</b>	Tier 2	
Impavido	Tier 2	
Ingrezza	Tier 2	PA QL 30 capsules/30 days; Initiation pack: 1 fill/lifetime
insulin lispro	Tier 2	Humalog
<b>Intence</b>	Tier 2	
Invirase	Tier 2	
Iressa	Tier 2	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Isentress	Tier 2	
Isentress HD	Tier 2	
Isentress Oral Suspension	Tier 2	
<b>itraconazole capsules</b>	Tier 2	PA
<b>itraconazole solution</b>	Tier 2	
Janumet	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Janumet XR	Tier 2	
Januvia	Tier 2	
Jardiance	Tier 2	
Juluca	Tier 2	
Kerendia	Tier 2	PA QL 1 tablet/day
<b>lamotrigine ext-rel</b>	Tier 2	QL
<b>lamotrigine orally disintegrating tablets</b>	Tier 2	
<b>lamotrigine starter kit</b>	Tier 2	
<b>lansoprazole delayed-rel</b>	Tier 2	PA QL
<b>lanthanum oral powder</b>	Tier 2	
Lantus	Tier 2	
Latuda	Tier 2	STPA
<b>leflunomide</b>	Tier 2	
<b>levothyroxine capsules</b>	Tier 2	
<b>lidocaine ointment 5%</b>	Tier 2	QL 50 grams/30 days
<b>lidocaine patch 4%</b>	Tier 2	QL
<b>Lidocare</b>	Tier 2	QL 30 patches/30 days
Linzess	Tier 2	
Lithium Citrate	Tier 2	
Lo Loestrin Fe	Tier 2	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Lokelma	Tier 2	
<b>lopinavir/ritonavir solution</b>	Tier 2	
<b>lopinavir/ritonavir tablets</b>	Tier 2	
<b>loteprednol ophthalmic gel 0.5%</b>	Tier 2	
<b>loteprednol suspension 0.5%</b>	Tier 2	
<b>lubiprostone</b>	Tier 2	
<b>luliconazole cream</b>	Tier 2	
Lysodren	Tier 2	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>mafenide acetate 5%</b>	Tier 2	
<b>malathion</b>	Tier 2	
<b>megestrol acetate 625 mg/5 mL</b>	Tier 2	
<b>melphalan</b>	Tier 2	
<b>memantine ext-rel</b>	Tier 2	
<b>mesalamine delayed-rel</b>	Tier 2	
<b>mesalamine delayed-rel 1.2 gm</b>	Tier 2	
<b>mesalamine delayed-rel tablets</b>	Tier 2	
<b>mesalamine ext-rel capsules</b>	Tier 2	
<b>mesalamine suppositories</b>	Tier 2	
<b>metaxalone</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>metformin oral solution</b>	Tier 2	
<b>methylphenidate ext-rel 10 mg, 20 mg, 30 mg, 40 mg, 60 mg</b>	Tier 2	PA QL 10 mg, 20 mg, 40 mg, 60 mg: 30 capsules/30 days; 30 mg: 60 capsules/30 days, Prior Authorization applies to members 25 years of age or older.
<b>methylphenidate ext-rel capsules</b>	Tier 2	PA QL Prior Authorization required for members 25 years of age and older., 30 capsules/30 days
<b>methylphenidate ext-rel tablets</b>	Tier 2	PA QL 30 tablets/30 days, Prior Authorization required for members 25 years of age and older.
<b>methylphenidate HCl ER</b>	Tier 2	PA QL Prior Authorization applies to members 25 years of age or older., 18, 27 & 54 mg: 30 tablets/30 days; 36 mg: 60 tablets/30 days
<b>methylphenidate oral solution</b>	Tier 2	PA Prior Authorization applies to members 25 years of age or older.
<b>metronidazole gel</b>	Tier 2	
<b>metronidazole lotion</b>	Tier 2	
<b>metronidazole vaginal gel</b>	Tier 2	
<b>metirosine</b>	Tier 2	
<b>Miacalcin injection</b>	Tier 2	
<b>miglitol</b>	Tier 2	
<b>minocycline tablets</b>	Tier 2	
Mircera	Tier 2	QL 2 syringes/28 days
mitotane	Tier 2	
<b>modafinil</b>	Tier 2	PA QL
Morphine suppositories 30 mg	Tier 2	QL 3 suppositories/day
Movantik	Tier 2	
<b>moxifloxacin</b>	Tier 2	
<b>mupirocin</b>	Tier 2	
<b>mycophenolate mofetil suspension</b>	Tier 2	
<b>mycophenolate sodium delayed-rel tablets</b>	Tier 2	
Myfembree	Tier 2	PA QL 30 tablets/30 days
Mytesi	Tier 2	PA
<b>nadolol</b>	Tier 2	
<b>naftifine cream 1%</b>	Tier 2	
<b>naftifine cream 2%</b>	Tier 2	
<b>naftifine gel 1%</b>	Tier 2	
<b>naproxen sodium</b>	Tier 2	
Nascobal	Tier 2	
Natazia	Tier 2	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>nebivolol</b>	Tier 2	
<b>nefazodone</b>	Tier 2	PA Prior Authorization applies to members through age 12.
<b>neomycin/polymyxin B/hydrocortisone eye drops</b>	Tier 2	
<b>niacin ext-rel</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Nifedipine 20 mg	Tier 2	
<b>nizatidine</b>	Tier 2	
norethindrone acetate/EE 1/10 and EE 10	Tier 2	
Norvir Powder Packet	Tier 2	
Norvir solution	Tier 2	
<b>Norvir Tablets</b>	Tier 2	
<b>Novarel</b>	Tier 2	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
Nuedexta	Tier 2	PA
Nurtec ODT	Tier 2	PA QL For acute migraines: 8 tablets/30 days; For prevention: 16 tablets/30 days
<b>octreotide</b>	Tier 2	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Odefsey	Tier 2	
<b>olmesartan</b>	Tier 2	
<b>olmesartan/amlodipine/hydrochlorothiazide</b>	Tier 2	
<b>olmesartan/hydrochlorothiazide</b>	Tier 2	
<b>olopatadine nasal spray</b>	Tier 2	QL
<b>omega-3 acid ethyl esters</b>	Tier 2	
<b>omeprazole/sodium bicarbonate oral packets</b>	Tier 2	PA QL
<b>omeprazole/sodium bicarbonate OTC capsules</b>	Tier 2	PA
Omnipod DASH Pods	Tier 2	QL 2 boxes(10 pods)/30 days
OneTouch Ultra test strips	Tier 2	
OneTouch Verio test strips	Tier 2	
Oriahnn cap	Tier 2	PA QL
Orilissa	Tier 2	PA QL 150 mg: 30 tablets/30 days; 200 mg: 60 tablets/30 days
<b>orphenadrine/aspirin/caffeine</b>	Tier 2	
<b>oseltamivir capsules</b>	Tier 2	QL
<b>oseltamivir suspension</b>	Tier 2	QL
Ovidrel	Tier 2	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
<b>oxandrolone</b>	Tier 2	
<b>oxiconazole cream</b>	Tier 2	
Oxistat lotion	Tier 2	
<b>oxycodone ext-rel</b>	Tier 2	QL
<b>OxyContin</b>	Tier 2	QL 2 tablets/day
<b>oxymorphone ext-rel</b>	Tier 2	QL 2 tablets/day
Ozempic	Tier 2	
<b>pacerone</b>	Tier 2	
palbociclib	Tier 2	SP PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>paliperidone ext-rel tablets</b>	Tier 2	
<b>pantoprazole sodium suspension</b>	Tier 2	PA QL PA for members > 12 years., 90 packets/90 days
<b>paromomycin</b>	Tier 2	
<b>paroxetine HCl ext-rel</b>	Tier 2	PA
<b>paroxetine mesylate 7.5 mg</b>	Tier 2	
