CareFirst
Family of health care plans

# CareFirst Exchange Formulary

# 2019

**PLEASE READ: This document contains information about the drugs we cover in this plan. This formulary is for:**

- **Individuals or families purchasing their own plan, and**
- **Members of an employer group with less than 51 employees purchasing a plan**
- **Members with a student health plan**

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **carefirst.com/rx**.

Last updated 12/01/2019

# Introduction

A formulary is a list of covered prescription drugs. Our drug list is reviewed and approved by an independent national committee comprised of physicians, pharmacists and other health care professionals, known as the Pharmacy and Therapeutics Committee. This committee makes sure the drugs on the formulary are safe and clinically effective.

Within the formulary, prescription drugs are divided into tiers as described below. Depending on your plan, prescription drugs fall into one of five drug tiers which determines the price you pay.

## Using Your Formulary

The first column of the formulary lists drugs by name. If the drugs are shown in lowercase italics, they are *generic drugs*. If the drugs are bold and capitalized, they are **BRAND-NAME DRUGS**. If the brand drug has a generic drug option available, it is listed under the brand-name drug.

You may search the formulary for a drug by pressing "CTRL" and "F" at the same time to prompt a search.

The second column indicates the drug tier for a covered drug.

The third column indicates any prescription guidelines a drug requires such as prior authorization (PA), step therapy (ST) or quantity limits (QL).

- **Prior Authorization** from CareFirst is required before you fill prescriptions for certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CareFirst, your drugs may not be covered.
- **Step Therapy** requires that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your doctor will need to provide information to CareFirst about your experience with these alternatives prior to dispensing a more expensive drug.
- **Quantity Limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time.

Members can view specific cost-share (copay or coinsurance) information and prescription guidelines by logging in to *My Account* at **carefirst.com/myaccount** and clicking on *Tools* and *Drug Pricing Tool* or by reviewing their annual summary of benefits.

| | |
|---|---|
| **Tier 0:** $0 Drugs | ■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor.<br>■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share. |
| **Tier 1:** Generic Drugs $ | ■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.<br>■ Generic drugs generally cost less than brand-name drugs. |
| **Tier 2:** Preferred Brand Drugs $$ | ■ Preferred brand drugs are brand-name drugs that may not be available in generic form.<br>■ They are chosen for their cost-effectiveness compared to alternatives.<br>■ Your cost-share will be more than generic drugs but less than non-preferred brand drugs.<br>■ If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand tier. |
| **Tier 3:** Non-preferred Brand Drugs $$$ | ■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower. |
| **Tier 4:** Preferred Specialty Drugs $$$$ | ■ Preferred specialty drugs are specialty drugs that are used to treat chronic, complex, and/or rare health conditions.<br>■ Preferred specialty drugs may have a lower cost-share than non-preferred specialty drugs. |
| **Tier 5:** Non-Preferred Specialty Drugs $$$$ | ■ Non-preferred specialty drugs often have a specialty drug option where your cost-share will be lower. |

# CareFirst Exchange Formulary - 5-Tier eff 12/01/2019

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| **ANALGESICS** | | |
| ***COX-2 INHIBITORS*** | | |
| *celecoxib cap 50 mg* | 1 | |
| *celecoxib cap 100 mg* | 1 | |
| *celecoxib cap 200 mg* | 1 | |
| *celecoxib cap 400 mg* | 1 | |
| ***GOUT*** | | |
| *allopurinol sodium for inj 500 mg* | M | M |
| *allopurinol tab 100 mg* | 1 | |
| *allopurinol tab 300 mg* | 1 | |
| *colchicine tab 0.6 mg* | 1 | |
| *colchicine w/ probenecid tab 0.5-500 mg* | 1 | |
| *febuxostat tab 40 mg* | 1 | ST; PA** |
| *febuxostat tab 80 mg* | 1 | ST; PA** |
| *probenecid tab 500 mg* | 1 | |
| ULORIC TAB 40MG | 3 | ST; PA** |
| ULORIC TAB 80MG | 3 | ST; PA** |
| ***NON-OPIOID ANALGESICS§*** | | |
| *butalbital-acetaminophen-caffeine cap 50-300-40 mg* | 1 | QL (48 caps / 25 days) |
| *butalbital-acetaminophen-caffeine cap 50-325-40 mg* | 1 | QL (48 caps / 25 days) |
| *butalbital-acetaminophen-caffeine tab 50-325-40 mg* | 1 | QL (48 tabs / 25 days) |
| *butalbital-aspirin-caffeine cap 50-325-40 mg* | 1 | QL (48 caps / 25 days) |
| *tencon tab 50-325mg* | 1 | QL (48 tabs / 25 days) |
| ***NSAIDS, COMBINATIONS§*** | | |
| *diclofenac w/ misoprostol tab delayed release 50-0.2 mg* | 1 | |
| *diclofenac w/ misoprostol tab delayed release 75-0.2 mg* | 1 | |
| ***NSAIDS§*** | | |
| *diclofenac potassium tab 50 mg* | 1 | |
| *diclofenac sodium tab delayed release 25 mg* | 1 | |
| *diclofenac sodium tab delayed release 50 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *diclofenac sodium tab delayed release 75 mg* | 1 | |
| *diclofenac sodium tab er 24hr 100 mg* | 1 | |
| *etodolac cap 200 mg* | 1 | |
| *etodolac cap 300 mg* | 1 | |
| *etodolac tab 400 mg* | 1 | |
| *etodolac tab 500 mg* | 1 | |
| *etodolac tab er 24hr 400 mg* | 1 | |
| *etodolac tab er 24hr 500 mg* | 1 | |
| *etodolac tab er 24hr 600 mg* | 1 | |
| *fenoprofen calcium cap 400 mg* | 1 | |
| *fenoprofen calcium tab 600 mg* | 1 | |
| *flurbiprofen tab 50 mg* | 1 | |
| *flurbiprofen tab 100 mg* | 1 | |
| *ibuprofen susp 100 mg/5ml* | 1 | |
| *ibuprofen tab 400 mg* | 1 | |
| *ibuprofen tab 600 mg* | 1 | |
| *ibuprofen tab 800 mg* | 1 | |
| *indomethacin cap 25 mg* | 1 | |
| *indomethacin cap 50 mg* | 1 | |
| *ketoprofen cap er 24hr 200 mg* | 1 | |
| *ketorolac tromethamine im inj 60 mg/2ml (30 mg/ml)* | M | M |
| *ketorolac tromethamine inj 15 mg/ml* | M | M |
| *ketorolac tromethamine inj 30 mg/ml* | M | M |
| *ketorolac tromethamine tab 10 mg* | 1 | QL (20 tabs / 25 days) |
| *meclofenamate sodium cap 50 mg* | 1 | |
| *meclofenamate sodium cap 100 mg* | 1 | |
| *mefenamic acid cap 250 mg* | 1 | |
| *meloxicam tab 7.5 mg* | 1 | |
| *meloxicam tab 15 mg* | 1 | |
| *nabumetone tab 500 mg* | 1 | |
| *nabumetone tab 750 mg* | 1 | |
| *naproxen dr tab 375mg* | 1 | |
| *naproxen dr tab 500mg* | 1 | |
| *naproxen tab 250 mg* | 1 | |
| *naproxen tab 375 mg* | 1 | |
| *naproxen tab 500 mg* | 1 | |
| *oxaprozin tab 600 mg* | 1 | |
| *piroxicam cap 10 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *piroxicam cap 20 mg* | 1 | |
| *sulindac tab 150 mg* | 1 | |
| *sulindac tab 200 mg* | 1 | |
| *tolmetin sodium cap 400 mg* | 1 | |
| *tolmetin sodium tab 200 mg* | 1 | |
| *tolmetin sodium tab 600 mg* | 1 | |
| ***OPIOID AGONIST/ANTAGONIST§*** | | |
| *buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)* | 1 | QL (90 units / 25 days) |
| *buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)* | 1 | QL (90 units / 25 days) |
| *buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)* | 1 | QL (90 units / 25 days) |
| *buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)* | 1 | QL (60 units / 25 days) |
| *buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)* | 1 | QL (90 tabs / 25 days); Must obtain approval after the initial fill |
| *buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)* | 1 | QL (90 tabs / 25 days); Must obtain approval after the initial fill |
| ZUBSOLV SUB 0.7-0.18 | 2 | QL (90 units / 25 days) |
| ZUBSOLV SUB 1.4-0.36 | 2 | QL (90 units / 25 days) |
| ZUBSOLV SUB 2.9-0.71 | 2 | QL (90 units / 25 days) |
| ZUBSOLV SUB 5.7-1.4 | 2 | QL (90 units / 25 days) |
| ZUBSOLV SUB 8.6-2.1 | 2 | QL (60 units / 25 days) |
| ZUBSOLV SUB 11.4-2.9 | 2 | QL (30 units / 25 days) |
| ***OPIOID ANALGESICS§*** | | |
| *acetaminophen w/ codeine soln 120-12 mg/5ml* | 1 | QL (2700 ml / 25 days), ST; Subject to initial 7-day limit |
| *acetaminophen w/ codeine tab 300-15 mg* | 1 | QL (400 tabs / 25 days), ST; Subject to initial 7-day limit |
| *acetaminophen w/ codeine tab 300-30 mg* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *acetaminophen w/ codeine tab 300-60 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg* | 1 | QL (48 caps / 25 days) |
| *butorphanol tartrate inj 1 mg/ml* | M | M |
| *butorphanol tartrate inj 2 mg/ml* | M | M |
| *butorphanol tartrate nasal soln 10 mg/ml* | 1 | QL (2 bottles / 25 days) |
| CAPITAL/COD SUS 120-12/5 | 3 | QL (2700 ml / 25 days), ST; Subject to initial 7-day limit |
| *codeine sulf tab 15mg* | 1 | QL (42 tabs / 25 days), ST; Subject to initial 7-day limit |
| *codeine sulf tab 60mg* | 1 | QL (42 tabs / 25 days), ST; Subject to initial 7-day limit |
| *codeine sulfate tab 30 mg* | 1 | QL (42 tabs / 25 days), ST; Subject to initial 7-day limit |
| EMBEDA CAP 20-0.8MG | 2 | QL (60 caps / 25 days), ST |
| EMBEDA CAP 30-1.2MG | 2 | QL (60 caps / 25 days), ST |
| EMBEDA CAP 50-2MG | 2 | QL (30 caps / 25 days), ST |
| EMBEDA CAP 60-2.4MG | 2 | QL (30 caps / 25 days), ST |
| EMBEDA CAP 80-3.2MG | 2 | QL (30 caps / 25 days), ST |
| EMBEDA CAP 100-4MG | 2 | PA, ST; High Strength Requires PA |
| *endocet tab 2.5-325* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *endocet tab 5-325mg* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *endocet tab 7.5-325* | 1 | QL (240 tabs / 25 days), ST; Subject to initial 7-day limit |
| *endocet tab 10-325mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fentanyl citrate lozenge on a handle 200 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl citrate lozenge on a handle 400 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl citrate lozenge on a handle 600 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl citrate lozenge on a handle 800 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl citrate lozenge on a handle 1200 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl citrate lozenge on a handle 1600 mcg* | 1 | QL (120 lozenges / 25 days), PA |
| *fentanyl td patch 72hr 12 mcg/hr* | 1 | QL (10 patches / 25 days), ST |
| *fentanyl td patch 72hr 25 mcg/hr* | 1 | QL (10 patches / 25 days), ST |
| *fentanyl td patch 72hr 50 mcg/hr* | 1 | PA, ST; High Strength Requires PA |
| *fentanyl td patch 72hr 75 mcg/hr* | 1 | PA, ST; High Strength Requires PA |
| *fentanyl td patch 72hr 100 mcg/hr* | 1 | PA, ST; High Strength Requires PA |
| *hydrocodone-acetaminophen soln 7.5-325 mg/15ml* | 1 | QL (2700 ml / 25 days), ST; Subject to initial 7-day limit |
| *hydrocodone-acetaminophen tab 5-325 mg* | 1 | QL (240 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydrocodone-acetaminophen tab 7.5-325 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydrocodone-acetaminophen tab 10-325 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydrocodone-ibuprofen tab 10-200 mg* | 1 | QL (50 tabs / 25 days), ST; Subject to initial 7-day limit |
| HYDROMORPHON SUP 3MG | 3 | QL (120 suppositories / 25 days), ST; Subject to initial 7-day limit |
| *hydromorphone hcl inj 1 mg/ml* | M | M |
| *hydromorphone hcl inj 2 mg/ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydromorphone hcl inj 4 mg/ml* | M | M |
| *hydromorphone hcl liqd 1 mg/ml* | 1 | QL (600 ml / 25 days), ST; Subject to initial 7-day limit |
| *hydromorphone hcl preservative free (pf) inj 10 mg/ml* | M | M |
| *hydromorphone hcl tab 2 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydromorphone hcl tab 4 mg* | 1 | QL (150 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydromorphone hcl tab 8 mg* | 1 | QL (60 tabs / 25 days), ST; Subject to initial 7-day limit |
| *hydromorphone hcl tab er 24hr deter 8 mg* | 1 | QL (30 tabs / 25 days), ST |
| *hydromorphone hcl tab er 24hr deter 12 mg* | 1 | QL (30 tabs / 25 days), ST |
| *hydromorphone hcl tab er 24hr deter 16 mg* | 1 | QL (30 tabs / 25 days), ST |
| *hydromorphone hcl tab er 24hr deter 32 mg* | 1 | PA, ST; High Strength Requires PA |
| HYSINGLA ER TAB 20 MG | 2 | QL (30 tabs / 25 days), ST |
| HYSINGLA ER TAB 30 MG | 2 | QL (30 tabs / 25 days), ST |
| HYSINGLA ER TAB 40 MG | 2 | QL (30 tabs / 25 days), ST |
| HYSINGLA ER TAB 60 MG | 2 | QL (30 tabs / 25 days), ST |
| HYSINGLA ER TAB 80 MG | 2 | QL (30 tabs / 25 days), ST |
| HYSINGLA ER TAB 100 MG | 2 | PA, ST; High Strength Requires PA |
| HYSINGLA ER TAB 120 MG | 2 | PA, ST; High Strength Requires PA |
| *lortab tab 10-325mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *methadone con 10mg/ml* | 1 | QL (60 mL / 25 days), ST; (generic of Methadone Intensol, indicated for pain) |
| *methadone hcl conc 10 mg/ml* | 1 | QL (30 ml / 25 days); (indicated for opioid addiction) |
| *methadone hcl inj 10 mg/ml* | M | M |
| *methadone hcl soln 5 mg/5ml* | 1 | QL (450 ml / 25 days), ST |
| *methadone hcl soln 10 mg/5ml* | 1 | QL (300 mL / 25 days), ST |
| *methadone hcl tab 5 mg* | 1 | QL (90 tabs / 25 days), ST |
| *methadone hcl tab 10 mg* | 1 | QL (60 tabs / 25 days), ST |
| *methadone hcl tab for oral susp 40 mg* | 1 | QL (9 tabs / 25 days) |
| *methadose tab 40mg* | 1 | QL (9 tabs / 25 days) |
| MORPHINE SUL INJ 2MG/ML | M | M |
| MORPHINE SUL INJ 4MG/ML | M | M |
| MORPHINE SUL INJ 5MG/ML | M | M |
| MORPHINE SUL INJ 150/30ML | M | M |
| *morphine sulfate beads cap er 24hr 30 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate beads cap er 24hr 45 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate beads cap er 24hr 60 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate beads cap er 24hr 75 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate beads cap er 24hr 90 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate beads cap er 24hr 120 mg* | 1 | PA, ST; High Strength Requires PA |
| *morphine sulfate cap er 24hr 10 mg* | 1 | QL (60 caps / 25 days), ST |
| *morphine sulfate cap er 24hr 20 mg* | 1 | QL (60 caps / 25 days), ST |
| *morphine sulfate cap er 24hr 30 mg* | 1 | QL (60 caps / 25 days), ST |
| *morphine sulfate cap er 24hr 50 mg* | 1 | QL (30 caps / 25 days), ST |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *morphine sulfate cap er 24hr 60 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate cap er 24hr 80 mg* | 1 | QL (30 caps / 25 days), ST |
| *morphine sulfate cap er 24hr 100 mg* | 1 | PA, ST; High Strength Requires PA |
| *morphine sulfate inj 8 mg/ml* | M | M |
| *morphine sulfate inj 10 mg/ml* | M | M |
| *morphine sulfate inj pf 0.5 mg/ml* | M | M |
| *morphine sulfate inj pf 1 mg/ml* | M | M |
| *morphine sulfate iv soln 1 mg/ml* | M | M |
| *morphine sulfate iv soln pf 4 mg/ml* | M | M |
| *morphine sulfate iv soln pf 8 mg/ml* | M | M |
| *morphine sulfate iv soln pf 10 mg/ml* | M | M |
| *morphine sulfate iv soln pf 15 mg/ml* | M | M |
| *morphine sulfate oral soln 10 mg/5ml* | 1 | QL (900 ml / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate oral soln 20 mg/5ml* | 1 | QL (675 mL / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate oral soln 100 mg/5ml (20 mg/ml)* | 1 | QL (135 mL / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate suppos 5 mg* | 1 | QL (180 suppositories / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate suppos 10 mg* | 1 | QL (180 suppositories / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate suppos 20 mg* | 1 | QL (120 supp / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate suppos 30 mg* | 1 | QL (90 supp / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate tab 15 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *morphine sulfate tab 30 mg* | 1 | QL (90 tabs / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *morphine sulfate tab er 15 mg* | 1 | QL (90 tabs / 25 days), ST |
| *morphine sulfate tab er 30 mg* | 1 | QL (90 tabs / 25 days), ST |
| *morphine sulfate tab er 60 mg* | 1 | PA, ST; High Strength Requires PA |
| *morphine sulfate tab er 100 mg* | 1 | PA, ST; High Strength Requires PA |
| *morphine sulfate tab er 200 mg* | 1 | PA, ST; High Strength Requires PA |
| *nalbuphine hcl inj 10 mg/ml* | M | M |
| *nalbuphine hcl inj 20 mg/ml* | M | M |
| NUCYNTA ER TAB 50MG | 2 | QL (60 tabs / 25 days), ST |
| NUCYNTA ER TAB 100MG | 2 | QL (60 tabs / 25 days), ST |
| NUCYNTA ER TAB 150MG | 2 | PA, ST; High Strength Requires PA |
| NUCYNTA ER TAB 200MG | 2 | PA, ST; High Strength Requires PA |
| NUCYNTA ER TAB 250MG | 2 | PA, ST; High Strength Requires PA |
| NUCYNTA TAB 50MG | 2 | QL (120 tabs / 25 days), ST; Subject to initial 7-day limit |
| NUCYNTA TAB 75MG | 2 | QL (90 tabs / 25 days), ST; Subject to initial 7-day limit |
| NUCYNTA TAB 100MG | 2 | QL (60 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl cap 5 mg* | 1 | QL (180 caps / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl conc 100 mg/5ml (20 mg/ml)* | 1 | QL (90 mL / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl soln 5 mg/5ml* | 1 | QL (900 ml / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oxycodone hcl tab 5 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl tab 10 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl tab 15 mg* | 1 | QL (120 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl tab 20 mg* | 1 | QL (90 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl tab 30 mg* | 1 | QL (60 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone hcl tab er 12hr deter 10 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxycodone hcl tab er 12hr deter 15 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxycodone hcl tab er 12hr deter 20 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxycodone hcl tab er 12hr deter 30 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxycodone hcl tab er 12hr deter 40 mg* | 1 | PA, ST; High Strength Requires PA |
| *oxycodone hcl tab er 12hr deter 60 mg* | 1 | PA, ST; High Strength Requires PA |
| *oxycodone hcl tab er 12hr deter 80 mg* | 1 | PA, ST; High Strength Requires PA |
| *oxycodone w/ acetaminophen soln 5-325 mg/5ml* | 1 | QL (1800 ml / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone w/ acetaminophen tab 2.5-325 mg* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone w/ acetaminophen tab 5-325 mg* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone w/ acetaminophen tab 7.5-325 mg* | 1 | QL (240 tabs / 25 days), ST; Subject to initial 7-day limit |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oxycodone w/ acetaminophen tab 10-325 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone-aspirin tab 4.8355-325 mg* | 1 | QL (360 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxycodone-ibuprofen tab 5-400 mg* | 1 | QL (28 tabs / 25 days), ST; Subject to initial 7-day limit |
| OXYCONTIN TAB 10MG CR | 2 | QL (60 tabs / 25 days), ST |
| OXYCONTIN TAB 15MG CR | 2 | QL (60 tabs / 25 days), ST |
| OXYCONTIN TAB 20MG CR | 2 | QL (60 tabs / 25 days), ST |
| OXYCONTIN TAB 30MG CR | 2 | QL (60 tabs / 25 days), ST |
| OXYCONTIN TAB 40MG CR | 2 | PA, ST; High Strength Requires PA |
| OXYCONTIN TAB 60MG CR | 2 | PA, ST; High Strength Requires PA |
| OXYCONTIN TAB 80MG CR | 2 | PA, ST; High Strength Requires PA |
| *oxymorphone hcl tab 5 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxymorphone hcl tab 10 mg* | 1 | QL (90 tabs / 25 days), ST; Subject to initial 7-day limit |
| *oxymorphone hcl tab er 12hr 5 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxymorphone hcl tab er 12hr 7.5 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxymorphone hcl tab er 12hr 10 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxymorphone hcl tab er 12hr 15 mg* | 1 | QL (60 tabs / 25 days), ST |
| *oxymorphone hcl tab er 12hr 20 mg* | 1 | PA, ST; High Strength Requires PA |
| *oxymorphone hcl tab er 12hr 30 mg* | 1 | PA, ST; High Strength Requires PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oxymorphone hcl tab er 12hr 40 mg* | 1 | PA, ST; High Strength Requires PA |
| *tramadol hcl tab 50 mg* | 1 | QL (180 tabs / 25 days), ST; Subject to initial 7-day limit |
| *tramadol hcl tab er 24hr 100 mg* | 1 | QL (30 tabs / 25 days), ST |
| *tramadol hcl tab er 24hr 200 mg* | 1 | PA, ST; High Strength Requires PA |
| *tramadol hcl tab er 24hr 300 mg* | 1 | PA, ST; High Strength Requires PA |
| XARTEMIS XR TAB 7.5-325 | 3 | QL (120 tabs / 25 days) |
| *xylon tab 10-200mg* | 1 | QL (50 tabs / 25 days), ST; Subject to initial 7-day limit |
| ***OPIOID PARTIAL AGONISTS§*** | | |
| BELBUCA MIS 75MCG | 2 | QL (60 films / 25 days), ST |
| BELBUCA MIS 150MCG | 2 | QL (60 films / 25 days), ST |
| BELBUCA MIS 300MCG | 2 | QL (60 films / 25 days), ST |
| BELBUCA MIS 450MCG | 2 | QL (60 films / 25 days), ST |
| BELBUCA MIS 600MCG | 2 | PA, ST; High Strength Requires Prior Auth |
| BELBUCA MIS 750MCG | 2 | PA, ST; High Strength Requires Prior Auth |
| BELBUCA MIS 900MCG | 2 | PA, ST; High Strength Requires Prior Auth |
| *buprenorphine hcl inj 0.3 mg/ml (base equiv)* | M | M |
| *buprenorphine hcl sl tab 2 mg (base equiv)* | 1 | QL (90 tabs / 25 days); Must obtain approval after the initial fill |
| *buprenorphine hcl sl tab 8 mg (base equiv)* | 1 | QL (90 tabs / 25 days); Must obtain approval after the initial fill |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***SALICYLATES*** | | |
| *aspirin chw 81mg* | 0 | OTC, QL (100 tabs / 30 days); $0 copay for members age 50-59 or members at risk for preeclampsia, otherwise not covered |
| *aspirin low tab 81mg ec* | 0 | OTC, QL (100 tabs / 30 days); $0 copay for members age 50-59 or members at risk for preeclampsia, otherwise not covered |
| *diflunisal tab 500 mg* | 1 | |
| **ANESTHETICS** | | |
| ***LOCAL ANESTHETICS*** | | |
| LIDO/DEXTROS INJ 5-7.5% | M | M |
| *lidocaine hcl local inj 0.5%* | M | M |
| *lidocaine hcl local inj 1%* | M | M |
| *lidocaine hcl local inj 2%* | M | M |
| *lidocaine hcl local preservative free (pf) inj 0.5%* | M | M |
| *lidocaine hcl local preservative free (pf) inj 1%* | M | M |
| *lidocaine hcl local preservative free (pf) inj 1.5%* | M | M |
| *lidocaine hcl local preservative free (pf) inj 2%* | M | M |
| *lidocaine hcl local preservative free (pf) inj 4%* | M | M |
| **ANTI-INFECTIVES** | | |
| ***ANTI-BACTERIALS - MISCELLANEOUS*** | | |
| *amikacin sulfate inj 1 gm/4ml (250 mg/ml)* | M | M |
| *amikacin sulfate inj 500 mg/2ml (250 mg/ml)* | M | M |
| *chloramphenicol sodium succinate for iv inj 1 gm* | M | M |
| GENTAM/NACL INJ 0.9MG/ML | M | M |
| GENTAM/NACL INJ 1.4MG/ML | M | M |
| *gentamicin in saline inj 0.8 mg/ml* | M | M |
| *gentamicin in saline inj 1 mg/ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *gentamicin in saline inj 1.2 mg/ml* | M | M |
| *gentamicin in saline inj 1.6 mg/ml* | M | M |
| *gentamicin in saline inj 2 mg/ml* | M | M |
| *gentamicin sulfate inj 10 mg/ml* | M | M |
| *gentamicin sulfate inj 40 mg/ml* | M | M |
| MONUROL PAK GRANULES | 3 | |
| *neomycin sulfate tab 500 mg* | 1 | |
| *paromomycin sulfate cap 250 mg* | 1 | |
| *streptomycin sulfate for inj 1 gm* | M | M |
| SULFADIAZINE TAB 500MG | 3 | |
| *tinidazole tab 250 mg* | 1 | |
| *tinidazole tab 500 mg* | 1 | |
| *tobramycin nebu soln 300 mg/5ml* | 4 | QL (280 mL / 28 days), PA |
| *tobramycin sulfate for inj 1.2 gm* | M | M |
| *tobramycin sulfate inj 1.2 gm/30ml (40 mg/ml) (base equiv)* | M | M |
| *tobramycin sulfate inj 2 gm/50ml (40 mg/ml) (base equiv)* | M | M |
| *tobramycin sulfate inj 10 mg/ml (base equivalent)* | M | M |
| *tobramycin sulfate inj 80 mg/2ml (40 mg/ml) (base equiv)* | M | M |
| ***ANTI-INFECTIVES - MISCELLANEOUS*** | | |
| ALINIA SUS 100/5ML | 2 | |
| ALINIA TAB 500MG | 2 | |
| *atovaquone susp 750 mg/5ml* | 1 | |
| AZACTAM/DEX INJ 1GM | M | M |
| AZACTAM/DEX INJ 2GM | M | M |
| *aztreonam for inj 1 gm* | M | M |
| *aztreonam for inj 2 gm* | M | M |
| CAYSTON INH 75MG | 4 | QL (84 vials / 28 days), PA |
| *clindamycin hcl cap 75 mg* | 1 | |
| *clindamycin hcl cap 150 mg* | 1 | |
| *clindamycin hcl cap 300 mg* | 1 | |
| *clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)* | 1 | |
| *clindamycin phosphate inj 9 gm/60ml* | M | M |
| *clindamycin phosphate inj 300 mg/2ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *clindamycin phosphate inj 600 mg/4ml* | M | M |
| *clindamycin phosphate inj 900 mg/6ml* | M | M |
| *clindamycin phosphate iv soln 300 mg/2ml* | M | M |
| *clindamycin phosphate iv soln 900 mg/6ml* | M | M |
| *dapsone tab 25 mg* | 1 | |
| *dapsone tab 100 mg* | 1 | |
| *daptomycin for iv soln 500 mg* | M | M |
| DARAPRIM TAB 25MG | 3 | |
| *doripenem for iv infusion 250 mg* | M | M |
| *doripenem for iv infusion 500 mg* | M | M |
| EMVERM CHW 100MG | 3 | QL (12 tabs / 365 days) |
| *ertapenem sodium for inj 1 gm (base equivalent)* | M | M |
| *imipenem-cilastatin intravenous for soln 250 mg* | M | M |
| *imipenem-cilastatin intravenous for soln 500 mg* | M | M |
| INVANZ INJ 1GM | M | M |
| *ivermectin tab 3 mg* | 1 | |
| *linezolid for susp 100 mg/5ml* | 1 | |
| *linezolid in sodium chloride iv soln 600 mg/300ml-0.9%* | M | M |
| *linezolid iv soln 600 mg/300ml (2 mg/ml)* | M | M |
| *linezolid tab 600 mg* | 1 | |
| *meropenem iv for soln 1 gm* | M | M |
| *meropenem iv for soln 500 mg* | M | M |
| *methenamine hippurate tab 1 gm* | 1 | |
| *metronidazole cap 375 mg* | 1 | |
| *metronidazole in nacl 0.79% iv soln 500 mg/100ml* | M | M |
| *metronidazole tab 250 mg* | 1 | |
| *metronidazole tab 500 mg* | 1 | |
| NEBUPENT INH 300MG | 3 | |
| *nitrofurantoin macrocrystalline cap 25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *nitrofurantoin macrocrystalline cap 50 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *nitrofurantoin macrocrystalline cap 100 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *nitrofurantoin monohydrate macrocrystalline cap 100 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *nitrofurantoin susp 25 mg/5ml* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *pentamidine isethionate for soln 300 mg* | M | M |
| *polymyxin b sulfate for inj 500000 unit* | M | M |
| *praziquantel tab 600 mg* | 1 | QL (24 tabs / 365 days) |
| PRIMSOL SOL 50MG/5ML | 2 | |
| SIVEXTRO INJ 200MG | M | M |
| SIVEXTRO TAB 200MG | 3 | |
| *sulfamethoxazole-trimethoprim iv soln 400-80 mg/5ml* | M | M |
| *sulfamethoxazole-trimethoprim susp 200-40 mg/5ml* | 1 | |
| *sulfamethoxazole-trimethoprim tab 400-80 mg* | 1 | |
| *sulfamethoxazole-trimethoprim tab 800-160 mg* | 1 | |
| *trimethoprim tab 100 mg* | 1 | |
| *vancomycin hcl cap 125 mg (base equivalent)* | 1 | QL (80 caps / 10 days) |
| *vancomycin hcl cap 250 mg (base equivalent)* | 1 | QL (80 caps / 10 days) |
| *vancomycin hcl for iv soln 1 gm (base equivalent)* | 1 | |
| *vancomycin hcl for iv soln 5 gm (base equivalent)* | 1 | |
| *vancomycin hcl for iv soln 10 gm (base equivalent)* | 1 | |
| *vancomycin hcl for iv soln 500 mg (base equivalent)* | 1 | |
| *vancomycin hcl for iv soln 750 mg (base equivalent)* | 1 | |
| XIFAXAN TAB 200MG | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| XIFAXAN TAB 550MG | 2 | PA |
| ***ANTIFUNGALS*** | | |
| *amphotericin b for iv soln 50 mg* | M | M |
| BIO-STATIN CAP 500000 | 2 | |
| BIO-STATIN CAP 1000000 | 2 | |
| *bio-statin pow* | 1 | |
| CRESEMBA CAP 186 MG | 3 | |
| *fluconazole for susp 10 mg/ml* | 1 | |
| *fluconazole for susp 40 mg/ml* | 1 | |
| *fluconazole in dextrose inj 200 mg/100ml* | M | M |
| *fluconazole in dextrose inj 400 mg/200ml* | M | M |
| *fluconazole in nacl 0.9% inj 200 mg/100ml* | M | M |
| *fluconazole in nacl 0.9% inj 400 mg/200ml* | M | M |
| *fluconazole tab 50 mg* | 1 | |
| *fluconazole tab 100 mg* | 1 | |
| *fluconazole tab 150 mg* | 1 | |
| *fluconazole tab 200 mg* | 1 | |
| FLUCONAZOLE/ INJ NACL 100 | M | M |
| *griseofulvin microsize susp 125 mg/5ml* | 1 | |
| *griseofulvin microsize tab 500 mg* | 1 | |
| *griseofulvin ultramicrosize tab 125 mg* | 1 | |
| *griseofulvin ultramicrosize tab 250 mg* | 1 | |
| *itraconazole cap 100 mg* | 1 | PA |
| *itraconazole oral soln 10 mg/ml* | 1 | PA |
| NOXAFIL SUS 40MG/ML | 2 | |
| NOXAFIL TAB 100MG | 2 | |
| *nystatin tab 500000 unit* | 1 | |
| *posaconazole tab delayed release 100 mg* | 1 | |
| *terbinafine hcl tab 250 mg* | 1 | PA |
| *voriconazole for susp 40 mg/ml* | 3 | PA |
| *voriconazole tab 50 mg* | 3 | PA |
| *voriconazole tab 200 mg* | 3 | PA |
| ***ANTIMALARIALS*** | | |
| *atovaquone-proguanil hcl tab 62.5-25 mg* | 1 | |
| *atovaquone-proguanil hcl tab 250-100 mg* | 1 | |
| *chloroquine phosphate tab 250 mg* | 1 | |
| *chloroquine phosphate tab 500 mg* | 1 | |
| COARTEM TAB 20-120MG | 3 | |
| *mefloquine hcl tab 250 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *primaquine phosphate tab 26.3 mg (15 mg base)* | 1 | |
| *quinine sulfate cap 324 mg* | 1 | |
| ***ANTIRETROVIRAL AGENTS*** | | |
| *abacavir sulfate soln 20 mg/ml (base equiv)* | 1 | QL (900 mL / 30 days) |
| *abacavir sulfate tab 300 mg (base equiv)* | 1 | QL (60 tabs / 30 days) |
| APTIVUS CAP 250MG | 2 | QL (120 caps / 30 days) |
| APTIVUS SOL | 2 | QL (285 mL / 28 days) |
| *atazanavir sulfate cap 150 mg (base equiv)* | 1 | QL (30 caps / 30 days) |
| *atazanavir sulfate cap 200 mg (base equiv)* | 1 | QL (60 caps / 30 days) |
| *atazanavir sulfate cap 300 mg (base equiv)* | 1 | QL (30 caps / 30 days) |
| CRIXIVAN CAP 200MG | 2 | QL (450 caps / 30 days) |
| CRIXIVAN CAP 400MG | 2 | QL (180 caps / 30 days) |
| *didanosine delayed release capsule 200 mg* | 1 | QL (30 caps / 30 days) |
| *didanosine delayed release capsule 250 mg* | 1 | QL (30 caps / 30 days) |
| *didanosine delayed release capsule 400 mg* | 1 | QL (30 caps / 30 days) |
| EDURANT TAB 25MG | 2 | QL (60 tabs / 30 days) |
| *efavirenz cap 50 mg* | 1 | QL (90 caps / 30 days) |
| *efavirenz cap 200 mg* | 1 | QL (90 caps / 30 days) |
| *efavirenz tab 600 mg* | 1 | QL (30 tabs / 30 days) |
| EMTRIVA CAP 200MG | 2 | QL (30 caps / 30 days) |
| EMTRIVA SOL 10MG/ML | 2 | QL (680 ml / 28 days) |
| *fosamprenavir calcium tab 700 mg (base equiv)* | 1 | QL (120 tabs / 30 days) |
| FUZEON INJ 90MG | 4 | QL (60 vials / 30 days) |
| INTELENCE TAB 25MG | 2 | QL (120 tabs / 30 days) |
| INTELENCE TAB 100MG | 2 | QL (120 tabs / 30 days) |
| INTELENCE TAB 200MG | 2 | QL (60 tabs / 30 days) |
| INVIRASE CAP 200MG | 2 | QL (300 caps / 30 days) |
| INVIRASE TAB 500MG | 2 | QL (120 tabs / 30 days) |
| ISENTRESS CHW 25MG | 2 | QL (180 tabs / 30 days) |
| ISENTRESS CHW 100MG | 2 | QL (180 tabs / 30 days) |
| ISENTRESS HD TAB 600MG | 2 | QL (60 tabs / 30 days) |
| ISENTRESS POW 100MG | 2 | QL (60 packets / 30 days) |
| ISENTRESS TAB 400MG | 2 | QL (120 tabs / 30 days) |
| *lamivudine oral soln 10 mg/ml* | 1 | QL (900 ml / 30 days) |
| *lamivudine tab 150 mg* | 1 | QL (60 tabs / 30 days) |
| *lamivudine tab 300 mg* | 1 | QL (30 tabs / 30 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| LEXIVA SUS 50MG/ML | 2 | QL (1575 mL / 28 days) |
| *nevirapine susp 50 mg/5ml* | 1 | QL (1200 mL / 30 days) |
| *nevirapine tab 200 mg* | 1 | QL (60 tabs / 30 days) |
| *nevirapine tab er 24hr 100 mg* | 1 | QL (90 tabs / 30 days) |
| *nevirapine tab er 24hr 400 mg* | 1 | QL (30 tabs / 30 days) |
| NORVIR CAP 100MG | 2 | QL (360 caps / 30 days) |
| NORVIR POW 100MG | 2 | QL (360 packets / 30 days) |
| NORVIR SOL 80MG/ML | 2 | QL (480 mL / 30 days) |
| PREZISTA SUS 100MG/ML | 2 | QL (400 ml / 30 days) |
| PREZISTA TAB 75MG | 2 | QL (300 tabs / 30 days) |
| PREZISTA TAB 150MG | 2 | QL (180 tabs / 30 days) |
| PREZISTA TAB 600MG | 2 | QL (60 tabs / 30 days) |
| PREZISTA TAB 800MG | 2 | QL (30 tabs / 30 days) |
| RESCRIPTOR TAB 100 MG | 3 | QL (900 tabs / 30 days) |
| RESCRIPTOR TAB 200MG | 3 | QL (450 tabs / 30 days) |
| RETROVIR INJ 10MG/ML | M | M |
| REYATAZ POW 50MG | 2 | QL (180 packets / 30 days) |
| *ritonavir tab 100 mg* | 1 | QL (360 tabs / 30 days) |
| SELZENTRY SOL 20MG/ML | 2 | QL (1840 mL / 30 days) |
| SELZENTRY TAB 25MG | 2 | QL (240 tabs / 30 days) |
| SELZENTRY TAB 75MG | 2 | QL (60 tabs / 30 days) |
| SELZENTRY TAB 150MG | 2 | QL (60 tabs / 30 days) |
| SELZENTRY TAB 300MG | 2 | QL (120 tabs / 30 days) |
| *stavudine cap 15 mg* | 1 | QL (60 caps / 30 days) |
| *stavudine cap 20 mg* | 1 | QL (60 caps / 30 days) |
| *stavudine cap 30 mg* | 1 | QL (60 caps / 30 days) |
| *stavudine cap 40 mg* | 1 | QL (60 caps / 30 days) |
| *tenofovir disoproxil fumarate tab 300 mg* | 1 | QL (30 tabs / 30 days) |
| TIVICAY TAB 10MG | 2 | QL (60 tabs / 30 days) |
| TIVICAY TAB 25MG | 2 | QL (60 tabs / 30 days) |
| TIVICAY TAB 50MG | 2 | QL (60 tabs / 30 days) |
| TROGARZO INJ 150MG/ML | M | M |
| TYBOST TAB 150MG | 2 | QL (30 tabs / 30 days) |
| VIDEX EC CAP 125MG | 2 | QL (30 caps / 30 days) |
| VIDEX SOL 2GM | 2 | QL (1200 ml / 30 days) |
| VIDEX SOL 4GM | 2 | QL (1200 ml / 30 days) |
| VIRACEPT TAB 250MG | 2 | QL (300 tabs / 30 days) |
| VIRACEPT TAB 625MG | 2 | QL (120 tabs / 30 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| VIREAD POW 40MG/GM | 2 | QL (240 gm / 30 days) |
| VIREAD TAB 150MG | 2 | QL (30 tabs / 30 days) |
| VIREAD TAB 200MG | 2 | QL (30 tabs / 30 days) |
| VIREAD TAB 250MG | 2 | QL (30 tabs / 30 days) |
| ZERIT SOL 1MG/ML | 2 | QL (2400 ml / 30 days) |
| *zidovudine cap 100 mg* | 1 | QL (180 caps / 30 days) |
| *zidovudine syrup 10 mg/ml* | 1 | QL (1800 ml / 30 days) |
| *zidovudine tab 300 mg* | 1 | QL (60 tabs / 30 days) |
| ***ANTIRETROVIRAL COMBINATION AGENTS*** | | |
| *abacavir sulfate-lamivudine tab 600-300 mg* | 1 | QL (30 tabs / 30 days) |
| *abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg* | 1 | QL (60 tabs / 30 days) |
| BIKTARVY TAB | 2 | QL (30 tabs / 30 days) |
| CIMDUO TAB 300-300 | 2 | QL (30 tabs / 30 days) |
| COMPLERA TAB | 2 | QL (30 tabs / 30 days) |
| DESCOVY TAB 200/25 | 2 | QL (30 tabs / 30 days) |
| EVOTAZ TAB 300-150 | 2 | QL (30 tabs / 30 days) |
| GENVOYA TAB | 2 | QL (30 tabs / 30 days) |
| KALETRA TAB 100-25MG | 2 | QL (240 tabs / 30 days) |
| KALETRA TAB 200-50MG | 2 | QL (120 tabs / 30 days) |
| *lamivudine-zidovudine tab 150-300 mg* | 1 | QL (60 tabs / 30 days) |
| *lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)* | 1 | QL (390 mL / 30 days) |
| ODEFSEY TAB | 2 | QL (30 tabs / 30 days) |
| PREZCOBIX TAB 800-150 | 2 | QL (30 tabs / 30 days) |
| STRIBILD TAB | 2 | QL (30 tabs / 30 days) |
| SYMFI LO TAB | 2 | QL (30 tabs / 30 days) |
| SYMFI TAB | 2 | QL (30 tabs / 30 days) |
| TRIUMEQ TAB | 2 | QL (30 tabs / 30 days) |
| TRUVADA TAB 100-150 | 2 | QL (30 tabs / 30 days) |
| TRUVADA TAB 133-200 | 2 | QL (30 tabs / 30 days) |
| TRUVADA TAB 167-250 | 2 | QL (30 tabs / 30 days) |
| TRUVADA TAB 200-300 | 2 | QL (30 tabs / 30 days), ST; PA**; (coverage for pre and post-exposure prophylaxis only) |
| ***ANTITUBERCULAR AGENTS*** | | |
| *cycloserine cap 250 mg* | 1 | |
| *ethambutol hcl tab 100 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ethambutol hcl tab 400 mg* | 1 | |
| *isoniazid inj 100 mg/ml* | M | M |
| *isoniazid syrup 50 mg/5ml* | 1 | |
| *isoniazid tab 100 mg* | 1 | |
| *isoniazid tab 300 mg* | 1 | |
| PASER GRA 4GM | 3 | |
| PRIFTIN TAB 150MG | 2 | |
| *pyrazinamide tab 500 mg* | 1 | |
| *rifabutin cap 150 mg* | 1 | |
| RIFAMATE CAP | 2 | |
| *rifampin cap 150 mg* | 1 | |
| *rifampin cap 300 mg* | 1 | |
| *rifampin for inj 600 mg* | M | M |
| RIFATER TAB | 2 | |
| SIRTURO TAB 100MG | 3 | |
| TRECATOR TAB 250MG | 2 | |
| ***ANTIVIRALS§*** | | |
| *acyclovir cap 200 mg* | 1 | |
| *acyclovir sodium for inj 500 mg* | M | M |
| *acyclovir sodium iv soln 50 mg/ml* | M | M |
| *acyclovir susp 200 mg/5ml* | 1 | |
| *acyclovir tab 400 mg* | 1 | |
| *acyclovir tab 800 mg* | 1 | |
| *adefovir dipivoxil tab 10 mg* | 4 | |
| BARACLUDE SOL | 3 | |
| *cidofovir iv inj 75 mg/ml* | M | M |
| *entecavir tab 0.5 mg* | 4 | |
| *entecavir tab 1 mg* | 4 | |
| EPIVIR HBV SOL 5MG/ML | 2 | |
| *famciclovir tab 125 mg* | 1 | |
| *famciclovir tab 250 mg* | 1 | |
| *famciclovir tab 500 mg* | 1 | |
| *lamivudine tab 100 mg (hbv)* | 1 | |
| *oseltamivir phosphate cap 30 mg (base equiv)* | 1 | QL (40 caps / 90 days) |
| *oseltamivir phosphate cap 45 mg (base equiv)* | 1 | QL (20 caps / 90 days) |
| *oseltamivir phosphate cap 75 mg (base equiv)* | 1 | QL (20 caps / 90 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *oseltamivir phosphate for susp 6 mg/ml (base equiv)* | 1 | QL (360 mL / 90 days) |
| RELENZA MIS DISKHALE | 2 | QL (2 inhalers / 90 days) |
| *ribavirin for inhal soln 6 gm* | 1 | |
| *rimantadine hydrochloride tab 100 mg* | 1 | |
| *valacyclovir hcl tab 1 gm* | 1 | |
| *valacyclovir hcl tab 500 mg* | 1 | |
| *valganciclovir hcl for soln 50 mg/ml (base equiv)* | 1 | |
| *valganciclovir hcl tab 450 mg (base equivalent)* | 1 | |
| VEMLIDY TAB 25MG | 3 | |
| ***CEPHALOSPORINS*** | | |
| *cefaclor cap 250 mg* | 1 | |
| *cefaclor cap 500 mg* | 1 | |
| CEFACLOR ER TAB 500MG | 2 | |
| *cefaclor for susp 125 mg/5ml* | 1 | |
| *cefaclor for susp 250 mg/5ml* | 1 | |
| *cefaclor for susp 375 mg/5ml* | 1 | |
| *cefadroxil cap 500 mg* | 1 | |
| *cefadroxil for susp 250 mg/5ml* | 1 | |
| *cefadroxil for susp 500 mg/5ml* | 1 | |
| *cefadroxil tab 1 gm* | 1 | |
| *cefazolin sodium for inj 1 gm* | M | M |
| *cefazolin sodium for inj 10 gm* | M | M |
| *cefazolin sodium for inj 20 gm* | M | M |
| *cefazolin sodium for inj 500 mg* | M | M |
| *cefazolin sodium for iv soln 1 gm* | M | M |
| *cefdinir cap 300 mg* | 1 | |
| *cefdinir for susp 125 mg/5ml* | 1 | |
| *cefdinir for susp 250 mg/5ml* | 1 | |
| *cefditoren pivoxil tab 200 mg (base equivalent)* | 1 | |
| *cefditoren pivoxil tab 400 mg (base equivalent)* | 1 | |
| *cefepime hcl for inj 1 gm* | M | M |
| *cefepime hcl for inj 2 gm* | M | M |
| *cefixime cap 400 mg* | 1 | |
| *cefixime for susp 100 mg/5ml* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *cefixime for susp 200 mg/5ml* | 1 | |
| *cefotaxime sodium for inj 1 gm* | M | M |
| *cefotaxime sodium for inj 2 gm* | M | M |
| *cefotaxime sodium for inj 10 gm* | M | M |
| *cefotaxime sodium for inj 500 mg* | M | M |
| *cefotetan disodium for inj 1 gm* | M | M |
| *cefotetan disodium for inj 2 gm* | M | M |
| *cefotetan disodium for inj 10 gm* | M | M |
| *cefoxitin sodium for inj 10 gm* | M | M |
| *cefoxitin sodium for iv soln 1 gm* | M | M |
| *cefoxitin sodium for iv soln 2 gm* | M | M |
| *cefpodoxime proxetil for susp 50 mg/5ml* | 1 | |
| *cefpodoxime proxetil for susp 100 mg/5ml* | 1 | |
| *cefpodoxime proxetil tab 100 mg* | 1 | |
| *cefpodoxime proxetil tab 200 mg* | 1 | |
| *cefprozil for susp 125 mg/5ml* | 1 | |
| *cefprozil for susp 250 mg/5ml* | 1 | |
| *cefprozil tab 250 mg* | 1 | |
| *cefprozil tab 500 mg* | 1 | |
| *ceftazidime for inj 2 gm* | M | M |
| *ceftibuten cap 400 mg* | 1 | |
| *ceftibuten for susp 180 mg/5ml* | 1 | |
| CEFTIN SUS 125/5ML | 2 | |
| CEFTIN SUS 250/5ML | 2 | |
| *ceftriaxone sodium for inj 1 gm* | M | M |
| *ceftriaxone sodium for inj 2 gm* | M | M |
| *ceftriaxone sodium for inj 10 gm* | M | M |
| *ceftriaxone sodium for inj 250 mg* | M | M |
| *ceftriaxone sodium for inj 500 mg* | M | M |
| *ceftriaxone sodium for iv soln 1 gm* | M | M |
| *ceftriaxone sodium for iv soln 2 gm* | M | M |
| *cefuroxime axetil tab 250 mg* | 1 | |
| *cefuroxime axetil tab 500 mg* | 1 | |
| *cefuroxime sodium for inj 7.5 gm* | M | M |
| *cefuroxime sodium for inj 750 mg* | M | M |
| *cefuroxime sodium for iv soln 1.5 gm* | M | M |
| *cephalexin cap 250 mg* | 1 | |
| *cephalexin cap 500 mg* | 1 | |
| *cephalexin cap 750 mg* | 1 | |
| *cephalexin for susp 125 mg/5ml* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *cephalexin for susp 250 mg/5ml* | 1 | |
| *cephalexin tab 250 mg* | 1 | |
| *cephalexin tab 500 mg* | 1 | |
| SUPRAX CHW 100MG | 2 | |
| SUPRAX CHW 200MG | 2 | |
| SUPRAX SUS 500/5ML | 2 | |
| *tazicef inj 1gm* | M | M |
| *tazicef inj 2gm* | M | M |
| *tazicef inj 6gm* | M | M |
| ZINACEF INJ 750MG | M | M |
| ZINACEF/H20 INJ 1.5GM PB | M | M |
| ***ERYTHROMYCINS/MACROLIDES*** | | |
| *azithromycin for susp 100 mg/5ml* | 1 | |
| *azithromycin for susp 200 mg/5ml* | 1 | |
| *azithromycin iv for soln 500 mg* | M | M |
| *azithromycin powd pack for susp 1 gm* | 1 | |
| *azithromycin tab 250 mg* | 1 | |
| *azithromycin tab 500 mg* | 1 | |
| *azithromycin tab 600 mg* | 1 | |
| *clarithromycin for susp 125 mg/5ml* | 1 | |
| *clarithromycin for susp 250 mg/5ml* | 1 | |
| *clarithromycin tab 250 mg* | 1 | |
| *clarithromycin tab 500 mg* | 1 | |
| *clarithromycin tab er 24hr 500 mg* | 1 | |
| DIFICID TAB 200MG | 2 | PA |
| *e.e.s. 400 tab 400mg* | 1 | |
| *ery-tab tab 250mg ec* | 1 | |
| *ery-tab tab 333mg ec* | 1 | |
| *ery-tab tab 500mg ec* | 1 | |
| ERYTHROCIN INJ 500MG | M | M |
| *erythrocin tab 250mg* | 1 | |
| *erythromycin ethylsuccinate for susp 200 mg/5ml* | 1 | |
| *erythromycin ethylsuccinate for susp 400 mg/5ml* | 1 | |
| *erythromycin ethylsuccinate tab 400 mg* | 1 | |
| *erythromycin tab 250 mg* | 1 | |
| *erythromycin tab 500 mg* | 1 | |
| *erythromycin w/ delayed release particles cap 250 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PCE TAB 333MG EC | 3 | |
| PCE TAB 500MG EC | 3 | |
| ZMAX SUS 2GM | 3 | |
| ***FLUOROQUINOLONES*** | | |
| *ciprofloxacin 200 mg/100ml in d5w* | M | M |
| *ciprofloxacin 400 mg/200ml in d5w* | M | M |
| *ciprofloxacin for oral susp 250 mg/5ml (5%) (5 gm/100ml)* | 1 | |
| *ciprofloxacin for oral susp 500 mg/5ml (10%) (10 gm/100ml)* | 1 | |
| *ciprofloxacin hcl tab 100 mg (base equiv)* | 1 | |
| *ciprofloxacin hcl tab 250 mg (base equiv)* | 1 | |
| *ciprofloxacin hcl tab 500 mg (base equiv)* | 1 | |
| *ciprofloxacin hcl tab 750 mg (base equiv)* | 1 | |
| *ciprofloxacin iv soln 200 mg/20ml (1%)* | M | M |
| *ciprofloxacin iv soln 400 mg/40ml (1%)* | M | M |
| *ciprofloxacin-ciprofloxacin hcl tab er 24hr 500 mg (base eq)* | 1 | |
| *ciprofloxacin-ciprofloxacin hcl tab er 24hr 1000 mg(base eq)* | 1 | |
| FACTIVE TAB 320MG | 3 | |
| *levofloxacin in d5w iv soln 250 mg/50ml* | M | M |
| *levofloxacin in d5w iv soln 500 mg/100ml* | M | M |
| *levofloxacin in d5w iv soln 750 mg/150ml* | M | M |
| *levofloxacin iv soln 25 mg/ml* | M | M |
| *levofloxacin oral soln 25 mg/ml* | 1 | |
| *levofloxacin tab 250 mg* | 1 | |
| *levofloxacin tab 500 mg* | 1 | |
| *levofloxacin tab 750 mg* | 1 | |
| *moxifloxacin hcl 400 mg/250ml in sodium chloride 0.8% inj* | M | M |
| *moxifloxacin hcl tab 400 mg (base equiv)* | 1 | |
| *ofloxacin tab 300 mg* | 1 | |
| *ofloxacin tab 400 mg* | 1 | |
| ***HEPATITIS C*** | | |
| EPCLUSA TAB 400-100 | 4 | QL (28 tabs / 28 days), PA |
| HARVONI TAB 90-400MG | 4 | QL (28 tabs / 28 days), PA |
| PEGASYS INJ | 4 | PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PEGASYS INJ 180MCG/M | 4 | PA |
| PEGASYS INJ PROCLICK | 4 | PA |
| REBETOL SOL 40MG/ML | 4 | PA |
| *ribasphere cap 200mg* | 1 | PA |
| *ribasphere tab 200mg* | 1 | PA |
| *ribasphere tab 400mg* | 1 | PA |
| *ribasphere tab 600mg* | 1 | PA |
| *ribavirin cap 200 mg* | 1 | PA |
| *ribavirin tab 200 mg* | 1 | PA |
| SOVALDI TAB 400MG | 5 | QL (28 tabs / 28 days), PA, ST |
| TECHNIVIE TAB | 5 | QL (56 tabs / 28 days), PA, ST |
| VOSEVI TAB | 4 | QL (28 tabs / 28 days), PA |
| ZEPATIER TAB 50-100MG | 5 | QL (28 tabs / 28 days), PA, ST |
| ***PENICILLINS*** | | |
| *amoxicillin & k clavulanate chew tab 200-28.5 mg* | 1 | |
| *amoxicillin & k clavulanate chew tab 400-57 mg* | 1 | |
| *amoxicillin & k clavulanate for susp 200-28.5 mg/5ml* | 1 | |
| *amoxicillin & k clavulanate for susp 250-62.5 mg/5ml* | 1 | |
| *amoxicillin & k clavulanate for susp 400-57 mg/5ml* | 1 | |
| *amoxicillin & k clavulanate for susp 600-42.9 mg/5ml* | 1 | |
| *amoxicillin & k clavulanate tab 250-125 mg* | 1 | |
| *amoxicillin & k clavulanate tab 500-125 mg* | 1 | |
| *amoxicillin & k clavulanate tab 875-125 mg* | 1 | |
| *amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg* | 1 | |
| *amoxicillin (trihydrate) cap 250 mg* | 1 | |
| *amoxicillin (trihydrate) cap 500 mg* | 1 | |
| *amoxicillin (trihydrate) chew tab 125 mg* | 1 | |
| *amoxicillin (trihydrate) chew tab 250 mg* | 1 | |
| *amoxicillin (trihydrate) for susp 125 mg/5ml* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amoxicillin (trihydrate) for susp 200 mg/5ml* | 1 | |
| *amoxicillin (trihydrate) for susp 250 mg/5ml* | 1 | |
| *amoxicillin (trihydrate) for susp 400 mg/5ml* | 1 | |
| *amoxicillin (trihydrate) tab 500 mg* | 1 | |
| *amoxicillin (trihydrate) tab 875 mg* | 1 | |
| *ampicillin & sulbactam sodium for inj 1.5 (1-0.5) gm* | M | M |
| *ampicillin & sulbactam sodium for inj 3 (2-1) gm* | M | M |
| *ampicillin & sulbactam sodium for iv soln 15 (10-5) gm* | M | M |
| *ampicillin cap 250 mg* | 1 | |
| *ampicillin cap 500 mg* | 1 | |
| *ampicillin for susp 125 mg/5ml* | 1 | |
| *ampicillin for susp 250 mg/5ml* | 1 | |
| *ampicillin sodium for inj 1 gm* | M | M |
| *ampicillin sodium for inj 2 gm* | M | M |
| *ampicillin sodium for inj 125 mg* | M | M |
| *ampicillin sodium for inj 250 mg* | M | M |
| *ampicillin sodium for inj 500 mg* | M | M |
| *ampicillin sodium for iv soln 1 gm* | M | M |
| *ampicillin sodium for iv soln 2 gm* | M | M |
| *ampicillin sodium for iv soln 10 gm* | M | M |
| AUGMENTIN SUS 125/5ML | 2 | |
| *dicloxacillin sodium cap 250 mg* | 1 | |
| *dicloxacillin sodium cap 500 mg* | 1 | |
| *nafcillin sodium for inj 1 gm* | M | M |
| *nafcillin sodium for inj 2 gm* | M | M |
| *nafcillin sodium for iv soln 1 gm* | M | M |
| *nafcillin sodium for iv soln 2 gm* | M | M |
| *nafcillin sodium for iv soln 10 gm* | M | M |
| *oxacillin sodium for inj 1 gm (base equivalent)* | M | M |
| *oxacillin sodium for inj 2 gm (base equivalent)* | M | M |
| *oxacillin sodium for inj 10 gm (base equivalent)* | M | M |
| *penicillin g potassium for inj 5000000 unit* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *penicillin g potassium for inj 20000000 unit* | M | M |
| *penicillin g sodium for inj 5000000 unit* | M | M |
| *penicillin v potassium for soln 125 mg/5ml* | 1 | |
| *penicillin v potassium for soln 250 mg/5ml* | 1 | |
| *penicillin v potassium tab 250 mg* | 1 | |
| *penicillin v potassium tab 500 mg* | 1 | |
| *pfizerpen inj 20000000* | M | M |
| *piperacillin sod-tazobactam na for inj 3.375 gm (3-0.375 gm)* | M | M |
| *piperacillin sod-tazobactam sod for inj 2.25 gm (2-0.25 gm)* | M | M |
| *piperacillin sod-tazobactam sod for inj 4.5 gm (4-0.5 gm)* | M | M |
| *piperacillin sod-tazobactam sod for inj 40.5 gm (36-4.5 gm)* | M | M |
| ***TETRACYCLINES*** | | |
| *avidoxy tab 100mg* | 1 | |
| *demeclocycline hcl tab 150 mg* | 1 | |
| *demeclocycline hcl tab 300 mg* | 1 | |
| *doxy 100 inj 100mg* | M | M |
| *doxycycline hyclate cap 50 mg* | 1 | |
| *doxycycline hyclate cap 100 mg* | 1 | |
| *doxycycline hyclate for inj 100 mg* | M | M |
| *doxycycline hyclate tab 20 mg* | 1 | |
| *doxycycline hyclate tab 100 mg* | 1 | |
| *doxycycline hyclate tab delayed release 75 mg* | 1 | |
| *doxycycline hyclate tab delayed release 100 mg* | 1 | |
| *doxycycline hyclate tab delayed release 150 mg* | 1 | |
| *doxycycline monohydrate cap 50 mg* | 1 | |
| *doxycycline monohydrate cap 75 mg* | 1 | |
| *doxycycline monohydrate cap 100 mg* | 1 | |
| *doxycycline monohydrate cap 150 mg* | 1 | |
| *doxycycline monohydrate for susp 25 mg/5ml* | 1 | |
| *doxycycline monohydrate tab 50 mg* | 1 | |
| *doxycycline monohydrate tab 75 mg* | 1 | |
| *doxycycline monohydrate tab 150 mg* | 1 | |
| *minocycline hcl cap 50 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *minocycline hcl cap 75 mg* | 1 | |
| *minocycline hcl cap 100 mg* | 1 | |
| *minocycline hcl tab 50 mg* | 1 | |
| *minocycline hcl tab 75 mg* | 1 | |
| *minocycline hcl tab 100 mg* | 1 | |
| *morgidox cap 1x100mg* | 1 | |
| *tetracycline hcl cap 250 mg* | 1 | |
| *tetracycline hcl cap 500 mg* | 1 | |
| VIBRAMYCIN SYP 50MG/5ML | 3 | |

