

CareFirst Formulary 3 Choice

2024

PLEASE READ: This document contains information about the drugs we cover in this plan. This formulary is for members of an employer group with 51 or more employees. For your specific prescription benefit plan information, log into your account at carefirst.com.

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

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**.

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. For example, quantity limits apply to specialty drugs. Specialty drugs are medications that may be used to treat complex and/or rare health conditions and require special handling, administration or monitoring. Specialty drugs are typically covered for a one-month supply.

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	<ul style="list-style-type: none"> ■ 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. ■ 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 \$	<ul style="list-style-type: none"> ■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs \$\$	<ul style="list-style-type: none"> ■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-preferred Brand Drugs \$\$\$	<ul style="list-style-type: none"> ■ 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 \$\$\$\$	<ul style="list-style-type: none"> ■ Preferred specialty drugs are medications that may be used to treat complex and/or rare health conditions. These drugs may have a lower cost-share than non-preferred specialty drugs.
Tier 5: Non-Preferred Specialty Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Non-preferred specialty drugs often have a specialty drug option where your cost-share will be lower.

Drug Name	Drug Tier	Requirements/Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
AMPHETAMI ER SUS 1.25/ML	1	QL (540 mL every 30 days)
<i>amphetamine sulfate tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>amphetamine sulfate tab 10 mg</i>	1	QL (150 tabs every 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	1	QL (120 caps every 25 days)
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1	QL (120 caps every 25 days)
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1	QL (30 caps every 25 days)
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1	QL (30 caps every 25 days)
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	1	QL (30 caps every 25 days)
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	1	QL (30 caps every 25 days)
<i>amphetamine-dextroamphetamine tab 5 mg</i>	1	QL (120 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	1	QL (120 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 10 mg</i>	1	QL (120 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	1	QL (120 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 15 mg</i>	1	QL (60 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>amphetamine-dextroamphetamine tab 30 mg</i>	1	QL (30 tabs every 30 days)
DESOXYN TAB 5MG	3	QL (180 tabs every 30 days)
DEXEDRINE CAP 5MG CR	3	QL (150 caps every 30 days)
DEXEDRINE CAP 10MG CR	3	QL (150 caps every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

1

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DEXEDRINE CAP 15MG CR	3	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	QL (1440 mL every 30 days)
<i>dextroamphetamine sulfate tab 2.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 7.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 10 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 15 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	1	QL (30 tabs every 30 days)
<i>lisdexamfetamine dimesylate cap 10 mg</i>	1	QL (60 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 20 mg</i>	1	QL (60 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 30 mg</i>	1	QL (60 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 40 mg</i>	1	QL (30 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 50 mg</i>	1	QL (30 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 60 mg</i>	1	QL (30 caps every 30 days)
<i>lisdexamfetamine dimesylate cap 70 mg</i>	1	QL (30 caps every 30 days)
<i>lisdexamfetamine dimesylate chew tab 10 mg</i>	1	QL (60 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

2

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>lisdexamfetamine dimesylate chew tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>lisdexamfetamine dimesylate chew tab 30 mg</i>	1	QL (60 tabs every 30 days)
<i>lisdexamfetamine dimesylate chew tab 40 mg</i>	1	QL (30 tabs every 30 days)
<i>lisdexamfetamine dimesylate chew tab 50 mg</i>	1	QL (30 tabs every 30 days)
<i>lisdexamfetamine dimesylate chew tab 60 mg</i>	1	QL (30 tabs every 30 days)
<i>methamphetamine hcl tab 5 mg</i>	1	QL (180 tabs every 30 days)
VYVANSE CAP 10MG	3	QL (60 caps every 30 days)
VYVANSE CAP 20MG	3	QL (60 caps every 30 days)
VYVANSE CAP 30MG	3	QL (60 caps every 30 days)
VYVANSE CAP 40MG	3	QL (30 caps every 30 days)
VYVANSE CAP 50MG	3	QL (30 caps every 30 days)
VYVANSE CAP 60MG	3	QL (30 caps every 30 days)
VYVANSE CAP 70MG	3	QL (30 caps every 30 days)
VYVANSE CHW 10MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 20MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 30MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 40MG	3	QL (30 tabs every 30 days)
VYVANSE CHW 50MG	3	QL (30 tabs every 30 days)
VYVANSE CHW 60MG	3	QL (30 tabs every 30 days)
ANALEPTICS		
<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	1	
ANOREXIANTS NON-AMPHETAMINE		
ADIPEX-P CAP 37.5MG	3	PA, QL (30 units per 28 days); Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