<b>peg 3350/electrolytes</b>	Tier 2	Generics may be covered at no copayment for members age 45 through 74
peg 3350/electrolytes powder packets	Tier 2	
<b>penicillamine</b>	Tier 2	
Pentasa	Tier 2	
Perforomist	Tier 2	QL 180 vials/90 days
<b>phytonadione</b>	Tier 2	
Pifeltro	Tier 2	
Pilopine HS gel	Tier 2	
<b>pimecrolimus 1%</b>	Tier 2	
<b>potassium chloride liquid</b>	Tier 2	
<b>potassium chloride powder</b>	Tier 2	
<b>potassium citrate ext-rel</b>	Tier 2	
<b>pramipexole ext-rel</b>	Tier 2	
<b>prasugrel</b>	Tier 2	
<b>praziquantel</b>	Tier 2	
Pred Mild	Tier 2	
Pred-G	Tier 2	
<b>prednicarbate cream 0.1%</b>	Tier 2	PA
Prednisolone Phosphate 1%	Tier 2	
<b>prednisolone sodium phosphate orally disintegratin</b>	Tier 2	
Prefest	Tier 2	
<b>Pregnyl</b>	Tier 2	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
Premarin cream	Tier 2	
Prempro	Tier 2	
Prezcobix	Tier 2	
Prezista	Tier 2	
Procrit	Tier 2	SP QL 10 vials/14 days; Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>promethazine suppositories</b>	Tier 2	
<b>propafenone ext-rel</b>	Tier 2	
Pulmicort Flexhaler	Tier 2	QL 6 inhalers/90 days
Pylera	Tier 2	
<b>pyridostigmine ext-rel</b>	Tier 2	
<b>quetiapine ext-rel</b>	Tier 2	
<b>quinidine gluconate ext-rel</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>rabeprazole delayed-rel</b>	Tier 2	PA QL
<b>ramelteon</b>	Tier 2	QL
<b>ranolazine</b>	Tier 2	
<b>rasagiline mesylate</b>	Tier 2	
Regranex	Tier 2	
Relenza	Tier 2	QL 20 units/365 days
Repatha	Tier 2	PA QL Preferred PCSK9 Inhibitor., 140 mg syringes or auto-injectors: 6 per 84 days; 420 mg Pushtronex system: 3 per 84 days
Restasis	Tier 2	PA
Retacrit	Tier 2	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 10 vials/14 days; Covered under the Prescription Drug Benefit when self-administered.
Reyataz oral powder	Tier 2	
Reyvow	Tier 2	PA QL 50mg: 4 tablets/30 days, 100mg: 8 tablets/30 days
Rheumatrex	Tier 2	
<b>rifabutin</b>	Tier 2	
<b>risedronate</b>	Tier 2	
<b>risedronate delayed-rel</b>	Tier 2	
<b>ritonavir tablets</b>	Tier 2	
<b>rivastigmine transdermal</b>	Tier 2	
<b>rosuvastatin 20 mg, 40 mg</b>	Tier 2	
<b>rosuvastatin 5 mg, 10 mg</b>	Tier 2	QL
<b>rufinamide</b>	Tier 2	
<b>rufinamide susp 40 mg/ml</b>	Tier 2	
Rukobia	Tier 2	
Rybelsus	Tier 2	QL 30 tablets/30 days
Savella	Tier 2	QL STPA 180 tablets/90 days
Saxenda	Tier 2	PA
<b>scopolamine transdermal</b>	Tier 2	
Selzentry	Tier 2	
Selzentry solution	Tier 2	
Serevent Diskus	Tier 2	QL 3 diskus/90 days
<b>sevelamer carbonate oral powder packets</b>	Tier 2	
<b>sevelamer carbonate tablets 800 mg</b>	Tier 2	
<b>sevelamer HCl</b>	Tier 2	
Siklos	Tier 2	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>sildenafil</b>	Tier 2	QL
Simbrinza	Tier 2	
Sirturo	Tier 2	PA
<b>sodium phenylbutyrate</b>	Tier 2	
<b>solifenacin succinate</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Soltamox	Tier 2	No copayment required for women under Preventive Services.
<b>spinosad</b>	Tier 2	QL
Spiriva HandiHaler	Tier 2	QL 3 HandiHalers/90 days
Spiriva Respimat	Tier 2	QL 3 Respimat inhalers/90 days
Stiolto Respimat	Tier 2	QL 6 inhalers/90 days
Stremsiq	Tier 2	PA QL 24 single dose vials/28 days
Stribild	Tier 2	
Striverdi Respimat	Tier 2	QL 3 Respimat inhalers/90 days
<b>sumatriptan injection</b>	Tier 2	QL
<b>sumatriptan nasal spray</b>	Tier 2	QL
Symbicort	Tier 2	QL 6 inhalers/90 days; Generic Formulations are non-covered and are subject to non-covered cost share.
Symtuza	Tier 2	
Synjardy	Tier 2	
Synjardy XR	Tier 2	
Tabloid	Tier 2	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>tacrolimus</b>	Tier 2	
<b>tacrolimus ointment</b>	Tier 2	
<b>tadalafil 2.5 mg, 10 mg, 20 mg</b>	Tier 2	QL
<b>tadalafil 5 mg</b>	Tier 2	PA QL
tamoxifen	Tier 2	No copayment required for women under Preventive Services.
<b>tazarotene cream 0.1% (Tazorac)</b>	Tier 2	PA
Tazorac cream 0.05%, gel 0.05%, 0.1%	Tier 2	PA Prior Authorization required for members 26 years of age and older.
<b>telmisartan/amlodipine</b>	Tier 2	
<b>telmisartan/hydrochlorothiazide</b>	Tier 2	
<b>temozolomide</b>	Tier 2	SP For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>tenofovir 300 mg</b>	Tier 2	
<b>terconazole suppositories</b>	Tier 2	
<b>testosterone 50 mg/5 g gel</b>	Tier 2	
<b>testosterone gel</b>	Tier 2	
<b>testosterone gel 10 mg</b>	Tier 2	
<b>testosterone soln</b>	Tier 2	
Theo-24	Tier 2	
thioguanine	Tier 2	SP
<b>tiagabine 12 mg, 16 mg</b>	Tier 2	
<b>timolol maleate 0.5% eye drops</b>	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Tivicay	Tier 2	
Tivicay PD	Tier 2	
<b>tizanidine</b>	Tier 2	
<b>tobramycin/dexamethasone 0.3%/0.1% eye suspension</b>	Tier 2	
<b>tolterodine ext-rel</b>	Tier 2	
<b>tolvaptan</b>	Tier 2	QL
<b>topiramate ext-rel</b>	Tier 2	
<b>toremifene</b>	Tier 2	
Toujeo	Tier 2	
<b>tranlycypromine</b>	Tier 2	PA
<b>travoprost</b>	Tier 2	
TRELEGY ELLIPTA	Tier 2	QL 3 inhalers/90 days
Tresiba	Tier 2	
<b>tretinoin cream 0.025%, 0.05%, 0.1%</b>	Tier 2	PA
Trexall	Tier 2	
<b>Trezix</b>	Tier 2	QL 10 capsules/day
<b>triamcinolone acetonide aerosol 0.2%</b>	Tier 2	PA
<b>triamterene</b>	Tier 2	
<b>trientine</b>	Tier 2	
<b>trifluridine eye drops</b>	Tier 2	
Triumeq	Tier 2	
<b>tropium ext-rel</b>	Tier 2	
Trulicity	Tier 2	
Tybost	Tier 2	
Uceris rectal foam	Tier 2	
<b>ursodiol capsules</b>	Tier 2	
<b>Valcyte</b>	Tier 2	
<b>valganciclovir</b>	Tier 2	
<b>vancomycin</b>	Tier 2	
<b>ildenafil</b>	Tier 2	QL
Vascepa	Tier 2	PA
Veltassa	Tier 2	
Vemlidy	Tier 2	
Verquvo	Tier 2	
Vexol	Tier 2	
Viberzi	Tier 2	PA
Victoza	Tier 2	
Vimpat	Tier 2	
Viracept	Tier 2	
<b>voriconazole tablets 50 mg, 200 mg</b>	Tier 2	
Wegovy	Tier 2	PA
Xarelto	Tier 2	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