**ANTINEOPLASTIC AGENTS**

***ALKYLATING AGENTS***

| | | |
|---|---|---|
| *busulfan inj 6 mg/ml* | M | M |
| *carmustine for inj 100 mg* | M | M |
| *cyclophosphamide cap 25 mg* | 0 | |
| *cyclophosphamide cap 50 mg* | 0 | |
| *cyclophosphamide for inj 1 gm* | M | M |
| *cyclophosphamide for inj 2 gm* | M | M |
| *cyclophosphamide for inj 500 mg* | M | M |
| *dacarbazine for inj 100 mg* | M | M |
| *dacarbazine for inj 200 mg* | M | M |
| EMCYT CAP 140MG | 0 | |
| GLEOSTINE CAP 5MG | 0 | |
| GLEOSTINE CAP 10MG | 0 | |
| GLEOSTINE CAP 40MG | 0 | |
| GLEOSTINE CAP 100MG | 0 | |
| GLIADEL WAF 7.7MG | M | M |
| HEXALEN CAP 50MG | 0 | |
| *ifosfamide for inj 1 gm* | M | M |
| *ifosfamide iv inj 1 gm/20ml (50 mg/ml)* | M | M |
| *ifosfamide iv inj 3 gm/60ml (50 mg/ml)* | M | M |
| LEUKERAN TAB 2MG | 0 | |
| *melphalan hcl for inj 50 mg (base equiv)* | M | M |
| *melphalan tab 2 mg* | 0 | |
| TEMODAR INJ 100MG | M | M |
| *temozolomide cap 5 mg* | 0 | PA |
| *temozolomide cap 20 mg* | 0 | PA |
| *temozolomide cap 100 mg* | 0 | PA |
| *temozolomide cap 140 mg* | 0 | PA |
| *temozolomide cap 180 mg* | 0 | PA |
| *temozolomide cap 250 mg* | 0 | PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***ANTHRACYCLINES*** | | |
| *daunorubicin hcl iv soln 20 mg/4ml (base equiv)* | 1 | |
| *doxorubicin hcl for inj 10 mg* | M | M |
| *doxorubicin hcl for inj 50 mg* | M | M |
| *doxorubicin hcl inj 2 mg/ml* | M | M |
| *doxorubicin hcl liposomal inj (for iv infusion) 2 mg/ml* | M | M |
| *epirubicin hcl iv soln 50 mg/25ml (2 mg/ml)* | M | M |
| *epirubicin hcl iv soln 200 mg/100ml (2 mg/ml)* | M | M |
| *idarubicin hcl iv inj 5 mg/5ml (1 mg/ml)* | M | M |
| *idarubicin hcl iv inj 10 mg/10ml (1 mg/ml)* | M | M |
| *idarubicin hcl iv inj 20 mg/20ml (1 mg/ml)* | M | M |
| ***ANTIBIOTICS*** | | |
| *bleomycin sulfate for inj 15 unit* | M | M |
| *bleomycin sulfate for inj 30 unit* | M | M |
| *mitomycin for iv soln 5 mg* | M | M |
| *mitomycin for iv soln 20 mg* | M | M |
| *mitomycin for iv soln 40 mg* | M | M |
| ***ANTIMETABOLITES*** | | |
| *adrucil inj 500/10ml* | M | M |
| ALIMTA INJ 100MG | M | M |
| ALIMTA INJ 500MG | M | M |
| ARRANON INJ 5MG/ML | M | M |
| *azacitidine for inj 100 mg* | M | M |
| *capecitabine tab 150 mg* | 0 | QL (120 tabs / 30 days), PA |
| *capecitabine tab 500 mg* | 0 | QL (300 tabs / 30 days), PA |
| *cladribine iv soln 10 mg/10ml (1 mg/ml)* | M | M |
| *clofarabine iv soln 1 mg/ml* | M | M |
| *cytarabine inj 20 mg/ml* | M | M |
| *cytarabine inj pf 20 mg/ml* | M | M |
| *cytarabine inj pf 100 mg/ml* | M | M |
| *decitabine for inj 50 mg* | M | M |
| *floxuridine for inj 0.5 gm* | M | M |
| *fludarabine phosphate for inj 50 mg* | M | M |
| *fludarabine phosphate inj 25 mg/ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fluorouracil iv soln 1 gm/20ml (50 mg/ml)* | M | M |
| *fluorouracil iv soln 2.5 gm/50ml (50 mg/ml)* | M | M |
| *fluorouracil iv soln 5 gm/100ml (50 mg/ml)* | M | M |
| *fluorouracil iv soln 500 mg/10ml (50 mg/ml)* | M | M |
| *gemcitabine hcl for inj 1 gm* | M | M |
| *gemcitabine hcl for inj 2 gm* | M | M |
| *gemcitabine hcl for inj 200 mg* | M | M |
| *gemcitabine hcl inj 1 gm/26.3ml (38 mg/ml) (base equiv)* | M | M |
| *gemcitabine hcl inj 2 gm/52.6ml (38 mg/ml) (base equiv)* | M | M |
| *gemcitabine hcl inj 200 mg/5.26ml (38 mg/ml) (base equiv)* | M | M |
| *mercaptopurine tab 50 mg* | 0 | |
| *methotrexate sodium for inj 1 gm* | M | M |
| *methotrexate sodium inj 50 mg/2ml (25 mg/ml)* | M | M |
| *methotrexate sodium inj 250 mg/10ml (25 mg/ml)* | M | M |
| *methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)* | M | M |
| *methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)* | M | M |
| *methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)* | M | M |
| NIPENT INJ 10MG | M | M |
| TABLOID TAB 40MG | 0 | |
| ***ANTIMITOTIC, TAXOIDS*** | | |
| ABRAXANE INJ 100MG | M | M |
| DOCEFREZ INJ 20MG | M | M |
| *docetaxel for inj conc 20 mg/ml* | M | M |
| *docetaxel for inj conc 80 mg/4ml (20 mg/ml)* | M | M |
| *docetaxel for inj conc 160 mg/8ml (20 mg/ml)* | M | M |
| DOCETAXEL INJ 20/0.5ML | M | M |
| DOCETAXEL INJ 80MG/2ML | M | M |
| DOCETAXEL INJ 140/7ML | M | M |
| DOCETAXEL INJ 160/8ML | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| DOCETAXEL INJ NON-ALCO | M | M |
| *docetaxel soln for iv infusion 20 mg/2ml* | M | M |
| *docetaxel soln for iv infusion 80 mg/8ml* | M | M |
| *docetaxel soln for iv infusion 160 mg/16ml* | M | M |
| *paclitaxel iv conc 30 mg/5ml (6 mg/ml)* | M | M |
| *paclitaxel iv conc 100 mg/16.7ml (6 mg/ml)* | M | M |
| *paclitaxel iv conc 150 mg/25ml (6 mg/ml)* | M | M |
| *paclitaxel iv conc 300 mg/50ml (6 mg/ml)* | M | M |
| ***ANTIMITOTIC, VINCA ALKALOIDS*** | | |
| *vinblastine sulfate inj 1 mg/ml* | M | M |
| *vincasar pfs inj 1mg/ml* | M | M |
| *vincristine sulfate iv soln 1 mg/ml* | M | M |
| *vinorelbine tartrate inj 10 mg/ml (base equiv)* | M | M |
| *vinorelbine tartrate inj 50 mg/5ml (10 mg/ml) (base equiv)* | M | M |
| ***BIOLOGIC RESPONSE MODIFIERS*** | | |
| ERBITUX INJ 100MG | M | M |
| ERBITUX INJ 200MG | M | M |
| ERIVEDGE CAP 150MG | 0 | QL (30 caps / 30 days), PA |
| FARYDAK CAP 10MG | 0 | PA |
| FARYDAK CAP 15MG | 0 | PA |
| FARYDAK CAP 20MG | 0 | PA |
| GAZYVA INJ 25MG/ML | M | M |
| IBRANCE CAP 75MG | 0 | QL (21 caps / 28 days), PA |
| IBRANCE CAP 100MG | 0 | QL (21 caps / 28 days), PA |
| IBRANCE CAP 125MG | 0 | QL (21 caps / 28 days), PA |
| KADCYLA INJ 100MG | M | M |
| KADCYLA INJ 160MG | M | M |
| KEYTRUDA INJ 100MG/4M | M | M |
| KISQALI TAB 200DOSE | 4 | QL (63 tabs / 28 days), PA |
| KISQALI TAB 400DOSE | 4 | QL (63 tabs / 28 days), PA |
| KISQALI TAB 600DOSE | 4 | QL (63 tabs / 28 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| LYNPARZA CAP 50MG | 0 | QL (480 caps / 30 days), PA |
| LYNPARZA TAB 100MG | 0 | QL (180 tabs / 30 days), PA |
| LYNPARZA TAB 150MG | 0 | QL (120 tabs / 30 days), PA |
| RYDAPT CAP 25MG | 0 | QL (224 caps / 28 days), PA |
| ZEJULA CAP 100MG | 0 | QL (90 caps / 30 days), PA |
| ZOLINZA CAP 100MG | 0 | QL (120 caps / 30 days), PA |
| ***HORMONAL ANTINEOPLASTIC AGENTS*** | | |
| *abiraterone acetate tab 250 mg* | 0 | QL (120 tabs / 30 days), PA |
| *anastrozole tab 1 mg* | 0 | |
| *bicalutamide tab 50 mg* | 0 | |
| DEPO-PROVERA INJ 400/ML | M | M |
| ELIGARD INJ 7.5MG | M | M |
| ELIGARD INJ 22.5MG | M | M |
| ELIGARD INJ 30MG | M | M |
| ELIGARD INJ 45MG | M | M |
| *exemestane tab 25 mg* | 0 | |
| *flutamide cap 125 mg* | 0 | |
| *fulvestrant inj 250 mg/5ml* | M | M |
| *letrozole tab 2.5 mg* | 0 | |
| *leuprolide acetate inj kit 5 mg/ml* | 4 | PA |
| LUPR DEP-PED INJ 3M 30MG | M | M |
| LUPR DEP-PED INJ 7.5MG | M | M |
| LUPR DEP-PED INJ 11.25MG | M | M |
| LUPR DEP-PED INJ 15MG | M | M |
| LYSODREN TAB 500MG | 0 | |
| *megestrol acetate susp 40 mg/ml* | 0 | |
| *megestrol acetate susp 625 mg/5ml* | 0 | |
| *megestrol acetate tab 20 mg* | 0 | |
| *megestrol acetate tab 40 mg* | 0 | |
| *nilutamide tab 150 mg* | 0 | |
| *tamoxifen citrate tab 10 mg (base equivalent)* | 0 | $0 copay for women ages 35 and older for the primary prevention of breast cancer |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tamoxifen citrate tab 20 mg (base equivalent)* | 0 | $0 copay for women ages 35 and older for the primary prevention of breast cancer |
| *toremifene citrate tab 60 mg (base equivalent)* | 0 | |
| XTANDI CAP 40MG | 0 | QL (120 caps / 30 days), PA |
| ZYTIGA TAB 500MG | 0 | QL (60 tabs / 30 days), PA |
| ***KINASE INHIBITORS*** | | |
| AFINITOR DIS TAB 2MG | 0 | QL (60 tabs / 30 days), PA |
| AFINITOR DIS TAB 3MG | 0 | QL (90 tabs / 30 days), PA |
| AFINITOR DIS TAB 5MG | 0 | QL (60 tabs / 30 days), PA |
| AFINITOR TAB 2.5MG | 0 | QL (30 tabs / 30 days), PA |
| AFINITOR TAB 5MG | 0 | QL (30 tabs / 30 days), PA |
| AFINITOR TAB 7.5MG | 0 | QL (30 tabs / 30 days), PA |
| AFINITOR TAB 10MG | 0 | QL (30 tabs / 30 days), PA |
| ALECENSA CAP 150MG | 0 | QL (240 caps / 30 days), PA |
| BOSULIF TAB 100MG | 0 | QL (90 tabs / 30 days), PA |
| BOSULIF TAB 400MG | 0 | QL (30 tabs / 30 days), PA |
| BOSULIF TAB 500MG | 0 | QL (30 tabs / 30 days), PA |
| CALQUENCE CAP 100MG | 0 | QL (60 caps / 30 days), PA |
| CAPRELSA TAB 100MG | 0 | QL (60 tabs / 30 days), PA |
| CAPRELSA TAB 300MG | 0 | QL (30 tabs / 30 days), PA |
| COMETRIQ KIT 60MG | 0 | QL (1 kit / 28 days), PA |
| COMETRIQ KIT 100MG | 0 | QL (1 kit / 28 days), PA |
| COMETRIQ KIT 140MG | 0 | QL (1 kit / 28 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *erlotinib hcl tab 25 mg (base equivalent)* | 0 | QL (60 tabs / 30 days), PA |
| *erlotinib hcl tab 100 mg (base equivalent)* | 0 | QL (30 tabs / 30 days), PA |
| *erlotinib hcl tab 150 mg (base equivalent)* | 0 | QL (30 tabs / 30 days), PA |
| ICLUSIG TAB 15MG | 0 | QL (60 tabs / 30 days), PA |
| ICLUSIG TAB 45MG | 0 | QL (30 tabs / 30 days), PA |
| IDHIFA TAB 50MG | 0 | QL (30 tabs / 30 days), PA |
| IDHIFA TAB 100MG | 0 | QL (30 tabs / 30 days), PA |
| *imatinib mesylate tab 100 mg (base equivalent)* | 0 | QL (90 tabs / 30 days), PA |
| *imatinib mesylate tab 400 mg (base equivalent)* | 0 | QL (60 tabs / 30 days), PA |
| IMBRUVICA CAP 70MG | 0 | QL (30 caps / 30 days), PA |
| IMBRUVICA CAP 140MG | 0 | QL (90 caps / 30 days), PA |
| IMBRUVICA TAB 140MG | 0 | QL (30 tabs / 30 days), PA |
| IMBRUVICA TAB 280MG | 0 | QL (30 tabs / 30 days), PA |
| IMBRUVICA TAB 420MG | 0 | QL (30 tabs / 30 days), PA |
| IMBRUVICA TAB 560MG | 0 | QL (30 tabs / 30 days), PA |
| INLYTA TAB 1MG | 0 | QL (180 tabs / 30 days), PA |
| INLYTA TAB 5MG | 0 | QL (120 tabs / 30 days), PA |
| JAKAFI TAB 5MG | 0 | QL (60 tabs / 30 days), PA |
| JAKAFI TAB 10MG | 0 | QL (60 tabs / 30 days), PA |
| JAKAFI TAB 15MG | 0 | QL (60 tabs / 30 days), PA |
| JAKAFI TAB 20MG | 0 | QL (60 tabs / 30 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| JAKAFI TAB 25MG | 0 | QL (60 tabs / 30 days), PA |
| LENVIMA CAP 4MG | 0 | QL (30 caps / 30 days), PA |
| LENVIMA CAP 8 MG | 0 | QL (60 caps / 30 days), PA |
| LENVIMA CAP 10 MG | 0 | QL (30 caps / 30 days), PA |
| LENVIMA CAP 12MG | 0 | QL (90 caps / 30 days), PA |
| LENVIMA CAP 14 MG | 0 | QL (60 caps / 30 days), PA |
| LENVIMA CAP 18 MG | 0 | QL (90 caps / 30 days), PA |
| LENVIMA CAP 20 MG | 0 | QL (60 caps / 30 days), PA |
| LENVIMA CAP 24 MG | 0 | QL (90 caps / 30 days), PA |
| LORBRENA TAB 25MG | 0 | QL (90 tabs / 30 days), PA |
| LORBRENA TAB 100MG | 0 | QL (30 tabs / 30 days), PA |
| MEKINIST TAB 0.5MG | 0 | QL (90 tabs / 30 days), PA |
| MEKINIST TAB 2MG | 0 | QL (30 tabs / 30 days), PA |
| NEXAVAR TAB 200MG | 0 | QL (120 tabs / 30 days), PA |
| SPRYCEL TAB 20MG | 0 | QL (90 tabs / 30 days), PA |
| SPRYCEL TAB 50MG | 0 | QL (30 tabs / 30 days), PA |
| SPRYCEL TAB 70MG | 0 | QL (30 tabs / 30 days), PA |
| SPRYCEL TAB 80MG | 0 | QL (30 tabs / 30 days), PA |
| SPRYCEL TAB 100MG | 0 | QL (30 tabs / 30 days), PA |
| SPRYCEL TAB 140MG | 0 | QL (30 tabs / 30 days), PA |
| STIVARGA TAB 40MG | 0 | QL (84 tabs / 28 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SUTENT CAP 12.5MG | 0 | QL (30 caps / 30 days), PA |
| SUTENT CAP 25MG | 0 | QL (30 caps / 30 days), PA |
| SUTENT CAP 37.5MG | 0 | QL (30 caps / 30 days), PA |
| SUTENT CAP 50MG | 0 | QL (30 caps / 30 days), PA |
| TAFINLAR CAP 50MG | 0 | QL (120 caps / 30 days), PA |
| TAFINLAR CAP 75MG | 0 | QL (120 caps / 30 days), PA |
| TYKERB TAB 250MG | 0 | QL (180 tabs / 30 days), PA |
| VITRAKVI CAP 25MG | 0 | QL (180 caps / 30 days), PA |
| VITRAKVI CAP 100MG | 0 | QL (60 caps / 30 days), PA |
| VITRAKVI SOL 20MG/ML | 0 | QL (300 mL / 30 days), PA |
| VOTRIENT TAB 200MG | 0 | QL (120 tabs / 30 days), PA |
| XALKORI CAP 200MG | 0 | QL (60 caps / 30 days), PA |
| XALKORI CAP 250MG | 0 | QL (60 caps / 30 days), PA |
| ZELBORAF TAB 240MG | 0 | QL (240 tabs / 30 days), PA |
| ZYDELIG TAB 100MG | 0 | QL (60 tabs / 30 days), PA |
| ZYDELIG TAB 150MG | 0 | QL (60 tabs / 30 days), PA |
| ZYKADIA CAP 150MG | 0 | QL (90 caps / 30 days), PA |
| ZYKADIA TAB 150MG | 0 | QL (90 tabs / 30 days), PA |
| ***MISCELLANEOUS*** | | |
| ARSENIC TRIOXIDE IV SOLN 10 MG/10ML (1 MG/ML) | M | M |
| *bexarotene cap 75 mg* | 0 | PA |
| DROXIA CAP 200MG | 0 | |
| DROXIA CAP 300MG | 0 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| DROXIA CAP 400MG | 0 | |
| *hydroxyurea cap 500 mg* | 0 | |
| MATULANE CAP 50MG | 0 | |
| *mitoxantrone hcl inj conc 20 mg/10ml (2 mg/ml)* | M | M |
| *mitoxantrone hcl inj conc 25 mg/12.5ml (2 mg/ml)* | M | M |
| *mitoxantrone hcl inj conc 30 mg/15ml (2 mg/ml)* | M | M |
| ODOMZO CAP 200MG | 0 | QL (30 caps / 30 days), PA |
| ONCASPAR INJ 750/ML | M | M |
| PHOTOFRIN INJ 75MG | M | M |
| QUADRAMET INJ | M | M |
| THERACYS INJ | M | M |
| TICE BCG INJ | M | M |
| *tretinoin cap 10 mg* | 0 | |
| TRISENOX INJ 12MG/6ML | M | M |
| UVADEX INJ 20MCG/ML | M | M |
| VISTOGARD PAK 10GM | 2 | |
| ***PLATINUM-BASED AGENTS*** | | |
| *carboplatin iv soln 50 mg/5ml* | M | M |
| *carboplatin iv soln 150 mg/15ml* | M | M |
| *carboplatin iv soln 450 mg/45ml* | M | M |
| *carboplatin iv soln 600 mg/60ml* | M | M |
| *cisplatin inj 50 mg/50ml (1 mg/ml)* | M | M |
| *cisplatin inj 100 mg/100ml (1 mg/ml)* | M | M |
| *cisplatin inj 200 mg/200ml (1 mg/ml)* | M | M |
| *oxaliplatin for iv inj 50 mg* | M | M |
| *oxaliplatin for iv inj 100 mg* | M | M |
| *oxaliplatin iv soln 50 mg/10ml* | M | M |
| *oxaliplatin iv soln 100 mg/20ml* | M | M |
| ***PROTECTIVE AGENTS*** | | |
| *amifostine for inj 500 mg* | M | M |
| *dexrazoxane hcl for inj 250 mg (base equivalent)* | 1 | |
| *dexrazoxane hcl for inj 500 mg (base equivalent)* | 1 | |
| *leucovorin calcium for inj 50 mg* | M | M |
| *leucovorin calcium for inj 100 mg* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *leucovorin calcium for inj 200 mg* | M | M |
| *leucovorin calcium for inj 350 mg* | M | M |
| *leucovorin calcium for inj 500 mg* | M | M |
| *leucovorin calcium tab 5 mg* | 0 | |
| *leucovorin calcium tab 10 mg* | 0 | |
| *leucovorin calcium tab 15 mg* | 0 | |
| *leucovorin calcium tab 25 mg* | 0 | |
| *mesna inj 100 mg/ml* | M | M |
| MESNEX TAB 400MG | 0 | |
| ***TOPOISOMERASE INHIBITORS*** | | |
| CAMPTOSAR INJ 300/15ML | M | M |
| *etoposide cap 50 mg* | 0 | |
| *etoposide inj 100 mg/5ml (20 mg/ml)* | M | M |
| *irinotecan hcl inj 40 mg/2ml (20 mg/ml)* | M | M |
| *irinotecan hcl inj 100 mg/5ml (20 mg/ml)* | M | M |
| *irinotecan hcl inj 500 mg/25ml (20 mg/ml)* | M | M |
| TENIPOSIDE INJ 50MG/5ML | M | M |
| *toposar inj 20mg/ml* | M | M |
| *toposar inj 100/5ml* | M | M |
| *topotecan hcl for inj 4 mg (base equiv)* | M | M |
| **ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES** | | |
| ***ANTINEOPLASTIC, BCL-2 INHIBITORS*** | | |
| VENCLEXTA TAB 10MG | 0 | PA |
| VENCLEXTA TAB 50MG | 0 | PA |
| VENCLEXTA TAB 100MG | 0 | PA |
| VENCLEXTA TAB START PK | 0 | PA |
| **CARDIOVASCULAR** | | |
| ***ACE INHIBITOR COMBINATIONS*** | | |
| *amlodipine besylate-benazepril hcl cap 2.5-10 mg* | 1 | |
| *amlodipine besylate-benazepril hcl cap 5-10 mg* | 1 | |
| *amlodipine besylate-benazepril hcl cap 5-20 mg* | 1 | |
| *amlodipine besylate-benazepril hcl cap 5-40 mg* | 1 | |
| *amlodipine besylate-benazepril hcl cap 10-20 mg* | 1 | |
| *amlodipine besylate-benazepril hcl cap 10-40 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *benazepril & hydrochlorothiazide tab 5-6.25 mg* | 1 | |
| *benazepril & hydrochlorothiazide tab 10-12.5 mg* | 1 | |
| *benazepril & hydrochlorothiazide tab 20-12.5 mg* | 1 | |
| *benazepril & hydrochlorothiazide tab 20-25 mg* | 1 | |
| *captopril & hydrochlorothiazide tab 25-15 mg* | 1 | |
| *captopril & hydrochlorothiazide tab 25-25 mg* | 1 | |
| *captopril & hydrochlorothiazide tab 50-15 mg* | 1 | |
| *captopril & hydrochlorothiazide tab 50-25 mg* | 1 | |
| *enalapril maleate & hydrochlorothiazide tab 5-12.5 mg* | 1 | |
| *enalapril maleate & hydrochlorothiazide tab 10-25 mg* | 1 | |
| *fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg* | 1 | |
| *fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg* | 1 | |
| *lisinopril & hydrochlorothiazide tab 10-12.5 mg* | 1 | |
| *lisinopril & hydrochlorothiazide tab 20-12.5 mg* | 1 | |
| *lisinopril & hydrochlorothiazide tab 20-25 mg* | 1 | |
| *moexipril-hydrochlorothiazide tab 7.5-12.5 mg* | 1 | |
| *moexipril-hydrochlorothiazide tab 15-12.5 mg* | 1 | |
| *moexipril-hydrochlorothiazide tab 15-25 mg* | 1 | |
| *quinapril-hydrochlorothiazide tab 10-12.5 mg* | 1 | |
| *quinapril-hydrochlorothiazide tab 20-12.5 mg* | 1 | |
| *quinapril-hydrochlorothiazide tab 20-25 mg* | 1 | |
| *trandolapril-verapamil hcl tab er 1-240 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *trandolapril-verapamil hcl tab er 2-180 mg* | 1 | |
| *trandolapril-verapamil hcl tab er 2-240 mg* | 1 | |
| *trandolapril-verapamil hcl tab er 4-240 mg* | 1 | |
| ***ACE INHIBITORS*** | | |
| *benazepril hcl tab 5 mg* | 1 | |
| *benazepril hcl tab 10 mg* | 1 | |
| *benazepril hcl tab 20 mg* | 1 | |
| *benazepril hcl tab 40 mg* | 1 | |
| *captopril tab 12.5 mg* | 1 | |
| *captopril tab 25 mg* | 1 | |
| *captopril tab 50 mg* | 1 | |
| *captopril tab 100 mg* | 1 | |
| *enalapril maleate tab 2.5 mg* | 1 | |
| *enalapril maleate tab 5 mg* | 1 | |
| *enalapril maleate tab 10 mg* | 1 | |
| *enalapril maleate tab 20 mg* | 1 | |
| *fosinopril sodium tab 10 mg* | 1 | |
| *fosinopril sodium tab 20 mg* | 1 | |
| *fosinopril sodium tab 40 mg* | 1 | |
| *lisinopril tab 2.5 mg* | 1 | |
| *lisinopril tab 5 mg* | 1 | |
| *lisinopril tab 10 mg* | 1 | |
| *lisinopril tab 20 mg* | 1 | |
| *lisinopril tab 30 mg* | 1 | |
| *lisinopril tab 40 mg* | 1 | |
| *moexipril hcl tab 7.5 mg* | 1 | |
| *moexipril hcl tab 15 mg* | 1 | |
| *perindopril erbumine tab 2 mg* | 1 | |
| *perindopril erbumine tab 4 mg* | 1 | |
| *perindopril erbumine tab 8 mg* | 1 | |
| *quinapril hcl tab 5 mg* | 1 | |
| *quinapril hcl tab 10 mg* | 1 | |
| *quinapril hcl tab 20 mg* | 1 | |
| *quinapril hcl tab 40 mg* | 1 | |
| *ramipril cap 1.25 mg* | 1 | |
| *ramipril cap 2.5 mg* | 1 | |
| *ramipril cap 5 mg* | 1 | |
| *ramipril cap 10 mg* | 1 | |
| *trandolapril tab 1 mg* | 1 | |
| *trandolapril tab 2 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *trandolapril tab 4 mg* | 1 | |
| ***ALDOSTERONE RECEPTOR ANTAGONISTS*** | | |
| *eplerenone tab 25 mg* | 1 | |
| *eplerenone tab 50 mg* | 1 | |
| ***ALPHA BLOCKERS*** | | |
| *doxazosin mesylate tab 1 mg* | 1 | |
| *doxazosin mesylate tab 2 mg* | 1 | |
| *doxazosin mesylate tab 4 mg* | 1 | |
| *doxazosin mesylate tab 8 mg* | 1 | |
| *prazosin hcl cap 1 mg* | 1 | |
| *prazosin hcl cap 2 mg* | 1 | |
| *prazosin hcl cap 5 mg* | 1 | |
| *terazosin hcl cap 1 mg (base equivalent)* | 1 | |
| *terazosin hcl cap 2 mg (base equivalent)* | 1 | |
| *terazosin hcl cap 5 mg (base equivalent)* | 1 | |
| *terazosin hcl cap 10 mg (base equivalent)* | 1 | |
| ***ANGIOTENSIN II RECEPTOR ANTAGONIST COMBINATIONS*** | | |
| *amlodipine besylate-olmesartan medoxomil tab 5-20 mg* | 1 | |
| *amlodipine besylate-olmesartan medoxomil tab 5-40 mg* | 1 | |
| *amlodipine besylate-olmesartan medoxomil tab 10-20 mg* | 1 | |
| *amlodipine besylate-olmesartan medoxomil tab 10-40 mg* | 1 | |
| *amlodipine besylate-valsartan tab 5-160 mg* | 1 | |
| *amlodipine besylate-valsartan tab 5-320 mg* | 1 | |
| *amlodipine besylate-valsartan tab 10-160 mg* | 1 | |
| *amlodipine besylate-valsartan tab 10-320 mg* | 1 | |
| *amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg* | 1 | |
| *amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg* | 1 | |
| *amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg* | 1 | |
| *amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg* | 1 | |
| BYVALSON TAB 5-80MG | 3 | |
| *candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg* | 1 | |
| *candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg* | 1 | |
| *candesartan cilexetil-hydrochlorothiazide tab 32-25 mg* | 1 | |
| *irbesartan-hydrochlorothiazide tab 150-12.5 mg* | 1 | |
| *irbesartan-hydrochlorothiazide tab 300-12.5 mg* | 1 | |
| *losartan potassium & hydrochlorothiazide tab 50-12.5 mg* | 1 | |
| *losartan potassium & hydrochlorothiazide tab 100-12.5 mg* | 1 | |
| *losartan potassium & hydrochlorothiazide tab 100-25 mg* | 1 | |
| *olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg* | 1 | |
| *olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg* | 1 | |
| *olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg* | 1 | |
| *olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg* | 1 | |
| *olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg* | 1 | |
| *olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg* | 1 | |
| *olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg* | 1 | |
| *olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg* | 1 | |
| *telmisartan-amlodipine tab 40-5 mg* | 1 | |
| *telmisartan-amlodipine tab 40-10 mg* | 1 | |
| *telmisartan-amlodipine tab 80-5 mg* | 1 | |
| *telmisartan-amlodipine tab 80-10 mg* | 1 | |
| *telmisartan-hydrochlorothiazide tab 40-12.5 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *telmisartan-hydrochlorothiazide tab 80-12.5 mg* | 1 | |
| *telmisartan-hydrochlorothiazide tab 80-25 mg* | 1 | |
| *valsartan-hydrochlorothiazide tab 80-12.5 mg* | 1 | |
| *valsartan-hydrochlorothiazide tab 160-12.5 mg* | 1 | |
| *valsartan-hydrochlorothiazide tab 160-25 mg* | 1 | |
| *valsartan-hydrochlorothiazide tab 320-12.5 mg* | 1 | |
| *valsartan-hydrochlorothiazide tab 320-25 mg* | 1 | |
| ***ANGIOTENSIN II RECEPTOR ANTAGONISTS*** | | |
| *candesartan cilexetil tab 4 mg* | 1 | |
| *candesartan cilexetil tab 8 mg* | 1 | |
| *candesartan cilexetil tab 16 mg* | 1 | |
| *candesartan cilexetil tab 32 mg* | 1 | |
| EDARBI TAB 40MG | 3 | ST; PA** |
| EDARBI TAB 80MG | 3 | ST; PA** |
| *eprosartan mesylate tab 600 mg* | 1 | |
| *irbesartan tab 75 mg* | 1 | |
| *irbesartan tab 150 mg* | 1 | |
| *irbesartan tab 300 mg* | 1 | |
| *losartan potassium tab 25 mg* | 1 | |
| *losartan potassium tab 50 mg* | 1 | |
| *losartan potassium tab 100 mg* | 1 | |
| *olmesartan medoxomil tab 5 mg* | 1 | |
| *olmesartan medoxomil tab 20 mg* | 1 | |
| *olmesartan medoxomil tab 40 mg* | 1 | |
| *telmisartan tab 20 mg* | 1 | |
| *telmisartan tab 40 mg* | 1 | |
| *telmisartan tab 80 mg* | 1 | |
| *valsartan tab 40 mg* | 1 | |
| *valsartan tab 80 mg* | 1 | |
| *valsartan tab 160 mg* | 1 | |
| *valsartan tab 320 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***ANTIARRHYTHMICS*** | | |
| *amiodarone hcl inj 150 mg/3ml (50 mg/ml)* | M | M |
| *amiodarone hcl inj 450 mg/9ml (50 mg/ml)* | M | M |
| *amiodarone hcl inj 900 mg/18ml (50 mg/ml)* | M | M |
| *amiodarone hcl tab 200 mg* | 1 | |
| *amiodarone hcl tab 400 mg* | 1 | |
| *disopyramide phosphate cap 100 mg* | 1 | |
| *disopyramide phosphate cap 150 mg* | 1 | |
| *dofetilide cap 125 mcg (0.125 mg)* | 1 | PA |
| *dofetilide cap 250 mcg (0.25 mg)* | 1 | PA |
| *dofetilide cap 500 mcg (0.5 mg)* | 1 | PA |
| *flecainide acetate tab 50 mg* | 1 | |
| *flecainide acetate tab 100 mg* | 1 | |
| *flecainide acetate tab 150 mg* | 1 | |
| *lidocaine hcl (cardiac) iv pf soln pref syr 50 mg/5ml(1%)* | 1 | |
| *lidocaine hcl (cardiac) iv soln pref syr 50 mg/5ml (1%)* | M | M |
| *lidocaine hcl (cardiac) iv soln pref syr 100 mg/5ml (2%)* | M | M |
| *lidocaine hcl(cardiac) iv pf soln pref syr 100 mg/5ml (2%)* | M | M |
| *lidocaine inj 20mg/ml* | 1 | |
| *lidocaine iv infusion in d5w inj 4 mg/ml* | M | M |
| *lidocaine iv infusion in d5w inj 8 mg/ml* | M | M |
| *mexiletine hcl cap 150 mg* | 1 | |
| *mexiletine hcl cap 200 mg* | 1 | |
| *mexiletine hcl cap 250 mg* | 1 | |
| MULTAQ TAB 400MG | 3 | PA |
| NEXTERONE INJ | M | M |
| NORPACE CAP 100MG CR | 2 | |
| NORPACE CAP 150MG CR | 2 | |
| *pacerone tab 100mg* | 1 | |
| *pacerone tab 200mg* | 1 | |
| *procainamide hcl inj 100 mg/ml* | M | M |
| *propafenone hcl cap er 12hr 225 mg* | 1 | |
| *propafenone hcl cap er 12hr 325 mg* | 1 | |
| *propafenone hcl cap er 12hr 425 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *propafenone hcl tab 150 mg* | 1 | |
| *propafenone hcl tab 225 mg* | 1 | |
| *propafenone hcl tab 300 mg* | 1 | |
| *quinidine sulfate tab 200 mg* | 1 | |
| *quinidine sulfate tab 300 mg* | 1 | |
| *sorine tab 80mg* | 1 | |
| *sorine tab 120mg* | 1 | |
| *sorine tab 160mg* | 1 | |
| *sorine tab 240mg* | 1 | |
| *sotalol hcl (afib/afl) tab 80 mg* | 1 | |
| *sotalol hcl (afib/afl) tab 120 mg* | 1 | |
| *sotalol hcl (afib/afl) tab 160 mg* | 1 | |
| SOTALOL HCL INJ 150/10ML | M | M |
| *sotalol hcl tab 80 mg* | 1 | |
| *sotalol hcl tab 120 mg* | 1 | |
| *sotalol hcl tab 160 mg* | 1 | |
| *sotalol hcl tab 240 mg* | 1 | |
| ***ANTILIPEMICS, BILE ACID RESINS*** | | |
| *cholestyramine light powder 4 gm/dose* | 1 | |
| *cholestyramine light powder packets 4 gm* | 1 | |
| *cholestyramine powder 4 gm/dose* | 1 | |
| *cholestyramine powder packets 4 gm* | 1 | |
| *colesevelam hcl packet for susp 3.75 gm* | 1 | |
| *colesevelam hcl tab 625 mg* | 1 | |
| *colestipol hcl granule packets 5 gm* | 1 | |
| *colestipol hcl granules 5 gm* | 1 | |
| *colestipol hcl tab 1 gm* | 1 | |
| *prevalite pow 4gm* | 1 | |
| ***ANTILIPEMICS, CHOLESTEROL ABSORPTION INHIBITOR*** | | |
| *ezetimibe tab 10 mg* | 1 | |
| ***ANTILIPEMICS, FIBRATES*** | | |
| *choline fenofibrate cap dr 45 mg (fenofibric acid equiv)* | 1 | |
| *choline fenofibrate cap dr 135 mg (fenofibric acid equiv)* | 1 | |
| *fenofibrate cap 50 mg* | 1 | |
| *fenofibrate cap 150 mg* | 1 | |
| *fenofibrate micronized cap 43 mg* | 1 | |
| *fenofibrate micronized cap 67 mg* | 1 | |
| *fenofibrate micronized cap 130 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fenofibrate micronized cap 134 mg* | 1 | |
| *fenofibrate micronized cap 200 mg* | 1 | |
| *fenofibrate tab 48 mg* | 1 | |
| *fenofibrate tab 54 mg* | 1 | |
| *fenofibrate tab 145 mg* | 1 | |
| *fenofibrate tab 160 mg* | 1 | |
| *fenofibric acid tab 35 mg* | 1 | |
| FENOFIBRIC TAB 105MG | 1 | |
| *gemfibrozil tab 600 mg* | 1 | |
| ***ANTILIPEMICS, HMG-COA REDUCTASE INHIBITORS/COMBINATIONS*** | | |
| *ezetimibe-simvastatin tab 10-10 mg* | 1 | |
| *ezetimibe-simvastatin tab 10-20 mg* | 1 | |
| *ezetimibe-simvastatin tab 10-40 mg* | 1 | |
| *ezetimibe-simvastatin tab 10-80 mg* | 1 | |
| ***ANTILIPEMICS, HMG-CoA REDUCTASE INHIBITORS*** | | |
| *atorvastatin calcium tab 10 mg (base equivalent)* | 1 | $0 copay for members age 40 through 75 |
| *atorvastatin calcium tab 20 mg (base equivalent)* | 1 | $0 copay for members age 40 through 75 |
| *atorvastatin calcium tab 40 mg (base equivalent)* | 1 | |
| *atorvastatin calcium tab 80 mg (base equivalent)* | 1 | |
| *fluvastatin sodium cap 20 mg (base equivalent)* | 1 | $0 copay for members age 40 through 75 |
| *fluvastatin sodium cap 40 mg (base equivalent)* | 1 | $0 copay for members age 40 through 75 |
| *fluvastatin sodium tab er 24 hr 80 mg (base equivalent)* | 1 | $0 copay for members age 40 through 75 |
| LIVALO TAB 1MG | 3 | ST; PA** |
| LIVALO TAB 2MG | 3 | ST; PA** |
| LIVALO TAB 4MG | 3 | ST; PA** |
| *lovastatin tab 10 mg* | 1 | $0 copay for members age 40 through 75 |
| *lovastatin tab 20 mg* | 1 | $0 copay for members age 40 through 75 |
| *lovastatin tab 40 mg* | 1 | $0 copay for members age 40 through 75 |
| *pravastatin sodium tab 10 mg* | 1 | $0 copay for members age 40 through 75 |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *pravastatin sodium tab 20 mg* | 1 | $0 copay for members age 40 through 75 |
| *pravastatin sodium tab 40 mg* | 1 | $0 copay for members age 40 through 75 |
| *pravastatin sodium tab 80 mg* | 1 | $0 copay for members age 40 through 75 |
| *rosuvastatin calcium tab 5 mg* | 1 | ST; $0 copay for members age 40 through 75; PA** |
| *rosuvastatin calcium tab 10 mg* | 1 | ST; $0 copay for members age 40 through 75; PA** |
| *rosuvastatin calcium tab 20 mg* | 1 | |
| *rosuvastatin calcium tab 40 mg* | 1 | |
| *simvastatin tab 5 mg* | 1 | $0 copay for members age 40 through 75 |
| *simvastatin tab 10 mg* | 1 | $0 copay for members age 40 through 75 |
| *simvastatin tab 20 mg* | 1 | $0 copay for members age 40 through 75 |
| *simvastatin tab 40 mg* | 1 | $0 copay for members age 40 through 75 |
| *simvastatin tab 80 mg* | 1 | ST; PA** |
| ***ANTILIPEMICS, MISCELLANEOUS*** | | |
| *niacin tab er 500 mg (antihyperlipidemic)* | 1 | |
| *niacin tab er 750 mg (antihyperlipidemic)* | 1 | |
| *niacin tab er 1000 mg (antihyperlipidemic)* | 1 | |
| ***ANTILIPEMICS, OMEGA-3 FATTY ACIDS*** | | |
| *omega-3-acid ethyl esters cap 1 gm* | 1 | PA |
| VASCEPA CAP 0.5GM | 2 | |
| VASCEPA CAP 1GM | 2 | |
| ***ANTILIPEMICS, PCSK9 INHIBITORS*** | | |
| REPATHA INJ 140MG/ML | 4 | QL (2 syringes / 28 days), PA |
| REPATHA PUSH INJ 420/3.5 | 4 | QL (1 cartridge / 28 days), PA |
| REPATHA SURE INJ 140MG/ML | 4 | QL (2 pens / 28 days), PA |
| ***BETA-BLOCKER/DIURETIC COMBINATIONS*** | | |
| *atenolol & chlorthalidone tab 50-25 mg* | 1 | |
| *atenolol & chlorthalidone tab 100-25 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg* | 1 | |
| *bisoprolol & hydrochlorothiazide tab 5-6.25 mg* | 1 | |
| *bisoprolol & hydrochlorothiazide tab 10-6.25 mg* | 1 | |
| *metoprolol & hydrochlorothiazide tab 50-25 mg* | 1 | |
| *metoprolol & hydrochlorothiazide tab 100-25 mg* | 1 | |
| *metoprolol & hydrochlorothiazide tab 100-50 mg* | 1 | |
| *nadolol & bendroflumethiazide tab 40-5 mg* | 1 | |
| *propranolol & hydrochlorothiazide tab 40-25 mg* | 1 | |
| *propranolol & hydrochlorothiazide tab 80-25 mg* | 1 | |
| ***BETA-BLOCKERS*** | | |
| *acebutolol hcl cap 200 mg* | 1 | |
| *acebutolol hcl cap 400 mg* | 1 | |
| *atenolol tab 25 mg* | 1 | |
| *atenolol tab 50 mg* | 1 | |
| *atenolol tab 100 mg* | 1 | |
| *betaxolol hcl tab 10 mg* | 1 | |
| *betaxolol hcl tab 20 mg* | 1 | |
| *bisoprolol fumarate tab 5 mg* | 1 | |
| *bisoprolol fumarate tab 10 mg* | 1 | |
| BYSTOLIC TAB 2.5MG | 3 | |
| BYSTOLIC TAB 5MG | 3 | |
| BYSTOLIC TAB 10MG | 3 | |
| BYSTOLIC TAB 20MG | 3 | |
| *carvedilol phosphate cap er 24hr 10 mg* | 1 | |
| *carvedilol phosphate cap er 24hr 20 mg* | 1 | |
| *carvedilol phosphate cap er 24hr 40 mg* | 1 | |
| *carvedilol phosphate cap er 24hr 80 mg* | 1 | |
| *carvedilol tab 3.125 mg* | 1 | |
| *carvedilol tab 6.25 mg* | 1 | |
| *carvedilol tab 12.5 mg* | 1 | |
| *carvedilol tab 25 mg* | 1 | |
| *labetalol hcl iv soln 5 mg/ml* | M | M |
| *labetalol hcl tab 100 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *labetalol hcl tab 200 mg* | 1 | |
| *labetalol hcl tab 300 mg* | 1 | |
| *metoprolol succinate tab er 24hr 25 mg (tartrate equiv)* | 1 | |
| *metoprolol succinate tab er 24hr 50 mg (tartrate equiv)* | 1 | |
| *metoprolol succinate tab er 24hr 100 mg (tartrate equiv)* | 1 | |
| *metoprolol succinate tab er 24hr 200 mg (tartrate equiv)* | 1 | |
| *metoprolol tartrate iv soln 5 mg/5ml* | M | M |
| *metoprolol tartrate iv soln cart inj 5 mg/5ml (1 mg/ml)* | M | M |
| *metoprolol tartrate tab 25 mg* | 1 | |
| *metoprolol tartrate tab 50 mg* | 1 | |
| *metoprolol tartrate tab 100 mg* | 1 | |
| *nadolol tab 20 mg* | 1 | |
| *nadolol tab 40 mg* | 1 | |
| *nadolol tab 80 mg* | 1 | |
| *pindolol tab 5 mg* | 1 | |
| *pindolol tab 10 mg* | 1 | |
| *propranolol hcl cap er 24hr 60 mg* | 1 | |
| *propranolol hcl cap er 24hr 80 mg* | 1 | |
| *propranolol hcl cap er 24hr 120 mg* | 1 | |
| *propranolol hcl cap er 24hr 160 mg* | 1 | |
| *propranolol hcl inj 1 mg/ml* | M | M |
| *propranolol hcl oral soln 20 mg/5ml* | 1 | |
| *propranolol hcl oral soln 40 mg/5ml* | 1 | |
| *propranolol hcl tab 10 mg* | 1 | |
| *propranolol hcl tab 20 mg* | 1 | |
| *propranolol hcl tab 40 mg* | 1 | |
| *propranolol hcl tab 60 mg* | 1 | |
| *propranolol hcl tab 80 mg* | 1 | |
| *timolol maleate tab 5 mg* | 1 | |
| *timolol maleate tab 10 mg* | 1 | |
| *timolol maleate tab 20 mg* | 1 | |
| ***CALCIUM CHANNEL BLOCKER/ANTILIPEMIC COMBINATIONS*** | | |
| *amlodipine besylate-atorvastatin calcium tab 2.5-10 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amlodipine besylate-atorvastatin calcium tab 2.5-20 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 2.5-40 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 5-10 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 5-20 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 5-40 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 5-80 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 10-10 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 10-20 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 10-40 mg* | 1 | |
| *amlodipine besylate-atorvastatin calcium tab 10-80 mg* | 1 | |
| ***CALCIUM CHANNEL BLOCKERS*** | | |
| *afeditab tab 30mg cr* | 1 | |
| *afeditab tab 60mg cr* | 1 | |
| *amlodipine besylate tab 2.5 mg (base equivalent)* | 1 | |
| *amlodipine besylate tab 5 mg (base equivalent)* | 1 | |
| *amlodipine besylate tab 10 mg (base equivalent)* | 1 | |
| CARDENE IV INJ 40/200ML | M | M |
| CARDENE IV SOL 20/200ML | M | M |
| CARDIZEM LA TAB 120MG | 2 | |
| *cartia xt cap 120/24hr* | 1 | |
| *cartia xt cap 180/24hr* | 1 | |
| *cartia xt cap 240/24hr* | 1 | |
| *cartia xt cap 300/24hr* | 1 | |
| *diltiazem hcl cap er 12hr 60 mg* | 1 | |
| *diltiazem hcl cap er 12hr 90 mg* | 1 | |
| *diltiazem hcl cap er 12hr 120 mg* | 1 | |
| *diltiazem hcl cap er 24hr 120 mg* | 1 | |
| *diltiazem hcl cap er 24hr 180 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *diltiazem hcl cap er 24hr 240 mg* | 1 | |
| *diltiazem hcl coated beads cap er 24hr 120 mg* | 1 | |
| *diltiazem hcl coated beads cap er 24hr 180 mg* | 1 | |
| *diltiazem hcl coated beads cap er 24hr 240 mg* | 1 | |
| *diltiazem hcl coated beads cap er 24hr 300 mg* | 1 | |
| *diltiazem hcl coated beads cap er 24hr 360 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 120 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 180 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 240 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 300 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 360 mg* | 1 | |
| *diltiazem hcl extended release beads cap er 24hr 420 mg* | 1 | |
| *diltiazem hcl iv soln 25 mg/5ml (5 mg/ml)* | M | M |
| *diltiazem hcl iv soln 50 mg/10ml (5 mg/ml)* | M | M |
| *diltiazem hcl iv soln 125 mg/25ml (5 mg/ml)* | M | M |
| *diltiazem hcl tab 30 mg* | 1 | |
| *diltiazem hcl tab 60 mg* | 1 | |
| *diltiazem hcl tab 90 mg* | 1 | |
| *diltiazem hcl tab 120 mg* | 1 | |
| DILTIAZEM INJ 100MG | M | M |
| *felodipine tab er 24hr 2.5 mg* | 1 | |
| *felodipine tab er 24hr 5 mg* | 1 | |
| *felodipine tab er 24hr 10 mg* | 1 | |
| *isradipine cap 2.5 mg* | 1 | |
| *isradipine cap 5 mg* | 1 | |
| *matzim la tab 180mg/24* | 1 | |
| *matzim la tab 240mg/24* | 1 | |
| *matzim la tab 300mg/24* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *matzim la tab 360mg/24* | 1 | |
| *matzim la tab 420mg/24* | 1 | |
| *nicardipine hcl cap 20 mg* | 1 | |
| *nicardipine hcl cap 30 mg* | 1 | |
| *nicardipine hcl iv soln 2.5 mg/ml* | M | M |
| *nifedipine tab er 24hr 30 mg* | 1 | |
| *nifedipine tab er 24hr 60 mg* | 1 | |
| *nifedipine tab er 24hr 90 mg* | 1 | |
| *nifedipine tab er 24hr osmotic release 30 mg* | 1 | |
| *nifedipine tab er 24hr osmotic release 60 mg* | 1 | |
| *nifedipine tab er 24hr osmotic release 90 mg* | 1 | |
| *nimodipine cap 30 mg* | 1 | |
| *nisoldipine tab er 24hr 8.5 mg* | 1 | |
| *nisoldipine tab er 24hr 17 mg* | 1 | |
| *nisoldipine tab er 24hr 20 mg* | 1 | |
| *nisoldipine tab er 24hr 25.5 mg* | 1 | |
| *nisoldipine tab er 24hr 30 mg* | 1 | |
| *nisoldipine tab er 24hr 34 mg* | 1 | |
| *nisoldipine tab er 24hr 40 mg* | 1 | |
| *taztia xt cap 120mg/24* | 1 | |
| *taztia xt cap 180mg/24* | 1 | |
| *taztia xt cap 240mg/24* | 1 | |
| *taztia xt cap 300mg er* | 1 | |
| *taztia xt cap 360mg/24* | 1 | |
| *verapamil hcl cap er 24hr 100 mg* | 1 | |
| *verapamil hcl cap er 24hr 120 mg* | 1 | |
| *verapamil hcl cap er 24hr 180 mg* | 1 | |
| *verapamil hcl cap er 24hr 200 mg* | 1 | |
| *verapamil hcl cap er 24hr 240 mg* | 1 | |
| *verapamil hcl cap er 24hr 300 mg* | 1 | |
| *verapamil hcl cap er 24hr 360 mg* | 1 | |
| *verapamil hcl iv soln 2.5 mg/ml* | M | M |
| *verapamil hcl tab 40 mg* | 1 | |
| *verapamil hcl tab 80 mg* | 1 | |
| *verapamil hcl tab 120 mg* | 1 | |
| *verapamil hcl tab er 120 mg* | 1 | |
| *verapamil hcl tab er 180 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *verapamil hcl tab er 240 mg* | 1 | |
| ***DIGITALIS GLYCOSIDES*** | | |
| *digox tab 0.25mg* | 1 | |
| *digox tab 0.125mg* | 1 | |
| *digoxin inj 0.25 mg/ml* | M | M |
| *digoxin oral soln 0.05 mg/ml* | 1 | |
| *digoxin tab 125 mcg (0.125 mg)* | 1 | |
| *digoxin tab 250 mcg (0.25 mg)* | 1 | |
| LANOXIN PED INJ 0.1MG/ML | M | M |
| LANOXIN TAB 0.0625MG | 2 | |
| LANOXIN TAB 0.1875MG | 2 | |
| ***DIRECT RENIN INHIBITORS/COMBINATIONS*** | | |
| *aliskiren fumarate tab 150 mg (base equivalent)* | 1 | |
| *aliskiren fumarate tab 300 mg (base equivalent)* | 1 | |
| ***DIURETICS*** | | |
| *acetazolamide cap er 12hr 500 mg* | 1 | |
| *acetazolamide sodium for inj 500 mg* | M | M |
| *acetazolamide tab 125 mg* | 1 | |
| *acetazolamide tab 250 mg* | 1 | |
| ALDACTAZIDE TAB 50/50 | 2 | |
| *amiloride & hydrochlorothiazide tab 5-50 mg* | 1 | |
| *amiloride hcl tab 5 mg* | 1 | |
| *bumetanide inj 0.25 mg/ml* | M | M |
| *bumetanide tab 0.5 mg* | 1 | |
| *bumetanide tab 1 mg* | 1 | |
| *bumetanide tab 2 mg* | 1 | |
| *chlorothiazide sodium for inj 500 mg* | M | M |
| *chlorothiazide tab 250 mg* | 1 | |
| *chlorothiazide tab 500 mg* | 1 | |
| *chlorthalidone tab 25 mg* | 1 | |
| *chlorthalidone tab 50 mg* | 1 | |
| DIURIL SUS 250/5ML | 3 | |
| DYRENIUM CAP 50MG | 3 | |
| DYRENIUM CAP 100MG | 3 | |
| *ethacrynate sodium for inj 50 mg* | M | M |
| *ethacrynic acid tab 25 mg* | 1 | |
| *furosemide inj 10 mg/ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *furosemide oral soln 8 mg/ml* | 1 | |
| *furosemide oral soln 10 mg/ml* | 1 | |
| *furosemide tab 20 mg* | 1 | |
| *furosemide tab 40 mg* | 1 | |
| *furosemide tab 80 mg* | 1 | |
| *hydrochlorothiazide cap 12.5 mg* | 1 | |
| *hydrochlorothiazide tab 12.5 mg* | 1 | |
| *hydrochlorothiazide tab 25 mg* | 1 | |
| *hydrochlorothiazide tab 50 mg* | 1 | |
| *indapamide tab 1.25 mg* | 1 | |
| *indapamide tab 2.5 mg* | 1 | |
| *methazolamide tab 25 mg* | 1 | |
| *methazolamide tab 50 mg* | 1 | |
| *methyclothiazide tab 5 mg* | 1 | |
| *metolazone tab 2.5 mg* | 1 | |
| *metolazone tab 5 mg* | 1 | |
| *metolazone tab 10 mg* | 1 | |
| *spironolactone & hydrochlorothiazide tab 25-25 mg* | 1 | |
| *spironolactone tab 25 mg* | 1 | |
| *spironolactone tab 50 mg* | 1 | |
| *spironolactone tab 100 mg* | 1 | |
| *torsemide tab 5 mg* | 1 | |
| *torsemide tab 10 mg* | 1 | |
| *torsemide tab 20 mg* | 1 | |
| *torsemide tab 100 mg* | 1 | |
| *triamterene & hydrochlorothiazide cap 37.5-25 mg* | 1 | |
| *triamterene & hydrochlorothiazide cap 50-25 mg* | 1 | |
| *triamterene & hydrochlorothiazide tab 37.5-25 mg* | 1 | |
| *triamterene & hydrochlorothiazide tab 75-50 mg* | 1 | |
| *triamterene cap 50 mg* | 1 | |
| *triamterene cap 100 mg* | 1 | |
| ***MISCELLANEOUS*** | | |
| *clonidine hcl tab 0.1 mg* | 1 | |
| *clonidine hcl tab 0.2 mg* | 1 | |
| *clonidine hcl tab 0.3 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *clonidine td patch weekly 0.1 mg/24hr* | 1 | |
| *clonidine td patch weekly 0.2 mg/24hr* | 1 | |
| *clonidine td patch weekly 0.3 mg/24hr* | 1 | |
| CORLANOR TAB 5MG | 2 | |
| CORLANOR TAB 7.5MG | 2 | |
| ENTRESTO TAB 24-26MG | 2 | |
| ENTRESTO TAB 49-51MG | 2 | |
| ENTRESTO TAB 97-103MG | 2 | |
| *guanfacine hcl tab 1 mg* | 1 | |
| *guanfacine hcl tab 2 mg* | 1 | |
| *hydralazine hcl inj 20 mg/ml* | M | M |
| *hydralazine hcl tab 10 mg* | 1 | |
| *hydralazine hcl tab 25 mg* | 1 | |
| *hydralazine hcl tab 50 mg* | 1 | |
| *hydralazine hcl tab 100 mg* | 1 | |
| *methyldopa tab 250 mg* | 1 | |
| *methyldopa tab 500 mg* | 1 | |
| *methyldopate hcl inj 250 mg/5ml* | M | M |
| *midodrine hcl tab 2.5 mg* | 1 | |
| *midodrine hcl tab 5 mg* | 1 | |
| *midodrine hcl tab 10 mg* | 1 | |
| *minoxidil tab 2.5 mg* | 1 | |
| *minoxidil tab 10 mg* | 1 | |
| *phenoxybenzamine hcl cap 10 mg* | 1 | |
| *ranolazine tab er 12hr 500 mg* | 1 | ST; PA** |
| *ranolazine tab er 12hr 1000 mg* | 1 | ST; PA** |
| ***NITRATES*** | | |
| DILATRATE SR CAP 40MG | 3 | |
| ISORDIL TAB 40MG | 2 | |
| *isosorbide dinitrate tab 5 mg* | 1 | |
| *isosorbide dinitrate tab 10 mg* | 1 | |
| *isosorbide dinitrate tab 20 mg* | 1 | |
| *isosorbide dinitrate tab 30 mg* | 1 | |
| *isosorbide dinitrate tab er 40 mg* | 1 | |
| *isosorbide mononitrate tab 10 mg* | 1 | |
| *isosorbide mononitrate tab 20 mg* | 1 | |
| *isosorbide mononitrate tab er 24hr 30 mg* | 1 | |
| *isosorbide mononitrate tab er 24hr 60 mg* | 1 | |
| *isosorbide mononitrate tab er 24hr 120 mg* | 1 | |
| *minitran dis 0.1mg/hr* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *minitran dis 0.2mg/hr* | 1 | |
| *minitran dis 0.4mg/hr* | 1 | |
| *minitran dis 0.6mg/hr* | 1 | |
| NITRO-BID OIN 2% | 3 | |
| NITRO-DUR DIS 0.3MG/HR | 2 | |
| NITRO-DUR DIS 0.8MG/HR | 2 | |
| NITROGLYCER INJ 5MG/ML | M | M |
| *nitroglycerin iv soln 100 mcg/ml in d5w* | M | M |
| *nitroglycerin iv soln 200 mcg/ml in d5w* | M | M |
| *nitroglycerin iv soln 400 mcg/ml in d5w* | M | M |
| *nitroglycerin sl tab 0.3 mg* | 1 | |
| *nitroglycerin sl tab 0.4 mg* | 1 | |
| *nitroglycerin sl tab 0.6 mg* | 1 | |
| *nitroglycerin td patch 24hr 0.1 mg/hr* | 1 | |
| *nitroglycerin td patch 24hr 0.2 mg/hr* | 1 | |
| *nitroglycerin td patch 24hr 0.4 mg/hr* | 1 | |
| *nitroglycerin td patch 24hr 0.6 mg/hr* | 1 | |
| *nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)* | 1 | |
| ***PULMONARY ARTERIAL HYPERTENSION*** | | |
| ADEMPAS TAB 0.5MG | 5 | QL (90 tabs / 30 days), PA |
| ADEMPAS TAB 1.5MG | 5 | QL (90 tabs / 30 days), PA |
| ADEMPAS TAB 1MG | 5 | QL (90 tabs / 30 days), PA |
| ADEMPAS TAB 2.5MG | 5 | QL (90 tabs / 30 days), PA |
| ADEMPAS TAB 2MG | 5 | QL (90 tabs / 30 days), PA |
| *ambrisentan tab 5 mg* | 4 | QL (30 tabs / 30 days), PA |
| *ambrisentan tab 10 mg* | 4 | QL (30 tabs / 30 days), PA |
| *bosentan tab 62.5 mg* | 4 | QL (60 tabs / 30 days), PA |
| *bosentan tab 125 mg* | 4 | QL (60 tabs / 30 days), PA |
| *epoprostenol sodium for inj 0.5 mg* | M | M |
| *epoprostenol sodium for inj 1.5 mg* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| LETAIRIS TAB 5MG | 4 | QL (30 tabs / 30 days), PA |
| LETAIRIS TAB 10MG | 4 | QL (30 tabs / 30 days), PA |
| OPSUMIT TAB 10MG | 4 | QL (30 tabs / 30 days), PA |
| ORENITRAM TAB 0.25MG | 4 | PA |
| ORENITRAM TAB 0.125MG | 4 | PA |
| ORENITRAM TAB 1MG | 4 | PA |
| ORENITRAM TAB 2.5MG | 4 | PA |
| ORENITRAM TAB 5MG | 4 | PA |
| REMODULIN INJ 1MG/ML | 5 | PA |
| REMODULIN INJ 2.5MG/ML | 5 | PA |
| REMODULIN INJ 5MG/ML | 5 | PA |
| REMODULIN INJ 10MG/ML | 5 | PA |
| *sildenafil citrate iv soln 10 mg/12.5ml (base equivalent)* | M | M |
| *sildenafil citrate tab 20 mg* | 4 | QL (90 tabs / 30 days), PA |
| *tadalafil tab 20 mg (pah)* | 5 | QL (60 tabs / 30 days), PA |
| TRACLEER TAB 32MG | 4 | QL (112 tabs / 28 days), PA |
| TRACLEER TAB 62.5MG | 4 | QL (60 tabs / 30 days), PA |
| TRACLEER TAB 125MG | 4 | QL (60 tabs / 30 days), PA |
| TYVASO START SOL 0.6MG/ML | 4 | QL (28 ampules / 28 days), PA |
| UPTRAVI TAB 200/800 | 4 | PA |
| UPTRAVI TAB 200MCG | 4 | PA |
| UPTRAVI TAB 400MCG | 4 | PA |
| UPTRAVI TAB 600MCG | 4 | PA |
| UPTRAVI TAB 800MCG | 4 | PA |
| UPTRAVI TAB 1000MCG | 4 | PA |
| UPTRAVI TAB 1200MCG | 4 | PA |
| UPTRAVI TAB 1400MCG | 4 | PA |
| UPTRAVI TAB 1600MCG | 4 | PA |
| VENTAVIS SOL 10MCG/ML | 4 | QL (270 ampules / 30 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| VENTAVIS SOL 20MCG/ML | 4 | QL (270 ampules / 30 days), PA |