3

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ADIPEX-P TAB 37.5MG	3	PA, QL (30 units per 28 days); Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 25 mg</i>	1	PA, QL (90 tabs per 28 days); Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 50 mg</i>	1	PA, QL (90 tabs per 28 days); Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab 25 mg</i>	1	PA, QL (90 tabs per 28 days); Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA, QL (30 tabs per 28 days); Coverage is subject to your plan/benefits
PHENDIMETRAZ CAP 105MG ER	1	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA, QL (180 tabs per 28 days); Coverage is subject to your plan/benefits
<i>phentermine hcl cap 15 mg</i>	1	PA, QL (60 caps per 28 days); Coverage is subject to your plan/benefits
<i>phentermine hcl cap 30 mg</i>	1	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits
<i>phentermine hcl cap 37.5 mg</i>	1	PA, QL (30 units per 28 days); Coverage is subject to your plan/benefits
<i>phentermine hcl tab 37.5 mg</i>	1	PA, QL (30 units per 28 days); Coverage is subject to your plan/benefits
QSYMIA CAP 3.75-23	2	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

4

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
QSYMIA CAP 7.5-46MG	2	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits
QSYMIA CAP 11.25-69	2	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits
QSYMIA CAP 15-92MG	2	PA, QL (30 caps per 28 days); Coverage is subject to your plan/benefits
ANTI-OBESITY AGENTS		
<i>orlistat cap 120 mg</i>	1	PA, QL (90 caps per 28 days); Coverage is subject to your plan/benefits
SAXENDA INJ 18MG/3ML	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
WEGOVY INJ 0.5MG	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
WEGOVY INJ 0.25MG	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
WEGOVY INJ 1.7MG	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
WEGOVY INJ 1MG	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
WEGOVY INJ 2.4MG	2	PA, QL (1 package per 28 days); Coverage is subject to your plan/benefits
ANTI-OBESITY AGENTS, ORAL		
REGIMEX TAB 25MG	3	PA; Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

5

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XENICAL CAP 120MG	3	PA, QL (90 caps per 28 days); Coverage is subject to your plan/benefits

ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS

<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	QL (60 caps every 30 days)
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	
STRATTERA CAP 10MG	3	QL (150 caps every 30 days)
STRATTERA CAP 18MG	3	QL (150 caps every 30 days)
STRATTERA CAP 25MG	3	QL (150 caps every 30 days)
STRATTERA CAP 40MG	3	QL (60 caps every 30 days)
STRATTERA CAP 60MG	3	QL (30 caps every 30 days)
STRATTERA CAP 80MG	3	QL (30 caps every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

6

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
STRATTERA CAP 100MG	3	QL (30 caps every 30 days)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG	2	
SUNOSI TAB 150MG	2	
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG	4	PA, QL (60 TABLETS PER 30 DAYS)
WAKIX TAB 17.8MG	4	PA, QL (60 TABLETS PER 30 DAYS)
STIMULANTS - MISC.		
<i>armodafinil tab 50 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>armodafinil tab 150 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>armodafinil tab 200 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>armodafinil tab 250 mg</i>	1	PA, QL (30 tabs every 30 days)
AZSTARYS CAP 26.1-5.2	2	
AZSTARYS CAP 39.2-7.8	2	
AZSTARYS CAP 52.3-10.	2	
<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	QL (30 caps every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

7

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl tab 2.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dexmethylphenidate hcl tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>dexmethylphenidate hcl tab 10 mg</i>	1	QL (60 tabs every 30 days)
FOCALIN TAB 2.5MG	3	QL (150 tabs every 30 days)
FOCALIN TAB 5MG	3	QL (150 tabs every 30 days)
FOCALIN TAB 10MG	3	QL (60 tabs every 30 days)
METHYLIN SOL 5MG/5ML	3	QL (2160 mL every 30 days)
METHYLIN SOL 10MG/5ML	3	QL (1080 mL every 30 days)
METHYLPHENID TAB 72MG ER	3	QL (30 tabs every 30 days)
<i>methylphenidate hcl cap er 10 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 20 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	1	QL (60 caps every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

8

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 30 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 40 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 50 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 60 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl chew tab 2.5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl chew tab 5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl chew tab 10 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl soln 5 mg/5ml</i>	1	QL (2160 mL every 30 days)
<i>methylphenidate hcl soln 10 mg/5ml</i>	1	QL (1080 mL every 30 days)
<i>methylphenidate hcl tab 5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl tab 10 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl tab 20 mg</i>	1	QL (120 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