Xarelto starter pack	Tier 2	
Xcopri	Tier 2	
Xifaxan	Tier 2	PA QL 200 mg tablets: 9 tablets/30 days; 550 mg tablets: 60 tablets/30 days
Xigduo XR	Tier 2	
Xiidra	Tier 2	PA
Xuriden	Tier 2	QL 120 packets/30 days
Zenpep	Tier 2	
<b>zileuton ext-rel</b>	Tier 2	
<b>zolmitriptan</b>	Tier 2	QL
<b>zolmitriptan nasal spray</b>	Tier 2	QL
<b>zolpidem sublingual</b>	Tier 2	QL 10 tablets/30 days

### Tier 3

Drug Name	Tier	Pharmacy Program
Abilify Mycite	Tier 3	PA QL 1 tablet/day
<b>Abilify tablets</b>	Tier 3	STPA
<b>acamprosate calcium</b>	Tier 3	
<b>Accolate</b>	Tier 3	
<b>Accupril</b>	Tier 3	
<b>AcipHex</b>	Tier 3	PA QL 90 tablets/90 days, Prior Authorization applies to brand name drug only., Quantity Limitation (QL) only applies to the brand name.
<b>Aclovate</b>	Tier 3	PA Prior Authorization applies to brand name drug only.
<b>Activella</b>	Tier 3	
<b>Actoplus Met</b>	Tier 3	
Actoplus Met XR	Tier 3	
<b>Actos</b>	Tier 3	
<b>Acular</b>	Tier 3	
<b>Acular LS</b>	Tier 3	
<b>adapalene cream</b>	Tier 3	PA
<b>adapalene gel 0.1%</b>	Tier 3	PA
<b>adapalene gel 0.3%</b>	Tier 3	PA
Addyi	Tier 3	PA
<b>Adipex-P</b>	Tier 3	PA Prior Authorization applies to brand name drug only.
Advicor	Tier 3	
Aemcolo	Tier 3	QL 12 tablets/fill
<b>Agrylin</b>	Tier 3	
Akynzeo	Tier 3	QL 1 capsule/fill; maximum QL=3 capsules/28 days
<b>Alinia</b>	Tier 3	
Alora	Tier 3	
Alphagan P 0.1%	Tier 3	
<b>Alphagan P 0.15%</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Altabax	Tier 3	QL 1 tube/5 days
Altreno	Tier 3	PA Prior Authorization required for members 26 years of age and older.
<b>Amaryl</b>	Tier 3	
<b>Amicar oral solution</b>	Tier 3	
<b>Amicar tablets</b>	Tier 3	
Angeliq	Tier 3	
Annovera	Tier 3	QL Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., 1 ring/year
Aplenzin	Tier 3	PA STPA Step Therapy Prior Authorization required for members 13 years of age and older., Prior Authorization applies to members through age 12.
<b>Aricept</b>	Tier 3	
<b>Arixtra</b>	Tier 3	
<b>armodafinil</b>	Tier 3	PA QL
<b>Arthrotec</b>	Tier 3	
Atabex EC	Tier 3	
<b>Atrovent nasal aerosol</b>	Tier 3	QL 6 nasal spray units/90 days
<b>Augmentin</b>	Tier 3	
<b>Avita</b>	Tier 3	PA Prior Authorization required for members 26 years of age or older.
<b>Avodart</b>	Tier 3	
<b>Aygestin</b>	Tier 3	
Azasite	Tier 3	QL 1 bottle/7 days
<b>Azilect</b>	Tier 3	
<b>Azulfidine</b>	Tier 3	
<b>Azulfidine EN-Tablets</b>	Tier 3	
<b>Bactrim/Bactrim DS</b>	Tier 3	
Balcoltra	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Banzel</b>	Tier 3	
Banzel 40 mg/mL suspension	Tier 3	
<b>Baraclude tablets</b>	Tier 3	
Baxdela	Tier 3	
Belbuca	Tier 3	PA QL 60 films/30 days
Belsomra	Tier 3	QL STPA 10 tablets/30 days
<b>Benzamycin</b>	Tier 3	
Besivance	Tier 3	
<b>Betapace</b>	Tier 3	
<b>Betapace AF</b>	Tier 3	
Betoptic S	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Beyaz</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Biaxin</b>	Tier 3	
Bionect	Tier 3	
<b>Bleph-10</b>	Tier 3	
Blephamide	Tier 3	
<b>Brevicon</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Brilinta	Tier 3	
Briviact	Tier 3	
Bunavail	Tier 3	PA
<b>Buphenyl</b>	Tier 3	
<b>butalbital/acetaminophen/caffeine</b>	Tier 3	
<b>butalbital/acetaminophen/caffeine tabs</b>	Tier 3	
<b>Bystolic</b>	Tier 3	
<b>Caduet</b>	Tier 3	
<b>Canasa</b>	Tier 3	
Capex	Tier 3	PA
Capital w/Codeine	Tier 3	
Caplyta	Tier 3	STPA
<b>Carafate</b>	Tier 3	
<b>Carbatrol</b>	Tier 3	
Caverject	Tier 3	
<b>Ceftin</b>	Tier 3	
Celontin	Tier 3	
Cequa	Tier 3	PA
<b>Cetraxal</b>	Tier 3	
Chemet	Tier 3	
chlorambucil	Tier 3	
<b>chlordiazepoxide/clidinium</b>	Tier 3	
<b>chorionic gonadotropin</b>	Tier 3	SP Please contact your sponsor / employer about applicability and effective date for your group., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Ciloxan</b>	Tier 3	
<b>Cipro</b>	Tier 3	
Cipro HC Otic	Tier 3	
Citranatal Rx	Tier 3	
<b>Claravis</b>	Tier 3	
Clenpiq	Tier 3	May be covered at no copayment for members age 45 through 74
<b>Cleocin</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Cleocin Pediatric</b>	Tier 3	
<b>Cleocin T</b>	Tier 3	
<b>Cleocin vaginal cream</b>	Tier 3	
Cleocin vaginal suppositories	Tier 3	
<b>clindamycin 1%/benzoyl peroxide 5%</b>	Tier 3	
<b>clindamycin phosphate foam 1%</b>	Tier 3	
<b>clindamycin/benzoyl peroxide gel</b>	Tier 3	
Clindesse	Tier 3	
<b>Clobex</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Cloderm</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Clozaril</b>	Tier 3	STPA
<b>Coenzyme Q10</b>	Tier 3	PA
<b>Colazal</b>	Tier 3	
<b>Colcrys</b>	Tier 3	
<b>Combivir</b>	Tier 3	
<b>Comtan</b>	Tier 3	
Concept DHA	Tier 3	
Concept OB	Tier 3	
Contrave	Tier 3	PA
<b>Cordran</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Coreg</b>	Tier 3	
<b>Corgard</b>	Tier 3	
<b>Cortef</b>	Tier 3	
Cortisporin	Tier 3	
Corvite 150	Tier 3	
<b>Cosopt</b>	Tier 3	
<b>Cosopt PF</b>	Tier 3	
Cresemba capsule	Tier 3	PA
<b>Cutivate lotion</b>	Tier 3	PA Prior Authorization applies to brand and generic drug.
<b>Cyclessa</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Cyclogyl</b>	Tier 3	
<b>Cytomel</b>	Tier 3	
<b>Cytotec</b>	Tier 3	
<b>D.H.E. 45</b>	Tier 3	
<b>Dantrium</b>	Tier 3	
<b>dapsone gel 7.5%</b>	Tier 3	
Daytrana	Tier 3	PA QL STPA 30 patches/30 days, Prior Authorization applies to members 25 years of age or older., Step Therapy Prior Authorization applies to members under the age of 25.
Dayvigo	Tier 3	QL STPA 10 tablets/30 days
<b>DDAVP</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Delestrogen</b>	Tier 3	
Denavir	Tier 3	PA
<b>Depakote</b>	Tier 3	
<b>Depakote ER</b>	Tier 3	
<b>Depakote Sprinkle</b>	Tier 3	
Derma-N	Tier 3	
<b>Derma-Smoothe/FS</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Dermotic</b>	Tier 3	
<b>Desowen cream</b>	Tier 3	PA Prior authorization applies to brand name only
Desvenlafaxine ER	Tier 3	PA STPA Generic product covered only., Prior Authorization applies to members through age 12., Step Therapy Prior Authorization required for members 13 years of age and older.
desvenlafaxine ext-rel	Tier 3	PA STPA
Desvenlafaxine Fumarate ER	Tier 3	PA STPA Step Therapy Prior Authorization required for members 13 years of age and older., Prior Authorization applies to members through age 12., Generic product covered only.
desvenlafaxine fumarate ext-rel	Tier 3	PA STPA
<b>Detrol</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
<b>Detrol LA</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
Dexilant	Tier 3	PA QL 90 capsules/90 days
<b>DiaBeta</b>	Tier 3	
<b>Diamox Sequels</b>	Tier 3	
<b>Diastat/Diastat AcuDial</b>	Tier 3	QL 1 kit (2 units)/fill
<b>Dibenzyline</b>	Tier 3	
<b>diclofenac sodium gel 3%</b>	Tier 3	QL 200 grams/30 days & max 90 days per year
Dificid	Tier 3	PA
Dificid suspension	Tier 3	PA
<b>Diffucan</b>	Tier 3	
<b>dihydroergotamine spray</b>	Tier 3	QL
<b>Dilantin</b>	Tier 3	
<b>Dilantin Infatabs</b>	Tier 3	
<b>Diovan</b>	Tier 3	
<b>Diovan HCT</b>	Tier 3	
<b>Diprolene</b>	Tier 3	
<b>Diprolene AF</b>	Tier 3	PA Prior Authorization applies to brand name drug only.
<b>Ditropan XL</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
Divigel	Tier 3	
<b>doxycycline hyclate delayed-rel tablets</b>	Tier 3	
<b>Drisdol</b>	Tier 3	
Drizalma	Tier 3	QL STPA 20 mg: 60 capsules/30 days; 30 mg: 90 capsules/30 days; 40 mg: 90 capsules/30 days; 60 mg: 60 capsules/30 days
drosiprenone	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

drospirenone/estetrol	Tier 3	
<b>Duetact</b>	Tier 3	
Dutoprol	Tier 3	
Dyanavel XR	Tier 3	PA QL STPA Step Therapy Prior Authorization applies to members under the age of 25., Prior Authorization applies to members 25 years of age or older., 240 mL/30 days
<b>E.E.S. 200 suspension</b>	Tier 3	
<b>EC-Naprosyn</b>	Tier 3	
<b>Edecrin</b>	Tier 3	
Edex	Tier 3	
Effer-K 10 mEq, 20 mEq	Tier 3	
<b>Efudex</b>	Tier 3	
Elestrin	Tier 3	
Eletone	Tier 3	
<b>Elidel</b>	Tier 3	STPA
Ella	Tier 3	QL 1 tablet/fill, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Elmiron	Tier 3	
Emend suspension	Tier 3	QL 3 units/7 days
Emsam	Tier 3	PA STPA Step Therapy Prior Authorization required for members 13 years of age and older., Prior Authorization applies to members through age 12.
<b>Emtriva</b>	Tier 3	
Emverm	Tier 3	
<b>Enablex</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
<b>Entocort EC</b>	Tier 3	
<b>Epaned</b>	Tier 3	
<b>Epivir</b>	Tier 3	
<b>Epivir-HBV tablets</b>	Tier 3	
<b>Epzicom</b>	Tier 3	
Equetro	Tier 3	
Ertaczo	Tier 3	
<b>Eryped</b>	Tier 3	
<b>esgic capsules</b>	Tier 3	
<b>Estrace</b>	Tier 3	
Estrogel	Tier 3	
<b>Estrostep Fe</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred, Generic preferred