## CENTRAL NERVOUS SYSTEM

### *ANTIANXIETY§*

| | | |
|---|---|---|
| ALPRAZOLAM CON 1 MG/ML | 2 | QL (300 mL / 25 days) |
| *alprazolam orally disintegrating tab 0.5 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam orally disintegrating tab 0.25 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam orally disintegrating tab 1 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam orally disintegrating tab 2 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam tab 0.5 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam tab 0.25 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam tab 1 mg* | 1 | QL (150 tabs / 25 days) |
| *alprazolam tab 2 mg* | 1 | QL (150 tabs / 25 days) |
| *lorazepam conc 2 mg/ml* | 1 | QL (150 mL / 25 days) |
| *lorazepam tab 0.5 mg* | 1 | QL (150 tabs / 25 days) |
| *lorazepam tab 1 mg* | 1 | QL (150 tabs / 25 days) |
| *lorazepam tab 2 mg* | 1 | QL (150 tabs / 25 days) |
| *meprobamate tab 200 mg* | 1 | |
| *meprobamate tab 400 mg* | 1 | |
| *oxazepam cap 10 mg* | 1 | QL (120 caps / 25 days) |
| *oxazepam cap 15 mg* | 1 | QL (120 caps / 25 days) |
| *oxazepam cap 30 mg* | 1 | QL (120 caps / 25 days) |