9

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl tab er 10 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 20 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 18 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 36 mg</i>	1	QL (60 tabs every 30 days); MNPA
<i>methylphenidate hcl tab er 24hr 54 mg</i>	1	QL (30 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	1	QL (60 tabs every 25 days)
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	1	QL (60 tabs every 25 days)
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	1	QL (60 tabs every 25 days)
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	1	QL (30 tabs every 25 days)
<i>modafinil tab 100 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>modafinil tab 200 mg</i>	1	PA, QL (60 tabs every 30 days)
RITALIN LA CAP 10MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 20MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 30MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 40MG	3	QL (30 caps every 30 days)
RITALIN TAB 5MG	3	QL (210 tabs every 30 days)
RITALIN TAB 10MG	3	QL (210 tabs every 30 days)
RITALIN TAB 20MG	3	QL (120 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

10

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
ARIKAYCE SUS	5	PA
<i>neomycin sulfate tab 500 mg</i>	1	
<i>paromomycin sulfate cap 250 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)
<i>tobramycin nebu soln 300 mg/5ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)
ANALGESICS - ANTI-INFLAMMATORY		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HUMIRA INJ 10/0.1ML	4	PA, QL (2 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

11

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA INJ 20/0.2ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 40/0.4ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA KIT 40MG/0.8	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEDIA INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 2 syringes per 28 days.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

12

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEDIA INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 3 syringes per 28 days.
HUMIRA PEN INJ 40/0.4ML	4	PA, QL (4.5 pens every 30 days); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 40MG/0.8	4	PA, QL (4 PENS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 80/0.8ML	4	PA, QL (2 PENS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

13

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN INJ CD/UC/HS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 6 pens per 28 days.
HUMIRA PEN INJ PS/UV	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 4 pens per 28 days.
HUMIRA PEN KIT CD/UC/HS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 3 pens per 28 days.
HUMIRA PEN KIT PED UC	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

14

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN KIT PS/UV	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HYRIMOZ	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ INJ 10/0.1ML	4	PA, QL (2 syringes per 28 days); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ INJ 20/0.2ML	4	PA, QL (4 syringes per 28 days); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

15

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ INJ 40/0.4ML	4	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ INJ 80/0.8ML	4	PA, QL (2 pens PER 28 days); LOADING DOSE: 4 pens per 14 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 2 syringes per 28 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

16

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
HYRIMOZ-PLAQ INJ PSORIASI	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days. Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits.
ANTIRHEUMATIC - ENZYME INHIBITORS		
RINVOQ TAB 15MG ER	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits.
RINVOQ TAB 30MG ER	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

17

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RINVOQ TAB 45MG ER	4	PA, QL (NOT FOR DAILY USE); referred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 84 tablets per 84 days
XELJANZ SOL 1MG/ML	4	PA, QL (240ML PER 24 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ TAB 5MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

18

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XELJANZ TAB 10MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ XR TAB 11MG	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ XR TAB 22MG	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ANTIRHEUMATIC ANTIMETABOLITES		
RASUVO INJ 7.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 10MG	4	PA, QL (4 INJ PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

19

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RASUVO INJ 12.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 15MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 17.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 20MG	4	PA, QL (4 PENS PER 28 DAYS)
RASUVO INJ 22.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 25MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 30MG	4	PA, QL (4 INJ PER 28 DAYS)
GOLD COMPOUNDS		
RIDAURA CAP 3MG	3	
INTERLEUKIN-6 RECEPTOR INHIBITORS		
KEVZARA INJ 150/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

20

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
<i>celecoxib cap 50 mg</i>	1	
<i>celecoxib cap 100 mg</i>	1	
<i>celecoxib cap 200 mg</i>	1	
<i>celecoxib cap 400 mg</i>	1	
DAYPRO TAB 600MG	3	
<i>diclofenac potassium tab 50 mg</i>	1	
<i>diclofenac sodium tab delayed release 25 mg</i>	1	
<i>diclofenac sodium tab delayed release 50 mg</i>	1	
<i>diclofenac sodium tab delayed release 75 mg</i>	1	
<i>diclofenac sodium tab er 24hr 100 mg</i>	1	
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i>	1	
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i>	1	
DUEXIS TAB 800-26.6	3	
EC-NAPROSYN TAB 375MG	3	
EC-NAPROSYN TAB 500MG	3	
<i>etodolac cap 200 mg</i>	1	
<i>etodolac cap 300 mg</i>	1	
<i>etodolac tab 400 mg</i>	1	
<i>etodolac tab 500 mg</i>	1	
<i>etodolac tab er 24hr 400 mg</i>	1	
<i>etodolac tab er 24hr 500 mg</i>	1	
<i>etodolac tab er 24hr 600 mg</i>	1	
FELDENE CAP 10MG	3	
FELDENE CAP 20MG	3	
<i>flurbiprofen tab 50 mg</i>	1	
<i>flurbiprofen tab 100 mg</i>	1	
<i>ibuprofen tab 400 mg</i>	1	
<i>ibuprofen tab 600 mg</i>	1	
<i>ibuprofen tab 800 mg</i>	1	
<i>indomethacin cap 25 mg</i>	1	
<i>indomethacin cap 50 mg</i>	1	
<i>indomethacin cap er 75 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