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>ethacrynic acid</b>	Tier 3	
ethinyl estradiol-levonorgestrel	Tier 3	
Eucrisa	Tier 3	PA
Evamist	Tier 3	
<b>Evista</b>	Tier 3	No copayment required for women under Preventive Services
<b>Evoxac</b>	Tier 3	
<b>Exelon capsules</b>	Tier 3	
<b>Exelon Patch</b>	Tier 3	
Exelon solution	Tier 3	
<b>Exforge</b>	Tier 3	
<b>Exforge HCT</b>	Tier 3	
Fabior	Tier 3	PA Prior Authorization required for members 26 years of age or older.
<b>Famvir</b>	Tier 3	
<b>Felbatol</b>	Tier 3	
<b>Feldene</b>	Tier 3	
Femcon FE	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Femhrt 0.5 mg/2.5 mcg</b>	Tier 3	
<b>fenoprofen</b>	Tier 3	
Feriva	Tier 3	
Ferralet 90	Tier 3	
Fintepla	Tier 3	PA
First-BXN	Tier 3	
First-Duke's Mouthwash	Tier 3	
First-Lansoprazole	Tier 3	QL 300 mL/30 days
First-Omeprazole	Tier 3	QL 300 mL/30 days
First-Vancomycin 25	Tier 3	QL 1 kit/25 days
Firvanq	Tier 3	QL 2 bottles/10 days
<b>Flagyl</b>	Tier 3	
Flarex	Tier 3	
<b>Flomax</b>	Tier 3	
Fluoroplex	Tier 3	
<b>fluorouracil</b>	Tier 3	
<b>FML</b>	Tier 3	
Fortical	Tier 3	
Fragmin	Tier 3	
Freshkote	Tier 3	
<b>frovatriptan</b>	Tier 3	QL
Fusion Plus	Tier 3	
<b>Gabitril 2 mg, 4 mg</b>	Tier 3	
Gelnique	Tier 3	STPA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Gemtesa	Tier 3	STPA
<b>Generess Fe</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Geodon</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
Gleostine	Tier 3	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Glucophage</b>	Tier 3	
<b>Glucophage XR</b>	Tier 3	
<b>Glucotrol XL</b>	Tier 3	
<b>Glynase</b>	Tier 3	
<b>Golytely</b>	Tier 3	Generics may be covered at no copayment for members age 45 through 74
Grastek	Tier 3	PA
<b>Grifulvin V tablets</b>	Tier 3	
<b>Hectorol</b>	Tier 3	
<b>Hepsera</b>	Tier 3	
Hetlioz oral suspension	Tier 3	PA QL 48 mL: 3 bottles/30 days; 158 mL: 1 bottle/30 days
Horizant	Tier 3	QL 60 tablets/30 days
<b>hydrocodone bitartrate ER 24HR deterrent</b>	Tier 3	QL
<b>hydrocodone bitartrate ER 24HR deterrent 100 mg, 120 mg</b>	Tier 3	PA QL 2 tablets/day
<b>hydrocodone/chlorpheniramine</b>	Tier 3	QL
Ilevro	Tier 3	
<b>Imuran</b>	Tier 3	
Inbrija	Tier 3	PA
Injection device for insulin (Humapen/Novopen)	Tier 3	
Innopran XL	Tier 3	
<b>Inspira</b>	Tier 3	
Integra F	Tier 3	
Integra Plus	Tier 3	
Intrarosa	Tier 3	
<b>Intuniv</b>	Tier 3	
Inveltys	Tier 3	
<b>Iopidine 0.5%</b>	Tier 3	
Iopidine 1%	Tier 3	
Irospan	Tier 3	
Isturisa	Tier 3	PA
Jatenzo	Tier 3	PA QL 158 mg, 237 mg: 2 capsules/day; 198 mg: 4 capsules/day
<b>Kaletra solution</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