### *ANTICONVULSANTS§*

| | | |
|---|---|---|
| APTIOM TAB 200MG | 3 | PA |
| APTIOM TAB 400MG | 3 | PA |
| APTIOM TAB 600MG | 3 | PA |
| APTIOM TAB 800MG | 3 | PA |
| BANZEL SUS 40MG/ML | 3 | PA |
| BANZEL TAB 200MG | 3 | PA |
| BANZEL TAB 400MG | 3 | PA |
| BRIVIACT INJ 50MG/5ML | M | M |
| BRIVIACT SOL 10MG/ML | 3 | PA |
| BRIVIACT TAB 10MG | 3 | PA |
| BRIVIACT TAB 25MG | 3 | PA |
| BRIVIACT TAB 50MG | 3 | PA |
| BRIVIACT TAB 75MG | 3 | PA |
| BRIVIACT TAB 100MG | 3 | PA |
| *carbamazepine cap er 12hr 100 mg* | 1 | |
| *carbamazepine cap er 12hr 200 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *carbamazepine cap er 12hr 300 mg* | 1 | |
| *carbamazepine chew tab 100 mg* | 1 | |
| *carbamazepine susp 100 mg/5ml* | 1 | |
| *carbamazepine tab 200 mg* | 1 | |
| *carbamazepine tab er 12hr 100 mg* | 1 | |
| *carbamazepine tab er 12hr 200 mg* | 1 | |
| *carbamazepine tab er 12hr 400 mg* | 1 | |
| CELONTIN CAP 300MG | 3 | |
| *clobazam suspension 2.5 mg/ml* | 1 | PA |
| *clobazam tab 10 mg* | 1 | PA |
| *clobazam tab 20 mg* | 1 | PA |
| *clonazepam tab 0.5 mg* | 1 | |
| *clonazepam tab 1 mg* | 1 | |
| *clonazepam tab 2 mg* | 1 | |
| *clorazepate dipotassium tab 3.75 mg* | 1 | QL (180 tabs / 25 days) |
| *clorazepate dipotassium tab 7.5 mg* | 1 | QL (180 tabs / 25 days) |
| *clorazepate dipotassium tab 15 mg* | 1 | QL (180 tabs / 25 days) |
| *diazepam con 5mg/ml* | 1 | QL (240 mL / 25 days) |
| *diazepam inj 5 mg/ml* | M | M |
| *diazepam oral soln 1 mg/ml* | 1 | QL (1200 mL / 25 days) |
| *diazepam tab 2 mg* | 1 | QL (120 tabs / 25 days) |
| *diazepam tab 5 mg* | 1 | QL (120 tabs / 25 days) |
| *diazepam tab 10 mg* | 1 | QL (120 tabs / 25 days) |
| DILANTIN CAP 30MG | 3 | |
| *divalproex sodium cap delayed release sprinkle 125 mg* | 1 | |
| *divalproex sodium tab delayed release 125 mg* | 1 | |
| *divalproex sodium tab delayed release 250 mg* | 1 | |
| *divalproex sodium tab delayed release 500 mg* | 1 | |
| *divalproex sodium tab er 24 hr 250 mg* | 1 | |
| *divalproex sodium tab er 24 hr 500 mg* | 1 | |
| *epitol tab 200mg* | 1 | |
| *ethosuximide cap 250 mg* | 1 | |
| *ethosuximide soln 250 mg/5ml* | 1 | |
| *felbamate susp 600 mg/5ml* | 1 | |
| *felbamate tab 400 mg* | 1 | |
| *felbamate tab 600 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fosphenytoin sodium inj 100 mg/2ml (phenytoin equiv)* | M | M |
| *fosphenytoin sodium inj 500 mg/10ml (phenytoin equiv)* | M | M |
| FYCOMPA SUS 0.5MG/ML | 2 | |
| FYCOMPA TAB 2MG | 2 | |
| FYCOMPA TAB 4MG | 2 | |
| FYCOMPA TAB 6MG | 2 | |
| FYCOMPA TAB 8MG | 2 | |
| FYCOMPA TAB 10MG | 2 | |
| FYCOMPA TAB 12MG | 2 | |
| *gabapentin cap 100 mg* | 1 | |
| *gabapentin cap 300 mg* | 1 | |
| *gabapentin cap 400 mg* | 1 | |
| *gabapentin oral soln 250 mg/5ml* | 1 | |
| *gabapentin tab 600 mg* | 1 | |
| *gabapentin tab 800 mg* | 1 | |
| *lamotrigine orally disintegrating tab 25 mg* | 1 | |
| *lamotrigine orally disintegrating tab 50 mg* | 1 | |
| *lamotrigine orally disintegrating tab 100 mg* | 1 | |
| *lamotrigine orally disintegrating tab 200 mg* | 1 | |
| *lamotrigine tab 25 mg* | 1 | |
| *lamotrigine tab 25 mg (35) starter kit* | 1 | |
| *lamotrigine tab 25 mg (42) & 100 mg (7) starter kit* | 1 | |
| *lamotrigine tab 25 mg (84) & 100 mg (14) starter kit* | 1 | |
| *lamotrigine tab 100 mg* | 1 | |
| *lamotrigine tab 150 mg* | 1 | |
| *lamotrigine tab 200 mg* | 1 | |
| *lamotrigine tab chewable dispersible 5 mg* | 1 | |
| *lamotrigine tab chewable dispersible 25 mg* | 1 | |
| *lamotrigine tab er 24hr 25 mg* | 1 | |
| *lamotrigine tab er 24hr 50 mg* | 1 | |
| *lamotrigine tab er 24hr 100 mg* | 1 | |
| *lamotrigine tab er 24hr 200 mg* | 1 | |
| *lamotrigine tab er 24hr 250 mg* | 1 | |
| *lamotrigine tab er 24hr 300 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *levetiracetam in sodium chloride iv soln 500 mg/100ml* | M | M |
| *levetiracetam in sodium chloride iv soln 1000 mg/100ml* | M | M |
| *levetiracetam in sodium chloride iv soln 1500 mg/100ml* | M | M |
| *levetiracetam inj 500 mg/5ml (100 mg/ml)* | M | M |
| *levetiracetam oral soln 100 mg/ml* | 1 | |
| *levetiracetam tab 250 mg* | 1 | |
| *levetiracetam tab 500 mg* | 1 | |
| *levetiracetam tab 750 mg* | 1 | |
| *levetiracetam tab 1000 mg* | 1 | |
| *levetiracetam tab er 24hr 500 mg* | 1 | |
| *levetiracetam tab er 24hr 750 mg* | 1 | |
| LYRICA CAP 25MG | 3 | ST; PA** |
| LYRICA CAP 50MG | 3 | ST; PA** |
| LYRICA CAP 75MG | 3 | ST; PA** |
| LYRICA CAP 100MG | 3 | ST; PA** |
| LYRICA CAP 150MG | 3 | ST; PA** |
| LYRICA CAP 200MG | 3 | ST; PA** |
| LYRICA CAP 225MG | 3 | ST; PA** |
| LYRICA CAP 300MG | 3 | ST; PA** |
| LYRICA SOL 20MG/ML | 3 | ST; PA** |
| *oxcarbazepine susp 300 mg/5ml (60 mg/ml)* | 1 | |
| *oxcarbazepine tab 150 mg* | 1 | |
| *oxcarbazepine tab 300 mg* | 1 | |
| *oxcarbazepine tab 600 mg* | 1 | |
| PEGANONE TAB 250MG | 3 | |
| *phenobarbital elixir 20 mg/5ml* | 1 | |
| *phenobarbital tab 15 mg* | 1 | |
| *phenobarbital tab 16.2 mg* | 1 | |
| *phenobarbital tab 30 mg* | 1 | |
| *phenobarbital tab 32.4 mg* | 1 | |
| *phenobarbital tab 60 mg* | 1 | |
| *phenobarbital tab 64.8 mg* | 1 | |
| *phenobarbital tab 97.2 mg* | 1 | |
| *phenobarbital tab 100 mg* | 1 | |
| *phenytoin chew tab 50 mg* | 1 | |
| *phenytoin sodium extended cap 100 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *phenytoin sodium extended cap 200 mg* | 1 | |
| *phenytoin sodium extended cap 300 mg* | 1 | |
| *phenytoin sodium inj 50 mg/ml* | M | M |
| *phenytoin susp 125 mg/5ml* | 1 | |
| *pregabalin cap 25 mg* | 1 | ST; PA** |
| *pregabalin cap 50 mg* | 1 | ST; PA** |
| *pregabalin cap 75 mg* | 1 | ST; PA** |
| *pregabalin cap 100 mg* | 1 | ST; PA** |
| *pregabalin cap 150 mg* | 1 | ST; PA** |
| *pregabalin cap 200 mg* | 1 | ST; PA** |
| *pregabalin cap 225 mg* | 1 | ST; PA** |
| *pregabalin cap 300 mg* | 1 | ST; PA** |
| *pregabalin soln 20 mg/ml* | 1 | ST; PA** |
| *primidone tab 50 mg* | 1 | |
| *primidone tab 250 mg* | 1 | |
| *tiagabine hcl tab 2 mg* | 1 | |
| *tiagabine hcl tab 4 mg* | 1 | |
| *tiagabine hcl tab 12 mg* | 1 | |
| *tiagabine hcl tab 16 mg* | 1 | |
| *topiramate sprinkle cap 15 mg* | 1 | |
| *topiramate sprinkle cap 25 mg* | 1 | |
| *topiramate tab 25 mg* | 1 | |
| *topiramate tab 50 mg* | 1 | |
| *topiramate tab 100 mg* | 1 | |
| *topiramate tab 200 mg* | 1 | |
| *valproate sodium inj 100 mg/ml* | M | M |
| *valproate sodium oral soln 250 mg/5ml (base equiv)* | 1 | |
| *valproic acid cap 250 mg* | 1 | |
| *vigabatrin powd pack 500 mg* | 4 | QL (180 packets / 30 days), PA |
| *vigabatrin tab 500 mg* | 4 | QL (180 tabs / 30 days), PA |
| VIMPAT INJ 200MG/20 | M | M |
| VIMPAT SOL 10MG/ML | 3 | |
| VIMPAT TAB 50MG | 3 | |
| VIMPAT TAB 100MG | 3 | |
| VIMPAT TAB 150MG | 3 | |
| VIMPAT TAB 200MG | 3 | |
| *zonisamide cap 25 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *zonisamide cap 50 mg* | 1 | |
| *zonisamide cap 100 mg* | 1 | |
| ***ANTIDEMENTIA*** | | |
| *donepezil hydrochloride orally disintegrating tab 5 mg* | 1 | |
| *donepezil hydrochloride orally disintegrating tab 10 mg* | 1 | |
| *donepezil hydrochloride tab 5 mg* | 1 | |
| *donepezil hydrochloride tab 10 mg* | 1 | |
| *donepezil hydrochloride tab 23 mg* | 1 | |
| *ergoloid mesylates tab 1 mg* | 1 | |
| *galantamine hydrobromide cap er 24hr 8 mg* | 1 | |
| *galantamine hydrobromide cap er 24hr 16 mg* | 1 | |
| *galantamine hydrobromide cap er 24hr 24 mg* | 1 | |
| *galantamine hydrobromide oral soln 4 mg/ml* | 1 | |
| *galantamine hydrobromide tab 4 mg* | 1 | |
| *galantamine hydrobromide tab 8 mg* | 1 | |
| *galantamine hydrobromide tab 12 mg* | 1 | |
| *memantine hcl cap er 24hr 7 mg* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl cap er 24hr 14 mg* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl cap er 24hr 21 mg* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl cap er 24hr 28 mg* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl oral solution 2 mg/ml* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl tab 5 mg* | 1 | PA; PA applies for members less than 30 years of age |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *memantine hcl tab 5 mg (28) & 10 mg (21) titration pak* | 1 | PA; PA applies for members less than 30 years of age |
| *memantine hcl tab 10 mg* | 1 | PA; PA applies for members less than 30 years of age |
| NAMENDA XR CAP TITRATIO | 2 | PA; PA applies for members less than 30 years of age |
| *rivastigmine tartrate cap 1.5 mg (base equivalent)* | 1 | PA |
| *rivastigmine tartrate cap 3 mg (base equivalent)* | 1 | PA |
| *rivastigmine tartrate cap 4.5 mg (base equivalent)* | 1 | PA |
| *rivastigmine tartrate cap 6 mg (base equivalent)* | 1 | PA |
| *rivastigmine td patch 24hr 4.6 mg/24hr* | 1 | PA |
| *rivastigmine td patch 24hr 9.5 mg/24hr* | 1 | PA |
| *rivastigmine td patch 24hr 13.3 mg/24hr* | 1 | PA |
| ***ANTIDEPRESSANTS§*** | | |
| *amitriptyline hcl tab 10 mg* | 1 | QL (150 tabs / 25 days); QL applies to members age 65 and older |
| *amitriptyline hcl tab 25 mg* | 1 | QL (60 tabs / 25 days); QL applies to members age 65 and older |
| *amitriptyline hcl tab 50 mg* | 1 | QL (30 tabs / 25 days); QL applies to members age 65 and older |
| *amitriptyline hcl tab 75 mg* | 1 | PA; Members 70 and older subject to PA |
| *amitriptyline hcl tab 100 mg* | 1 | PA; Members 70 and older subject to PA |
| *amitriptyline hcl tab 150 mg* | 1 | PA; Members 70 and older subject to PA |
| *amoxapine tab 25 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *amoxapine tab 50 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *amoxapine tab 100 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *amoxapine tab 150 mg* | 1 | QL (60 tabs / 25 days); QL applies to members age 65 and older |
| *bupropion hcl tab 75 mg* | 1 | |
| *bupropion hcl tab 100 mg* | 1 | |
| *bupropion hcl tab er 12hr 100 mg* | 1 | |
| *bupropion hcl tab er 12hr 150 mg* | 1 | |
| *bupropion hcl tab er 12hr 200 mg* | 1 | |
| *bupropion hcl tab er 24hr 150 mg* | 1 | |
| *bupropion hcl tab er 24hr 300 mg* | 1 | |
| *citalopram hydrobromide oral soln 10 mg/5ml* | 1 | |
| *citalopram hydrobromide tab 10 mg (base equiv)* | 1 | |
| *citalopram hydrobromide tab 20 mg (base equiv)* | 1 | |
| *citalopram hydrobromide tab 40 mg (base equiv)* | 1 | |
| *desipramine hcl tab 10 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *desipramine hcl tab 25 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *desipramine hcl tab 50 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *desipramine hcl tab 75 mg* | 1 | QL (60 tabs / 25 days); QL applies to members age 65 and older |
| *desipramine hcl tab 100 mg* | 1 | QL (30 tabs / 25 days); QL applies to members age 65 and older |
| *desipramine hcl tab 150 mg* | 1 | QL (30 tabs / 25 days); QL applies to members age 65 and older |
| *desvenlafaxine succinate tab er 24hr 25 mg (base equiv)* | 1 | ST; (generic of Pristiq) PA** |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *desvenlafaxine succinate tab er 24hr 50 mg (base equiv)* | 1 | ST; (generic of Pristiq) PA** |
| *desvenlafaxine succinate tab er 24hr 100 mg (base equiv)* | 1 | ST; (generic of Pristiq) PA** |
| *doxepin hcl cap 10 mg* | 1 | QL (90 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl cap 25 mg* | 1 | QL (90 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl cap 50 mg* | 1 | QL (90 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl cap 75 mg* | 1 | QL (60 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl cap 100 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl cap 150 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| *doxepin hcl conc 10 mg/ml* | 1 | QL (450 mL / 25 days); QL applies to members age 65 and older |
| *duloxetine hcl enteric coated pellets cap 20 mg (base eq)* | 1 | |
| *duloxetine hcl enteric coated pellets cap 30 mg (base eq)* | 1 | |
| *duloxetine hcl enteric coated pellets cap 60 mg (base eq)* | 1 | |
| EMSAM DIS 6MG/24HR | 3 | PA |
| EMSAM DIS 9MG/24HR | 3 | PA |
| EMSAM DIS 12MG/24H | 3 | PA |
| *escitalopram oxalate soln 5 mg/5ml (base equiv)* | 1 | |
| *escitalopram oxalate tab 5 mg (base equiv)* | 1 | |
| *escitalopram oxalate tab 10 mg (base equiv)* | 1 | |
| *escitalopram oxalate tab 20 mg (base equiv)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| FETZIMA CAP 20MG | 3 | ST; PA** |
| FETZIMA CAP 40MG | 3 | ST; PA** |
| FETZIMA CAP 80MG | 3 | ST; PA** |
| FETZIMA CAP 120MG | 3 | ST; PA** |
| FETZIMA CAP TITRATIO | 3 | ST; PA** |
| *fluoxetine hcl cap 10 mg* | 1 | |
| *fluoxetine hcl cap 20 mg* | 1 | |
| *fluoxetine hcl cap 40 mg* | 1 | |
| *fluoxetine hcl cap delayed release 90 mg* | 1 | |
| *fluoxetine hcl solution 20 mg/5ml* | 1 | |
| *fluoxetine hcl tab 10 mg* | 1 | (generic Sarafem not covered) |
| *fluoxetine hcl tab 20 mg* | 1 | (generic Sarafem not covered) |
| *fluoxetine hcl tab 60 mg* | 1 | |
| *imipramine hcl tab 10 mg* | 1 | QL (120 tabs / 25 days); QL applies to members age 65 and older |
| *imipramine hcl tab 25 mg* | 1 | QL (120 tabs / 25 days); QL applies to members age 65 and older |
| *imipramine hcl tab 50 mg* | 1 | QL (60 tabs / 25 days); QL applies to members age 65 and older |
| *imipramine pamoate cap 75 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| *imipramine pamoate cap 100 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| *imipramine pamoate cap 125 mg* | 1 | PA; Members 70 and older subject to PA |
| *imipramine pamoate cap 150 mg* | 1 | PA; Members 70 and older subject to PA |
| *maprotiline hcl tab 25 mg* | 1 | |
| *maprotiline hcl tab 50 mg* | 1 | |
| *maprotiline hcl tab 75 mg* | 1 | |
| MARPLAN TAB 10MG | 3 | |
| *mirtazapine orally disintegrating tab 15 mg* | 1 | |
| *mirtazapine orally disintegrating tab 30 mg* | 1 | |
| *mirtazapine orally disintegrating tab 45 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *mirtazapine tab 7.5 mg* | 1 | |
| *mirtazapine tab 15 mg* | 1 | |
| *mirtazapine tab 30 mg* | 1 | |
| *mirtazapine tab 45 mg* | 1 | |
| *nefazodone hcl tab 50 mg* | 1 | |
| *nefazodone hcl tab 100 mg* | 1 | |
| *nefazodone hcl tab 150 mg* | 1 | |
| *nefazodone hcl tab 200 mg* | 1 | |
| *nefazodone hcl tab 250 mg* | 1 | |
| *nortriptyline hcl cap 10 mg* | 1 | QL (150 caps / 25 days); QL applies to members age 65 and older |
| *nortriptyline hcl cap 25 mg* | 1 | QL (60 caps / 25 days); QL applies to members age 65 and older |
| *nortriptyline hcl cap 50 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| *nortriptyline hcl cap 75 mg* | 1 | PA; Members 70 and older subject to PA |
| *nortriptyline hcl soln 10 mg/5ml* | 1 | QL (750 mL / 25 days); QL applies to members age 65 and older |
| *paroxetine hcl tab 10 mg* | 1 | |
| *paroxetine hcl tab 20 mg* | 1 | |
| *paroxetine hcl tab 30 mg* | 1 | |
| *paroxetine hcl tab 40 mg* | 1 | |
| *paroxetine hcl tab er 24hr 12.5 mg* | 1 | |
| *paroxetine hcl tab er 24hr 25 mg* | 1 | |
| *paroxetine hcl tab er 24hr 37.5 mg* | 1 | |
| *phenelzine sulfate tab 15 mg* | 1 | |
| *protriptyline hcl tab 5 mg* | 1 | QL (90 tabs / 25 days); QL applies to members age 65 and older |
| *protriptyline hcl tab 10 mg* | 1 | QL (60 tabs / 25 days); QL applies to members age 65 and older |
| *sertraline hcl oral concentrate for solution 20 mg/ml* | 1 | |
| *sertraline hcl tab 25 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sertraline hcl tab 50 mg* | 1 | |
| *sertraline hcl tab 100 mg* | 1 | |
| *tranylcypromine sulfate tab 10 mg* | 1 | |
| *trazodone hcl tab 50 mg* | 1 | |
| *trazodone hcl tab 100 mg* | 1 | |
| *trazodone hcl tab 150 mg* | 1 | |
| *trazodone hcl tab 300 mg* | 1 | |
| *trimipramine maleate cap 25 mg* | 1 | QL (60 caps / 25 days); QL applies to members age 65 and older |
| *trimipramine maleate cap 50 mg* | 1 | QL (60 caps / 25 days); QL applies to members age 65 and older |
| *trimipramine maleate cap 100 mg* | 1 | QL (30 caps / 25 days); QL applies to members age 65 and older |
| TRINTELLIX TAB 5MG | 3 | ST; PA** |
| TRINTELLIX TAB 10MG | 3 | ST; PA** |
| TRINTELLIX TAB 20MG | 3 | ST; PA** |
| *venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)* | 1 | |
| *venlafaxine hcl cap er 24hr 75 mg (base equivalent)* | 1 | |
| *venlafaxine hcl cap er 24hr 150 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab 25 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab 37.5 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab 50 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab 75 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab 100 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab er 24hr 75 mg (base equivalent)* | 1 | |
| *venlafaxine hcl tab er 24hr 150 mg (base equivalent)* | 1 | |
| VIIBRYD KIT STARTER | 3 | ST; PA** |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| VIIBRYD TAB 10MG | 3 | ST; PA** |
| VIIBRYD TAB 20MG | 3 | ST; PA** |
| VIIBRYD TAB 40MG | 3 | ST; PA** |
| ***ANTIPARKINSONIAN AGENTS*** | | |
| *amantadine hcl cap 100 mg* | 1 | |
| *amantadine hcl syrup 50 mg/5ml* | 1 | |
| *amantadine hcl tab 100 mg* | 1 | |
| APOKYN INJ 10MG/ML | 4 | PA |
| *benztropine mesylate inj 1 mg/ml* | M | M |
| *benztropine mesylate tab 0.5 mg* | 1 | |
| *benztropine mesylate tab 1 mg* | 1 | |
| *benztropine mesylate tab 2 mg* | 1 | |
| *bromocriptine mesylate cap 5 mg (base equivalent)* | 1 | |
| *bromocriptine mesylate tab 2.5 mg (base equivalent)* | 1 | |
| *carbidopa & levodopa orally disintegrating tab 10-100 mg* | 1 | |
| *carbidopa & levodopa orally disintegrating tab 25-100 mg* | 1 | |
| *carbidopa & levodopa orally disintegrating tab 25-250 mg* | 1 | |
| *carbidopa & levodopa tab 10-100 mg* | 1 | |
| *carbidopa & levodopa tab 25-100 mg* | 1 | |
| *carbidopa & levodopa tab 25-250 mg* | 1 | |
| *carbidopa & levodopa tab er 25-100 mg* | 1 | |
| *carbidopa & levodopa tab er 50-200 mg* | 1 | |
| *carbidopa tab 25 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 12.5-50-200 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 18.75-75-200 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 25-100-200 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 31.25-125-200 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 37.5-150-200 mg* | 1 | |
| *carbidopa-levodopa-entacapone tabs 50-200-200 mg* | 1 | |
| *entacapone tab 200 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| NEUPRO DIS 1MG/24HR | 2 | |
| NEUPRO DIS 2MG/24HR | 2 | |
| NEUPRO DIS 3MG/24HR | 2 | |
| NEUPRO DIS 4MG/24HR | 2 | |
| NEUPRO DIS 6MG/24HR | 2 | |
| NEUPRO DIS 8MG/24HR | 2 | |
| *pramipexole dihydrochloride tab 0.5 mg* | 1 | |
| *pramipexole dihydrochloride tab 0.25 mg* | 1 | |
| *pramipexole dihydrochloride tab 0.75 mg* | 1 | |
| *pramipexole dihydrochloride tab 0.125 mg* | 1 | |
| *pramipexole dihydrochloride tab 1 mg* | 1 | |
| *pramipexole dihydrochloride tab 1.5 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 0.75 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 0.375 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 1.5 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 2.25 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 3 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 3.75 mg* | 1 | |
| *pramipexole dihydrochloride tab er 24hr 4.5 mg* | 1 | |
| *rasagiline mesylate tab 0.5 mg (base equiv)* | 1 | |
| *rasagiline mesylate tab 1 mg (base equiv)* | 1 | |
| *ropinirole hydrochloride tab 0.5 mg* | 1 | |
| *ropinirole hydrochloride tab 0.25 mg* | 1 | |
| *ropinirole hydrochloride tab 1 mg* | 1 | |
| *ropinirole hydrochloride tab 2 mg* | 1 | |
| *ropinirole hydrochloride tab 3 mg* | 1 | |
| *ropinirole hydrochloride tab 4 mg* | 1 | |
| *ropinirole hydrochloride tab 5 mg* | 1 | |
| *selegiline hcl cap 5 mg* | 1 | |
| *selegiline hcl tab 5 mg* | 1 | |
| *tolcapone tab 100 mg* | 1 | |
| *trihexyphenidyl hcl elixir 0.4 mg/ml* | 1 | |
| *trihexyphenidyl hcl tab 2 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *trihexyphenidyl hcl tab 5 mg* | 1 | |
| ***ANTIPSYCHOTICS*** | | |
| *aripiprazole oral solution 1 mg/ml* | 1 | |
| *aripiprazole orally disintegrating tab 10 mg* | 1 | |
| *aripiprazole orally disintegrating tab 15 mg* | 1 | |
| *aripiprazole tab 2 mg* | 1 | |
| *aripiprazole tab 5 mg* | 1 | |
| *aripiprazole tab 10 mg* | 1 | |
| *aripiprazole tab 15 mg* | 1 | |
| *aripiprazole tab 20 mg* | 1 | |
| *aripiprazole tab 30 mg* | 1 | |
| ARISTADA INJ 441MG/1. | M | M |
| ARISTADA INJ 662MG/2 | M | M |
| ARISTADA INJ 882MG/3 | M | M |
| ARISTADA INJ 1064MG | M | M |
| ARISTADA INJ INITIO | M | M |
| CHLORPROMAZ INJ 25MG/ML | M | M |
| CHLORPROMAZ INJ 50MG/2ML | M | M |
| *chlorpromazine hcl tab 10 mg* | 1 | |
| *chlorpromazine hcl tab 25 mg* | 1 | |
| *chlorpromazine hcl tab 50 mg* | 1 | |
| *chlorpromazine hcl tab 100 mg* | 1 | |
| *chlorpromazine hcl tab 200 mg* | 1 | |
| *clozapine orally disintegrating tab 12.5 mg* | 1 | |
| *clozapine orally disintegrating tab 25 mg* | 1 | |
| *clozapine orally disintegrating tab 100 mg* | 1 | |
| *clozapine orally disintegrating tab 150 mg* | 1 | |
| *clozapine orally disintegrating tab 200 mg* | 1 | |
| *clozapine tab 25 mg* | 1 | |
| *clozapine tab 50 mg* | 1 | |
| *clozapine tab 100 mg* | 1 | |
| *clozapine tab 200 mg* | 1 | |
| *fluphenazine decanoate inj 25 mg/ml* | M | M |
| *fluphenazine hcl elixir 2.5 mg/5ml* | 1 | |
| *fluphenazine hcl inj 2.5 mg/ml* | M | M |
| *fluphenazine hcl oral conc 5 mg/ml* | 1 | |
| *fluphenazine hcl tab 1 mg* | 1 | |
| *fluphenazine hcl tab 2.5 mg* | 1 | |
| *fluphenazine hcl tab 5 mg* | 1 | |
| *fluphenazine hcl tab 10 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *haloperidol decanoate im soln 50 mg/ml* | M | M |
| *haloperidol decanoate im soln 100 mg/ml* | M | M |
| *haloperidol lactate inj 5 mg/ml* | M | M |
| *haloperidol lactate oral conc 2 mg/ml* | 1 | |
| *haloperidol tab 0.5 mg* | 1 | |
| *haloperidol tab 1 mg* | 1 | |
| *haloperidol tab 2 mg* | 1 | |
| *haloperidol tab 5 mg* | 1 | |
| *haloperidol tab 10 mg* | 1 | |
| *haloperidol tab 20 mg* | 1 | |
| LATUDA TAB 20MG | 2 | ST; PA** |
| LATUDA TAB 40MG | 2 | ST; PA** |
| LATUDA TAB 60MG | 2 | ST; PA** |
| LATUDA TAB 80MG | 2 | ST; PA** |
| LATUDA TAB 120MG | 2 | ST; PA** |
| *loxapine succinate cap 5 mg* | 1 | |
| *loxapine succinate cap 10 mg* | 1 | |
| *loxapine succinate cap 25 mg* | 1 | |
| *loxapine succinate cap 50 mg* | 1 | |
| NUPLAZID TAB 17MG | 4 | PA |
| *olanzapine for im inj 10 mg* | M | M |
| *olanzapine orally disintegrating tab 5 mg* | 1 | |
| *olanzapine orally disintegrating tab 10 mg* | 1 | |
| *olanzapine orally disintegrating tab 15 mg* | 1 | |
| *olanzapine orally disintegrating tab 20 mg* | 1 | |
| *olanzapine tab 2.5 mg* | 1 | |
| *olanzapine tab 5 mg* | 1 | |
| *olanzapine tab 7.5 mg* | 1 | |
| *olanzapine tab 10 mg* | 1 | |
| *olanzapine tab 15 mg* | 1 | |
| *olanzapine tab 20 mg* | 1 | |
| *paliperidone tab er 24hr 1.5 mg* | 1 | |
| *paliperidone tab er 24hr 3 mg* | 1 | |
| *paliperidone tab er 24hr 6 mg* | 1 | |
| *paliperidone tab er 24hr 9 mg* | 1 | |
| *perphenazine tab 2 mg* | 1 | |
| *perphenazine tab 4 mg* | 1 | |
| *perphenazine tab 8 mg* | 1 | |
| *perphenazine tab 16 mg* | 1 | |
| *quetiapine fumarate tab 25 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *quetiapine fumarate tab 50 mg* | 1 | |
| *quetiapine fumarate tab 100 mg* | 1 | |
| *quetiapine fumarate tab 200 mg* | 1 | |
| *quetiapine fumarate tab 300 mg* | 1 | |
| *quetiapine fumarate tab 400 mg* | 1 | |
| *quetiapine fumarate tab er 24hr 50 mg* | 1 | |
| *quetiapine fumarate tab er 24hr 150 mg* | 1 | |
| *quetiapine fumarate tab er 24hr 200 mg* | 1 | |
| *quetiapine fumarate tab er 24hr 300 mg* | 1 | |
| *quetiapine fumarate tab er 24hr 400 mg* | 1 | |
| REXULTITAB 0.5MG | 3 | ST; PA** |
| REXULTITAB 0.25MG | 3 | ST; PA** |
| REXULTITAB 1MG | 3 | ST; PA** |
| REXULTITAB 2MG | 3 | ST; PA** |
| REXULTITAB 3MG | 3 | ST; PA** |
| REXULTITAB 4MG | 3 | ST; PA** |
| *risperidone orally disintegrating tab 0.5 mg* | 1 | |
| *risperidone orally disintegrating tab 0.25 mg* | 1 | |
| *risperidone orally disintegrating tab 1 mg* | 1 | |
| *risperidone orally disintegrating tab 2 mg* | 1 | |
| *risperidone orally disintegrating tab 3 mg* | 1 | |
| *risperidone orally disintegrating tab 4 mg* | 1 | |
| *risperidone soln 1 mg/ml* | 1 | |
| *risperidone tab 0.5 mg* | 1 | |
| *risperidone tab 0.25 mg* | 1 | |
| *risperidone tab 1 mg* | 1 | |
| *risperidone tab 2 mg* | 1 | |
| *risperidone tab 3 mg* | 1 | |
| *risperidone tab 4 mg* | 1 | |
| SAPHRIS SUB 2.5MG | 3 | ST; PA** |
| SAPHRIS SUB 5MG | 3 | ST; PA** |
| SAPHRIS SUB 10MG | 3 | ST; PA** |
| *thioridazine hcl tab 10 mg* | 1 | |
| *thioridazine hcl tab 25 mg* | 1 | |
| *thioridazine hcl tab 50 mg* | 1 | |
| *thioridazine hcl tab 100 mg* | 1 | |
| *thiothixene cap 1 mg* | 1 | |
| *thiothixene cap 2 mg* | 1 | |
| *thiothixene cap 5 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *thiothixene cap 10 mg* | 1 | |
| *trifluoperazine hcl tab 1 mg (base equivalent)* | 1 | |
| *trifluoperazine hcl tab 2 mg (base equivalent)* | 1 | |
| *trifluoperazine hcl tab 5 mg (base equivalent)* | 1 | |
| *trifluoperazine hcl tab 10 mg (base equivalent)* | 1 | |
| *ziprasidone hcl cap 20 mg* | 1 | |
| *ziprasidone hcl cap 40 mg* | 1 | |
| *ziprasidone hcl cap 60 mg* | 1 | |
| *ziprasidone hcl cap 80 mg* | 1 | |
| ***ATTENTION DEFICIT HYPERACTIVITY DISORDER§*** | | |
| *amphetamine-dextroamphetamine cap er 24hr 5 mg* | 1 | QL (90 caps / 25 days) |
| *amphetamine-dextroamphetamine cap er 24hr 10 mg* | 1 | QL (90 caps / 25 days) |
| *amphetamine-dextroamphetamine cap er 24hr 15 mg* | 1 | QL (30 caps / 25 days) |
| *amphetamine-dextroamphetamine cap er 24hr 20 mg* | 1 | QL (30 caps / 25 days) |
| *amphetamine-dextroamphetamine cap er 24hr 25 mg* | 1 | QL (30 caps / 25 days) |
| *amphetamine-dextroamphetamine cap er 24hr 30 mg* | 1 | QL (30 caps / 25 days) |
| *amphetamine-dextroamphetamine tab 5 mg* | 1 | QL (90 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 7.5 mg* | 1 | QL (90 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 10 mg* | 1 | QL (90 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 12.5 mg* | 1 | QL (90 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 15 mg* | 1 | QL (60 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 20 mg* | 1 | QL (60 tabs / 25 days) |
| *amphetamine-dextroamphetamine tab 30 mg* | 1 | QL (30 tabs / 25 days) |
| *atomoxetine hcl cap 10 mg (base equiv)* | 1 | |
| *atomoxetine hcl cap 18 mg (base equiv)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *atomoxetine hcl cap 25 mg (base equiv)* | 1 | |
| *atomoxetine hcl cap 40 mg (base equiv)* | 1 | |
| *atomoxetine hcl cap 60 mg (base equiv)* | 1 | |
| *atomoxetine hcl cap 80 mg (base equiv)* | 1 | |
| *atomoxetine hcl cap 100 mg (base equiv)* | 1 | |
| *dexmethylphenidate hcl cap er 24 hr 5 mg* | 1 | QL (60 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 10 mg* | 1 | QL (60 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 15 mg* | 1 | QL (60 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 20 mg* | 1 | QL (60 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 25 mg* | 1 | QL (30 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 30 mg* | 1 | QL (30 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 35 mg* | 1 | QL (30 caps / 25 days) |
| *dexmethylphenidate hcl cap er 24 hr 40 mg* | 1 | QL (30 caps / 25 days) |
| *dexmethylphenidate hcl tab 2.5 mg* | 1 | QL (120 tabs / 25 days) |
| *dexmethylphenidate hcl tab 5 mg* | 1 | QL (120 tabs / 25 days) |
| *dexmethylphenidate hcl tab 10 mg* | 1 | QL (60 tabs / 25 days) |
| *dextroamphetamine sulfate cap er 24hr 5 mg* | 1 | QL (120 caps / 25 days) |
| *dextroamphetamine sulfate cap er 24hr 10 mg* | 1 | QL (120 caps / 25 days) |
| *dextroamphetamine sulfate cap er 24hr 15 mg* | 1 | QL (60 caps / 25 days) |
| *dextroamphetamine sulfate oral solution 5 mg/5ml* | 1 | QL (1,200 mL / 25 days) |
| *dextroamphetamine sulfate tab 5 mg* | 1 | QL (120 tabs / 25 days) |
| *dextroamphetamine sulfate tab 10 mg* | 1 | QL (120 tabs / 25 days) |
| *guanfacine hcl tab er 24hr 1 mg (base equiv)* | 1 | ST; PA** |
| *guanfacine hcl tab er 24hr 2 mg (base equiv)* | 1 | ST; PA** |
| *guanfacine hcl tab er 24hr 3 mg (base equiv)* | 1 | ST; PA** |
| *guanfacine hcl tab er 24hr 4 mg (base equiv)* | 1 | ST; PA** |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *methamphetamine hcl tab 5 mg* | 1 | QL (150 tabs / 25 days) |
| *methylphenidate hcl cap er 10 mg (cd)* | 1 | QL (60 caps / 25 days) |
| *methylphenidate hcl cap er 20 mg (cd)* | 1 | QL (60 caps / 25 days) |
| *methylphenidate hcl cap er 24hr 20 mg (la)* | 1 | QL (60 caps / 25 days) |
| *methylphenidate hcl cap er 24hr 30 mg (la)* | 1 | QL (60 caps / 25 days) |
| *methylphenidate hcl cap er 24hr 40 mg (la)* | 1 | QL (30 caps / 25 days) |
| *methylphenidate hcl cap er 24hr 60 mg (la)* | 1 | QL (30 caps / 25 days) |
| *methylphenidate hcl cap er 30 mg (cd)* | 1 | QL (60 caps / 25 days) |
| *methylphenidate hcl cap er 40 mg (cd)* | 1 | QL (30 caps / 25 days) |
| *methylphenidate hcl cap er 50 mg (cd)* | 1 | QL (30 caps / 25 days) |
| *methylphenidate hcl cap er 60 mg (cd)* | 1 | QL (30 caps / 25 days) |
| *methylphenidate hcl chew tab 2.5 mg* | 1 | QL (180 chew tabs / 25 days) |
| *methylphenidate hcl chew tab 5 mg* | 1 | QL (180 chew tabs / 25 days) |
| *methylphenidate hcl chew tab 10 mg* | 1 | QL (180 chew tabs / 25 days) |
| *methylphenidate hcl soln 5 mg/5ml* | 1 | QL (1800 mL / 25 days) |
| *methylphenidate hcl soln 10 mg/5ml* | 1 | QL (900 mL / 25 days) |
| *methylphenidate hcl tab 5 mg* | 1 | QL (180 tabs / 25 days) |
| *methylphenidate hcl tab 10 mg* | 1 | QL (180 tabs / 25 days) |
| *methylphenidate hcl tab 20 mg* | 1 | QL (90 tabs / 25 days) |
| *methylphenidate hcl tab er 10 mg* | 1 | QL (90 tabs / 25 days) |
| *methylphenidate hcl tab er 20 mg* | 1 | QL (90 tabs / 25 days) |
| *methylphenidate hcl tab er 24hr 18 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er 24hr 27 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er 24hr 36 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er 24hr 54 mg* | 1 | QL (30 tabs / 25 days) |
| *methylphenidate hcl tab er osmotic release (osm) 18 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er osmotic release (osm) 27 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er osmotic release (osm) 36 mg* | 1 | QL (60 tabs / 25 days) |
| *methylphenidate hcl tab er osmotic release (osm) 54 mg* | 1 | QL (30 tabs / 25 days) |
| VYVANSE CAP 10MG | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| VYVANSE CAP 20MG | 2 | |
| VYVANSE CAP 30MG | 2 | |
| VYVANSE CAP 40MG | 2 | |
| VYVANSE CAP 50MG | 2 | |
| VYVANSE CAP 60MG | 2 | |
| VYVANSE CAP 70MG | 2 | |
| VYVANSE CHW 10MG | 2 | |
| VYVANSE CHW 20MG | 2 | |
| VYVANSE CHW 30MG | 2 | |
| VYVANSE CHW 40MG | 2 | |
| VYVANSE CHW 50MG | 2 | |
| VYVANSE CHW 60MG | 2 | |