21

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>ketoprofen cap 50 mg</i>	1	
<i>ketoprofen cap 75 mg</i>	1	
<i>ketorolac tromethamine tab 10 mg</i>	1	
<i>meclofenamate sodium cap 50 mg</i>	1	
<i>meclofenamate sodium cap 100 mg</i>	1	
<i>mefenamic acid cap 250 mg</i>	1	
<i>meloxicam tab 7.5 mg</i>	1	
<i>meloxicam tab 15 mg</i>	1	
MOBIC TAB 7.5MG	3	
MOBIC TAB 15MG	3	
<i>nabumetone tab 500 mg</i>	1	
<i>nabumetone tab 750 mg</i>	1	
NALFON CAP 400MG	3	
NALFON TAB 600MG	3	
NAPROSYN TAB 500MG	3	
<i>naproxen sodium tab 275 mg</i>	1	
<i>naproxen sodium tab 550 mg</i>	1	
<i>naproxen tab 250 mg</i>	1	
<i>naproxen tab 375 mg</i>	1	
<i>naproxen tab 500 mg</i>	1	
<i>naproxen tab ec 375 mg</i>	1	
<i>naproxen tab ec 500 mg</i>	1	
<i>oxaprozin tab 600 mg</i>	1	
<i>piroxicam cap 10 mg</i>	1	
<i>piroxicam cap 20 mg</i>	1	
<i>sulindac tab 150 mg</i>	1	
<i>sulindac tab 200 mg</i>	1	
<i>tolmetin sodium cap 400 mg</i>	1	
<i>tolmetin sodium tab 600 mg</i>	1	
VIMOVO TAB 375-20MG	3	
VIMOVO TAB 500-20MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

22

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20/30	4	PA, QL (55 TABLETS PER 28 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
OTEZLA TAB 30MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
PYRIMIDINE SYNTHESIS INHIBITORS		
ARAVA TAB 10MG	3	
ARAVA TAB 20MG	3	
leflunomide tab 10 mg	1	
leflunomide tab 20 mg	1	
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLCK INJ 125MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

23

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ORENCIA INJ 50/0.4ML	4	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ORENCIA INJ 87.5/0.7	4	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ORENCIA INJ 125MG/ML	4	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

24

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25/0.5ML	4	PA, QL (8 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ENBREL INJ 50MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:8 SYRINGES PER 28 DAYS
ENBREL MINI INJ 50MG/ML	4	PA, QL (4 CARTRIDGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:8 CARTRIDGES PER 28 DAYS

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

25

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ENBREL SRCLK INJ 50MG/ML	4	PA, QL (4 INJ PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:8 INJECTORS PER 28 DAYS

ANALGESICS - NONNARCOTIC**ANALGESIC COMBINATIONS**

<i>butalbital-acetaminophen tab 50-325 mg</i>	1	
<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i>	1	
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	1	
ESGIC TAB	3	

SALICYLATES

<i>aspirin chew tab 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>aspirin tab delayed release 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>diflunisal tab 500 mg</i>	1	
<i>salsalate tab 500 mg</i>	1	
<i>salsalate tab 750 mg</i>	1	

ANALGESICS - OPIOID**OPIOID AGONISTS**

ACTIQ LOZ 200MCG	3	PA
ACTIQ LOZ 400MCG	3	PA
ACTIQ LOZ 600MCG	3	PA
ACTIQ LOZ 800MCG	3	PA
ACTIQ LOZ 1200MCG	3	PA
ACTIQ LOZ 1600MCG	3	PA
CODEINE SULF TAB 15MG	3	PA, QL (42 tabs every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

26

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CODEINE SULF TAB 60MG	3	PA, QL (42 tabs every 25 days)
<i>codeine sulfate tab 30 mg</i>	1	PA, QL (42 tabs every 25 days)
CONZIP CAP 100MG	3	PA, QL (30 caps every 25 days)
CONZIP CAP 200MG	3	PA, QL (30 caps every 25 days)
CONZIP CAP 300MG	3	PA, QL (30 caps every 25 days)
DILAUDID LIQ 1MG/ML	3	PA, QL (16 mL per day)
DILAUDID TAB 2MG	3	PA, QL (180 tabs every 25 days)
DILAUDID TAB 4MG	3	PA, QL (4 tabs per day)
DILAUDID TAB 8MG	3	PA, QL (60 tabs every 25 days)
DURAGESIC DIS 12MCG/HR	3	PA, QL (10 patches every 25 days)
DURAGESIC DIS 25MCG/HR	3	PA, QL (10 patches every 25 days)
DURAGESIC DIS 50MCG/HR	3	PA
DURAGESIC DIS 75MCG/HR	3	PA
DURAGESIC DIS 100MCG/H	3	PA
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