<b>Kaletra tablets</b>	Tier 3	
<b>Kapvay</b>	Tier 3	
<b>Keflex</b>	Tier 3	
<b>Kenalog Spray</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Keppra</b>	Tier 3	
Keralyt	Tier 3	
<b>ketoconazole foam 2%</b>	Tier 3	
Keveyis	Tier 3	PA
<b>Klaron</b>	Tier 3	
<b>Lac-Hydrin</b>	Tier 3	
lactic acid/citric acid/potassium bitartrate gel	Tier 3	
<b>Lamictal</b>	Tier 3	
<b>Lamictal ODT</b>	Tier 3	
<b>Lamictal Starter Kit</b>	Tier 3	
<b>Lamictal XR</b>	Tier 3	QL 25 mg: 90 tablets/90 days; 50 mg: 90 tablets/90 days; 100 mg: 90 tablets/90 days; 200 mg: 270 tablets/90 days; 250 mg: 180 tablets/90 days; 300 mg: 180 tablets/90 days
Lamisil oral granules packet	Tier 3	QL 125 mg packets: 56 packets/28 days; 187.5 mg packets: 28 packets/28 days. Annual limit of 12 weeks applies.
<b>Lamisil tablets</b>	Tier 3	
Lampit	Tier 3	
<b>Lanoxin</b>	Tier 3	
<b>lansoprazole soluble tablets</b>	Tier 3	PA QL
<b>lanthanum carbonate chew tabs</b>	Tier 3	
<b>Lasix</b>	Tier 3	
Leukeran	Tier 3	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Levitol	Tier 3	
<b>Levbid</b>	Tier 3	
levonorgestrel/EE 0.1/20 and iron	Tier 3	
<b>Levora</b>	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Levsin</b>	Tier 3	
<b>Lexiva</b>	Tier 3	
<b>lidocaine patch 5%</b>	Tier 3	PA QL
<b>lidocaine/tetracaine cream</b>	Tier 3	QL
<b>linezolid 100 mg/5 mL oral suspension</b>	Tier 3	
<b>Lithobid</b>	Tier 3	
<b>Locoid Lipocream</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Lodosyn</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Loestrin</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred, Generic preferred
<b>Loestrin Fe</b>	Tier 3	PA Generic preferred, Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Lomaira	Tier 3	PA
<b>Lomotil</b>	Tier 3	
lomustine	Tier 3	SP
<b>Loprox</b>	Tier 3	
<b>LoSeasonique</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
Lotemax	Tier 3	
<b>Lotensin</b>	Tier 3	
<b>Lotronex</b>	Tier 3	
Lucemyra	Tier 3	QL 132 tablets/fill
Lumigan	Tier 3	STPA
<b>Luride Lozi-Tabs</b>	Tier 3	No copayment required for children through age 6. Coverage is excluded for members age 16 and older.
<b>Luxiq</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
Lybalvi	Tier 3	STPA
<b>Lysteda</b>	Tier 3	QL 30 tablets/28 days
<b>Macrobid</b>	Tier 3	
<b>Macrodantin</b>	Tier 3	
<b>Malarone</b>	Tier 3	
Marplan	Tier 3	PA Prior Authorization applies to members through age 12.
<b>Mavik</b>	Tier 3	
Maxaron Forte	Tier 3	
Maxidex	Tier 3	
<b>Maxitrol</b>	Tier 3	
<b>Maxzide</b>	Tier 3	
<b>Maxzide-25</b>	Tier 3	
<b>meclofenamate</b>	Tier 3	
<b>Medrol</b>	Tier 3	
<b>mefenamic acid</b>	Tier 3	
Menest	Tier 3	
Menostar	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Mepron suspension</b>	Tier 3	
<b>Mestinon</b>	Tier 3	
<b>Mestinon Timespan</b>	Tier 3	
<b>metformin ext-rel</b>	Tier 3	PA
<b>methamphetamine</b>	Tier 3	PA QL
<b>methenamine/hyoscyamine/methylene blue/phenyl sali</b>	Tier 3	
methotrexate oral solution	Tier 3	PA
<b>methylphenidate ER osmotic release 72 mg</b>	Tier 3	PA QL
Metoclopramide orally disintegrating tablets 10 mg	Tier 3	QL 120 tablets/30 days
<b>metoprolol tartrate 37.5 mg, 75 mg</b>	Tier 3	
<b>Metozolv ODT 5 mg</b>	Tier 3	QL 120 tablets/30 days
<b>MetroCream</b>	Tier 3	
<b>MetroLotion</b>	Tier 3	
<b>metronidazole 375 mg capsules</b>	Tier 3	
<b>Miacalcin nasal</b>	Tier 3	
Migergot suppository	Tier 3	
<b>miglustat</b>	Tier 3	PA
<b>Millipred</b>	Tier 3	
<b>Minastrin 24 Fe</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Minipress</b>	Tier 3	
<b>Minivelle</b>	Tier 3	
<b>minocycline SR</b>	Tier 3	
<b>Mirapex</b>	Tier 3	
<b>Mirapex ER</b>	Tier 3	
<b>Mircette</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Mobic</b>	Tier 3	
<b>Modicon</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
Multaq	Tier 3	
MUSE	Tier 3	
Myalept	Tier 3	PA QL 30 injections/30 days
<b>Myambutol</b>	Tier 3	
Mycapssa	Tier 3	PA
<b>Mycobutin</b>	Tier 3	
Myrbetriq	Tier 3	STPA
Myrbetriq suspension	Tier 3	STPA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Mysoline</b>	Tier 3	
<b>Nalfon</b>	Tier 3	
<b>Namenda</b>	Tier 3	
<b>naproxen suspension</b>	Tier 3	
Nayzilam	Tier 3	PA QL 1 box (2 nasal spray units)/fill, Prior authorization required through age 11; Covered for age 12 and older
Necon 10/11	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Neevo DHA	Tier 3	
<b>Neoral</b>	Tier 3	
<b>Nephrocaps</b>	Tier 3	
Neupro	Tier 3	
<b>Neurontin</b>	Tier 3	
Nevanac	Tier 3	
<b>Nexium 24HR OTC</b>	Tier 3	Only OTC esomeprazole products are covered.
Nextstellis	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Niaspan</b>	Tier 3	
<b>Nitro-Dur</b>	Tier 3	
<b>nitrofurantoin suspension</b>	Tier 3	
<b>Nitrolingual</b>	Tier 3	
<b>Nitrostat</b>	Tier 3	
norethindrone/EE	Tier 3	
norethindrone/EE 0.4/35 and iron chewable	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Norinyl 1+35</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Norpace</b>	Tier 3	
Norpace CR	Tier 3	
<b>Nor-QD</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Nourianz	Tier 3	PA QL 30 tablets/30 days
Novaferrum oral solution	Tier 3	
Noxafil oral suspension	Tier 3	PA
<b>Nulytely</b>	Tier 3	
Numoisyn	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Nuvaring</b>	Tier 3	PA Generic preferred; Prior Authorization applies to brand name drug only., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Nuversa	Tier 3	
Nuzyra tablets	Tier 3	
Nymalize	Tier 3	
OB Complete caplet	Tier 3	
OB Complete DHA	Tier 3	
Obtrex DHA	Tier 3	
<b>Ocuflox</b>	Tier 3	
Odactra	Tier 3	PA
<b>Olux foam 0.05%</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>omeprazole/sodium bicarbonate capsules</b>	Tier 3	PA QL
<b>Onfi</b>	Tier 3	
Ongentys	Tier 3	PA QL 30 capsules/30 days
Onzetra Xsail	Tier 3	QL STPA 16 units/30 days
Oralair	Tier 3	PA
<b>Orapred ODT</b>	Tier 3	
<b>Ortho Micronor</b>	Tier 3	PA Generic preferred, Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Ortho Tri-Cyclen</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred, Generic preferred
<b>Ortho Tri-Cyclen Lo</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Ortho-Cyclen</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred, Generic preferred
<b>Ortho-Novum 1/35</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Ortho-Novum 7/7/7</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred, Generic preferred
Osphena	Tier 3	
<b>Ovcon 35</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>oxaprozin</b>	Tier 3	
<b>Oxistat cream</b>	Tier 3	
Oxtellar XR	Tier 3	
Palforzia capsules	Tier 3	PA
Palforzia packets	Tier 3	PA
Pancreaze	Tier 3	
Pandel	Tier 3	PA
Panretin	Tier 3	
<b>Parlodel</b>	Tier 3	
PCE	Tier 3	
peg 3350/electrolytes	Tier 3	Generics may be covered at no copayment for members age 45 through 74
<b>Peridex</b>	Tier 3	
<b>Persantine</b>	Tier 3	
Pertzye	Tier 3	
Pexeva	Tier 3	PA STPA Prior Authorization applies to members through age 12., Step Therapy Prior Authorization required for members 13 years of age and older.
Phexxi	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Plan B One-Step</b>	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Plaquenil</b>	Tier 3	
<b>Plavix</b>	Tier 3	
Plenvu	Tier 3	May be covered at no copayment for members age 45 through 74
<b>Pletal</b>	Tier 3	
<b>Polytrim</b>	Tier 3	
<b>Ponstel</b>	Tier 3	
<b>posaconazole delayed-release tablets</b>	Tier 3	PA
<b>Precose</b>	Tier 3	
<b>Pred Forte</b>	Tier 3	
Prednisone Intensol	Tier 3	
Premarin	Tier 3	
Premphase	Tier 3	
<b>Prenatal Vitamins</b>	Tier 3	
Preque 10	Tier 3	
Pretomanid	Tier 3	
<b>Prevacid</b>	Tier 3	PA QL 90 capsules/90 days; Quantity Limitation (QL) only applies to the brand name., Prior Authorization applies to brand name drug only.
<b>Prevacid Solutab</b>	Tier 3	PA QL Prior Authorization for the generic drug required for members older than 12 years of age. Prior authorization for the brand name drug required for all ages., 90 tablets/90 days
<b>Prevalite</b>	Tier 3	
<b>Prevpac</b>	Tier 3	
<b>Prilosec</b>	Tier 3	PA QL Quantity Limitation (QL) only applies to the brand name., 90 capsules/90 days, Prior Authorization applies to brand name drug only.
Prilosec Oral Suspension	Tier 3	PA QL PA for members > 12 years., 90 packets/90 days
Primsol	Tier 3	
<b>Prinivil</b>	Tier 3	
ProctoFoam-HC	Tier 3	
<b>Prograf</b>	Tier 3	
Prograf granules	Tier 3	
Prolate solution	Tier 3	QL 30 mL/day
Prolensa	Tier 3	
<b>Prometrium</b>	Tier 3	
<b>Protonix</b>	Tier 3	PA QL Prior Authorization applies to brand name drug only., 90 tablets/90 days; Quantity Limitation (QL) only applies to the brand name.
<b>Protopic ointment</b>	Tier 3	STPA
<b>Provera</b>	Tier 3	
<b>Psorcon</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Pulmicort Respules</b>	Tier 3	QL 180 vials/90 days
Purixan	Tier 3	
Qbrexza	Tier 3	PA QL 30 pads/30 days
Qelbree	Tier 3	PA QL 100 mg: 1 capsule/day; 150 mg and 200 mg: 2 capsules/day
Qsymia	Tier 3	PA
<b>Qualaquin</b>	Tier 3	
<b>Quartette</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Quillivant XR	Tier 3	PA QL STPA 360 mL/30 days, Prior Authorization applies to members 25 years of age or older., Step Therapy Prior Authorization applies to members under the age of 25.
Radiogardase	Tier 3	
Ragwitek	Tier 3	PA
Rasuvo	Tier 3	
<b>Razadyne ER</b>	Tier 3	
Rectiv Ointment	Tier 3	QL 1 tube/30 days
<b>Reglan</b>	Tier 3	
<b>Retrovir</b>	Tier 3	
<b>Revia</b>	Tier 3	
Rexulti	Tier 3	QL STPA 1 tablet/day
<b>Reyataz</b>	Tier 3	
Rhopressa	Tier 3	STPA
<b>Rilutek</b>	Tier 3	
<b>Risperdal</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
<b>Rocaltrol</b>	Tier 3	
Rocklatan	Tier 3	STPA
<b>Rowasa</b>	Tier 3	
<b>Rythmol</b>	Tier 3	
<b>Rythmol SR</b>	Tier 3	
<b>Safyral</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Salagen</b>	Tier 3	
<b>salicylic acid foam 6%</b>	Tier 3	
<b>Sandimmune</b>	Tier 3	
Santyl	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



<b>Seasonique</b>	Tier 3	PA Generic preferred, Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Secuado	Tier 3	STPA
segesterone acetate/ethinyl estradiol	Tier 3	QL
Select-OB + DHA	Tier 3	
<b>Seroquel XR</b>	Tier 3	STPA
<b>Silvadene</b>	Tier 3	
Silvrstat	Tier 3	
<b>Sinemet</b>	Tier 3	
<b>Singulair</b>	Tier 3	
Sivextro tablets	Tier 3	
Slynd	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
sodium picosulfate/magnesium oxide/citric acid	Tier 3	
sodium sulfate/magnesium sulfate/potassium chlorid	Tier 3	
sodium sulfate/potassium sulfate/magnesium sulfate	Tier 3	
Solosec	Tier 3	
<b>Soma 350 mg</b>	Tier 3	
Soolantra cream 1%	Tier 3	
<b>Soriatane</b>	Tier 3	
Sotylize 5 mg/mL	Tier 3	
<b>Stalevo</b>	Tier 3	
Stavzor	Tier 3	
Stimate	Tier 3	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Stromectol</b>	Tier 3	QL 20 tablets/90 days
Subsys	Tier 3	QL 30 bottles/30 days
Sucraid	Tier 3	
<b>sucrafate suspension</b>	Tier 3	
<b>sumatriptan/naproxen 85 mg/500 mg</b>	Tier 3	PA QL
Sunosi	Tier 3	PA QL 30 tablets/30 days
<b>Suprax capsules, suspension</b>	Tier 3	
Suprax tablets	Tier 3	
Suprep	Tier 3	May be covered at no copayment for members age 45 through 74
<b>Sustiva</b>	Tier 3	
Sutab	Tier 3	May be covered at no copayment for members age 45 through 74