| *zenzedi tab 2.5mg* | 1 | QL (120 tabs / 25 days) |
| *zenzedi tab 7.5mg* | 1 | QL (120 tabs / 25 days) |
| *zenzedi tab 15mg* | 1 | QL (60 tabs / 25 days) |
| *zenzedi tab 20mg* | 1 | QL (60 tabs / 25 days) |
| *zenzedi tab 30mg* | 1 | QL (30 tabs / 25 days) |
| ***HYPNOTICS§*** | | |
| BELSOMRA TAB 5MG | 2 | ST; PA** |
| BELSOMRA TAB 10MG | 2 | ST; PA** |
| BELSOMRA TAB 15MG | 2 | ST; PA** |
| BELSOMRA TAB 20MG | 2 | ST; PA** |
| *eszopiclone tab 1 mg* | 1 | QL (15 tabs / 25 days) |
| *eszopiclone tab 2 mg* | 1 | QL (15 tabs / 25 days) |
| *eszopiclone tab 3 mg* | 1 | QL (15 tabs / 25 days) |
| HETLIOZ CAP 20MG | 5 | QL (30 caps / 30 days), PA |
| *ramelteon tab 8 mg* | 1 | QL (15 tabs / 25 days) |
| ROZEREM TAB 8MG | 3 | QL (15 tabs / 25 days), ST; PA** |
| SILENOR TAB 3MG | 2 | QL (30 tabs / 25 days), ST; QL applies to members age 65 and older; PA** |
| SILENOR TAB 6MG | 2 | QL (30 tabs / 25 days), ST; QL applies to members age 65 and older; PA** |
| *sleep-aid tab 25mg* | 0 | OTC |
| *temazepam cap 7.5 mg* | 1 | QL (15 caps / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *temazepam cap 15 mg* | 1 | QL (15 caps / 25 days) |
| *temazepam cap 22.5 mg* | 1 | QL (15 caps / 25 days) |
| *temazepam cap 30 mg* | 1 | QL (15 caps / 25 days) |
| *zaleplon cap 5 mg* | 1 | QL (15 caps / 25 days) |
| *zaleplon cap 10 mg* | 1 | QL (15 caps / 25 days) |
| *zolpidem tartrate tab 5 mg* | 1 | QL (15 tabs / 25 days) |
| *zolpidem tartrate tab 10 mg* | 1 | QL (15 tabs / 25 days) |
| *zolpidem tartrate tab er 6.25 mg* | 1 | QL (15 tabs / 25 days) |
| *zolpidem tartrate tab er 12.5 mg* | 1 | QL (15 tabs / 25 days) |
| ***MIGRAINE§*** | | |
| *almotriptan malate tab 6.25 mg* | 1 | QL (12 tabs / 25 days) |
| *almotriptan malate tab 12.5 mg* | 1 | QL (12 tabs / 25 days) |
| *dihydroergotamine mesylate inj 1 mg/ml* | M | M |
| *dihydroergotamine mesylate nasal spray 4 mg/ml* | 1 | QL (8 units / 25 days) |
| *eletriptan hydrobromide tab 20 mg (base equivalent)* | 1 | QL (12 tabs / 25 days) |
| *eletriptan hydrobromide tab 40 mg (base equivalent)* | 1 | QL (12 tabs / 25 days) |
| *ergotamine w/ caffeine tab 1-100 mg* | 1 | |
| *frovatriptan succinate tab 2.5 mg (base equivalent)* | 1 | QL (18 tabs / 25 days) |
| *naratriptan hcl tab 1 mg (base equiv)* | 1 | QL (12 tabs / 25 days) |
| *naratriptan hcl tab 2.5 mg (base equiv)* | 1 | QL (12 tabs / 25 days) |
| *rizatriptan benzoate oral disintegrating tab 5 mg (base eq)* | 1 | QL (18 tabs / 25 days) |
| *rizatriptan benzoate oral disintegrating tab 10 mg (base eq)* | 1 | QL (18 tabs / 25 days) |
| *rizatriptan benzoate tab 5 mg (base equivalent)* | 1 | QL (18 tabs / 25 days) |
| *rizatriptan benzoate tab 10 mg (base equivalent)* | 1 | QL (18 tabs / 25 days) |
| *sumatriptan nasal spray 5 mg/act* | 1 | QL (24 sprays / 25 days) |
| *sumatriptan nasal spray 20 mg/act* | 1 | QL (12 sprays / 25 days) |
| *sumatriptan succinate inj 6 mg/0.5ml* | 1 | QL (12 vials / 25 days) |
| *sumatriptan succinate solution auto-injector 4 mg/0.5ml* | 1 | QL (18 syringes / 25 days) |
| *sumatriptan succinate solution auto-injector 6 mg/0.5ml* | 1 | QL (12 units / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sumatriptan succinate solution cartridge 4 mg/0.5ml* | 1 | QL (18 syringes / 25 days) |
| *sumatriptan succinate solution cartridge 6 mg/0.5ml* | 1 | QL (12 units / 25 days) |
| *sumatriptan succinate solution prefilled syringe 6 mg/0.5ml* | 1 | QL (12 units / 25 days) |
| *sumatriptan succinate tab 25 mg* | 1 | QL (12 tabs / 25 days) |
| *sumatriptan succinate tab 50 mg* | 1 | QL (12 tabs / 25 days) |
| *sumatriptan succinate tab 100 mg* | 1 | QL (12 tabs / 25 days) |
| *zolmitriptan orally disintegrating tab 2.5 mg* | 1 | QL (12 tabs / 25 days) |
| *zolmitriptan orally disintegrating tab 5 mg* | 1 | QL (12 tabs / 25 days) |
| *zolmitriptan tab 2.5 mg* | 1 | QL (12 tabs / 25 days) |
| *zolmitriptan tab 5 mg* | 1 | QL (12 tabs / 25 days) |
| ZOMIG SPR 2.5MG | 3 | QL (12 sprays / 25 days) |
| ZOMIG SPR 5MG | 3 | QL (12 sprays / 25 days) |
| ***MISCELLANEOUS*** | | |
| *buspirone hcl tab 5 mg* | 1 | |
| *buspirone hcl tab 7.5 mg* | 1 | |
| *buspirone hcl tab 10 mg* | 1 | |
| *buspirone hcl tab 15 mg* | 1 | |
| *buspirone hcl tab 30 mg* | 1 | |
| *clomipramine hcl cap 25 mg* | 1 | QL (150 caps / 25 days); QL applies to members age 65 and older |
| *clomipramine hcl cap 50 mg* | 1 | QL (150 caps / 25 days); QL applies to members age 65 and older |
| *clomipramine hcl cap 75 mg* | 1 | QL (90 caps / 25 days); QL applies to members age 65 and older |
| *fluvoxamine maleate cap er 24hr 100 mg* | 1 | |
| *fluvoxamine maleate cap er 24hr 150 mg* | 1 | |
| *fluvoxamine maleate tab 25 mg* | 1 | |
| *fluvoxamine maleate tab 50 mg* | 1 | |
| *fluvoxamine maleate tab 100 mg* | 1 | |
| GUANIDINE TAB 125MG | 3 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *lithium carbonate cap 150 mg* | 1 | |
| *lithium carbonate cap 300 mg* | 1 | |
| *lithium carbonate cap 600 mg* | 1 | |
| *lithium carbonate tab 300 mg* | 1 | |
| *lithium carbonate tab er 300 mg* | 1 | |
| *lithium carbonate tab er 450 mg* | 1 | |
| LITHIUM SOL 8MEQ/5ML | 3 | |
| NUEDEXTA CAP 20-10MG | 2 | PA |
| *pimozide tab 1 mg* | 1 | |
| *pimozide tab 2 mg* | 1 | |
| *pyridostigmine bromide oral soln 60 mg/5ml* | 1 | |
| *pyridostigmine bromide tab 60 mg* | 1 | |
| *pyridostigmine bromide tab er 180 mg* | 1 | |
| REGONOL INJ 5MG/ML | M | M |
| *riluzole tab 50 mg* | 1 | |
| SAVELLA MIS TITR PAK | 3 | ST; PA** |
| SAVELLA TAB 12.5MG | 3 | ST; PA** |
| SAVELLA TAB 25MG | 3 | ST; PA** |
| SAVELLA TAB 50MG | 3 | ST; PA** |
| SAVELLA TAB 100MG | 3 | ST; PA** |
| *tetrabenazine tab 12.5 mg* | 4 | QL (240 tabs / 30 days), PA |
| *tetrabenazine tab 25 mg* | 4 | QL (120 tabs / 30 days), PA |
| ***MULTIPLE SCLEROSIS AGENTS*** | | |
| AUBAGIO TAB 7MG | 4 | QL (30 tabs / 30 days), PA |
| AUBAGIO TAB 14MG | 4 | QL (30 tabs / 30 days), PA |
| AVONEX KIT 30MCG | 5 | QL (4 injections / 28 days), PA, ST |
| AVONEX PEN KIT 30MCG | 5 | QL (4 injections / 28 days), PA, ST |
| AVONEX PREFL KIT 30MCG | 5 | QL (4 injections / 28 days), PA, ST |
| BETASERON INJ 0.3MG | 4 | QL (14 injections / 28 days), PA |
| COPAXONE INJ 20MG/ML | 4 | QL (30 injections / 30 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| COPAXONE INJ 40MG/ML | 4 | QL (12 syringes / 28 days), PA |
| *dalfampridine tab er 12hr 10 mg* | 5 | QL (60 tabs / 30 days), PA |
| GILENYA CAP 0.5MG | 4 | QL (30 caps / 30 days), PA |
| *glatiramer acetate soln prefilled syringe 40 mg/ml* | 2 | QL (12 syringes / 28 days), PA |
| *glatopa inj 20mg/ml* | 2 | QL (30 injections / 30 days), PA |
| PLEGRIDY INJ | 5 | QL (1 carton / 28 days), PA, ST |
| PLEGRIDY INJ PEN | 5 | QL (1 carton / 28 days), PA, ST |
| PLEGRIDY INJ STARTER | 5 | QL (1 kit / 28 days), PA, ST |
| PLEGRIDY PEN INJ STARTER | 5 | QL (1 pack / 28 days), PA, ST |
| REBIF INJ 22/0.5 | 4 | QL (12 syringes / 28 days), PA |
| REBIF INJ 44/0.5 | 4 | QL (12 syringes / 28 days), PA |
| REBIF REBIDO INJ 22/0.5 | 4 | QL (12 syringes / 28 days), PA |
| REBIF REBIDO INJ 44/0.5 | 4 | QL (12 syringes / 28 days), PA |
| REBIF REBIDO INJ TITRATN | 4 | QL (1 box / 28 days), PA |
| REBIF TITRTN INJ PACK | 4 | QL (1 box / 28 days), PA |
| TECFIDERA CAP 120MG | 4 | QL (14 caps / 28 days), PA |
| TECFIDERA CAP 240MG | 4 | QL (60 caps / 30 days), PA |
| TECFIDERA MIS STARTER | 4 | QL (1 kit / 30 days), PA |
| TYSABRI INJ 300/15ML | M | M |
| ***MUSCULOSKELETAL THERAPY AGENTS*** | | |
| *baclofen tab 5 mg* | 1 | |
| *baclofen tab 10 mg* | 1 | |
| *baclofen tab 20 mg* | 1 | |
| *carisoprodol tab 250 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *carisoprodol tab 350 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *chlorzoxazone tab 500 mg* | 1 | |
| *cyclobenzaprine hcl tab 5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *cyclobenzaprine hcl tab 7.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *cyclobenzaprine hcl tab 10 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *dantrolene sodium cap 25 mg* | 1 | |
| *dantrolene sodium cap 50 mg* | 1 | |
| *dantrolene sodium cap 100 mg* | 1 | |
| *metaxalone tab 400 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *metaxalone tab 800 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *methocarbamol tab 500 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *methocarbamol tab 750 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *orphenadrine citrate inj 30 mg/ml* | M | M |
| *orphenadrine citrate tab er 12hr 100 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *tizanidine hcl tab 2 mg (base equivalent)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tizanidine hcl tab 4 mg (base equivalent)* | 1 | |
| ***NARCOLEPSY/CATAPLEXY*** | | |
| *armodafinil tab 50 mg* | 1 | PA |
| *armodafinil tab 150 mg* | 1 | PA |
| *armodafinil tab 200 mg* | 1 | PA |
| *armodafinil tab 250 mg* | 1 | PA |
| *modafinil tab 100 mg* | 1 | PA |
| *modafinil tab 200 mg* | 1 | PA |
| XYREM SOL 500MG/ML | 4 | PA |
| ***PSYCHOTHERAPEUTIC-MISC*** | | |
| *acamprosate calcium tab delayed release 333 mg* | 1 | PA |
| *bupropion hcl (smoking deterrent) tab er 12hr 150 mg* | 0 | $0 limited to 2 treatment cycles/year |
| CHANTIX PAK 0.5& 1MG | 0 | $0 limited to 2 treatment cycles/year |
| CHANTIX PAK 1MG | 0 | $0 limited to 2 treatment cycles/year |
| CHANTIX TAB 0.5MG | 0 | $0 limited to 2 treatment cycles/year |
| CHANTIX TAB 1MG | 0 | $0 limited to 2 treatment cycles/year |
| *disulfiram tab 250 mg* | 1 | |
| *disulfiram tab 500 mg* | 1 | |
| *naloxone hcl inj 0.4 mg/ml* | 1 | |
| *naloxone hcl inj 4 mg/10ml* | 1 | |
| *naloxone hcl soln cartridge 0.4 mg/ml* | 1 | |
| *naloxone hcl soln prefilled syringe 2 mg/2ml* | 1 | |
| *naltrexone hcl tab 50 mg* | 1 | Must obtain approval after the initial fill |
| NARCAN SPR | 2 | |
| *nicorelief gum 4mg mint* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine dis 7mg/24hr* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine pol loz 4mg mint* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine polacrilex gum 2 mg* | 0 | OTC; $0 limited to 2 treatment cycles/year |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *nicotine polacrilex gum 4 mg* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine polacrilex lozenge 2 mg* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine td patch 24hr 7 mg/24hr* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine td patch 24hr 14 mg/24hr* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *nicotine td patch 24hr 21 mg/24hr* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| NICOTROL INH | 0 | QL (max 168 days / year); $0 limited to 2 treatment cycles/year |
| NICOTROL NS SPR 10MG/ML | 0 | QL (max 168 days / year); $0 limited to 2 treatment cycles/year |
| *sm nicotine dis 7mg/24hr* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *sm nicotine dis 14mg/24h* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| *sm nicotine dis 21mg* | 0 | OTC; $0 limited to 2 treatment cycles/year |
| VIVITROL INJ 380MG | M | M |
| **ENDOCRINE AND METABOLIC** | | |
| ***ANDROGENS*** | | |
| ANADROL-50 TAB 50MG | 3 | PA |
| INTRAROSA SUP 6.5MG | 3 | |
| *methyltestosterone cap 10 mg* | 1 | PA |
| *oxandrolone tab 2.5 mg* | 1 | PA |
| *oxandrolone tab 10 mg* | 1 | PA |
| *testosterone cypionate im inj in oil 100 mg/ml* | 1 | PA |
| *testosterone cypionate im inj in oil 200 mg/ml* | 1 | PA |
| *testosterone enanthate im inj in oil 200 mg/ml* | 1 | PA |
| *testosterone td gel 10mg/act (2%)* | 1 | PA |
| *testosterone td gel 25 mg/2.5gm (1%)* | 1 | PA |
| ***ANTIDIABETICS, ALPHA-GLUCOSIDASE INHIBITORS*** | | |
| *acarbose tab 25 mg* | 1 | |
| *acarbose tab 50 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *acarbose tab 100 mg* | 1 | |
| *miglitol tab 25 mg* | 1 | |
| *miglitol tab 50 mg* | 1 | |
| *miglitol tab 100 mg* | 1 | |
| ***ANTIDIABETICS, AMYLIN ANALOGS*** | | |
| SYMLINPEN 60 INJ 1000MCG | 3 | ST; PA** |
| SYMLNPEN 120 INJ 1000MCG | 3 | ST; PA** |
| ***ANTIDIABETICS, BIGUANIDE*** | | |
| *metformin hcl tab 500 mg* | 1 | |
| *metformin hcl tab 850 mg* | 1 | |
| *metformin hcl tab 1000 mg* | 1 | |
| *metformin hcl tab er 24hr 500 mg* | 1 | |
| *metformin hcl tab er 24hr 750 mg* | 1 | |
| ***ANTIDIABETICS, BIGUANIDE/ SULFONYLUREA COMBINATIONS*** | | |
| *glipizide-metformin hcl tab 2.5-250 mg* | 1 | |
| *glipizide-metformin hcl tab 2.5-500 mg* | 1 | |
| *glipizide-metformin hcl tab 5-500 mg* | 1 | |
| *glyburide-metformin tab 1.25-250 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide-metformin tab 2.5-500 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide-metformin tab 5-500 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***ANTIDIABETICS, DIPEPTIDYL PEPTIDASE-4 INHIBITORS*** | | |
| *alogliptin benzoate tab 6.25 mg (base equiv)* | 1 | |
| *alogliptin benzoate tab 12.5 mg (base equiv)* | 1 | |
| *alogliptin benzoate tab 25 mg (base equiv)* | 1 | |
| JANUVIA TAB 25MG | 2 | ST; PA** |
| JANUVIA TAB 50MG | 2 | ST; PA** |
| JANUVIA TAB 100MG | 2 | ST; PA** |
| TRADJENTA TAB 5MG | 2 | ST; PA** |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***ANTIDIABETICS, DOPAMINE RECEPTOR AGONISTS*** | | |
| CYCLOSET TAB 0.8MG | 3 | |
| ***ANTIDIABETICS, DPP-4 INHIBITOR COMBINATIONS*** | | |
| JANUMET TAB 50-500MG | 2 | ST; PA** |
| JANUMET TAB 50-1000 | 2 | ST; PA** |
| JANUMET XR TAB 50-500MG | 2 | ST; PA** |
| JANUMET XR TAB 50-1000 | 2 | ST; PA** |
| JANUMET XR TAB 100-1000 | 2 | ST; PA** |
| JENTADUETO TAB XR | 3 | ST; PA** |
| ***ANTIDIABETICS, INCRETIN MIMETIC AGENTS*** | | |
| OZEMPIC INJ 2/1.5ML | 2 | ST; PA** |
| TRULICITY INJ 0.75/0.5 | 2 | ST; PA** |
| TRULICITY INJ 1.5/0.5 | 2 | ST; PA** |
| VICTOZA INJ 18MG/3ML | 2 | ST; PA** |
| ***ANTIDIABETICS, INCRETIN MIMETIC COMBINATION AGENTS*** | | |
| SOLIQUA INJ 100/33 | 2 | ST; PA** |
| XULTOPHY INJ 100/3.6 | 3 | ST; PA** |
| ***ANTIDIABETICS, INSULIN*** | | |
| BASAGLAR INJ 100UNIT | 2 | |
| FIASP FLEX INJ TOUCH | 2 | |
| FIASP INJ 100/ML | 2 | |
| HUMULIN INJ 70/30 | 3 | OTC |
| HUMULIN INJ 70/30KWP | 3 | OTC |
| HUMULIN N INJ U-100 | 3 | OTC |
| HUMULIN N INJ U-100KWP | 3 | OTC |
| HUMULIN R INJ U-100 | 3 | OTC |
| HUMULIN R INJ U-500 | 2 | |
| LEVEMIR INJ | 2 | |
| LEVEMIR INJ FLEXTOUC | 2 | |
| NOVOLIN INJ 70/30 | 2 | OTC; RELION not covered |
| NOVOLIN INJ FLEXPEN | 2 | OTC; RELION not covered |
| NOVOLIN N INJ U-100 | 2 | OTC; RELION not covered |
| NOVOLIN R INJ U-100 | 2 | OTC; RELION not covered |
| NOVOLOG INJ 100/ML | 2 | |
| NOVOLOG INJ FLEXPEN | 2 | |
| NOVOLOG INJ PENFILL | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| NOVOLOG MIX INJ 70/30 | 2 | |
| NOVOLOG MIX INJ FLEXPEN | 2 | |
| TRESIBA FLEX INJ 100UNIT | 2 | |
| TRESIBA FLEX INJ 200UNIT | 2 | |
| TRESIBA INJ 100UNIT | 2 | |
| ***ANTIDIABETICS, INSULIN SENSITIZER*** | | |
| *pioglitazone hcl tab 15 mg (base equiv)* | 1 | |
| *pioglitazone hcl tab 30 mg (base equiv)* | 1 | |
| *pioglitazone hcl tab 45 mg (base equiv)* | 1 | |
| ***ANTIDIABETICS, INSULIN SENSITIZER/BIGUANIDE COMBINATION*** | | |
| *pioglitazone hcl-metformin hcl tab 15-500 mg* | 1 | |
| *pioglitazone hcl-metformin hcl tab 15-850 mg* | 1 | |
| ***ANTIDIABETICS, INSULIN SENSITIZER/SULFONYLUREA COMBINATION*** | | |
| *pioglitazone hcl-glimepiride tab 30-2 mg* | 1 | |
| *pioglitazone hcl-glimepiride tab 30-4 mg* | 1 | |
| ***ANTIDIABETICS, MEGLITINIDE*** | | |
| *nateglinide tab 60 mg* | 1 | |
| *nateglinide tab 120 mg* | 1 | |
| *repaglinide tab 0.5 mg* | 1 | |
| *repaglinide tab 1 mg* | 1 | |
| *repaglinide tab 2 mg* | 1 | |
| ***ANTIDIABETICS, MEGLITINIDE/BIGUANIDE COMBINATION*** | | |
| *repaglinide-metformin hcl tab 1-500 mg* | 1 | |
| *repaglinide-metformin hcl tab 2-500 mg* | 1 | |
| ***ANTIDIABETICS, SODIUM-GLUC CO-TRANSPOR2 INHIB (SGLT2) COMBO*** | | |
| SYNJARDY TAB | 2 | ST; PA** |
| SYNJARDY TAB 5-500MG | 2 | ST; PA** |
| SYNJARDY TAB 5-1000MG | 2 | ST; PA** |
| SYNJARDY TAB 12.5-500 | 2 | ST; PA** |
| SYNJARDY XR TAB | 2 | ST; PA** |
| SYNJARDY XR TAB 5-1000MG | 2 | ST; PA** |
| SYNJARDY XR TAB 10-1000 | 2 | ST; PA** |
| SYNJARDY XR TAB 25-1000 | 2 | ST; PA** |
| XIGDUO XR TAB 2.5-1000 | 2 | ST; PA** |
| XIGDUO XR TAB 5-500MG | 2 | ST; PA** |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| XIGDUO XR TAB 5-1000MG | 2 | ST; PA** |
| XIGDUO XR TAB 10-500MG | 2 | ST; PA** |
| XIGDUO XR TAB 10-1000 | 2 | ST; PA** |
| ***ANTIDIABETICS, SODIUM-GLUC CO-TRANSPOR2 INHIB (SGLT2)/DPP-4 INHIBITOR COMBINATIONS*** | | |
| GLYXAMBI TAB 10-5 MG | 2 | ST; PA** |
| GLYXAMBI TAB 25-5 MG | 2 | ST; PA** |
| QTERN TAB 5-5MG | 2 | ST; PA** |
| QTERN TAB 10MG/5MG | 2 | ST; PA** |
| ***ANTIDIABETICS, SODIUM-GLUCOSE COTRANSPORTER2(SGLT2) INHIB*** | | |
| FARXIGA TAB 5MG | 2 | ST; PA** |
| FARXIGA TAB 10MG | 2 | ST; PA** |
| JARDIANCE TAB 10MG | 2 | ST; PA** |
| JARDIANCE TAB 25MG | 2 | ST; PA** |
| ***ANTIDIABETICS, SULFONYLUREA*** | | |
| *glimepiride tab 1 mg* | 1 | |
| *glimepiride tab 2 mg* | 1 | |
| *glimepiride tab 4 mg* | 1 | |
| *glipizide tab 5 mg* | 1 | |
| *glipizide tab 10 mg* | 1 | |
| *glipizide tab er 24hr 2.5 mg* | 1 | |
| *glipizide tab er 24hr 5 mg* | 1 | |
| *glipizide tab er 24hr 10 mg* | 1 | |
| *glyburide micronized tab 1.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide micronized tab 3 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide micronized tab 6 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide tab 1.25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *glyburide tab 2.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *glyburide tab 5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| ***ANTIDIABETICS, SUPPLIES*** | | |
| DEXCOM G5 MIS RECEIVER | 2 | |
| DEXCOM G5 MIS TRANSMIT | 2 | |
| DEXCOM G6 MIS RECEIVER | 2 | |
| DEXCOM G6 MIS SENSOR | 2 | |
| DEXCOM G6 MIS TRANSMIT | 2 | |
| FREESTYLE KIT SENSOR | 2 | |
| FREESTYLE MIS READER | 2 | |
| G4 PLAT PED MIS RVC/SHAR | 2 | |
| G4 PLATINUM MIS PEDIATRC | 2 | |
| G4 PLATINUM MIS RCV/SHAR | 2 | |
| G4 PLATINUM MIS RECEIVER | 2 | |
| G4 PLATINUM MIS TRANSMIT | 2 | |
| G4 SENSOR MIS | 2 | |
| G5/G4 MIS SENSOR | 2 | |
| ***BISPHOSPHONATES*** | | |
| *alendronate sodium oral soln 70 mg/75ml* | 1 | |
| *alendronate sodium tab 5 mg* | 1 | |
| *alendronate sodium tab 10 mg* | 1 | |
| *alendronate sodium tab 35 mg* | 1 | |
| *alendronate sodium tab 40 mg* | 1 | |
| *alendronate sodium tab 70 mg* | 1 | |
| FOSAMAX + D TAB 70-2800 | 3 | ST; PA** |
| FOSAMAX + D TAB 70-5600 | 3 | ST; PA** |
| *ibandronate sodium iv soln 3 mg/3ml (base equivalent)* | M | M |
| *ibandronate sodium tab 150 mg (base equivalent)* | 1 | |
| *pamidronate disodium for inj 30 mg* | M | M |
| *pamidronate disodium for inj 90 mg* | M | M |
| *pamidronate disodium iv soln 3 mg/ml* | M | M |
| *pamidronate disodium iv soln 9 mg/ml* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *risedronate sodium tab 5 mg* | 1 | |
| *risedronate sodium tab 30 mg* | 1 | |
| *risedronate sodium tab 35 mg* | 1 | |
| *risedronate sodium tab 150 mg* | 1 | |
| *risedronate sodium tab delayed release 35 mg* | 1 | |
| *zoledronic acid inj conc for iv infusion 4 mg/5ml* | M | M |
| *zoledronic acid iv soln 5 mg/100ml* | M | M |
| ***CALCIUM RECEPTOR AGONISTS*** | | |
| SENSIPAR TAB 30MG | 4 | QL (60 tabs / 30 days), PA |
| SENSIPAR TAB 60MG | 4 | QL (60 tabs / 30 days), PA |
| SENSIPAR TAB 90MG | 4 | QL (120 tabs / 30 days), PA |
| ***CHELATING AGENTS*** | | |
| CHEMET CAP 100MG | 3 | |
| DEPEN TITRA TAB 250MG | 3 | |
| FERRIPROX SOL 100MG/ML | 4 | PA |
| FERRIPROX TAB 500MG | 4 | PA |
| FERRIPROX TAB 1000MG | 4 | PA |
| *kionex sus 15gm/60* | 1 | |
| *sodium polystyrene sulfonate oral susp 15 gm/60ml* | 1 | |
| *sodium polystyrene sulfonate rectal susp 30 gm/120ml* | 1 | |
| THYROSAFE TAB 65MG | 2 | OTC |
| *trientine hcl cap 250 mg* | 1 | |
| ***CONTRACEPTIVES*** | | |
| *altavera tab* | 0 | |
| *alyacen tab 1/35* | 0 | |
| *alyacen tab 7/7/7* | 0 | |
| *amethia tab* | 0 | |
| *amethyst tab 90-20mcg* | 0 | |
| ANNOVERA MIS | 0 | QL (1 / 300 days) |
| *apri tab* | 0 | |
| *aranelle tab* | 0 | |
| *ashlyna tab* | 0 | |
| *aviane tab* | 0 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *azurette tab 28 day* | 0 | |
| BALCOLTRA TAB 0.1-20 | 0 | |
| *camila tab 0.35mg* | 0 | |
| *caziant pak* | 0 | |
| *chateal tab 0.15/30* | 0 | |
| *cryselle-28 tab 28 tabs* | 0 | |
| *cyclafem tab 1/35* | 0 | |
| *cyclafem tab 7/7/7* | 0 | |
| *dasetta tab 1/35* | 0 | |
| *dasetta tab 7/7/7* | 0 | |
| *delyla tab 0.1-0.02* | 0 | |
| DEPO-SQ PROV INJ 104 | 0 | QL (4 inj / 300 days) |
| *drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg* | 0 | |
| *drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg* | 0 | |
| *drospirenone-ethinyl estradiol tab 3-0.03 mg* | 0 | |
| *elinest tab* | 0 | |
| ELLA TAB 30MG | 0 | |
| *emoquette tab* | 0 | |
| *enpresse-28 tab* | 0 | |
| *enskyce tab* | 0 | |
| *errin tab 0.35mg* | 0 | |
| *ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg* | 0 | |
| *falmina tab* | 0 | |
| *fayosim tab* | 0 | |
| *gianvi tab 3-0.02mg* | 0 | |
| *gildess fe tab 1.5/30* | 0 | |
| *gildess fe tab 1/20* | 0 | |
| *heather tab 0.35mg* | 0 | |
| *introvale tab* | 0 | |
| *jolessa tab* | 0 | |
| *jolivette tab 0.35mg* | 0 | |
| *junel 1.5/30 tab* | 0 | |
| *junel 1/20 tab* | 0 | |
| *junel fe tab 1.5/30* | 0 | |
| *junel fe tab 1/20* | 0 | |
| *kariva tab 28 day* | 0 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *kelnor tab 1/35* | 0 | |
| *kurvelo tab 0.15/30* | 0 | |
| KYLEENA IUD 19.5MG | M | M |
| *larin tab 1.5/30* | 0 | |
| *leena tab* | 0 | |
| *lessina tab* | 0 | |
| *levonest tab* | 0 | |
| *levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)* | 0 | |
| *levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg* | 0 | |
| *levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg* | 0 | |
| *levora-28 tab 0.15/30* | 0 | |
| LILETTA IUD 52MG | M | M |
| LO LOESTRIN TAB 1-10-10 | 0 | |
| *loryna tab 3-0.02mg* | 0 | |
| *low-ogestrel tab* | 0 | |
| *lutera tab* | 0 | |
| *marlissa tab 0.15/30* | 0 | |
| *medroxyprogesterone acetate im susp 150 mg/ml* | 0 | QL (4 inj / 300 days) |
| *medroxyprogesterone acetate im susp prefilled syr 150 mg/ml* | 0 | QL (4 inj / 300 days) |
| *mibelas 24 chw fe* | 0 | |
| *microgestin tab 1.5/30* | 0 | |
| MIRENA IUD SYSTEM | M | M |
| *mono-linyah tab 0.25-35* | 0 | |
| *mononessa tab* | 0 | |
| *myzilra tab* | 0 | |
| NATAZIA TAB | 0 | |
| *necon tab 0.5/35* | 0 | |
| *necon tab 1/35* | 0 | |
| *necon tab 1/50-28* | 0 | |
| NECON TAB 10/11-28 | 0 | |
| NEXPLANON IMP 68MG | M | M |
| *nikki tab 3-0.02mg* | 0 | |
| *nora-be tab 0.35mg* | 0 | |
| *norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg* | 0 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg* | 0 | |
| *norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)* | 0 | |
| *norethindrone tab 0.35 mg* | 0 | |
| *norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg* | 0 | |
| *norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg* | 0 | |
| *norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg* | 0 | |
| *nortrel tab 0.5/35* | 0 | |
| *nortrel tab 1/35* | 0 | |
| *nortrel tab 7/7/7* | 0 | |
| NUVARING MIS | 0 | QL (13 / 300 days) |
| *ocella tab 3-0.03mg* | 0 | |
| *ogestrel tab* | 0 | |
| *orsythia tab* | 0 | |
| PARAGARD IUD T380A | M | M |
| *pirmella tab 1/35* | 0 | |
| *pirmella tab 7/7/7* | 0 | |
| *portia-28 tab* | 0 | |
| *previfem tab* | 0 | |
| *quasense tab* | 0 | |
| *reclipsen tab* | 0 | |
| *rivelsa tab* | 0 | |
| SKYLA IUD 13.5MG | M | M |
| SLYND TAB 4MG | 0 | |
| *sprintec 28 tab 28 day* | 0 | |
| *sronyx tab* | 0 | |
| *syeda tab 3-0.03mg* | 0 | |
| *take action tab 1.5mg* | 0 | OTC |
| TAYTULLA CAP 1MG/20MC | 0 | |
| *tilia fe tab* | 0 | |
| *tri-linyah tab* | 0 | |
| *tri-sprintec tab* | 0 | |
| *trinessa tab* | 0 | |
| *trivora-28 tab* | 0 | |
| *velivet pak* | 0 | |
| *vestura tab 3-0.02mg* | 0 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *viorele tab* | 0 | |
| *wera tab 0.5/35* | 0 | |
| *xulane dis 150-35* | 0 | |
| *zarah tab 3-0.03mg* | 0 | |
| *zenchent fe chw 0.4mg-35* | 0 | |
| *zenchent tab* | 0 | |
| *zovia 1/35e tab* | 0 | |
| ***ENDOMETRIOSIS*** | | |
| *danazol cap 50 mg* | 1 | |
| *danazol cap 100 mg* | 1 | |
| *danazol cap 200 mg* | 1 | |
| SYNAREL SOL 2MG/ML | 2 | |
| ***ENZYME REPLACEMENTS*** | | |
| CARBAGLU TAB 200MG | 4 | PA |
| CERDELGA CAP 84MG | 4 | QL (60 caps / 30 days), PA |
| CYSTADANE POW | 4 | |
| CYSTAGON CAP 50MG | 4 | PA |
| CYSTAGON CAP 150MG | 4 | PA |
| KUVAN POW 100MG | 4 | PA |
| KUVAN POW 500MG | 4 | PA |
| KUVAN TAB 100MG | 4 | PA |
| MYALEPT INJ 11.3MG | 4 | PA |
| ORFADIN CAP 2MG | 4 | PA |
| ORFADIN CAP 5MG | 4 | PA |
| ORFADIN CAP 10MG | 4 | PA |
| ORFADIN CAP 20MG | 4 | PA |
| ORFADIN SUS 4MG/ML | 4 | PA |
| *sodium phenylbutyrate oral powder 3 gm/teaspoonful* | 1 | PA |
| *sodium phenylbutyrate tab 500 mg* | 4 | PA |
| ***ESTROGENS*** | | |
| CLIMARA PRO DIS WEEKLY | 2 | |
| DEPO-ESTRADI INJ 5MG/ML | M | M |
| DIVIGEL GEL 0.5MG | 3 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| DIVIGEL GEL 0.25MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| DIVIGEL GEL 0.75MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| DIVIGEL GEL 1MG/GM | 3 | PA; High Risk Medications require PA for members age 70 and older |
| DUAVEE TAB 0.45-20 | 2 | |
| ELESTRIN GEL 0.06% | 3 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol & norethindrone acetate tab 0.5-0.1 mg* | 1 | |
| *estradiol & norethindrone acetate tab 1-0.5 mg* | 1 | |
| *estradiol tab 0.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol tab 1 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol tab 2 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch twice weekly 0.1 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch twice weekly 0.05 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *estradiol td patch twice weekly 0.025 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch twice weekly 0.075 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch twice weekly 0.0375 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.1 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.05 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.06 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.025 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.075 mg/24hr* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estradiol vaginal cream 0.1 mg/gm* | 1 | |
| *estradiol valerate im in oil 20 mg/ml* | M | M |
| *estradiol valerate im in oil 40 mg/ml* | M | M |
| ESTROGEL GEL | 3 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *estropipate tab 0.75 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estropipate tab 1.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *estropipate tab 3 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| EVAMIST SPR 1.53MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| *jinteli tab 1mg-5mcg* | 1 | |
| MENEST TAB 0.3MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| MENEST TAB 0.625MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| MENEST TAB 1.25MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| MENEST TAB 2.5MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| *mimvey lo tab 0.5-0.1* | 1 | |
| *mimvey tab 1-0.5mg* | 1 | |
| *norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg* | 1 | |
| PREMARIN INJ 25MG | M | M |
| PREMARIN TAB 0.3MG | 3 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PREMARIN TAB 0.9MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| PREMARIN TAB 0.45MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| PREMARIN TAB 0.625MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| PREMARIN TAB 1.25MG | 3 | PA; High Risk Medications require PA for members age 70 and older |
| PREMARIN VAG CRE 0.625MG | 3 | |
| *yuvafem tab 10mcg* | 1 | |
| ***FERTILITY REGULATORS*** | | |
| CHOR GONADOT INJ 10000UNT | 5 | PA |
| *clomiphene citrate tab 50 mg* | 1 | |
| *ganirelix acetate soln prefilled syringe 250 mcg/0.5ml* | 4 | PA |
| GONAL-F INJ 450UNIT | 4 | QL (10 vials / 28 days), PA |
| GONAL-F INJ 1050UNIT | 4 | QL (6 vials / 28 days), PA |
| GONAL-F RFF INJ 75UNIT | 4 | QL (60 vials / 28 days), PA |
| GONAL-F RFF INJ 300/0.5 | 4 | QL (15 cartridges / 28 days), PA |
| GONAL-F RFF INJ 450/0.75 | 4 | QL (10 cartridges / 28 days), PA |
| GONAL-F RFF INJ 900/1.5 | 4 | QL (7 cartridges / 28 days), PA |
| OVIDREL INJ | 4 | PA |
| ***GLUCOCORTICOIDS*** | | |
| *cortisone acetate tab 25 mg* | 1 | |
| DEPO-MEDROL INJ 20MG/ML | M | M |
| DEXAMETHASON CON 1MG/ML | 2 | |
| *dexamethasone elixir 0.5 mg/5ml* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *dexamethasone sod phosphate preservative free inj 10 mg/ml* | M | M |
| *dexamethasone sodium phosphate inj 4 mg/ml* | M | M |
| *dexamethasone sodium phosphate inj 10 mg/ml* | M | M |
| *dexamethasone sodium phosphate inj 20 mg/5ml* | M | M |
| *dexamethasone sodium phosphate inj 100 mg/10ml* | M | M |
| *dexamethasone sodium phosphate inj 120 mg/30ml* | M | M |
| *dexamethasone soln 0.5 mg/5ml* | 1 | |
| *dexamethasone tab 0.5 mg* | 1 | |
| *dexamethasone tab 0.75 mg* | 1 | |
| *dexamethasone tab 1 mg* | 1 | |
| *dexamethasone tab 1.5 mg* | 1 | |
| *dexamethasone tab 2 mg* | 1 | |
| *dexamethasone tab 4 mg* | 1 | |
| *dexamethasone tab 6 mg* | 1 | |
| *fludrocortisone acetate tab 0.1 mg* | 1 | |
| *hydrocortisone tab 5 mg* | 1 | |
| *hydrocortisone tab 10 mg* | 1 | |
| *hydrocortisone tab 20 mg* | 1 | |
| MEDROL TAB 2MG | 2 | |
| *methylprednisolone acetate inj susp 40 mg/ml* | M | M |
| *methylprednisolone acetate inj susp 80 mg/ml* | M | M |
| *methylprednisolone sod succ for inj 40 mg (base equiv)* | M | M |
| *methylprednisolone sod succ for inj 125 mg (base equiv)* | M | M |
| *methylprednisolone sod succ for inj 1000 mg (base equiv)* | M | M |
| *methylprednisolone tab 4 mg* | 1 | |
| *methylprednisolone tab 8 mg* | 1 | |
| *methylprednisolone tab 16 mg* | 1 | |
| *methylprednisolone tab 32 mg* | 1 | |
| *methylprednisolone tab therapy pack 4 mg (21)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *prednisolone sod phos orally disintegr tab 10 mg (base eq)* | 1 | |
| *prednisolone sod phos orally disintegr tab 15 mg (base eq)* | 1 | |
| *prednisolone sod phos orally disintegr tab 30 mg (base eq)* | 1 | |
| *prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)* | 1 | |
| *prednisolone sod phosphate oral soln 10 mg/5ml (base equiv)* | 1 | |
| *prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)* | 1 | |
| *prednisolone sod phosphate oral soln 20 mg/5ml (base equiv)* | 1 | |
| *prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)* | 1 | |
| *prednisolone syrup 15 mg/5ml (usp solution equivalent)* | 1 | |
| PREDNISONE CON 5MG/ML | 2 | |
| *prednisone oral soln 5 mg/5ml* | 1 | |