27

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	1	PA
<i>fentanyl td patch 72hr 12 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	1	PA, QL (60 caps every 25 days)
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	1	PA, QL (60 caps every 25 days)
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	1	PA, QL (60 caps every 25 days)
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	1	PA, QL (60 caps every 25 days)
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	1	PA, QL (60 caps every 25 days)
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	1	PA, QL (30 tabs every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

28

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	1	PA, QL (30 tabs every 25 days)
HYDROMORPHON SUP 3MG	3	PA, QL (120 supp every 25 days)
<i>hydromorphone hcl liqd 1 mg/ml</i>	1	PA, QL (16 mL per day)
<i>hydromorphone hcl tab 2 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>hydromorphone hcl tab 4 mg</i>	1	PA, QL (4 tabs per day)
<i>hydromorphone hcl tab 8 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>hydromorphone hcl tab er 24hr 8 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydromorphone hcl tab er 24hr 12 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydromorphone hcl tab er 24hr 16 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydromorphone hcl tab er 24hr 32 mg</i>	1	PA
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (1.5 mL per day)
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (60 mL every 25 days)
<i>methadone hcl soln 5 mg/5ml</i>	1	PA, QL (450 mL every 25 days)
<i>methadone hcl soln 10 mg/5ml</i>	1	PA, QL (7.5 mL per day)
<i>methadone hcl tab 5 mg</i>	1	PA, QL (90 tabs every 25 days)
<i>methadone hcl tab 10 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>methadone hcl tab for oral susp 40 mg</i>	1	
METHADOSE CON 10MG/ML	3	QL (60 mL every 25 days)
METHADOSE SF CON 10MG/ML	3	QL (60 mL every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

29

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>morphine sulfate beads cap er 24hr 30 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate beads cap er 24hr 45 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate beads cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate beads cap er 24hr 75 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate beads cap er 24hr 90 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate beads cap er 24hr 120 mg</i>	1	PA
<i>morphine sulfate cap er 24hr 10 mg</i>	1	PA, QL (60 caps every 25 days)
<i>morphine sulfate cap er 24hr 20 mg</i>	1	PA, QL (60 caps every 25 days)
<i>morphine sulfate cap er 24hr 30 mg</i>	1	PA, QL (60 caps every 25 days)
<i>morphine sulfate cap er 24hr 40 mg</i>	1	PA, QL (60 caps every 25 days)
<i>morphine sulfate cap er 24hr 50 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate cap er 24hr 80 mg</i>	1	PA, QL (30 caps every 25 days)
<i>morphine sulfate cap er 24hr 100 mg</i>	1	PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	1	PA, QL (900 mL every 25 days)
<i>morphine sulfate oral soln 20 mg/5ml</i>	1	PA, QL (675 mL every 25 days)
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 25 days)
<i>morphine sulfate suppos 5 mg</i>	1	PA, QL (180 supp every 25 days)
<i>morphine sulfate suppos 10 mg</i>	1	PA, QL (180 supp every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

30

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>morphine sulfate suppos 20 mg</i>	1	PA, QL (120 supp every 25 days)
<i>morphine sulfate suppos 30 mg</i>	1	PA, QL (90 supp every 25 days)
<i>morphine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>morphine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 25 days)
<i>morphine sulfate tab er 15 mg</i>	1	PA, QL (90 tabs every 25 days)
<i>morphine sulfate tab er 30 mg</i>	1	PA, QL (90 tabs every 25 days)
<i>morphine sulfate tab er 60 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 100 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>morphine sulfate tab er 200 mg</i>	1	PA, QL (30 tabs every 30 days)
MS CONTIN TAB 15MG ER	3	PA, QL (90 tabs every 25 days)
MS CONTIN TAB 30MG ER	3	PA, QL (90 tabs every 25 days)
MS CONTIN TAB 60MG ER	3	PA
MS CONTIN TAB 100MG ER	3	PA
MS CONTIN TAB 200MG ER	3	PA, QL (30 tabs every 30 days)
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 25 days)
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (90 mL every 30 days)
<i>oxycodone hcl soln 5 mg/5ml</i>	1	PA, QL (900 mL every 25 days)
<i>oxycodone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>oxycodone hcl tab 10 mg</i>	1	PA, QL (180 tabs every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