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Symbyax</b>	Tier 3	STPA Step Therapy Prior Authorization applies to both brand and generic drug.
<b>Symfi</b>	Tier 3	
<b>Symfi Lo</b>	Tier 3	
SymlinPen	Tier 3	
Sympazan	Tier 3	PA
<b>Synalar</b>	Tier 3	PA Prior Authorization applies to brand name drug only.
<b>Synalar solution</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
Synarel	Tier 3	PA
<b>Synthroid</b>	Tier 3	
<b>Tapazole</b>	Tier 3	
<b>Tarka</b>	Tier 3	
<b>Tasmar</b>	Tier 3	
<b>Taytulla</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
<b>Tazorac cream 0.1%</b>	Tier 3	PA Prior Authorization required for members 26 years of age and older.
<b>Tegretol</b>	Tier 3	
<b>Tegretol-XR</b>	Tier 3	
<b>Tekturna</b>	Tier 3	
Tekturna HCT	Tier 3	
<b>Temovate</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Temovate-E</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.
<b>Terazol Vaginal cream</b>	Tier 3	
<b>Tessalon Perles</b>	Tier 3	
<b>testosterone 1.62% gel</b>	Tier 3	
<b>tetracycline</b>	Tier 3	
Texacort	Tier 3	PA
<b>Thiola</b>	Tier 3	
Thiola EC	Tier 3	
Thyquidity	Tier 3	
<b>Tikosyn</b>	Tier 3	
<b>Timoptic</b>	Tier 3	
<b>Timoptic-XE</b>	Tier 3	
<b>Tirosint</b>	Tier 3	
Tirosint-sol	Tier 3	
<b>Tobradex</b>	Tier 3	
Tobradex ointment	Tier 3	
Tobradex ST	Tier 3	
<b>Tobrex</b>	Tier 3	
<b>Topamax</b>	Tier 3	
<b>Topicort</b>	Tier 3	PA Prior Authorization applies to both brand and generic drug.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Toprol-XL</b>	Tier 3	
<b>Trandate</b>	Tier 3	
<b>Transderm Scop</b>	Tier 3	
<b>tretinoin gel 0.05%</b>	Tier 3	PA
<b>tretinoin gel microsphere 0.04%, 0.1%</b>	Tier 3	PA
Tricare DHA	Tier 3	
<b>Trileptal</b>	Tier 3	
<b>trimipramine</b>	Tier 3	PA Prior Authorization applies to members through age 12
<b>Tri-Norinyl</b>	Tier 3	PA Generic preferred, Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
Trintellix	Tier 3	PA STPA Prior Authorization applies to members through age 12., Step Therapy Prior Authorization required for members 13 years of age and older.
<b>Trizivir</b>	Tier 3	
<b>Trusopt</b>	Tier 3	
<b>Tussicaps</b>	Tier 3	QL 2 capsules/day
Twirla Dis	Tier 3	Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.
ulipristal	Tier 3	QL
<b>Uloric</b>	Tier 3	STPA
Ultra CoQ10 75 mg	Tier 3	PA
<b>Ultravate</b>	Tier 3	PA Prior Authorization applies to brand name drug only.
Upneeq	Tier 3	PA
<b>Urogesic Blue</b>	Tier 3	
<b>Urso</b>	Tier 3	
<b>Urso Forte</b>	Tier 3	
Valtoco	Tier 3	PA QL 1 box (2 blister packs) per fill
<b>Vancocin</b>	Tier 3	
<b>Vanos</b>	Tier 3	PA QL 240 grams/30 days, Prior Authorization applies to both brand and generic drug.
<b>Vaseretic</b>	Tier 3	
<b>Vasotec</b>	Tier 3	
<b>venlafaxine ext-rel tablets 225 mg</b>	Tier 3	
<b>Ventolin nebulizer solution</b>	Tier 3	QL 9 dropper bottles/90 days
Versacloz	Tier 3	STPA
<b>Vesicare</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
Vesicare LS	Tier 3	STPA
<b>Vfend</b>	Tier 3	

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Vfend suspension</b>	Tier 3	
<b>Vibramycin</b>	Tier 3	
Viibryd	Tier 3	PA STPA Step Therapy Prior Authorization required for members 13 years of age and older., Prior Authorization applies to members through age 12.
Viokace	Tier 3	
<b>Viramune</b>	Tier 3	
<b>Viramune XR</b>	Tier 3	
Viread	Tier 3	
<b>Viread 300 mg</b>	Tier 3	
<b>Vistaril</b>	Tier 3	
Vitafol-OB + DHA	Tier 3	
Vittrue	Tier 3	
Viva DHA	Tier 3	
<b>Vivelle-Dot</b>	Tier 3	
<b>Voltaren gel 1%</b>	Tier 3	QL 2 tubes/each fill
Vraylar	Tier 3	STPA
Vyleesi	Tier 3	PA QL 8 pens/30 days
Vyvanse	Tier 3	PA QL STPA Prior Authorization applies to members 25 years of age or older., Step Therapy Prior Authorization applies to members under the age of 25., 30 capsules/30 days
Vyvanse Chew	Tier 3	PA QL STPA 30 tablets/30 days, Step Therapy Prior Authorization applies to members under the age of 25., Prior Authorization applies to members 25 years of age or older.
Vyzulta	Tier 3	STPA
Wakix	Tier 3	PA QL 60 tablets/30 days
Winlevi	Tier 3	PA
Xadago	Tier 3	PA
Xartemis XR	Tier 3	QL 120 tablets/30 days
Xatmep	Tier 3	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Xelpros	Tier 3	STPA
Xenical	Tier 3	PA
Xenleta	Tier 3	
Xepi	Tier 3	QL 1 tube/fill
<b>Xodol</b>	Tier 3	QL 5/300: 8 tablets/day; 7.5/300: 6 tablets/day
Xofluza	Tier 3	QL 2 tablets per fill, max 2 fills per 365 days
<b>Xopenex inhalation solution</b>	Tier 3	
Xyrem	Tier 3	PA QL 18 mL/day
Xywav	Tier 3	PA QL 18 mL/day
<b>Yasmin</b>	Tier 3	PA Generic preferred, Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>YAZ</b>	Tier 3	PA Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group., Generic preferred
<b>Zanaflex</b>	Tier 3	
<b>Zarontin</b>	Tier 3	
<b>Zebeta</b>	Tier 3	
<b>Zegerid capsules</b>	Tier 3	PA QL 90 capsules/90 days, Prior Authorization applies to brand name drug only.
<b>Zegerid oral packets</b>	Tier 3	PA QL 90 packets/90 days
<b>Zemplar</b>	Tier 3	
<b>Zestoretic</b>	Tier 3	
<b>Zestril</b>	Tier 3	
<b>Zetia</b>	Tier 3	
<b>Ziac</b>	Tier 3	
<b>Ziagen</b>	Tier 3	
Zioptan	Tier 3	STPA
Zirgan	Tier 3	
<b>Zithromax</b>	Tier 3	
Zmax	Tier 3	
Zolpimist 5 mg Spray	Tier 3	QL STPA 1 metered spray unit/30 days
<b>Zonatuss</b>	Tier 3	
Zontivity	Tier 3	
Zubsolv	Tier 3	PA
Zuplenz	Tier 3	QL 10 films/7 days
Zyflo	Tier 3	
Zylet	Tier 3	
<b>Zyloprim</b>	Tier 3	
<b>Zyprexa</b>	Tier 3	STPA Step Therapy Prior Authorization applies to brand name drug only.
<b>Zyprexa Zydis</b>	Tier 3	STPA Step Therapy Prior Authorization applies to both brand and generic drug.
<b>Zyvox 100 mg/5 mL oral suspension</b>	Tier 3	
<b>Zyvox 600 mg tablets</b>	Tier 3	