| *prednisone tab 1 mg* | 1 | |
| *prednisone tab 2.5 mg* | 1 | |
| *prednisone tab 5 mg* | 1 | |
| *prednisone tab 10 mg* | 1 | |
| *prednisone tab 20 mg* | 1 | |
| *prednisone tab 50 mg* | 1 | |
| *prednisone tab therapy pack 5 mg (21)* | 1 | |
| *prednisone tab therapy pack 5 mg (48)* | 1 | |
| *prednisone tab therapy pack 10 mg (21)* | 1 | |
| *prednisone tab therapy pack 10 mg (48)* | 1 | |
| SOLU-CORTEF INJ 100MG | M | M |
| SOLU-CORTEF INJ 250MG | M | M |
| SOLU-CORTEF INJ 500MG | M | M |
| SOLU-CORTEF INJ 1000MG | M | M |
| SOLU-MEDROL INJ 2GM | M | M |
| ***GLUCOSE ELEVATING AGENTS*** | | |
| GLUCAGON KIT 1MG | 2 | |
| INSTA-GLUCOS GEL 77.4% | 2 | OTC |
| ***HUMAN GROWTH HORMONES*** | | |
| HUMATROPE INJ 5MG | 4 | PA |
| HUMATROPE INJ 6MG | 4 | PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| HUMATROPE INJ 12MG | 4 | PA |
| HUMATROPE INJ 24MG | 4 | PA |
| ***MISCELLANEOUS*** | | |
| *cabergoline tab 0.5 mg* | 1 | |
| *calcitonin (salmon) nasal soln 200 unit/act* | 1 | |
| INCRELEX INJ 40MG/4ML | 4 | PA |
| MIACALCIN INJ 200/ML | 3 | |
| *octreotide acetate inj 50 mcg/ml (0.05 mg/ml)* | 4 | QL (90 ml / 30 days), PA |
| *octreotide acetate inj 100 mcg/ml (0.1 mg/ml)* | 4 | QL (90 ml / 30 days), PA |
| *octreotide acetate inj 200 mcg/ml (0.2 mg/ml)* | 4 | QL (225 ml / 30 days), PA |
| *octreotide acetate inj 500 mcg/ml (0.5 mg/ml)* | 4 | QL (90 ml / 30 days), PA |
| *octreotide acetate inj 1000 mcg/ml (1 mg/ml)* | 4 | QL (45 ml / 30 days), PA |
| OSPHENA TAB 60MG | 2 | |
| PROLIA SOL 60MG/ML | 4 | QL (60mg / 24 weeks), PA |
| *raloxifene hcl tab 60 mg* | 1 | $0 copay for women ages 35 and older for the primary prevention of breast cancer |
| SAMSCA TAB 15MG | 4 | PA |
| SAMSCA TAB 30MG | 4 | PA |
| SIGNIFOR INJ 0.3MG/ML | 5 | QL (60 ampules / 30 days), PA |
| SIGNIFOR INJ 0.6MG/ML | 5 | QL (60 ampules / 30 days), PA |
| SIGNIFOR INJ 0.9MG/ML | 5 | QL (60 ampules / 30 days), PA |
| SOMATULINE INJ 60/0.2ML | 4 | QL (1 injection / 28 days), PA |
| SOMATULINE INJ 90/0.3ML | 4 | QL (1 injection / 28 days), PA |
| SOMATULINE INJ 120/.5ML | 4 | QL (1 injection / 28 days), PA |
| SOMAVERT INJ 10MG | 4 | QL (30 vials / 30 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SOMAVERT INJ 15MG | 4 | QL (30 vials / 30 days), PA |
| SOMAVERT INJ 20MG | 4 | QL (30 vials / 30 days), PA |
| SOMAVERT INJ 25MG | 4 | QL (30 vials / 30 days), PA |
| SOMAVERT INJ 30MG | 4 | QL (30 vials / 30 days), PA |
| TYMLOS INJ | 4 | QL (1 pen / 30 days), PA |
| ***PHOSPHATE BINDER AGENTS*** | | |
| *calcium acetate (phosphate binder) cap 667 mg (169 mg ca)* | 1 | |
| *calcium acetate (phosphate binder) tab 667 mg* | 1 | |
| FOSRENOL POW 750MG | 3 | |
| FOSRENOL POW 1000MG | 3 | |
| *lanthanum carbonate chew tab 500 mg (elemental)* | 1 | |
| *lanthanum carbonate chew tab 750 mg (elemental)* | 1 | |
| *lanthanum carbonate chew tab 1000 mg (elemental)* | 1 | |
| PHOSLYRA SOL | 2 | |
| *sevelamer carbonate packet 0.8 gm* | 1 | |
| *sevelamer carbonate packet 2.4 gm* | 1 | |
| *sevelamer carbonate tab 800 mg* | 1 | |
| VELPHORO CHW 500MG | 3 | |
| ***PROGESTINS*** | | |
| CRINONE GEL 4% VAG | 2 | |
| CRINONE GEL 8% VAG | 2 | |
| LUPANETA KIT 3.75-5 | M | M |
| LUPANETA KIT 11.25-5 | M | M |
| *medroxyprogesterone acetate tab 2.5 mg* | 1 | |
| *medroxyprogesterone acetate tab 5 mg* | 1 | |
| *medroxyprogesterone acetate tab 10 mg* | 1 | |
| *norethindrone acetate tab 5 mg* | 1 | |
| *progesterone micronized cap 100 mg* | 1 | |
| *progesterone micronized cap 200 mg* | 1 | |
| ***THYROID AGENTS*** | | |
| *levothyroxine sodium tab 25 mcg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *levothyroxine sodium tab 50 mcg* | 1 | |
| *levothyroxine sodium tab 75 mcg* | 1 | |
| *levothyroxine sodium tab 88 mcg* | 1 | |
| *levothyroxine sodium tab 100 mcg* | 1 | |
| *levothyroxine sodium tab 112 mcg* | 1 | |
| *levothyroxine sodium tab 125 mcg* | 1 | |
| *levothyroxine sodium tab 137 mcg* | 1 | |
| *levothyroxine sodium tab 150 mcg* | 1 | |
| *levothyroxine sodium tab 175 mcg* | 1 | |
| *levothyroxine sodium tab 200 mcg* | 1 | |
| *levothyroxine sodium tab 300 mcg* | 1 | |
| *levoxyl tab 25mcg* | 1 | |
| *levoxyl tab 50mcg* | 1 | |
| *levoxyl tab 75mcg* | 1 | |
| *levoxyl tab 88mcg* | 1 | |
| *levoxyl tab 100mcg* | 1 | |
| *levoxyl tab 112mcg* | 1 | |
| *levoxyl tab 125mcg* | 1 | |
| *levoxyl tab 137mcg* | 1 | |
| *levoxyl tab 150mcg* | 1 | |
| *levoxyl tab 175mcg* | 1 | |
| *levoxyl tab 200mcg* | 1 | |
| *liothyronine sodium iv soln 10 mcg/ml* | M | M |
| *liothyronine sodium tab 5 mcg* | 1 | |
| *liothyronine sodium tab 25 mcg* | 1 | |
| *liothyronine sodium tab 50 mcg* | 1 | |
| *methimazole tab 5 mg* | 1 | |
| *methimazole tab 10 mg* | 1 | |
| *propylthiouracil tab 50 mg* | 1 | |
| SYNTHROID TAB 25MCG | 2 | |
| SYNTHROID TAB 50MCG | 2 | |
| SYNTHROID TAB 75MCG | 2 | |
| SYNTHROID TAB 88MCG | 2 | |
| SYNTHROID TAB 100MCG | 2 | |
| SYNTHROID TAB 112MCG | 2 | |
| SYNTHROID TAB 125MCG | 2 | |
| SYNTHROID TAB 137MCG | 2 | |
| SYNTHROID TAB 150MCG | 2 | |
| SYNTHROID TAB 175MCG | 2 | |
| SYNTHROID TAB 200MCG | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SYNTHROID TAB 300MCG | 2 | |
| THYROLAR-1 TAB 60MG | 3 | |
| THYROLAR-1/2 TAB 30MG | 3 | |
| THYROLAR-1/4 TAB 15MG | 3 | |
| THYROLAR-2 TAB 120MG | 3 | |
| THYROLAR-3 TAB 180MG | 3 | |
| *unithroid tab 25mcg* | 1 | |
| *unithroid tab 50mcg* | 1 | |
| *unithroid tab 75mcg* | 1 | |
| *unithroid tab 88mcg* | 1 | |
| *unithroid tab 100mcg* | 1 | |
| *unithroid tab 112mcg* | 1 | |
| *unithroid tab 125mcg* | 1 | |
| *unithroid tab 200mcg* | 1 | |
| *unithroid tab 300mcg* | 1 | |
| ***VASOPRESSINS*** | | |
| *desmopressin acetate inj 4 mcg/ml* | M | M |
| *desmopressin acetate nasal spray soln 0.01%* | 1 | |
| *desmopressin acetate nasal spray soln 0.01% (refrigerated)* | 1 | |
| *desmopressin acetate tab 0.1 mg* | 1 | |
| *desmopressin acetate tab 0.2 mg* | 1 | |
| **GASTROINTESTINAL** | | |
| ***ANTICHOLINERGICS*** | | |
| *atropine sulfate soln prefill syr 0.25 mg/5ml (0.05 mg/ml)* | M | M |
| *atropine sulfate soln prefill syr 1 mg/10ml (0.1 mg/ml)* | M | M |
| CUVPOSA SOL 1MG/5ML | 2 | |
| *dicyclomine hcl cap 10 mg* | 1 | |
| *dicyclomine hcl inj 10 mg/ml* | M | M |
| *dicyclomine hcl oral soln 10 mg/5ml* | 1 | |
| *dicyclomine hcl tab 20 mg* | 1 | |
| *ed-spaz tab 0.125mg* | 1 | |
| *glycopyrrolate inj 0.2 mg/ml* | M | M |
| *glycopyrrolate inj 0.4 mg/2ml (0.2 mg/ml)* | M | M |
| *glycopyrrolate inj 1 mg/5ml (0.2 mg/ml)* | M | M |
| *glycopyrrolate inj 4 mg/20ml (0.2 mg/ml)* | M | M |
| *glycopyrrolate tab 1 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *glycopyrrolate tab 2 mg* | 1 | |
| *hyoscyamine sulfate sl tab 0.125 mg* | 1 | |
| *hyoscyamine sulfate tab 0.125 mg* | 1 | |
| *hyoscyamine sulfate tab disint 0.125 mg* | 1 | |
| *hyoscyamine sulfate tab er 12hr 0.375 mg* | 1 | |
| *methscopolamine bromide tab 2.5 mg* | 1 | |
| *methscopolamine bromide tab 5 mg* | 1 | |
| *nulev tab 0.125mg* | 1 | |
| *oscimin sr tab 0.375mg* | 1 | |
| *oscimin sub 0.125mg* | 1 | |
| *oscimin tab 0.125mg* | 1 | |
| *symax-sl sub 0.125mg* | 1 | |
| ***ANTIEMETICS§*** | | |
| AKYNZEO CAP 300-0.5 | 3 | QL (2 caps / 21 days) |
| *aprepitant capsule 40 mg* | 1 | QL (3 caps / 180 days) |
| *aprepitant capsule 80 mg* | 1 | QL (4 caps / 21 days) |
| *aprepitant capsule 125 mg* | 1 | QL (2 caps / 21 days) |
| *aprepitant capsule therapy pack 80 & 125 mg* | 1 | QL (2 packs / 21 days) |
| CESAMET CAP 1MG | 3 | QL (18 caps / 21 days) |
| *compro sup 25mg* | 1 | |
| *dronabinol cap 2.5 mg* | 1 | QL (60 caps / 25 days) |
| *dronabinol cap 5 mg* | 1 | QL (60 caps / 25 days) |
| *dronabinol cap 10 mg* | 1 | QL (60 caps / 25 days) |
| *granisetron hcl inj 0.1 mg/ml* | M | M |
| *granisetron hcl inj 1 mg/ml* | M | M |
| *granisetron hcl inj 4 mg/4ml (1 mg/ml)* | M | M |
| *granisetron hcl tab 1 mg* | 1 | QL (12 tabs / 21 days) |
| *meclizine hcl tab 12.5 mg* | 1 | |
| *meclizine hcl tab 25 mg* | 1 | |
| *metoclopramide hcl inj 5 mg/ml (base equivalent)* | M | M |
| *metoclopramide hcl orally disintegrating tab 5 mg (base eq)* | 1 | |
| *metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)* | 1 | |
| *metoclopramide hcl tab 5 mg (base equivalent)* | 1 | |
| *metoclopramide hcl tab 10 mg (base equivalent)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *ondansetron hcl inj 4 mg/2ml (2 mg/ml)* | M | M |
| *ondansetron hcl inj 40 mg/20ml (2 mg/ml)* | M | M |
| *ondansetron hcl oral soln 4 mg/5ml* | 1 | QL (200 mL / 21 days) |
| *ondansetron hcl tab 4 mg* | 1 | QL (18 tabs / 21 days) |
| *ondansetron hcl tab 8 mg* | 1 | QL (18 tabs / 21 days) |
| *ondansetron hcl tab 24 mg* | 1 | QL (2 tabs / 21 days) |
| *ondansetron orally disintegrating tab 4 mg* | 1 | QL (18 tabs / 21 days) |
| *ondansetron orally disintegrating tab 8 mg* | 1 | QL (18 tabs / 21 days) |
| *phenadoz sup 25mg* | 1 | |
| *prochlorperazine edisylate inj 10 mg/2ml* | 1 | |
| *prochlorperazine edisylate inj 50 mg/10ml* | M | M |
| *prochlorperazine maleate tab 5 mg (base equivalent)* | 1 | |
| *prochlorperazine maleate tab 10 mg (base equivalent)* | 1 | |
| *prochlorperazine suppos 25 mg* | 1 | |
| *promethazine hcl inj 25 mg/ml* | M | M |
| *promethazine hcl inj 50 mg/ml* | M | M |
| *promethazine hcl suppos 12.5 mg* | 1 | |
| *promethazine hcl suppos 25 mg* | 1 | |
| *promethazine hcl syrup 6.25 mg/5ml* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *promethazine hcl tab 12.5 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *promethazine hcl tab 25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *promethazine hcl tab 50 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *promethegan sup 12.5mg* | 1 | |
| *promethegan sup 25mg* | 1 | |
| *promethegan sup 50mg* | 1 | |
| SANCUSO DIS 3.1MG | 2 | QL (2 patches / 21 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *scopolamine td patch 72hr 1 mg/3days* | 1 | |
| TRANSDERM-SC DIS 1.5MG | 3 | |
| *trimethobenzamide hcl cap 300 mg* | 1 | |
| VARUBI INJ | M | M |
| VARUBI TAB 90MG | 2 | |
| ***H2-RECEPTOR ANTAGONISTS*** | | |
| *cimetidine hcl soln 300 mg/5ml* | 1 | |
| *cimetidine tab 200 mg* | 1 | |
| *cimetidine tab 300 mg* | 1 | |
| *cimetidine tab 400 mg* | 1 | |
| *cimetidine tab 800 mg* | 1 | |
| *famotidine for susp 40 mg/5ml* | 1 | |
| *famotidine in nacl 0.9% iv soln 20 mg/50ml* | M | M |
| *famotidine inj 20 mg/2ml* | M | M |
| *famotidine inj 40 mg/4ml* | M | M |
| *famotidine inj 200 mg/20ml* | M | M |
| *famotidine tab 20 mg* | 1 | |
| *famotidine tab 40 mg* | 1 | |
| *nizatidine cap 150 mg* | 1 | |
| *nizatidine cap 300 mg* | 1 | |
| *nizatidine oral soln 15 mg/ml* | 1 | |
| *ranitidine hcl cap 150 mg* | 1 | |
| *ranitidine hcl cap 300 mg* | 1 | |
| *ranitidine hcl inj 50 mg/2ml (25 mg/ml)* | M | M |
| *ranitidine hcl inj 150 mg/6ml (25 mg/ml)* | M | M |
| *ranitidine hcl syrup 15 mg/ml (75 mg/5ml)* | 1 | |
| *ranitidine hcl tab 150 mg* | 1 | |
| *ranitidine hcl tab 300 mg* | 1 | |
| ***INFLAMMATORY BOWEL DISEASE*** | | |
| APRISO CAP 0.375GM | 2 | |
| *balsalazide disodium cap 750 mg* | 1 | |
| *budesonide delayed release particles cap 3 mg* | 1 | |
| *colocortene 100mg* | 1 | |
| DIPENTUM CAP 250MG | 3 | |
| *mesalamine enema 4 gm* | 1 | |
| *mesalamine rectal enema 4 gm & cleanser wipe kit* | 1 | |
| *mesalamine suppos 1000 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sulfasalazine tab 500 mg* | 1 | |
| *sulfasalazine tab delayed release 500 mg* | 1 | |
| ***IRRITABLE BOWEL SYNDROME WITH CONSTIPATION*** | | |
| AMITIZA CAP 8MCG | 2 | |
| AMITIZA CAP 24MCG | 2 | |
| LINZESS CAP 72MCG | 2 | |
| LINZESS CAP 145MCG | 2 | |
| LINZESS CAP 290MCG | 2 | |
| ***IRRITABLE BOWEL SYNDROME WITH DIARRHEA*** | | |
| *alosetron hcl tab 0.5 mg (base equiv)* | 1 | PA |
| *alosetron hcl tab 1 mg (base equiv)* | 1 | PA |
| ***LAXATIVES*** | | |
| CLENPIQ SOL | 0 | $0 copay for members age 50 through 74, otherwise not covered |
| *enulose sol 10gm/15* | 1 | |
| *gavilyte-c sol* | 1 | |
| *gavilyte-g sol* | 1 | |
| *gavilyte-h kit* | 0 | $0 copay for members age 50 through 74, otherwise not covered |
| *gavilyte-n sol flav pk* | 1 | |
| *generlac sol 10gm/15* | 1 | |
| GOLYTELY SOL | 2 | |
| *lactulose solution 10 gm/15ml* | 1 | |
| MOVIPREP SOL | 0 | $0 copay for members age 50 through 74; Tier 2 for all others |
| OSMOPREP TAB 1.5GM | 3 | |
| *peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm* | 1 | |
| *peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm* | 1 | |
| *peg 3350-kcl-sod bicarb-nacl for soln 420 gm* | 1 | |
| PLENVU SOL | 0 | $0 copay for members age 50 through 74, otherwise not covered |
| *polyethylene glycol 3350 oral powder* | 1 | OTC |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PREPOPIK PAK | 0 | $0 copay for members age 50 through 74, otherwise not covered |
| SUPREP BOWEL SOL PREP KIT | 0 | $0 copay for members age 50 through 74; Tier 2 for all others |
| ***MISCELLANEOUS*** | | |
| CARAFATE SUS 1GM/10ML | 3 | |
| *cromolyn sodium oral conc 100 mg/5ml* | 1 | |
| *diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml* | 1 | |
| *diphenoxylate w/ atropine tab 2.5-0.025 mg* | 1 | |
| *loperamide hcl cap 2 mg* | 1 | |
| *misoprostol tab 100 mcg* | 1 | |
| *misoprostol tab 200 mcg* | 1 | |
| MOTOFEN TAB 1-0.025 | 3 | |
| MOVANTIK TAB 12.5MG | 2 | |
| MOVANTIK TAB 25MG | 2 | |
| SUCRAID SOL 8500/ML | 3 | |
| *sucralfate tab 1 gm* | 1 | |
| *ursodiol cap 300 mg* | 1 | |
| *ursodiol tab 250 mg* | 1 | |
| *ursodiol tab 500 mg* | 1 | |
| ***PANCREATIC ENZYMES*** | | |
| CREON CAP 3000UNIT | 2 | |
| CREON CAP 6000UNIT | 2 | |
| CREON CAP 12000UNT | 2 | |
| CREON CAP 24000UNT | 2 | |
| CREON CAP 36000UNT | 2 | |
| VIOKACE TAB 10440 | 2 | |
| VIOKACE TAB 20880 | 2 | |
| ZENPEP CAP 3000UNIT | 2 | |
| ZENPEP CAP 5000UNIT | 2 | |
| ZENPEP CAP 10000UNT | 2 | |
| ZENPEP CAP 15000UNT | 2 | |
| ZENPEP CAP 20000UNT | 2 | |
| ZENPEP CAP 25000 | 2 | |
| ZENPEP CAP 40000 | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***PROTON PUMP INHIBITORS§*** | | |
| DEXILANT CAP 30MG DR | 3 | QL (90 caps / 365 days), ST; PA** |
| DEXILANT CAP 60MG DR | 3 | QL (90 caps / 365 days), ST; PA** |
| *esomeprazole magnesium cap delayed release 20 mg (base eq)* | 1 | QL (90 caps / 365 days) |
| *esomeprazole magnesium cap delayed release 40 mg (base eq)* | 1 | QL (90 caps / 365 days) |
| *esomeprazole sodium for intravenous soln 20 mg (base equiv)* | M | M |
| *esomeprazole sodium for intravenous soln 40 mg (base equiv)* | M | M |
| *lansoprazole cap delayed release 15 mg* | 1 | QL (90 caps / 365 days) |
| *lansoprazole cap delayed release 30 mg* | 1 | QL (90 caps / 365 days) |
| *omeprazole cap delayed release 10 mg* | 1 | QL (90 caps / 365 days) |
| *omeprazole cap delayed release 20 mg* | 1 | QL (90 caps / 365 days) |
| *omeprazole cap delayed release 40 mg* | 1 | QL (90 caps / 365 days) |
| *pantoprazole sodium ec tab 20 mg (base equiv)* | 1 | QL (90 tabs / 365 days) |
| *pantoprazole sodium ec tab 40 mg (base equiv)* | 1 | QL (90 tabs / 365 days) |
| *rabeprazole sodium ec tab 20 mg* | 1 | QL (90 tabs / 365 days) |
| ***RECTAL,CORTICOSTEROIDS*** | | |
| *procto-pak cre 1%* | 1 | |
| *proctosol hc cre 2.5%* | 1 | |
| *proctozone cre -hc 2.5%* | 1 | |
| **GENITOURINARY** | | |
| ***BENIGN PROSTATIC HYPERPLASIA*** | | |
| *alfuzosin hcl tab er 24hr 10 mg* | 1 | |
| CARDURA XL TAB 4MG | 3 | ST; PA** |
| CARDURA XL TAB 8MG | 3 | ST; PA** |
| *dutasteride cap 0.5 mg* | 1 | |
| *dutasteride-tamsulosin hcl cap 0.5-0.4 mg* | 1 | |
| *finasteride tab 5 mg* | 1 | |
| *silodosin cap 4 mg* | 1 | |
| *silodosin cap 8 mg* | 1 | |
| *tadalafil tab 2.5 mg* | 1 | QL (30 tabs / 25 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tadalafil tab 5 mg* | 1 | QL (30 tabs / 25 days), PA |
| *tamsulosin hcl cap 0.4 mg* | 1 | |
| ***CONTRACEPTIVES*** | | |
| CONCEPTROL GEL 4% | 0 | OTC |
| ENCARE SUP 100MG | 0 | OTC |
| GYNOL II GEL 3% | 0 | OTC |
| SHUR-SEAL GEL 2% | 0 | OTC |
| TODAY SPONGE MIS | 0 | OTC |
| VCF VAGINAL AER CONTRACP | 0 | OTC |
| VCF VAGINAL MIS CONTRACP | 0 | OTC |
| ***ERECTILE DYSFUNCTION, PHOSPHODIESTERASE INHIBITORS*** | | |
| *sildenafil citrate tab 25 mg* | 1 | QL (6 tabs per month) |
| *sildenafil citrate tab 50 mg* | 1 | QL (6 tabs per month) |
| *sildenafil citrate tab 100 mg* | 1 | QL (6 tabs per month) |
| *tadalafil tab 10 mg* | 1 | QL (6 tabs per month) |
| *tadalafil tab 20 mg* | 1 | QL (6 tabs per month) |
| ***MISCELLANEOUS*** | | |
| *bethanechol chloride tab 5 mg* | 1 | |
| *bethanechol chloride tab 10 mg* | 1 | |
| *bethanechol chloride tab 25 mg* | 1 | |
| *bethanechol chloride tab 50 mg* | 1 | |
| ELMIRON CAP 100MG | 3 | |
| *flavoxate hcl tab 100 mg* | 1 | |
| *potassium citrate tab er 5 meq (540 mg)* | 1 | |
| *potassium citrate tab er 10 meq (1080 mg)* | 1 | |
| *potassium citrate tab er 15 meq (1620 mg)* | 1 | |
| *urinary pain tab 95mg* | 1 | OTC |
| ***URINARY ANTISPASMODICS*** | | |
| *darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)* | 1 | |
| *darifenacin hydrobromide tab er 24hr 15 mg (base equiv)* | 1 | |
| MYRBETRIQ TAB 25MG | 3 | ST; PA** |
| MYRBETRIQ TAB 50MG | 3 | ST; PA** |
| *oxybutynin chloride syrup 5 mg/5ml* | 1 | |
| *oxybutynin chloride tab 5 mg* | 1 | |
| *oxybutynin chloride tab er 24hr 5 mg* | 1 | |
| *oxybutynin chloride tab er 24hr 10 mg* | 1 | |
| *oxybutynin chloride tab er 24hr 15 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *solifenacin succinate tab 5 mg* | 1 | |
| *solifenacin succinate tab 10 mg* | 1 | |
| *tolterodine tartrate cap er 24hr 2 mg* | 1 | |
| *tolterodine tartrate cap er 24hr 4 mg* | 1 | |
| *tolterodine tartrate tab 1 mg* | 1 | |
| *tolterodine tartrate tab 2 mg* | 1 | |
| TOVIAZ TAB 4MG | 2 | |
| TOVIAZ TAB 8MG | 2 | |
| *trospium chloride cap er 24hr 60 mg* | 1 | |
| *trospium chloride tab 20 mg* | 1 | |
| ***VAGINAL ANTI-INFECTIVES*** | | |
| CLEOCIN SUP 100MG | 2 | |
| *clindamycin phosphate vaginal cream 2%* | 1 | |
| GYNAZOLE-1 CRE 2% | 3 | |
| *metronidazole vaginal gel 0.75%* | 1 | |
| *miconazole 3 sup 200mg* | 1 | |
| *terconazole vaginal cream 0.4%* | 1 | |
| *terconazole vaginal suppos 80 mg* | 1 | |
| *vandazole gel 0.75%* | 1 | |
| *zazole cre 0.8%* | 1 | |
| *zazole sup 80mg* | 1 | |
| **HEMATOLOGIC** | | |
| ***ANTICOAGULANTS*** | | |
| ARGATRB/NACL INJ 50MG/50 | M | M |
| ARGATROBAN INJ 125/125 | M | M |
| *argatroban inj 250 mg/2.5ml (concentrate for iv infusion)* | M | M |
| ARGATROBAN INJ 250/250 | M | M |
| ELIQUIS TAB 2.5MG | 2 | |
| ELIQUIS TAB 5MG | 2 | |
| *enoxaparin sodium inj 30 mg/0.3ml* | 1 | |
| *enoxaparin sodium inj 40 mg/0.4ml* | 1 | |
| *enoxaparin sodium inj 60 mg/0.6ml* | 1 | |
| *enoxaparin sodium inj 80 mg/0.8ml* | 1 | |
| *enoxaparin sodium inj 100 mg/ml* | 1 | |
| *enoxaparin sodium inj 120 mg/0.8ml* | 1 | |
| *enoxaparin sodium inj 150 mg/ml* | 1 | |
| *enoxaparin sodium inj 300 mg/3ml* | 1 | |
| *fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fondaparinux sodium subcutaneous inj 5 mg/0.4ml* | 1 | |
| *fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml* | 1 | |
| *fondaparinux sodium subcutaneous inj 10 mg/0.8ml* | 1 | |
| FRAGMIN INJ 2500/0.2 | 3 | |
| FRAGMIN INJ 5000/0.2 | 3 | |
| FRAGMIN INJ 7500/0.3 | 3 | |
| FRAGMIN INJ 10000/ML | 3 | |
| FRAGMIN INJ 12500UNT | 3 | |
| FRAGMIN INJ 15000UNT | 3 | |
| FRAGMIN INJ 18000UNT | 3 | |
| FRAGMIN INJ 95000UNT | 3 | |
| *heparin sodium (porcine) inj 1000 unit/ml* | M | M |
| *heparin sodium (porcine) inj 5000 unit/ml* | M | M |
| *heparin sodium (porcine) inj 10000 unit/ml* | M | M |
| *heparin sodium (porcine) inj 20000 unit/ml* | M | M |
| *heparin sodium (porcine) pf inj 5000 unit/0.5ml* | M | M |
| *jantoven tab 1mg* | 1 | |
| *jantoven tab 2.5mg* | 1 | |
| *jantoven tab 2mg* | 1 | |
| *jantoven tab 3mg* | 1 | |
| *jantoven tab 4mg* | 1 | |
| *jantoven tab 5mg* | 1 | |
| *jantoven tab 6mg* | 1 | |
| *jantoven tab 7.5mg* | 1 | |
| *jantoven tab 10mg* | 1 | |
| PRADAXA CAP 75MG | 3 | |
| PRADAXA CAP 110MG | 3 | |
| PRADAXA CAP 150MG | 3 | |
| *warfarin sodium tab 1 mg* | 1 | |
| *warfarin sodium tab 2 mg* | 1 | |
| *warfarin sodium tab 2.5 mg* | 1 | |
| *warfarin sodium tab 3 mg* | 1 | |
| *warfarin sodium tab 4 mg* | 1 | |
| *warfarin sodium tab 5 mg* | 1 | |
| *warfarin sodium tab 6 mg* | 1 | |
| *warfarin sodium tab 7.5 mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *warfarin sodium tab 10 mg* | 1 | |
| XARELTO STAR TAB 15/20MG | 2 | |
| XARELTO TAB 2.5MG | 2 | |
| XARELTO TAB 10MG | 2 | |
| XARELTO TAB 15MG | 2 | |
| XARELTO TAB 20MG | 2 | |
| ***HEMATOPOIETIC GROWTH FACTORS*** | | |
| ARANESP INJ 10MCG | 4 | PA |
| ARANESP INJ 25MCG | 4 | PA |
| ARANESP INJ 40MCG | 4 | PA |
| ARANESP INJ 60MCG | 4 | PA |
| ARANESP INJ 100MCG | 4 | PA |
| ARANESP INJ 150MCG | 4 | PA |
| ARANESP INJ 200MCG | 4 | PA |
| ARANESP INJ 300MCG | 4 | PA |
| ARANESP INJ 500MCG | 4 | PA |
| FULPHILA INJ 6/0.6ML | 4 | QL (2 injections / 28 days), PA |
| MIRCERA INJ 50MCG | 5 | PA |
| MIRCERA INJ 75MCG | 5 | PA |
| MIRCERA INJ 100MCG | 5 | PA |
| MIRCERA INJ 200MCG | 5 | PA |
| MIRCERA SOL 30/0.3ML | 5 | PA |
| MIRCERA SOL 150/0.3 | 5 | PA |
| PROMACTA TAB 12.5MG | 5 | QL (30 tabs / 30 days), PA |
| PROMACTA TAB 25MG | 5 | QL (30 tabs / 30 days), PA |
| PROMACTA TAB 50MG | 5 | QL (60 tabs / 30 days), PA |
| PROMACTA TAB 75MG | 5 | QL (60 tabs / 30 days), PA |
| RETACRIT INJ 2000UNIT | 4 | PA |
| RETACRIT INJ 3000UNIT | 4 | PA |
| RETACRIT INJ 4000UNIT | 4 | PA |
| RETACRIT INJ 10000UNT | 4 | PA |
| RETACRIT INJ 40000UNT | 4 | PA |
| ZARXIO INJ 300/0.5 | 4 | PA |
| ZARXIO INJ 480/0.8 | 4 | PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***MISCELLANEOUS*** | | |
| *anagrelide hcl cap 0.5 mg* | 1 | |
| *anagrelide hcl cap 1 mg* | 1 | |
| *cilostazol tab 50 mg* | 1 | |
| *cilostazol tab 100 mg* | 1 | |
| FIRAZYR INJ 30MG/3ML | M | M |
| HEMLIBRA INJ 30MG/ML | 5 | PA |
| HEMLIBRA INJ 60/0.4 | 5 | PA |
| HEMLIBRA INJ 105/0.7 | 5 | PA |
| HEMLIBRA INJ 150/ML | 5 | PA |
| *icatibant acetate inj 30 mg/3ml (base equivalent)* | M | M |
| *pentoxifylline tab er 400 mg* | 1 | |
| *tranexamic acid iv soln 1000 mg/10ml (100 mg/ml)* | M | M |
| *tranexamic acid tab 650 mg* | 1 | |
| ***PLATELET AGGREGATION INHIBITORS*** | | |
| *aspirin-dipyridamole cap er 12hr 25-200 mg* | 1 | |
| BRILINTA TAB 60MG | 2 | |
| BRILINTA TAB 90MG | 2 | |
| *clopidogrel bisulfate tab 75 mg (base equiv)* | 1 | |
| *clopidogrel bisulfate tab 300 mg (base equiv)* | 1 | |
| *dipyridamole tab 25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *dipyridamole tab 50 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *dipyridamole tab 75 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *prasugrel hcl tab 5 mg (base equiv)* | 1 | |
| *prasugrel hcl tab 10 mg (base equiv)* | 1 | |
| YOSPRALA TAB 81-40MG | 3 | |
| YOSPRALA TAB 325-40MG | 3 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ZONTIVITY TAB 2.08MG | 2 | |
| **IMMUNOLOGIC AGENTS** | | |
| ***BIOLOGIC DISEASE-MODIFYING AGENTS*** | | |
| ACTEMRA INJ 80MG/4ML | 5 | QL (5 vials / 28 days), PA, ST |
| ACTEMRA INJ 162/0.9 | 5 | QL (4 syringes / 28 days), PA, ST |
| ACTEMRA INJ 200/10ML | 5 | QL (4 vials / 14 days), PA, ST |
| ACTEMRA INJ 400/20ML | 5 | QL (2 vials / 14 days), PA, ST |
| ENBREL INJ 25/0.5ML | 4 | QL (8 syringes / 28 days), PA; Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis |
| ENBREL INJ 25MG | 4 | QL (8 syringes / 28 days), PA; Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis |
| ENBREL INJ 50MG/ML | 4 | QL (8 syringes / 28 days), PA; Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis |
| ENBREL MINI INJ 50MG/ML | 4 | QL (8 cartridges / 28 days), PA; Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis |
| ENBREL SRCLK INJ 50MG/ML | 4 | QL (8 syringes / 28 days), PA; Preferred agent for Ankylosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| HUMIRA INJ 10/0.1ML | 4 | QL (2 injections / 28 days), PA |
| HUMIRA INJ 10MG/0.2 | 4 | QL (2 injections / 28 days), PA |
| HUMIRA INJ 20/0.2ML | 4 | QL (2 injections / 28 days), PA |
| HUMIRA INJ 40/0.4ML | 4 | QL (4 injections / 28 days), PA |
| HUMIRA KIT 20MG/0.4 | 4 | QL (2 injections / 28 days), PA |
| HUMIRA KIT 40MG/0.8 | 4 | QL (4 injections / 28 days), PA |
| HUMIRA PEDIA INJ CROHNS | 4 | QL (2 injections / 28 days), PA; (80mg and 40mg dual strength kit) |
| HUMIRA PEDIA INJ CROHNS | 4 | QL (3 injections / 28 days), PA; (80mg single strength kit) |
| HUMIRA PEN INJ 40/0.4ML | 4 | QL (4 injections / 28 days), PA |
| HUMIRA PEN INJ CD/UC/HS | 4 | QL (6 pens / 28 days), PA |
| HUMIRA PEN INJ PS/UV | 4 | QL (4 pens / 28 days), PA |
| HUMIRA PEN KIT CD/UC/HS | 4 | QL (1 kit / 28 days), PA |
| HUMIRA PEN KIT PS/UV | 4 | QL (1 kit / 28 days), PA |
| KEVZARA INJ 150/1.14 | 4 | QL (2 pens / 28 days), PA; Preferred agent for Rheumatoid Arthritis |
| KEVZARA INJ 150/1.14 | 4 | QL (2 syringes / 4 weeks), PA; Preferred agent for Rheumatoid Arthritis |
| KEVZARA INJ 200/1.14 | 4 | QL (2 pens / 28 days), PA; Preferred agent for Rheumatoid Arthritis |
| KEVZARA INJ 200/1.14 | 4 | QL (2 syringes / 4 weeks), PA; Preferred agent for Rheumatoid Arthritis |
| SIMPONI ARIA SOL 50MG/4ML | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| SIMPONI INJ 50/0.5ML | 4 | QL (1 injection / 28 days), PA; Preferred agent for Ulcerative Colitis |
| SIMPONI INJ 100MG/ML | 4 | QL (1 injection / 28 days), PA; Preferred agent for Ulcerative Colitis |
| SKYRIZI INJ 150DOSE | 4 | QL (2 syringes / 12 weeks), PA; Preferred agent for Psoriasis |
| STELARA INJ 45MG/0.5 | 4 | QL (1 syringe / 84 days), PA; Preferred agent for Crohn's Disease (after failure of Humira) and Psoriasis |
| STELARA INJ 90MG/ML | 4 | QL (1 syringe / 56 days), PA; Preferred agent for Crohn's Disease (after failure of Humira) and Psoriasis |
| TALTZ INJ 80MG/ML | 4 | QL (1 injection / 28 days), PA; Preferred agent for Psoriasis |
| XELJANZ TAB 5MG | 4 | QL (60 tabs / 30 days), PA; Preferred agent for Rheumatoid Arthritis |
| XELJANZ XR TAB 11MG | 4 | QL (30 tabs / 30 days), PA; Preferred agent for Rheumatoid Arthritis |
| ***DISEASE-MODIFYING ANTI-RHEUMATIC DRUGS (DMARDS)*** | | |
| *hydroxychloroquine sulfate tab 200 mg* | 1 | |
| *leflunomide tab 10 mg* | 1 | |
| *leflunomide tab 20 mg* | 1 | |
| *methotrexate sodium tab 2.5 mg (base equiv)* | 0 | |
| OTEZLA TAB 10/20/30 | 4 | QL (55 tabs / 28 days), PA; Preferred agent for Psoriasis and Psoriatic Arthritis |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| OTEZLA TAB 30MG | 4 | QL (60 tabs / 30 days), PA; Preferred agent for Psoriasis and Psoriatic Arthritis |
| ***IMMUNOGLOBULIN*** | | |
| HYQVIA INJ 2.5-200 | 4 | PA |
| HYQVIA INJ 5-400 | 4 | PA |
| HYQVIA INJ 10-800 | 4 | PA |
| HYQVIA INJ 20-1600 | 4 | PA |
| HYQVIA INJ 30-2400 | 4 | PA |
| ***IMMUNOMODULATORS*** | | |
| ACTIMMUNE INJ 2MU/0.5 | 4 | PA |
| ALFERON N INJ 5MU/ML | M | M |
| ARCALYST INJ 220MG | 4 | QL (4 vials / 28 days), PA |
| INTRON A INJ 10MU | 4 | PA |
| INTRON A INJ 18MU | 4 | PA |
| INTRON A INJ 25MU | 4 | PA |
| INTRON A INJ 50MU | 4 | PA |
| POMALYST CAP 1MG | 0 | QL (21 caps / 21 days), PA |
| POMALYST CAP 2MG | 0 | QL (21 caps / 21 days), PA |
| POMALYST CAP 3MG | 0 | QL (21 caps / 21 days), PA |
| POMALYST CAP 4MG | 0 | QL (21 caps / 21 days), PA |
| REVLIMID CAP 2.5MG | 0 | QL (28 caps / 28 days), PA |
| REVLIMID CAP 5MG | 0 | QL (28 caps / 28 days), PA |
| REVLIMID CAP 10MG | 0 | QL (28 caps / 28 days), PA |
| REVLIMID CAP 15MG | 0 | QL (28 caps / 28 days), PA |
| REVLIMID CAP 20MG | 0 | QL (21 caps / 28 days), PA |
| REVLIMID CAP 25MG | 0 | QL (21 caps / 28 days), PA |
| THALOMID CAP 50MG | 0 | QL (28 caps / 28 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| THALOMID CAP 100MG | 0 | QL (28 caps / 28 days), PA |
| THALOMID CAP 150MG | 0 | QL (56 caps / 28 days), PA |
| THALOMID CAP 200MG | 0 | QL (56 caps / 28 days), PA |
| ***IMMUNOSUPPRESSANTS*** | | |
| AZASAN TAB 75 MG | 3 | |
| AZASAN TAB 100MG | 3 | |
| *azathioprine tab 50 mg* | 1 | |
| *cyclosporine cap 25 mg* | 1 | |
| *cyclosporine cap 100 mg* | 1 | |
| *cyclosporine iv soln 50 mg/ml* | M | M |
| *cyclosporine modified cap 25 mg* | 1 | |
| *cyclosporine modified cap 50 mg* | 1 | |
| *cyclosporine modified cap 100 mg* | 1 | |
| *cyclosporine modified oral soln 100 mg/ml* | 1 | |
| *gengraf cap 25mg* | 1 | |
| *gengraf cap 100mg* | 1 | |
| *gengraf sol 100mg/ml* | 1 | |
| *mycophenolate mofetil cap 250 mg* | 1 | |
| *mycophenolate mofetil for oral susp 200 mg/ml* | 1 | |
| *mycophenolate mofetil hcl for iv soln 500 mg (base equiv)* | M | M |
| *mycophenolate mofetil tab 500 mg* | 1 | |
| *mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)* | 1 | |
| *mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)* | 1 | |
| PROGRAF INJ 5MG/ML | M | M |
| SANDIMMUNE SOL 100MG/ML | 3 | |
| *sirolimus oral soln 1 mg/ml* | 1 | |
| *sirolimus tab 0.5 mg* | 1 | |
| *sirolimus tab 1 mg* | 1 | |
| *sirolimus tab 2 mg* | 1 | |
| *tacrolimus cap 0.5 mg* | 1 | |
| *tacrolimus cap 1 mg* | 1 | |
| *tacrolimus cap 5 mg* | 1 | |
| ZORTRESS TAB 0.5MG | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ZORTRESS TAB 0.25MG | 2 | |
| ZORTRESS TAB 0.75MG | 2 | |
| ZORTRESS TAB 1MG | 2 | |
| ***VACCINES*** | | |
| ACTHIB INJ | M | M |
| ADACEL INJ | M | M |
| AFLURIA QUAD INJ 2019-20 | M | M |
| BEXSERO INJ | M | M |
| BOOSTRIX INJ | M | M |
| DAPTACEL INJ | M | M |
| DIP/TET PED INJ 25-5LFU | M | M |
| ENGERIX-B INJ 10/0.5ML | M | M |
| ENGERIX-B INJ 20MCG/ML | M | M |
| FLUAD INJ 2019-20 | M | M |
| FLUARIX QUAD INJ 2019-20 | M | M |
| FLUBLOK QUAD INJ 2019-20 | M | M |
| FLUCLVX QUAD INJ 2019-20 | M | M |
| FLULAVAL QUA INJ 2019-20 | M | M |
| FLUMIST QUAD SUS 2019-20 | M | M |
| FLUZONE HD INJ PF 19-20 | M | M |
| FLUZONE QUAD INJ 2019-20 | M | M |
| GARDASIL 9 INJ | M | M |
| GARDASIL INJ | M | M |
| HAVRIX INJ 720UNIT | M | M |
| HAVRIX INJ 1440UNIT | M | M |
| HEPLISAV-B INJ 20/0.5ML | M | M |
| HEPLISAV-B INJ 20MCG | M | M |
| HIBERIX SOL 10MCG | M | M |
| INFANRIX INJ | M | M |
| IPOL INJ INACTIVE | M | M |
| KINRIX INJ | M | M |
| M-M-R II INJ | M | M |
| MENACTRA INJ | M | M |
| MENHIBRIX INJ | M | M |
| MENOMUNE INJ A/C/Y/W | M | M |
| MENVEO INJ | M | M |
| PEDIARIX INJ 0.5ML | M | M |
| PEDVAX HIB INJ | M | M |
| PENTACEL INJ | M | M |
| PNEUMOVAX 23 INJ 25/0.5 | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PREVNAR 13 INJ | M | M |
| PROQUAD INJ | M | M |
| RECOMBIVA HB INJ 5MCG/0.5 | M | M |
| RECOMBIVA HB INJ 10MCG/ML | M | M |
| RECOMBIVA-HB INJ 40MCG/ML | M | M |
| ROTARIX SUS | M | M |
| ROTATEQ SOL | M | M |
| SHINGRIX INJ 50MCG | M | M |
| TDVAX INJ 2-2 LF | M | M |
| TENIVAC INJ 5-2LF | M | M |
| TRUMENBA INJ | M | M |
| TWINRIX INJ | M | M |
| VAQTA INJ 25/0.5ML | M | M |
| VAQTA INJ 50UNT/ML | M | M |
| VARIVAX INJ | M | M |
| ZOSTAVAX INJ | M | M |