31

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone hcl tab 15 mg</i>	1	PA, QL (120 tabs every 25 days)
<i>oxycodone hcl tab 20 mg</i>	1	PA, QL (90 tabs every 25 days)
<i>oxycodone hcl tab 30 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	1	PA, QL (120 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	1	PA, QL (60 tabs every 25 days)
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxymorphone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>oxymorphone hcl tab 10 mg</i>	1	PA, QL (90 tabs every 25 days)
ROXICODONE TAB 5MG	3	PA, QL (180 tabs every 25 days)
ROXICODONE TAB 15MG	3	PA, QL (120 tabs every 25 days)
ROXICODONE TAB 30MG	3	PA, QL (60 tabs every 25 days)
<i>tramadol hcl tab 50 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>tramadol hcl tab er 24hr 100 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>tramadol hcl tab er 24hr 200 mg</i>	1	PA, QL (30 tabs every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

32

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA, QL (30 tabs every 25 days)
ULTRAM TAB 50MG	3	PA, QL (180 tabs every 25 days)

OPIOID COMBINATIONS

<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	PA, QL (2700 mL every 30 days)
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	PA, QL (390 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	PA, QL (300 caps every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	1	PA, QL (300 tabs every 30 days)
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	1	
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	1	
FIORICET CAP CODEINE	3	
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen soln 10-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	1	PA, QL (240 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

33

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	1	PA, QL (150 tabs every 30 days)
LORTAB ELX 10-300MG	3	PA, QL (2040 mL every 30 days)
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
ULTRACET TAB 37.5-325	3	PA, QL (240 tabs every 30 days)
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG	2	PA, QL (60 films every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

34

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BELBUCA MIS 150MCG	2	PA, QL (60 films every 25 days)
BELBUCA MIS 300MCG	2	PA, QL (60 films every 25 days)
BELBUCA MIS 450MCG	2	PA, QL (60 films every 25 days)
BELBUCA MIS 600MCG	2	PA
BELBUCA MIS 750MCG	2	PA
BELBUCA MIS 900MCG	2	PA
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	0	
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	0	
<i>buprenorphine td patch weekly 5 mcg/hr</i>	1	PA, QL (4 patches every 25 days)
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	1	PA, QL (4 patches every 25 days)
<i>buprenorphine td patch weekly 10 mcg/hr</i>	1	PA, QL (4 patches every 25 days)
<i>buprenorphine td patch weekly 15 mcg/hr</i>	1	PA
<i>buprenorphine td patch weekly 20 mcg/hr</i>	1	PA
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1	QL (2.4 bottles every 30 days)
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA
ZUBSOLV SUB 0.7-0.18	2	
ZUBSOLV SUB 1.4-0.36	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

35

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZUBSOLV SUB 2.9-0.71	2	
ZUBSOLV SUB 5.7-1.4	2	
ZUBSOLV SUB 8.6-2.1	2	
ZUBSOLV SUB 11.4-2.9	2	

ANDROGENS-ANABOLIC**ANABOLIC STEROIDS**

<i>oxandrolone tab 2.5 mg</i>	1	
<i>oxandrolone tab 10 mg</i>	1	

ANDROGENS

ANDRODERM DIS 2MG/24HR	3	PA
ANDRODERM DIS 4MG/24HR	3	PA
<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	
METHITEST TAB 10MG	3	
<i>methyltestosterone cap 10 mg</i>	1	
NATESTO GEL 5.5MG	2	PA
TESTOST CYP INJ 200MG/ML	1	PA
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	1	PA
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	3	PA
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	1	PA
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	3	PA
<i>testosterone enanthate im inj in oil 200 mg/ml</i>	1	PA
<i>testosterone td gel 10mg/act (2%)</i>	1	PA
<i>testosterone td gel 12.5 mg/act (1%)</i>	1	PA
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1	PA
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	1	PA
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	1	PA
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	1	PA
<i>testosterone td gel 50 mg/5gm (1%)</i>	1	PA
<i>testosterone td soln 30 mg/act</i>	1	PA
XYOSTED INJ 50/0.5	3	PA
XYOSTED INJ 75/0.5	3	PA
XYOSTED INJ 100/0.5	3	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