## Tier 4

<b>Drug Name</b>	<b>Tier</b>	<b>Pharmacy Program</b>
abemaciclib	Tier 4	SP PA
<b>abiraterone 250 mg</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>abiraterone 500 mg</b>	Tier 4	SP PA
acalabrutinib	Tier 4	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Actemra prefilled syringe	Tier 4	SP PA QL 4 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Acthar	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Adcirca</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Adempas	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
afatinib	Tier 4	PA
<b>Afinitor Disperz</b>	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Alecensa	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
alectinib	Tier 4	SP PA
alpelisib	Tier 4	SP PA
Alunbrig	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>ambrisentan</b>	Tier 4	SP PA
apremilast	Tier 4	SP PA QL
Arcalyst	Tier 4	SP PA QL 5 vials/28 days for initial 28 days, 4 vials/28 days thereafter, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Arikayce	Tier 4	
Aubagio	Tier 4	SP QL 30 tablets/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Austedo	Tier 4	SP PA QL 6 & 9 mg: 60 tablets/30 days; 12 mg: 120 tablets/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
avapritinib	Tier 4	PA
Avonex	Tier 4	SP QL 4 syringes/vials/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Avonex Pen	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 4 pens/28 days
axitinib	Tier 4	SP PA
Ayvakit	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
azacitidine	Tier 4	SP PA
Bafiertam	Tier 4	SP QL 120 units/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Balversa	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

belzutifan	Tier 4	PA
Benlysta Sub Q Injection	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Betaseron	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 15 vials/30 days
<b>bexarotene capsules</b>	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
binimetinib	Tier 4	PA
<b>bosentan tablets 62.5 mg, 125 mg</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Bosulif	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
bosutinib	Tier 4	SP PA
Braftovi	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Bravelle	Tier 4	SP PA Please contact your sponsor / employer about applicability and effective date for your group.
brigatinib	Tier 4	PA
Bronchitol	Tier 4	PA QL 20 capsules/day
Brukinsa	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
busulfan	Tier 4	
Bylvay	Tier 4	PA
Cablivi	Tier 4	
Cabometyx	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
cabozantinib	Tier 4	SP PA
Calquence	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
capmatinib	Tier 4	SP PA
Caprelsa	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Cayston	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Cellcept</b>	Tier 4	
Cerdelga	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

ceritinib	Tier 4	SP PA
cetorelix	Tier 4	SP PA
Cetrotide	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
Cimzia	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 injections/28 days; Starter Kit: 1 fill/lifetime
cobimetinib	Tier 4	SP PA
Cometriq	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Copaxone 20 mg/mL prefilled syringe	Tier 4	SP QL 1 kit (30 syringes)/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Copaxone 40 mg/mL prefilled syringe	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 1 kit (12 syringes)/30 days
Copiktra	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Cosentyx	Tier 4	SP PA QL 75 & 150 mg: 1 syringe/28 days; 300 mg: 2 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Cotellic	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
crizotinib	Tier 4	SP PA
Cystadrops	Tier 4	
Cystaran	Tier 4	
dabrafenib	Tier 4	SP PA
dacomitinib	Tier 4	SP PA
<b>dalfampridine</b>	Tier 4	SP PA QL 60 tablets/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>dalfampridine ext-rel</b>	Tier 4	SP PA QL
dasatinib	Tier 4	SP PA
Daurismo	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
decitabine-cedazuridine	Tier 4	SP PA
<b>deferasirox</b>	Tier 4	
Diacomit	Tier 4	PA
<b>dimethyl fumarate</b>	Tier 4	SP QL
Dojolvi	Tier 4	PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



Doptelet	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>droxidopa</b>	Tier 4	
Dupixent	Tier 4	SP PA QL 2 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Dupixent pen	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 pens/28 days
duvelisib	Tier 4	PA
Egrifta SV	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Emcyt	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Emflaza	Tier 4	PA QL tablets: 30 tablets/30 days; suspension: 26 mL/30 days
enasidenib	Tier 4	SP PA
Enbrel	Tier 4	SP PA QL 25 mg: 8 vials/syringes/28 days; 50 mg: 4 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Enbrel Mini	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 4 syringes/28 days
encorafenib	Tier 4	PA
Endari	Tier 4	PA
Enspryng	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
entrectinib	Tier 4	SP PA
enzalutamide	Tier 4	SP PA
Epclusa	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Generic formulations are non-covered and are subject to non-covered cost share.
Epidiolex	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
erdafitinib	Tier 4	PA
Erivedge	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>erlotinib</b>	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Esbriet	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 267 mg: 270 capsules or tablets/30 days; 801 mg: 90 tablets/30 days
estramustine	Tier 4	SP

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>etoposide capsules</b>	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>everolimus</b>	Tier 4	SP PA
<b>everolimus 2, 3, and 5 mg</b>	Tier 4	SP PA
Evrysdi	Tier 4	PA QL 240 mL/fill
Exkivity	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Exservan	Tier 4	
Farydak	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Fasenra Pen	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 1 pen/56 days
fedratinib	Tier 4	SP PA
filgrastim-sndz	Tier 4	SP QL
<b>Firazyr</b>	Tier 4	SP PA QL 2 units (6 mL)/fill, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Firdapse	Tier 4	PA
Follistim AQ	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
follitropin alfa	Tier 4	SP PA
follitropin beta	Tier 4	SP PA
Fotivda	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Fulphila	Tier 4	SP PA QL Covered under the Prescription Drug Benefit when self-administered., 0.6 mL/14 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Fuzeon	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Galafold	Tier 4	PA
Ganirelix	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
ganirelix acetate	Tier 4	SP PA
Gattex	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Gavreto	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Gilenya	Tier 4	SP QL 30 tablets/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Gilotrif	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
gilteritinib fumarate	Tier 4	PA
glasdegib maleate	Tier 4	SP PA
glatiramer acetate 20 mg/mL prefilled syringe	Tier 4	SP QL 1 kit (30 syringes)/30 days, Copaxone, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
glatiramer acetate 40 mg/mL prefilled syringe	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Copaxone, 1 kit (12 syringes)/30 days
Gonal-F	Tier 4	SP PA Please contact your sponsor / employer about applicability and effective date for your group., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Granix prefilled syringe	Tier 4	SP PA QL 10 syringes/14 days. Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Haegarda	Tier 4	SP PA QL 2,000 unit vials: 40 vials/30 days; 3,000 unit vials: 27 vials/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Harvoni 45mg/200mg	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 30 units/30 days, Generic formulations are non-covered and are subject to non-covered cost share.
Harvoni 90mg/400mg	Tier 4	SP PA Generic formulations are non-covered and are subject to non-covered cost share., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Harvoni pak	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Generic formulations are non-covered and are subject to non-covered cost share., 30 units/30 days
Hemlibra	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Hetlioz	Tier 4	PA QL 30 capsules/30 days
Humira	Tier 4	SP PA QL 2 pens or syringes/28 days; All Starter Kits: 1 fill/lifetime, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Hycamtin oral capsules	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
ibrutinib	Tier 4	PA
<b>icatibant</b>	Tier 4	SP PA QL
Iclusig	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
idelalisib	Tier 4	SP PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Idhifa	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Imbruvica	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Imcivree	Tier 4	PA
Increlex	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
infigratinib	Tier 4	PA
Inlyta	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Inqovi	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Inrebic	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Intron A	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
ivosidenib	Tier 4	PA
ixazomib	Tier 4	SP PA
Jakafi	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Juxtapid	Tier 4	PA QL 30 capsules/30 days
Jynarque	Tier 4	
Kalydeco	Tier 4	PA QL 60 tablets/30 days; 56 packets/28 days
Kesimpta	Tier 4	SP QL 1 auto-injector/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Kevzara	Tier 4	SP PA QL 2 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Kevzara auto-injector	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 injectors/28 days
Kineret	Tier 4	PA QL 28 syringes/28 days
Kisqali	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