## MEDICAL DEVICES

### *CONTRACEPTIVES*

| | | |
|---|---|---|
| CAYA DPR | 0 | QL (1 / 300 days) |
| FC2 FEMALE MIS CONDOM | 0 | OTC |
| FEMCAP MIS 22MM | 0 | QL (1 / 300 days) |
| FEMCAP MIS 26MM | 0 | QL (1 / 300 days) |
| FEMCAP MIS 30MM | 0 | QL (1 / 300 days) |
| OMNIFLEX DPR | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 60 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 65 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 70 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 75 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 80 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 85 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 90 | 0 | QL (1 / 300 days) |
| WIDE-SEAL DPR KIT 95 | 0 | QL (1 / 300 days) |

### *DIABETIC SUPPLIES*

| | | |
|---|---|---|
| ACCU-CHEK KIT AVA CONN | M | OTC; M |
| ACCU-CHEK KIT AVIVA PL | M | OTC; M |
| ACCU-CHEK KIT COMPACT | M | OTC; M |
| ACCU-CHEK KIT GUIDE | M | OTC; M |
| ACCU-CHEK KIT NANO | M | OTC; M |
| ACCU-CHEK LIQ SMART | 0 | OTC |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ACCU-CHEK MIS AVIVA | 2 | OTC |
| ACCU-CHEK MIS MLTICLIX | 0 | OTC |
| ACCU-CHEK TES AVIVA PL | 0 | OTC, QL (204 Test Strips / 25 days) |
| ACCU-CHEK TES COMPACT | 0 | OTC, QL (204 Test Strips / 25 days) |
| ACCU-CHEK TES GUIDE | 0 | OTC, QL (204 Test Strips / 25 days) |
| ACCU-CHEK TES SMART | 0 | OTC, QL (204 Test Strips / 25 days) |
| ALCOH-WIPE MIS 12"X12" | 0 | |
| BD SWAB REG PAD SNGL USE | 0 | OTC |
| BD ULTRAFINE INSULIN SYRINGES/NEEDLES | 0 | OTC |
| CHEMSTRIP 9 TES STRIPS | 0 | OTC |
| DIASCREEN 10 MIS | 0 | OTC |
| DIASTIX TES STRIPS | 0 | OTC |
| KETO-DIASTIX TES | 0 | OTC |
| LANCING DEVI MIS | 0 | OTC |
| MONOJECTOR MIS END CAPS | 0 | OTC |
| NOVOFINE MIS 32GX6MM | 0 | OTC |
| SHARPS CONT MIS 1/2 GAL | 0 | OTC |
| ***MISCELLANEOUS*** | | |
| AEROCHAMBER MIS PLUS | 2 | |
| FLEXICHAMBER MIS MASK SM | 2 | |
| HUMATROPEN MIS FOR 6MG | 2 | OTC |
| HUMATROPEN MIS FOR 12MG | 2 | OTC |
| HUMATROPEN MIS FOR 24MG | 2 | OTC |
| OPTICHAMBER MIS FACE MAS | 2 | OTC |
| PANDA MASK MIS PEDIATRI | 2 | OTC |
| **NUTRITIONAL/SUPPLEMENTS** | | |
| ***ELECTROLYTES*** | | |
| *fluor-a-day dro 0.125mg* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| FLUORABON DRO | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *fluoritab chw 0.5mg f* | 0 | $0 applies for ages 5 and under, otherwise not covered |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *fluoritab chw 0.25mg f* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *fluoritab chw 2.2mg* | 1 | |
| *flura-drops dro 0.25mg f* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *k-effervesce tab 25meq ef* | 1 | |
| *klor-con 8 tab 8meq er* | 1 | |
| *klor-con 10 tab 10meq er* | 1 | |
| *klor-con m15 tab 15meq er* | 1 | |
| *klor-con m20 tab 20meq er* | 1 | |
| *ludent chw 0.5mg f* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *ludent chw 0.25mg f* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *ludent chw 1mg f* | 1 | |
| LURIDE DRO 0.5MG/ML | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *magnesium sulfate in dextrose 5% iv soln 1 gm/100ml* | M | M |
| *magnesium sulfate inj 50%* | M | M |
| *magnesium sulfate iv soln 2 gm/50ml (40 mg/ml)* | M | M |
| *magnesium sulfate iv soln 4 gm/50ml (80 mg/ml)* | M | M |
| *magnesium sulfate iv soln 4 gm/100ml (40 mg/ml)* | M | M |
| *magnesium sulfate iv soln 20 gm/500ml (40 mg/ml)* | M | M |
| *magnesium sulfate iv soln 40 gm/1000ml (40 mg/ml)* | M | M |
| *nafrinse chw 1mg f* | 1 | |
| *nafrinse dro 0.125mg* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *potassium chloride cap er 8 meq* | 1 | |
| *potassium chloride cap er 10 meq* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *potassium chloride microencapsulated crys er tab 10 meq* | 1 | |
| *potassium chloride microencapsulated crys er tab 20 meq* | 1 | |
| *potassium chloride oral soln 10% (20 meq/15ml)* | 1 | |
| *potassium chloride oral soln 20% (40 meq/15ml)* | 1 | |
| *potassium chloride tab er 8 meq (600 mg)* | 1 | |
| *potassium chloride tab er 10 meq* | 1 | |
| *potassium chloride tab er 20 meq (1500 mg)* | 1 | |
| *sodium chloride flush iv soln 0.9%* | M | M |
| *sodium chloride inj 2.5 meq/ml (14.6%)* | M | M |
| *sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *sodium fluoride chew tab 1 mg f (from 2.2 mg naf)* | 1 | |
| *sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *sodium fluoride tab 0.5 mg f (from 1.1 mg naf)* | 0 | $0 applies for ages 5 and under, otherwise not covered |
| *sodium fluoride tab 1 mg f (from 2.2 mg naf)* | 1 | |
| ***IV REPLACEMENT SOLUTIONS*** | | |
| *kcl 20 meq/l (0.15%) in nacl 0.9% inj* | M | M |
| *kcl 20 meq/l (0.15%) in nacl 0.45% inj* | M | M |
| *kcl 40 meq/l (0.3%) in nacl 0.9% inj* | M | M |
| *potassium chloride inj 2 meq/ml* | M | M |
| *potassium chloride inj 10 meq/50ml* | M | M |
| *potassium chloride inj 10 meq/100ml* | M | M |
| *potassium chloride inj 20 meq/50ml* | M | M |
| *potassium chloride inj 20 meq/100ml* | M | M |
| *potassium chloride inj 40 meq/100ml* | M | M |
| *sodium chloride iv soln 0.9%* | M | M |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *sodium chloride iv soln 0.45%* | M | M |
| *sodium chloride iv soln 3%* | M | M |
| *sodium chloride iv soln 5%* | M | M |
| *sodium chloride preservative free (pf) inj 0.9%* | M | M |
| ***VITAMINS*** | | |
| *calcitriol cap 0.5 mcg* | 1 | |
| *calcitriol cap 0.25 mcg* | 1 | |
| *calcitriol inj 1 mcg/ml* | M | M |
| *calcitriol oral soln 1 mcg/ml* | 1 | |
| *cholecalciferol cap 1.25 mg (50000 unit)* | 1 | OTC |
| CITRANATAL CAP HARMONY | 2 | |
| CITRANATAL CAP MEDLEY | 2 | |
| CITRANATAL MIS | 2 | |
| CITRANATAL MIS 90 DHA | 2 | |
| CITRANATAL MIS B-CALM | 2 | |
| CITRANATAL PAK ASSURE | 2 | |
| CITRANATAL PAK DHA | 2 | |
| CITRANATAL TAB BLOOM | 2 | |
| CITRANATAL TAB RX | 2 | |
| *cyanocobalamin inj 1000 mcg/ml* | M | M |
| *doxercalciferol cap 0.5 mcg* | 1 | |
| *doxercalciferol cap 1 mcg* | 1 | |
| *doxercalciferol cap 2.5 mcg* | 1 | |
| *doxercalciferol inj 4 mcg/2ml (2 mcg/ml)* | M | M |
| *elite-ob tab* | 1 | |
| *ergocalciferol cap 1.25 mg (50000 unit)* | 1 | |
| *folic acid cap 0.8 mg* | 0 | OTC, QL (100 caps / 30 days); $0 copay for women ages 55 and under, otherwise not covered |
| *folic acid tab 1 mg* | 1 | |
| *folic acid tab 400 mcg* | 0 | OTC, QL (100 tabs / 30 days); $0 copay for women ages 55 and under, otherwise not covered |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *folic acid tab 800 mcg* | 0 | OTC, QL (100 tabs / 30 days); $0 copay for women ages 55 and under, otherwise not covered |
| *multi-vit/fe dro /fl 0.25* | 1 | |
| *multi-vit/fl dro 0.5mg/ml* | 1 | |
| *multi-vit/fl dro 0.25mg* | 1 | |
| *multi-vit/fl dro /fe 0.25* | 1 | |
| *multivit/fl chw 0.5mg* | 1 | |
| *multivit/fl chw 0.25mg* | 1 | |
| *multivit/fl chw 1mg* | 1 | |
| *mvc-fluoride chw 1mg* | 1 | |
| *paricalcitol cap 1 mcg* | 1 | |
| *paricalcitol cap 2 mcg* | 1 | |
| *paricalcitol cap 4 mcg* | 1 | |
| *paricalcitol iv soln 2 mcg/ml* | M | M |
| *paricalcitol iv soln 5 mcg/ml* | M | M |
| *phytonadione tab 5 mg* | 1 | |
| *prenatabs rx tab* | 1 | |
| *pyridoxine hcl tab 25 mg* | 1 | OTC |
| *pyridoxine hcl tab 50 mg* | 1 | OTC |
| *tri-vit/fe dro /fl 0.25* | 1 | |
| *tri-vit/fl dro 0.5mg* | 1 | |
| *tri-vit/fl dro 0.25mg* | 1 | |
| *virt-vite tab forte* | 1 | |
| *vit a/c/d/fl dro 0.25mg* | 1 | |
| **OPHTHALMIC** | | |
| ***ANTI-INFECTIVE/ANTI-INFLAMMATORY*** | | |
| *bacitracin-polymyxin-neomycin-hc ophth oint 1%* | 1 | |
| BLEPHAMIDE OIN S.O.P. | 2 | |
| BLEPHAMIDE SUS OP | 2 | |
| *neomycin-polymyxin-dexamethasone ophth oint 0.1%* | 1 | |
| *neomycin-polymyxin-dexamethasone ophth susp 0.1%* | 1 | |
| *neomycin-polymyxin-hc ophth susp* | 1 | |
| *sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| TOBRADEX OIN 0.3-0.1% | 2 | |
| TOBRADEX ST SUS 0.3-0.05 | 2 | |
| *tobramycin-dexamethasone ophth susp 0.3-0.1%* | 1 | |
| ***ANTI-INFECTIVES*** | | |
| AZASITE SOL 1% | 2 | |
| *bacitracin ophth oint 500 unit/gm* | 1 | |
| *bacitracin-polymyxin b ophth oint* | 1 | |
| BESIVANCE SUS 0.6% | 3 | |
| *ciprofloxacin hcl ophth soln 0.3% (base equivalent)* | 1 | |
| *erythromycin ophth oint 5 mg/gm* | 1 | |
| *gatifloxacin ophth soln 0.5%* | 1 | |
| *gentak oin 0.3% op* | 1 | |
| *gentamicin sulfate ophth oint 0.3%* | 1 | |
| *gentamicin sulfate ophth soln 0.3%* | 1 | |
| *levofloxacin ophth soln 0.5%* | 1 | |
| MOXEZA SOL 0.5% | 2 | |
| *moxifloxacin hcl ophth soln 0.5% (base equiv)* | 1 | |
| NATACYN SUS 5% OP | 2 | |
| *neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml* | 1 | |
| *ofloxacin ophth soln 0.3%* | 1 | |
| *polycin oin op* | 1 | |
| *polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%* | 1 | |
| *sulfacetamide sodium ophth oint 10%* | 1 | |
| *sulfacetamide sodium ophth soln 10%* | 1 | |
| *tobramycin ophth soln 0.3%* | 1 | |
| *trifluridine ophth soln 1%* | 1 | |
| ZIRGAN GEL 0.15% | 3 | |
| ***ANTI-INFLAMMATORIES*** | | |
| ACUVAIL SOL 0.45% | 2 | |
| ALREX SUS 0.2% | 3 | |
| *bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)* | 1 | |
| *bromfenac sodium ophth soln 0.09% (base equivalent)* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *dexamethasone sodium phosphate ophth soln 0.1%* | 1 | |
| *diclofenac sodium ophth soln 0.1%* | 1 | |
| DUREZOL EMU 0.05% | 2 | |
| FLAREX SUS 0.1% OP | 2 | |
| *fluorometholone ophth susp 0.1%* | 1 | |
| *flurbiprofen sodium ophth soln 0.03%* | 1 | |
| FML FORTE SUS 0.25% OP | 2 | |
| FML OIN 0.1% OP | 2 | |
| ILEVRO DRO 0.3% OP | 2 | |
| *ketorolac tromethamine ophth soln 0.4%* | 1 | |
| *ketorolac tromethamine ophth soln 0.5%* | 1 | |
| LOTEMAX GEL 0.5% | 3 | |
| LOTEMAX OIN 0.5% | 3 | |
| LOTEMAX SUS 0.5% | 3 | |
| *loteprednol etabonate ophth susp 0.5%* | 1 | |
| MAXIDEX SUS 0.1% OP | 2 | |
| NEVANAC SUS 0.1% | 2 | |
| PRED MILD SUS 0.12% OP | 2 | |
| PRED SOD PHO SOL 1% OP | 2 | |
| *prednisolone acetate ophth susp 1%* | 1 | |
| ***ANTIALLERGICS*** | | |
| ALOCRIL SOL 2% | 3 | |
| ALOMIDE SOL 0.1% OP | 3 | |
| *azelastine hcl ophth soln 0.05%* | 1 | |
| BEPREVE DRO 1.5% | 3 | |
| *cromolyn sodium ophth soln 4%* | 1 | |
| EMADINE SOL 0.05% OP | 3 | |
| *epinastine hcl ophth soln 0.05%* | 1 | |
| LASTACAFT SOL 0.25% | 2 | |
| *olopatadine hcl ophth soln 0.1% (base equivalent)* | 1 | |
| *olopatadine hcl ophth soln 0.2% (base equivalent)* | 1 | |
| PAZEO DRO 0.7% | 2 | |
| ***ANTIGLAUCOMA*** | | |
| ALPHAGAN P SOL 0.1% | 3 | |
| *apraclonidine hcl ophth soln 0.5% (base equivalent)* | 1 | |
| AZOPT SUS 1% OP | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *betaxolol hcl ophth soln 0.5%* | 1 | |
| BETIMOL SOL 0.5% | 3 | |
| BETIMOL SOL 0.25% | 3 | |
| BETOPTIC-S SUS 0.25% OP | 2 | |
| *bimatoprost ophth soln 0.03%* | 1 | |
| *brimonidine tartrate ophth soln 0.2%* | 1 | |
| *brimonidine tartrate ophth soln 0.15%* | 1 | |
| *carteolol hcl ophth soln 1%* | 1 | |
| COMBIGAN SOL 0.2/0.5% | 2 | |
| *dorzolamide hcl ophth soln 2%* | 1 | |
| *dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml* | 1 | |
| IOPIDINE SOL 1% OP | 3 | |
| *latanoprost ophth soln 0.005%* | 1 | |
| *levobunolol hcl ophth soln 0.5%* | 1 | |
| LUMIGAN SOL 0.01% | 2 | ST; PA** |
| *metipranolol ophth soln 0.3%* | 1 | |
| PHOSPHOLINE SOL 0.125%OP | 3 | |
| *pilocarpine hcl ophth soln 1%* | 1 | |
| SIMBRINZA SUS 1-0.2% | 2 | |
| *timolol maleate ophth gel forming soln 0.5%* | 1 | |
| *timolol maleate ophth gel forming soln 0.25%* | 1 | |
| *timolol maleate ophth soln 0.5%* | 1 | |
| *timolol maleate ophth soln 0.5% (once-daily)* | 1 | |
| *timolol maleate ophth soln 0.25%* | 1 | |
| TIMOPTIC OCU SOL 0.5% OP | 2 | |
| TIMOPTIC OCU SOL 0.25% OP | 2 | |
| TRAVATAN Z DRO 0.004% | 2 | |
| ZIOPTAN DRO 0.0015% | 3 | ST; PA** |
| ***MISCELLANEOUS*** | | |
| *atropine sul sol 1% op* | 1 | |
| CYSTARAN SOL 0.44% | 5 | PA |
| LACRISERT MIS 5MG OP | 3 | |
| *phenylephrine hcl ophth soln 2.5%* | 1 | |
| *phenylephrine hcl ophth soln 10%* | 1 | |
| *proparacaine hcl ophth soln 0.5%* | 1 | |
| RESTASIS EMU 0.05% | 2 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *tropicamide ophth soln 0.5%* | 1 | |
| *tropicamide ophth soln 1%* | 1 | |