36

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS		
CORTENEMA ENE 100MG	3	
CORTIFOAM AER 90MG	2	
<i>hydrocortisone enema 100 mg/60ml</i>	1	
RECTAL COMBINATIONS		
ANALPRAM-HC CRE 1-1%	3	
ANALPRAM-HC LOT 2.5%	3	
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
PROCTOFOAM AER HC 1%	2	
RECTAL STEROIDS		
ANUSOL-HC CRE 2.5%	3	
<i>hydrocortisone acetate suppos 25 mg</i>	1	
<i>hydrocortisone perianal cream 1%</i>	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
VASODILATING AGENTS		
RECTIV OIN 0.4%	3	
ANTHELMINTICS		
ANTHELMINTICS		
<i>albendazole tab 200 mg</i>	1	QL (336 tabs every year)
ALBENZA TAB 200MG	3	QL (336 tabs every year)
BENZNIDAZOLE TAB 12.5MG	3	
BENZNIDAZOLE TAB 100MG	3	
BILTRICIDE TAB 600MG	3	QL (24 tabs every year)
EMVERM CHW 100MG	3	QL (12 ea every year)
<i>ivermectin tab 3 mg</i>	1	PA, QL (9 tabs every 90 days)
<i>praziquantel tab 600 mg</i>	1	QL (24 tabs every year)
STROMECTOL TAB 3MG	3	PA, QL (9 tabs every 90 days)
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
AEMCOLO TAB 194MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

37

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FLAGYL CAP 375MG	3	
FLAGYL TAB 500MG	3	
IMPAVIDO CAP 50MG	3	
<i>metronidazole cap 375 mg</i>	1	
<i>metronidazole tab 250 mg</i>	1	
<i>metronidazole tab 500 mg</i>	1	
PRIMSOL SOL 50MG/5ML	3	
<i>tinidazole tab 250 mg</i>	1	
<i>tinidazole tab 500 mg</i>	1	
<i>trimethoprim tab 100 mg</i>	1	
XIFAXAN TAB 550MG	2	PA
ANTI-INFECTIVE MISC. - COMBINATIONS		
BACTRIM DS TAB 800-160	3	
BACTRIM TAB 400-80MG	3	
<i>methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg</i>	1	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
ANTIPROTOZOAL AGENTS		
ALINIA SUS 100/5ML	3	
ALINIA TAB 500MG	3	
<i>atovaquone susp 750 mg/5ml</i>	1	
LAMPIT TAB 30MG	3	
LAMPIT TAB 120MG	3	
MEPRON SUS	2	
<i>nitazoxanide tab 500 mg</i>	1	
GLYCOPEPTIDES		
VANCOGIN CAP 125MG	3	QL (80 caps every 10 days)
VANCOGIN CAP 250MG	3	QL (80 caps every 10 days)
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1	QL (80 caps every 10 days)
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1	QL (80 caps every 10 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

38

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	3	QL (450 mL every 10 days)
LEPROSTATICS		
<i>dapsone tab 25 mg</i>	1	
<i>dapsone tab 100 mg</i>	1	
LINCOSAMIDES		
CLEOCIN CAP 75MG	3	
CLEOCIN CAP 150MG	3	
CLEOCIN CAP 300MG	3	
CLEOCIN PED SOL 75MG/5ML	3	
<i>clindamycin hcl cap 75 mg</i>	1	
<i>clindamycin hcl cap 150 mg</i>	1	
<i>clindamycin hcl cap 300 mg</i>	1	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	1	
OXAZOLIDINONES		
<i>linezolid for susp 100 mg/5ml</i>	1	PA
<i>linezolid tab 600 mg</i>	1	PA
SIVEXTRO TAB 200MG	3	
PLEUROMUTILINS		
XENLETA TAB 600MG	3	
URINARY ANTI-INFECTIVES		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	3	
<i>methenamine hippurate tab 1 gm</i>	1	
<i>methenamine mandelate tab 0.5 gm</i>	1	
<i>methenamine mandelate tab 1 gm</i>	1	
MONUROL PAK GRANULES	3	
<i>nitrofurantoin macrocrystalline cap 25 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

39

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
RANEXA TAB 500MG	3	
RANEXA TAB 1000MG	3	
<i>ranolazine tab er 12hr 500 mg</i>	1	
<i>ranolazine tab er 12hr 1000 mg</i>	1	
NITRATES		
DILATRATE SR CAP 40MG	3	
<i>isosorbide dinitrate tab 5 mg</i>	1	
<i>isosorbide dinitrate tab 10 mg</i>	1	
<i>isosorbide dinitrate tab 20 mg</i>	1	
<i>isosorbide dinitrate tab 30 mg</i>	1	
<i>isosorbide mononitrate tab 10 mg</i>	1	
<i>isosorbide mononitrate tab 20 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	1	
NITRO-BID OIN 2%	3	
NITRO-DUR DIS 0.1MG/HR	3	
NITRO-DUR DIS 0.2MG/HR	3	
NITRO-DUR DIS 0.3MG/HR	3	
NITRO-DUR DIS 0.4MG/HR	3	
NITRO-DUR DIS 0.6MG/HR	3	
NITRO-DUR DIS 0.8MG/HR	3	
<i>nitroglycerin sl tab 0.3 mg</i>	1	
<i>nitroglycerin sl tab 0.4 mg</i>	1	
<i>nitroglycerin sl tab 0.6 mg</i>	1	
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	1	
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)</i>	1	
NITROLINGUAL SPR 400MCG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