<b>Kitabis Pak</b>	Tier 4	
Korlym	Tier 4	PA QL 120 tablets/30 days
Koselugo	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
<b>lapatinib</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
larotrectinib	Tier 4	SP PA
ledipasvir-sofosbuvir pak	Tier 4	SP PA QL
lenalidomide	Tier 4	SP PA
lenvatinib	Tier 4	SP PA
Lenvima	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Letairis</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Leukine	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 6 vials/14 days; Covered under the Prescription Drug Benefit when self-administered.
Livmarli	Tier 4	PA
Lonsurf	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Lorbrena	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
lorlatinib	Tier 4	SP PA
Lumakras	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Lupkynis	Tier 4	PA
Lynparza	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Matulane	Tier 4	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Mavenclad	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 10 tablets/30 days
Mayzent	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 0.25mg: 120 tablets/30 days; 2mg: 30 tablets/30 days; Starter Pack: 1 fill per lifetime
Mekinist	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Mektovi	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Menopur	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Please contact your sponsor / employer about applicability and effective date for your group.
menotropins	Tier 4	SP PA
mesna tablets 400 mg	Tier 4	
Mesnex	Tier 4	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
midostaurin	Tier 4	SP PA
mobocertinib	Tier 4	PA
Mulpleta	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Myfortic</b>	Tier 4	
Myleran tablets	Tier 4	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Natpara	Tier 4	SP QL 2 cartridges/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
neratinib	Tier 4	SP PA
Nerlynx	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Neulasta	Tier 4	SP PA QL 1 syringe/14 days; Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Neupogen	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 10 vials (1 mL and 1.6 mL)/14 days; Covered under the Prescription Drug Benefit when self-administered.
Neupogen/Single-Ject	Tier 4	SP PA QL 10 syringes/14 days; Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Nexavar	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
nilotinib	Tier 4	SP PA
<b>nilutamide</b>	Tier 4	
Ninlaro	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
niraparib	Tier 4	PA
<b>nitisinone 2, 5, 10 mg capsules</b>	Tier 4	
Nityr	Tier 4	
Nivestym	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 10 syringes/14 days; Covered under the Prescription Drug Benefit when self-administered.
Norditropin Products	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767. Applies to all Norditropin products including Norditropin Flexpro and Norditropin Nordiflex.
Nucala auto-injector, prefilled syringe	Tier 4	SP PA QL 3 auto-injectors or prefilled syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Nuplazid	Tier 4	SP PA QL 60 tablets/30 days; 30 capsules/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Nyvepria	Tier 4	SP PA QL Covered under the Prescription Drug Benefit when self-administered., 0.6 mL [1 syringe]/14 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Ocaliva	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 30 tablets/30 days
Odomzo	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Ofev	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 60 capsules/30 days
olaparib	Tier 4	SP PA
Olumiant	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Onureg	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
Opsumit	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Orencia auto-injector / prefilled syringe	Tier 4	SP PA QL 4 auto-injectors / syringes/28 days, Orencia auto-injectors / syringes are covered under the pharmacy benefit only, prior authorization applies. Orencia vials are covered under the medical benefit only, prior authorization applies., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Orenitram	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Orfadin 20mg capsules	Tier 4	
Orfadin suspension	Tier 4	
Orgovyx	Tier 4	PA
Orkambi	Tier 4	PA QL 112 tablets/28 days; 56 packets/28 days
Orladeyo	Tier 4	PA QL 1 unit/day
osimertinib	Tier 4	PA
Otezla	Tier 4	SP PA QL 60 tablets/30 days; Starter Kit: 1 fill/lifetime, 1 starter kit fill only, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Oxbryta	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Oxervate	Tier 4	PA
Ozobax	Tier 4	PA
Palyzniq	Tier 4	SP PA QL 20 mg/mL syringe only; 1 syringe per day, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
panobinostat	Tier 4	SP PA
pazopanib	Tier 4	SP PA
Pegasys/Pegasys ProClick	Tier 4	SP Preferred Product, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
peginterferon alfa-2a	Tier 4	SP
PegIntron	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Pemazyre	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
pemigatinib	Tier 4	PA
pexidartinib	Tier 4	PA
Piqray	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Plegridy	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 pens or syringes/28 days; one starter pack as a one-time fill only
pomalidomide	Tier 4	SP PA

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic



Pomalyst	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
ponatinib	Tier 4	PA
pralsetinib	Tier 4	SP PA
Prevymis tablets	Tier 4	PA
procarbazine	Tier 4	
Promacta	Tier 4	SP QL Suspension: 60 units/30 days; Tablets: 60 tablets/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Pulmozyme	Tier 4	
Qinlock	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
<b>Rapamune</b>	Tier 4	
Ravicti	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Rebif/Rebif Rebidose	Tier 4	SP QL 12 syringes or autoinjectors/28 days; Titration Packs: 1 fill/lifetime, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
regorafenib	Tier 4	SP PA
Repronex	Tier 4	SP PA Please contact your sponsor / employer about applicability and effective date for your group., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Retevmo	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
Revlimid	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Rezurock	Tier 4	PA
ribociclib	Tier 4	SP PA
Rinvoq	Tier 4	SP PA QL 1 tablet/day, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
ripretinib	Tier 4	PA
Rozlytrek	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Rubraca	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
rucaparib	Tier 4	SP PA
ruxolitinib	Tier 4	SP PA
Ruzurgi	Tier 4	PA
Rydapt	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>Sabril</b>	Tier 4	
Sajazir	Tier 4	PA QL 2 units (6 mL)/fill
Sancuso	Tier 4	QL 1 patch/7 days
<b>sapropterin</b>	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
selinexor therapy pack	Tier 4	PA
selpercatinib	Tier 4	SP PA
selumetinib	Tier 4	PA
Serostim	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Signifor	Tier 4	PA QL 60 ampules/30 days
Siliq	Tier 4	SP PA QL 2 syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Simponi	Tier 4	SP PA QL 1 pre-filled syringe or SmartJect autoinjector (50 mg or 100 mg)/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Skyrizi	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 syringes/84 days
Somavert	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
sonidegib	Tier 4	SP PA
sorafenib	Tier 4	SP PA
sotorasib	Tier 4	SP PA
Sprycel	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Stelara	Tier 4	SP PA QL 0.45 mg: 1 injection/84 days; 90 mg: 1 injection/54 days for Crohn's disease and Ulcerative disease, and 1 injection/84 days for Plaque Psoriasis and Psoriatic Arthritis, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Stivarga	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>sunitinib malate</b>	Tier 4	SP PA
<b>Sutent</b>	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Symdeko	Tier 4	PA QL 56 tablets/28 days
Tabrecta	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>tadalafil</b>	Tier 4	SP PA
Tafinlar	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tagrisso 40 mg	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tagrisso 80 mg	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Takhzyro	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 2 vials/28 days
talazoparib	Tier 4	SP PA
Taltz	Tier 4	SP PA QL One 80 mg auto-injector/syringe per 28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Talzenna	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Targretin gel	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Tasigna	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tavalisse	Tier 4	QL 60 tablets/30 days
tazemetostat	Tier 4	PA
Tazverik	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Tegsedi	Tier 4	PA QL 12 prefilled syringes (18 mL)/90 days
Tepmetko	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
tepotinib	Tier 4	PA
<b>teriparatide</b>	Tier 4	SP PA
<b>tetrabenazine</b>	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 12.5 tablets: 90 tablets/30 days; 25 mg tablets: 120 tablets/30 days
thalidomide	Tier 4	SP
Thalomid	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tibsovo	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tiglutik	Tier 4	
tivozanib	Tier 4	PA
<b>TOBI</b>	Tier 4	
TOBI Podhaler	Tier 4	
<b>tobramycin inhalation solution</b>	Tier 4	
topotecan	Tier 4	SP PA
Tracleer 32 mg oral tablet soluble	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
trametinib	Tier 4	SP PA
Tremfya	Tier 4	SP PA QL 1 syringe/54 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>tretinoin capsules</b>	Tier 4	SP Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
trifluridine/tipiracil	Tier 4	SP PA
Trikafta	Tier 4	PA QL 84 tablets/28 days
Truseltiq	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
tucatinib	Tier 4	PA
Tukysa	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document.
Turalio	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Tymlos	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Udenyca	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 0.6 mL/14 days, Covered under the Prescription Drug Benefit when self-administered.
Ukoniq	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
umbralisib	Tier 4	PA
Uptravi	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
uridine triacetate oral granules	Tier 4	
urofollitropin	Tier 4	SP PA
Valchlor	Tier 4	PA
vandetanib	Tier 4	PA
Varubi	Tier 4	QL 2 capsules/fill; 6 capsules/30 days
vemurafenib	Tier 4	SP PA
Venclexta	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
venetoclax	Tier 4	PA
Verzenio	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
<b>vigabatrin</b>	Tier 4	
vismodegib	Tier 4	SP PA
Vistogard	Tier 4	For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Vitrakvi	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Vizimpro	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
vorinostat	Tier 4	SP PA
Vosevi	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Votrient	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Vumerity	Tier 4	SP QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 120 units/30 days; Starter kit: 1 fill/lifetime

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Vyndamax	Tier 4	SP PA QL 30 capsules/30 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Vyndaqel	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 120 capsules/30 days
Welireg	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Xalkori	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Xeljanz	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 60 tablets/30 days
Xeljanz sol	Tier 4	SP PA QL 10 mL/day, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Xeljanz XR	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 30 tablets/30 days
Xermelo	Tier 4	
Xolair prefilled syringes	Tier 4	SP PA QL Covered under the Prescription Drug Benefit when self-administered., 8 prefilled syringes/28 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
Xospata	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Xpovio Pak	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Xtandi	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
zanubrutinib	Tier 4	PA
Zarxio	Tier 4	SP QL 10 syringes/14 days, Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., Covered under the Prescription Drug Benefit when self-administered.
Zejula	Tier 4	PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Zelboraf	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Zeposia	Tier 4	SP PA QL Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., 30 capsules/30 days; Starter kits: 1 fill/lifetime
Ziextenzo	Tier 4	SP PA QL 1 syringe/14 days, Covered under the Prescription Drug Benefit when self-administered., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic

Zokinvy	Tier 4	PA
Zolinza	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Zorbtive	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.
<b>Zortress</b>	Tier 4	
Zydelig	Tier 4	SP PA Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767., For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share of \$0 for up to a 30-day supply. Please check your benefit document.
Zykadia	Tier 4	SP PA For plans subject to the New Hampshire oral cancer therapy mandate, this drug may have a cost share up to \$200 or the cost of the drug, whichever is less. Please check your benefit document., Medication must be obtained from CVS/specialty; call CVS/specialty at 1-800-237-2767.

**CM** Cancer Mandate  
**NTM** New-to-Market  
**SI** Specialty Infusion  
**WH** Women's Health

**MM** Mandatory Mail  
**PA** Prior Authorization  
**SP** Designated Specialty Pharmacy  
**ACA** Preventive Service

**NC** Non Covered Drugs  
**QL** Quantity Limitation Program  
**STPA** Step Therapy Prior Authorization  
**LCG** Low Cost Generic