**OTHER**

***IRRIGATION SOLUTIONS***

| | | |
|---|---|---|
| *physiolyte sol* | M | M |
| *physiosol sol irrigat* | M | M |
| *tis-u-sol sol* | M | M |

**RESPIRATORY**

***ANAPHYLAXIS TREATMENT AGENTS***

| | | |
|---|---|---|
| *epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)* | 1 | (generic of Adrenaclick) |
| *epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)* | 1 | (generics manufactured by Teva/Mylan) |
| *epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)* | 1 | |
| *epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)* | 1 | (generic of Adrenaclick) |
| EPIPEN 2-PAK INJ 0.3MG | 2 | |
| EPIPEN-JR INJ 0.15MG | 2 | |

***ANTICHOLINERGIC/BETA AGONIST COMBINATIONS§***

| | | |
|---|---|---|
| BEVESPI AER 9-4.8MCG | 2 | QL (1 package / 25 days) |
| COMBIVENT AER 20-100 | 2 | QL (2 inhalers / 25 days) |
| *ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml* | 1 | QL (6 boxes / 25 days) |

***ANTICHOLINERGICS§***

| | | |
|---|---|---|
| INCRUSE ELPT INH 62.5MCG | 2 | QL (1 package / 25 days) |
| *ipratropium bromide inhal soln 0.02%* | 1 | QL (5 boxes / 25 days) |
| *ipratropium bromide nasal soln 0.03% (21 mcg/spray)* | 1 | |
| *ipratropium bromide nasal soln 0.06% (42 mcg/spray)* | 1 | |
| SPIRIVA AER 1.25MCG | 2 | QL (1 package / 25 days) |
| SPIRIVA CAP HANDIHLR | 2 | QL (1 package / 25 days) |
| SPIRIVA SPR 2.5MCG | 2 | QL (1 package / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***ANTIHISTAMINE COMBINATIONS*** | | |
| DYMISTA SPR 137-50 | 2 | QL (1 package / 25 days) |
| ***ANTIHISTAMINES§*** | | |
| *azelastine hcl nasal spray 0.1% (137 mcg/spray)* | 1 | QL (2 bottles / 25 days) |
| *azelastine hcl nasal spray 0.15% (205.5 mcg/spray)* | 1 | QL (2 bottles / 25 days) |
| *brompheniramine tannate chew tab 12 mg* | 1 | |
| *carbinoxamine maleate soln 4 mg/5ml* | 1 | |
| *carbinoxamine maleate tab 4 mg* | 1 | |
| CLARINEX SYP 0.5MG/ML | 3 | |
| *clemastine fumarate tab 2.68 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *cyproheptadine hcl syrup 2 mg/5ml* | 1 | |
| *cyproheptadine hcl tab 4 mg* | 1 | |
| *desloratadine tab 5 mg* | 1 | |
| *desloratadine tab orally disintegrating 2.5 mg* | 1 | |
| *desloratadine tab orally disintegrating 5 mg* | 1 | |
| *diphenhydramine hcl elixir 12.5 mg/5ml* | 1 | |
| *diphenhydramine hcl inj 50 mg/ml* | M | M |
| *hydroxyzine hcl im soln 25 mg/ml* | M | M |
| *hydroxyzine hcl im soln 50 mg/ml* | M | M |
| *hydroxyzine hcl syrup 10 mg/5ml* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *hydroxyzine hcl tab 10 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *hydroxyzine hcl tab 25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydroxyzine hcl tab 50 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *hydroxyzine pamoate cap 25 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *hydroxyzine pamoate cap 50 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *hydroxyzine pamoate cap 100 mg* | 1 | PA; High Risk Medications require PA for members age 70 and older |
| *levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)* | 1 | |
| *levocetirizine dihydrochloride tab 5 mg* | 1 | |
| *olopatadine hcl nasal soln 0.6%* | 1 | QL (1 container / 25 days) |
| ***BETA AGONISTS§*** | | |
| *albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)* | 1 | QL (2 inhalers / 25 days) |
| *albuterol sulfate soln nebu 0.5% (5 mg/ml)* | 1 | QL (60 mL / 25 days) |
| *albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)* | 1 | QL (5 boxes / 25 days) |
| *albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)* | 1 | QL (5 boxes / 25 days) |
| *albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)* | 1 | QL (5 boxes / 25 days) |
| *albuterol sulfate syrup 2 mg/5ml* | 1 | |
| *albuterol sulfate tab 2 mg* | 1 | |
| *albuterol sulfate tab 4 mg* | 1 | |
| *albuterol sulfate tab er 12hr 4 mg* | 1 | |
| *albuterol sulfate tab er 12hr 8 mg* | 1 | |
| *levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)* | 1 | QL (300 mL / 25 days) |
| *levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)* | 1 | QL (300 mL / 25 days) |
| *levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)* | 1 | QL (300 mL / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)* | 1 | QL (45 mL / 25 days) |
| *levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)* | 1 | QL (2 inhalers / 25 days) |
| *metaproterenol sulfate syrup 10 mg/5ml* | 1 | |
| *metaproterenol sulfate tab 10 mg* | 1 | |
| *metaproterenol sulfate tab 20 mg* | 1 | |
| PERFOROMIST NEB 20MCG | 2 | QL (2 boxes / 25 days) |
| PROAIR HFA AER | 2 | QL (2 inhalers / 25 days) |
| PROAIR RESPI AER | 2 | QL (2 packages / 25 days) |
| STRIVERDI AER 2.5MCG | 2 | QL (1 package / 25 days) |
| *terbutaline sulfate inj 1 mg/ml* | M | M |
| *terbutaline sulfate tab 2.5 mg* | 1 | |
| *terbutaline sulfate tab 5 mg* | 1 | |
| ***BIOLOGIC RESPONSE MODIFIERS*** | | |
| NUCALA INJ 100MG | M | M |
| NUCALA INJ 100MG/ML | 4 | QL (3 injections / 28 days), PA |
| XOLAIR INJ 75/0.5 | M | M |
| XOLAIR INJ 150MG/ML | M | M |
| XOLAIR SOL 150MG | M | M |
| ***COLD/COUGH*** | | |
| *benzonatate cap 100 mg* | 1 | |
| *benzonatate cap 200 mg* | 1 | |
| *cheratussin syp ac* | 1 | OTC |
| *hydrocodone w/ homatropine syrup 5-1.5 mg/5ml* | 1 | |
| *hydrocodone w/ homatropine tab 5-1.5 mg* | 1 | |
| *hydromet syp 5-1.5/5* | 1 | |
| NORTUSS-EX LIQ 200-20/5 | 2 | |
| *prometh vc sol plain* | 1 | |
| *prometh vc/ syp codeine* | 1 | |
| *promethazine w/ codeine syrup 6.25-10 mg/5ml* | 1 | |
| *promethazine-dm syrup 6.25-15 mg/5ml* | 1 | |
| *pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml* | 1 | |
| *tussigon tab 5-1.5mg* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| TUZISTRA XR SUS | 3 | |
| VITUZ SOL 5-4MG | 3 | |
| ***LEUKOTRIENE MODIFIERS*** | | |
| *zileuton tab er 12hr 600 mg* | 3 | |
| ***LEUKOTRIENE RECEPTOR ANTAGONISTS*** | | |
| *montelukast sodium chew tab 4 mg (base equiv)* | 1 | |
| *montelukast sodium chew tab 5 mg (base equiv)* | 1 | |
| *montelukast sodium oral granules packet 4 mg (base equiv)* | 1 | |
| *montelukast sodium tab 10 mg (base equiv)* | 1 | |
| *zafirlukast tab 10 mg* | 1 | |
| *zafirlukast tab 20 mg* | 1 | |
| ***MAST CELL STABILIZERS§*** | | |
| *cromolyn sodium soln nebu 20 mg/2ml* | 1 | QL (2 boxes / 25 days) |
| ***MISCELLANEOUS*** | | |
| *acetylcysteine inhal soln 10%* | 1 | |
| *acetylcysteine inhal soln 20%* | 1 | |
| DALIRESP TAB 250MCG | 3 | PA |
| DALIRESP TAB 500MCG | 3 | PA |
| ESBRIET CAP 267MG | 4 | QL (270 caps / 30 days), PA |
| ESBRIET TAB 267MG | 4 | QL (270 tabs / 30 days), PA |
| ESBRIET TAB 801MG | 4 | QL (90 tabs / 30 days), PA |
| GLASSIA INJ | M | M |
| KALYDECO PAK 25MG | 4 | QL (56 packets / 28 days), PA |
| KALYDECO PAK 50MG | 4 | QL (56 packets / 28 days), PA |
| KALYDECO PAK 75MG | 4 | QL (56 packets / 28 days), PA |
| KALYDECO TAB 150MG | 4 | QL (56 tabs / 28 days), PA |
| ORKAMBI GRA 100-125 | 4 | QL (56 packets / 28 days), PA |
| ORKAMBI GRA 150-188 | 4 | QL (56 packets / 28 days), PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ORKAMBI TAB 100-125 | 4 | QL (112 tabs / 28 days), PA |
| ORKAMBI TAB 200-125 | 4 | QL (112 tabs / 28 days), PA |
| PROLASTIN-C INJ 1000MG | M | M |
| *sodium chloride soln nebu 0.9%* | 1 | |
| *sodium chloride soln nebu 3%* | 1 | |
| *sodium chloride soln nebu 7%* | 1 | |
| *sodium chloride soln nebu 10%* | 1 | |
| SYMDEKO TAB 50-75MG | 4 | QL (56 tabs / 28 days), PA |
| SYMDEKO TAB 100-150 | 4 | QL (56 tabs / 28 days), PA |
| ***NASAL STEROIDS§*** | | |
| *flunisolide nasal soln 25 mcg/act (0.025%)* | 1 | QL (3 containers / 25 days) |
| *fluticasone propionate nasal susp 50 mcg/act* | 1 | QL (1 container / 25 days) |
| OMNARIS SPR | 3 | QL (1 package / 25 days), ST; PA** |
| *triamcinolone acetonide nasal aerosol suspension 55 mcg/act* | 1 | OTC, QL (1 bottle / 25 days) |
| ***STEROID INHALANTS§*** | | |
| ASMANEX 30 AER 110MCG | 2 | QL (2 inhalers / 25 days) |
| ASMANEX 30 AER 220MCG | 2 | QL (4 inhalers / 25 days) |
| ASMANEX 60 AER 220MCG | 2 | QL (2 inhalers / 25 days) |
| ASMANEX 120 AER 220MCG | 2 | QL (1 inhaler / 25 days) |
| ASMANEX HFA AER 100 MCG | 2 | QL (1 inhaler / 25 days) |
| ASMANEX HFA AER 200 MCG | 2 | QL (1 inhaler / 25 days) |
| *budesonide inhalation susp 0.5 mg/2ml* | 1 | QL (2 boxes / 25 days) |
| *budesonide inhalation susp 0.25 mg/2ml* | 1 | QL (3 boxes / 25 days) |
| *budesonide inhalation susp 1 mg/2ml* | 1 | QL (1 box / 25 days) |
| QVAR REDIHA AER 80MCG | 2 | QL (2 packages / 25 days) |
| QVAR REDIHAL AER 40MCG | 2 | QL (2 packages / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| ***STEROID/BETA-AGONIST COMBINATIONS§*** | | |
| ADVAIR DISKU AER 100/50 | 1 | QL (1 package / 25 days) |
| ADVAIR DISKU AER 250/50 | 1 | QL (1 package / 25 days) |
| ADVAIR DISKU AER 500/50 | 1 | QL (1 package / 25 days) |
| ADVAIR HFA AER 45/21 | 2 | QL (1 package / 25 days) |
| ADVAIR HFA AER 115/21 | 2 | QL (1 package / 25 days) |
| ADVAIR HFA AER 230/21 | 2 | QL (1 package / 25 days) |
| BREO ELLIPTA INH 100-25 | 2 | QL (1 package / 25 days) |
| BREO ELLIPTA INH 200-25 | 2 | QL (1 package / 25 days) |
| SYMBICORT AER 80-4.5 | 2 | QL (1 package / 25 days) |
| SYMBICORT AER 160-4.5 | 2 | QL (1 package / 25 days) |
| ***XANTHINES*** | | |
| *aminophylline inj 25 mg/ml* | M | M |
| ELIXOPHYLLIN ELX 80/15ML | 3 | |
| THEO-24 CAP 100MG CR | 3 | |
| THEO-24 CAP 200MG CR | 3 | |
| THEO-24 CAP 300MG CR | 3 | |
| THEO-24 CAP 400MG ER | 3 | |
| *theochron tab 100mg cr* | 1 | |
| *theochron tab 200mg cr* | 1 | |
| *theochron tab 300mg cr* | 1 | |
| *theophylline soln 80 mg/15ml* | 1 | |
| *theophylline tab er 12hr 450 mg* | 1 | |
| *theophylline tab er 24hr 400 mg* | 1 | |
| *theophylline tab er 24hr 600 mg* | 1 | |
| **TOPICAL** | | |
| ***DERMATOLOGY, ACNE*** | | |
| *adapalene cream 0.1%* | 1 | PA; PA applies for members age 35 and older |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *adapalene gel 0.1%* | 1 | PA; PA applies for members age 35 and older |
| *adapalene gel 0.3%* | 1 | PA; PA applies for members age 35 and older |
| *adapalene lotion 0.1%* | 1 | PA; PA applies for members age 35 and older |
| *adapalene-benzoyl peroxide gel 0.1-2.5%* | 1 | |
| *amnesteem cap 10mg* | 1 | PA |
| *amnesteem cap 20mg* | 1 | PA |
| *amnesteem cap 40mg* | 1 | PA |
| *avita cre 0.025%* | 1 | PA; PA applies for members age 35 and older |
| *avita gel 0.025%* | 1 | PA; PA applies for members age 35 and older |
| AZELEX CRE 20% | 3 | ST; PA** |
| BENZIQ GEL 5.25% | 2 | |
| BENZIQ LS GEL 2.75% | 2 | |
| *benziq wash liq 5.25%* | 1 | |
| *benzoyl peroxide-erythromycin gel 5-3%* | 1 | |
| *bp wash liq 2.5%* | 1 | |
| *claravis cap 10mg* | 1 | PA |
| *claravis cap 20mg* | 1 | PA |
| *claravis cap 30mg* | 1 | PA |
| *claravis cap 40mg* | 1 | PA |
| *clearplex x gel 10%* | 1 | |
| *clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%* | 1 | |
| *clindamycin phosphate foam 1%* | 1 | |
| *clindamycin phosphate gel 1%* | 1 | |
| *clindamycin phosphate lotion 1%* | 1 | |
| *clindamycin phosphate soln 1%* | 1 | |
| *clindamycin phosphate swab 1%* | 1 | |
| *clindamycin phosphate-benzoyl peroxide gel 1-5%* | 1 | |
| *clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| EPIDUO FORTE GEL 0.3-2.5% | 3 | |
| *ery pad 2%* | 1 | |
| *erythromycin gel 2%* | 1 | |
| *erythromycin pads 2%* | 1 | |
| *erythromycin soln 2%* | 1 | |
| *isotretinoin cap 10 mg* | 1 | PA |
| *myorisan cap 20mg* | 1 | PA |
| *myorisan cap 40mg* | 1 | PA |
| *sulfacetamide sodium lotion 10% (acne)* | 1 | |
| *tretinoin cream 0.1%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin cream 0.05%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin cream 0.025%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin gel 0.01%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin gel 0.05%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin gel 0.025%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin microsphere gel 0.1%* | 1 | PA; PA applies for members age 35 and older |
| *tretinoin microsphere gel 0.04%* | 1 | PA; PA applies for members age 35 and older |
| *zenatane cap 30mg* | 1 | PA |
| ***DERMATOLOGY, ACTINIC KERATOSIS*** | | |
| FLUOROPLEX CRE 1% | 3 | |
| *fluorouracil cream 0.5%* | 1 | |
| *fluorouracil cream 5%* | 1 | |
| *fluorouracil soln 2%* | 1 | |
| *fluorouracil soln 5%* | 1 | |
| *imiquimod cream 5%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| PICATO GEL 0.05% | 3 | |
| PICATO GEL 0.015% | 3 | |
| ***DERMATOLOGY, ANTIBIOTICS*** | | |
| ALTABAX OIN 1% | 3 | |
| BACTROBAN OIN NASAL 2% | 3 | |
| CORTISPORIN CRE 0.5% | 3 | |
| CORTISPORIN OIN 1% | 3 | |
| *gentamicin sulfate cream 0.1%* | 1 | |
| *gentamicin sulfate oint 0.1%* | 1 | |
| IV PREP WIPE PAD | 2 | OTC |
| *mupirocin oint 2%* | 1 | |
| *silver sulfadiazine cream 1%* | 1 | |
| *ssd cre 1%* | 1 | |
| SULFAMYLON CRE 85MG/GM | 3 | |
| ***DERMATOLOGY, ANTIFUNGALS*** | | |
| *ciclopirox gel 0.77%* | 1 | |
| *ciclopirox olamine cream 0.77% (base equiv)* | 1 | |
| *ciclopirox olamine susp 0.77% (base equiv)* | 1 | |
| *ciclopirox shampoo 1%* | 1 | |
| *ciclopirox solution 8%* | 1 | |
| *clotrimazole cream 1%* | 1 | |
| *clotrimazole soln 1%* | 1 | |
| *clotrimazole w/ betamethasone cream 1-0.05%* | 1 | |
| *clotrimazole w/ betamethasone lotion 1-0.05%* | 1 | |
| *econazole nitrate cream 1%* | 1 | |
| ERTACZO CRE 2% | 3 | |
| EXELDERM CRE 1% | 3 | ST; PA** |
| EXELDERM SOL 1% | 3 | ST; PA** |
| JUBLIA SOL 10% | 3 | PA |
| *ketoconazole cream 2%* | 1 | |
| *ketoconazole foam 2%* | 1 | |
| MENTAX CRE 1% | 3 | |
| *naftifine hcl cream 1%* | 1 | |
| *naftifine hcl cream 2%* | 1 | |
| *nyamyc pow 100000* | 1 | |
| *nystatin cream 100000 unit/gm* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *nystatin oint 100000 unit/gm* | 1 | |
| *nystatin topical powder 100000 unit/gm* | 1 | |
| *nystatin-triamcinolone cream 100000-0.1 unit/gm-%* | 1 | |
| *nystatin-triamcinolone oint 100000-0.1 unit/gm-%* | 1 | |
| *nystop pow 100000* | 1 | |
| *oxiconazole nitrate cream 1%* | 1 | |
| OXISTAT LOT 1% | 3 | |
| ***DERMATOLOGY, ANTIPRURITIC*** | | |
| *doxepin hcl cream 5%* | 1 | QL (90 grams / 25 days), ST; PA** |
| ***DERMATOLOGY, ANTIPSORIATICS*** | | |
| *acitretin cap 10 mg* | 1 | |
| *acitretin cap 17.5 mg* | 1 | |
| *acitretin cap 25 mg* | 1 | |
| *calcipotriene cream 0.005%* | 3 | |
| *calcipotriene oint 0.005%* | 1 | |
| *calcipotriene soln 0.005% (50 mcg/ml)* | 1 | |
| *calcitrene oin 0.005%* | 1 | |
| *calcitriol oint 3 mcg/gm* | 1 | |
| COSENTYX INJ 150MG/ML | 4 | QL (1 box / 28 days), PA; Preferred agent for Ankylosing Spondylitis and Psoriatic Arthritis |
| COSENTYX INJ 300DOSE | 4 | QL (1 box / 28 days), PA; Preferred agent for Ankylosing Spondylitis and Psoriatic Arthritis |
| COSENTYX PEN INJ 150MG/ML | 4 | QL (1 box / 28 days), PA; Preferred agent for Ankylosing Spondylitis and Psoriatic Arthritis |
| COSENTYX PEN INJ 300DOSE | 4 | QL (1 box / 28 days), PA; Preferred agent for Ankylosing Spondylitis and Psoriatic Arthritis |
| *methoxsalen rapid cap 10 mg* | 1 | |
| *tazarotene cream 0.1%* | 1 | PA |
| TAZORAC CRE 0.05% | 2 | PA |
| TAZORAC GEL 0.1% | 2 | PA |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| TAZORAC GEL 0.05% | 2 | PA |
| ***DERMATOLOGY, ANTISEBORRHEICS*** | | |
| *ketoconazole shampoo 2%* | 1 | |
| *selenium sulfide lotion 2.5%* | 1 | |
| ***DERMATOLOGY, CORTICOSTEROIDS*** | | |
| *ala-cort cre 1%* | 1 | |
| *alclometasone dipropionate cream 0.05%* | 1 | QL (120g / 25 days) |
| *alclometasone dipropionate oint 0.05%* | 1 | QL (120g / 25 days) |
| *alphatrex gel 0.05%* | 1 | QL (120g / 25 days) |
| *amcinonide cream 0.1%* | 1 | QL (120g / 25 days) |
| *amcinonide lotion 0.1%* | 1 | QL (120mL / 25 days) |
| AMCINONIDE OIN 0.1% | 2 | QL (120g / 25 days) |
| *betamethasone dipropionate augmented cream 0.05%* | 1 | QL (120g / 25 days) |
| *betamethasone dipropionate augmented gel 0.05%* | 1 | QL (120g / 25 days) |
| *betamethasone dipropionate augmented lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *betamethasone dipropionate augmented oint 0.05%* | 1 | QL (120g / 25 days) |
| *betamethasone dipropionate cream 0.05%* | 1 | QL (120g / 25 days) |
| *betamethasone dipropionate lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *betamethasone dipropionate oint 0.05%* | 1 | QL (120g / 25 days) |
| *betamethasone valerate aerosol foam 0.12%* | 1 | |
| *betamethasone valerate cream 0.1% (base equivalent)* | 1 | QL (120g / 25 days) |
| *betamethasone valerate lotion 0.1% (base equivalent)* | 1 | QL (120mL / 25 days) |
| *betamethasone valerate oint 0.1% (base equivalent)* | 1 | QL (120g / 25 days) |
| *calcipotriene-betamethasone dipropionate oint 0.005-0.064%* | 3 | |
| *clobetasol propionate cream 0.05%* | 1 | QL (120g / 25 days) |
| *clobetasol propionate foam 0.05%* | 1 | |
| *clobetasol propionate gel 0.05%* | 1 | QL (120g / 25 days) |
| *clobetasol propionate lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *clobetasol propionate oint 0.05%* | 1 | QL (120g / 25 days) |
| *clobetasol propionate shampoo 0.05%* | 1 | |
| *clobetasol propionate soln 0.05%* | 1 | |
| *clobetasol propionate spray 0.05%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *clocortolone pivalate cream 0.1%* | 1 | QL (120g / 25 days) |
| *desonide cream 0.05%* | 1 | QL (120g / 25 days) |
| *desonide lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *desonide oint 0.05%* | 1 | QL (120g / 25 days) |
| *desoximetasone cream 0.05%* | 1 | QL (120g / 25 days) |
| *desoximetasone cream 0.25%* | 1 | QL (120g / 25 days) |
| *desoximetasone gel 0.05%* | 1 | QL (120g / 25 days) |
| *desoximetasone oint 0.05%* | 1 | QL (120g / 25 days) |
| *desoximetasone oint 0.25%* | 1 | QL (120g / 25 days) |
| *diflorasone diacetate cream 0.05%* | 1 | QL (120g / 25 days) |
| *diflorasone diacetate oint 0.05%* | 1 | QL (120g / 25 days) |
| *fluocinolone acetonide cream 0.01%* | 1 | |
| *fluocinolone acetonide cream 0.025%* | 1 | QL (120g / 25 days) |
| *fluocinolone acetonide oil 0.01% (body oil)* | 1 | |
| *fluocinolone acetonide oil 0.01% (scalp oil)* | 1 | |
| *fluocinolone acetonide oint 0.025%* | 1 | QL (120g / 25 days) |
| *fluocinolone acetonide soln 0.01%* | 1 | |
| *fluocinonide cream 0.05%* | 1 | QL (120g / 25 days) |
| *fluocinonide gel 0.05%* | 1 | QL (120g / 25 days) |
| *fluocinonide oint 0.05%* | 1 | QL (120g / 25 days) |
| *fluocinonide soln 0.05%* | 1 | |
| *flurandrenolide cream 0.05%* | 1 | QL (120g / 25 days) |
| *flurandrenolide lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *flurandrenolide oint 0.05%* | 1 | QL (120g / 25 days) |
| *fluticasone propionate cream 0.05%* | 1 | QL (120g / 25 days) |
| *fluticasone propionate lotion 0.05%* | 1 | QL (120mL / 25 days) |
| *fluticasone propionate oint 0.005%* | 1 | QL (120g / 25 days) |
| *halcinonide cream 0.1%* | 1 | QL (120g / 25 days) |
| *halobetasol propionate cream 0.05%* | 1 | QL (120g / 25 days) |
| *halobetasol propionate oint 0.05%* | 1 | QL (120g / 25 days) |
| HALOG CRE 0.1% | 3 | QL (120g / 25 days) |
| HALOG OIN 0.1% | 3 | QL (120g / 25 days) |
| *hydrocortisone butyrate cream 0.1%* | 1 | QL (120g / 25 days) |
| *hydrocortisone butyrate hydrophilic lipo base cream 0.1%* | 1 | QL (120g / 25 days) |
| *hydrocortisone butyrate oint 0.1%* | 1 | QL (120g / 25 days) |
| *hydrocortisone butyrate soln 0.1%* | 1 | |
| *hydrocortisone cream 1%* | 1 | |
| *hydrocortisone cream 2.5%* | 1 | |
| *hydrocortisone lotion 2.5%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *hydrocortisone oint 1%* | 1 | |
| *hydrocortisone oint 2.5%* | 1 | |
| *hydrocortisone valerate cream 0.2%* | 1 | QL (120g / 25 days) |
| *hydrocortisone valerate oint 0.2%* | 1 | QL (120g / 25 days) |
| *lokara lot 0.05%* | 1 | QL (120mL / 25 days) |
| *mometasone furoate cream 0.1%* | 1 | QL (120g / 25 days) |
| *mometasone furoate oint 0.1%* | 1 | QL (120g / 25 days) |
| *mometasone furoate solution 0.1% (lotion)* | 1 | QL (120mL / 25 days) |
| *prednicarbate cream 0.1%* | 1 | QL (120g / 25 days) |
| *prednicarbate oint 0.1%* | 1 | QL (120g / 25 days) |
| *triamcinolone acetonide aerosol soln 0.147 mg/gm* | 1 | |
| *triamcinolone acetonide cream 0.1%* | 1 | |
| *triamcinolone acetonide cream 0.5%* | 1 | |
| *triamcinolone acetonide cream 0.025%* | 1 | |
| *triamcinolone acetonide lotion 0.1%* | 1 | |
| *triamcinolone acetonide lotion 0.025%* | 1 | |
| *triamcinolone acetonide oint 0.1%* | 1 | |
| *triamcinolone acetonide oint 0.5%* | 1 | |
| *triamcinolone acetonide oint 0.025%* | 1 | |
| *triderm cre 0.1%* | 1 | |
| ***DERMATOLOGY, LOCAL ANESTHETICS*** | | |
| *lidocaine hcl soln 4%* | 1 | QL (50mL / 25 days) |
| *lidocaine hcl urethral/mucosal gel 2%* | 1 | QL (30gm / 25 days) |
| *lidocaine hcl urethral/mucosal gel prefilled syringe 2%* | 1 | QL (30gm / 25 days) |
| *lidocaine oint 5%* | 1 | QL (50gm / 25 days) |
| *lidocaine patch 5%* | 1 | QL (90 patches / 25 days), PA |
| *lidocaine-prilocaine cream 2.5-2.5%* | 1 | QL (30gm / 25 days) |
| *lidocaine-prilocaine cream kit 2.5-2.5%* | 1 | |
| *pramox gel 1%* | 1 | |
| SYNERA DIS 70-70MG | 3 | QL (2 patches / 25 days) |
| *7t lido gel 2%* | 1 | QL (30gm / 25 days) |
| ***DERMATOLOGY, MISCELLANEOUS SKIN AND MUCOUS MEMBRANE*** | | |
| *acyclovir oint 5%* | 1 | |
| CONDYLOX GEL 0.5% | 3 | |
| DENAVIR CRE 1% | 3 | |
| *diclofenac sodium gel 1%* | 1 | QL (500g / 25 days) |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| EUCRISA OIN 2% | 2 | |
| *lactic acid (ammonium lactate) cream 12%* | 1 | |
| *lactic acid (ammonium lactate) lotion 10%* | 1 | |
| *lactic acid (ammonium lactate) lotion 12%* | 1 | |
| *pimecrolimus cream 1%* | 1 | |
| *podofilox soln 0.5%* | 1 | |
| RECTIV OIN 0.4% | 3 | |
| *tacrolimus oint 0.1%* | 1 | |
| *tacrolimus oint 0.03%* | 1 | |
| TARGRETIN GEL 1% | 0 | PA |
| VEREGEN OIN 15% | 3 | |
| ***DERMATOLOGY, ROSACEA*** | | |
| *azelaic acid gel 15%* | 1 | |
| FINACEA AER 15% | 2 | |
| *metronidazole cream 0.75%* | 1 | |
| *metronidazole gel 0.75%* | 1 | |
| *metronidazole gel 1%* | 1 | |
| *metronidazole lotion 0.75%* | 1 | |
| MIRVASO GEL 0.33% | 3 | |
| *rosadan cre 0.75%* | 1 | |
| ***DERMATOLOGY, SCABICIDES AND PEDICULIDES*** | | |
| *crotan lot 10%* | 1 | |
| EURAX CRE 10% | 3 | |
| *lindane shampoo 1%* | 1 | |
| *malathion lotion 0.5%* | 1 | |
| *permethrin cream 5%* | 1 | |
| SKLICE LOT 0.5% | 3 | |
| *spinosad susp 0.9%* | 1 | |
| ULESFIA LOT 5% | 3 | |
| ***DERMATOLOGY, WOUND CARE AGENTS*** | | |
| REGRANEX GEL 0.01% | 3 | PA |
| SANTYL OIN 250/GM | 3 | PA |
| *sodium chloride irrigation soln 0.9%* | M | M |
| ***MOUTH/THROAT/DENTAL AGENTS*** | | |
| *cevimeline hcl cap 30 mg* | 1 | |
| *chlorhexidine gluconate soln 0.12%* | 1 | |
| *clotrimazole troche 10 mg* | 1 | |
| *lidocaine hcl laryngotracheal soln 4%* | 1 | |
| *lidocaine hcl viscous soln 2%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

| Drug Name | Drug Tier | Requirements/Limits |
|---|---|---|
| *nystatin susp 100000 unit/ml* | 1 | |
| *oralone dent pst 0.1%* | 1 | |
| ORAVIG TAB 50MG | 3 | |
| *periogard sol 0.12%* | 1 | |
| *pilocarpine hcl tab 5 mg* | 1 | |
| *pilocarpine hcl tab 7.5 mg* | 1 | |
| *triamcinolone acetonide dental paste 0.1%* | 1 | |
| ***OTIC*** | | |
| *acetic acid 2% in aluminum acetate otic soln* | 1 | |
| *acetic acid otic soln 2%* | 1 | |
| CIPRO HC SUS OTIC | 3 | |
| CIPRODEX SUS 0.3-0.1% | 2 | |
| COLY-MYCIN S SUS OTIC | 3 | |
| *fluocinolone acetonide (otic) oil 0.01%* | 1 | |
| *hydrocortisone w/ acetic acid otic soln 1-2%* | 1 | |
| *neomycin-polymyxin-hc otic soln 1%* | 1 | |
| *neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%* | 1 | |
| *ofloxacin otic soln 0.3%* | 1 | |



Note: Coverage of prescription drugs and supplies listed on this formulary (drug list) is subject to your plan and benefits. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under Quick Links.

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **carefirst.com/rx**.

CareFirst
Family of health care plans

10455 Mill Run Circle
Owings Mills, MD 21117

**carefirst.com/rx**



SUM4659-1S (12/19)

# Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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, please call 855-258-6518.**

If you believe CareFirst 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 our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

**To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.**

## Civil Rights Coordinator, Corporate Office of Civil Rights

| | |
|---|---|
| Mailing Address | P.O. Box 8894<br>Baltimore, Maryland 21224 |
| Email Address | **civilrightscoordinator@carefirst.com** |
| Telephone Number | 410-528-7820 |
| Fax Number | 410-505-2011 |

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**.

## Foreign Language Assistance

*Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call* 855-258-6518 *and wait through the dialogue until prompted to push* 0*. When an agent answers, state the language you need and you will be connected to an interpreter.*

*አማርኛ(Amharic)* ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

*Èdè Yorùbá (Yoruba)* Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

*Tiếng Việt (Vietnamese)* Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

*Tagalog (Tagalog)* Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

*Español (Spanish)* Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

*Русский (Russian)* Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

*हिन्दी (Hindi)* ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

*Bǎsɔ́ɔ̀-wùdù (Bassa)* Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǘá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɛ́ nì ɓídɖí-wùdù mú ɓɛ́ m̀ ké se wídɖí dɔ̀ pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɖá fǘùn-nɔ̀ɓà nìà dɛ́ waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdɖàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓɛ́ ɔ ké nì wuduɔ̀ mú zà.

*বাংলা (Bengali)* লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

*اردو (Urdu)* توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

*فارسی (Farsi)* توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

*اللغة العربية (Arabic)* تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

*中文繁体 (Traditional Chinese)* 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

*Igbo (Igbo)* Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

*Deutsch (German)* Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

*Français (French)* Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

*한국어(Korean)* 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.