40

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NITROSTAT SUB 0.3MG	3	
NITROSTAT SUB 0.4MG	3	
NITROSTAT SUB 0.6MG	3	

ANTIAXIETY AGENTS**ANTIAXIETY AGENTS - MISC.**

<i>buspirone hcl tab 5 mg</i>	1	
<i>buspirone hcl tab 7.5 mg</i>	1	
<i>buspirone hcl tab 10 mg</i>	1	
<i>buspirone hcl tab 15 mg</i>	1	
<i>buspirone hcl tab 30 mg</i>	1	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl tab 10 mg</i>	1	
<i>hydroxyzine hcl tab 25 mg</i>	1	
<i>hydroxyzine hcl tab 50 mg</i>	1	
<i>hydroxyzine pamoate cap 25 mg</i>	1	
<i>hydroxyzine pamoate cap 50 mg</i>	1	
<i>hydroxyzine pamoate cap 100 mg</i>	1	
<i>meprobamate tab 200 mg</i>	1	
<i>meprobamate tab 400 mg</i>	1	
VISTARIL CAP 25MG	3	
VISTARIL CAP 50MG	3	

BENZODIAZEPINES

ALPRAZOLAM CON 1 MG/ML	3	
<i>alprazolam orally disintegrating tab 0.5 mg</i>	1	
<i>alprazolam orally disintegrating tab 0.25 mg</i>	1	
<i>alprazolam orally disintegrating tab 1 mg</i>	1	
<i>alprazolam orally disintegrating tab 2 mg</i>	1	
<i>alprazolam tab 0.5 mg</i>	1	
<i>alprazolam tab 0.25 mg</i>	1	
<i>alprazolam tab 1 mg</i>	1	
<i>alprazolam tab 2 mg</i>	1	
<i>alprazolam tab er 24hr 0.5 mg</i>	1	
<i>alprazolam tab er 24hr 1 mg</i>	1	
<i>alprazolam tab er 24hr 2 mg</i>	1	
<i>alprazolam tab er 24hr 3 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

41

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>chlordiazepoxide hcl cap 5 mg</i>	1	
<i>chlordiazepoxide hcl cap 10 mg</i>	1	
<i>chlordiazepoxide hcl cap 25 mg</i>	1	
<i>clorazepate dipotassium tab 3.75 mg</i>	1	
<i>clorazepate dipotassium tab 7.5 mg</i>	1	
<i>clorazepate dipotassium tab 15 mg</i>	1	
<i>diazepam conc 5 mg/ml</i>	1	
<i>diazepam oral soln 1 mg/ml</i>	1	
<i>diazepam tab 2 mg</i>	1	
<i>diazepam tab 5 mg</i>	1	
<i>diazepam tab 10 mg</i>	1	
<i>lorazepam conc 2 mg/ml</i>	1	
<i>lorazepam tab 0.5 mg</i>	1	
<i>lorazepam tab 1 mg</i>	1	
<i>lorazepam tab 2 mg</i>	1	
<i>oxazepam cap 10 mg</i>	1	
<i>oxazepam cap 15 mg</i>	1	
<i>oxazepam cap 30 mg</i>	1	
TRANXENE T TAB 7.5MG	3	
VALIUM TAB 2MG	3	
VALIUM TAB 5MG	3	
VALIUM TAB 10MG	3	

ANTIARRHYTHMICS**ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i>	1	
<i>disopyramide phosphate cap 150 mg</i>	1	
<i>quinidine gluconate tab er 324 mg</i>	1	
<i>quinidine sulfate tab 200 mg</i>	1	
<i>quinidine sulfate tab 300 mg</i>	1	

ANTIARRHYTHMICS TYPE I-B

<i>mexiletine hcl cap 150 mg</i>	1	
<i>mexiletine hcl cap 200 mg</i>	1	
<i>mexiletine hcl cap 250 mg</i>	1	

ANTIARRHYTHMICS TYPE I-C

<i>flecainide acetate tab 50 mg</i>	1	
-------------------------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

42

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>flecainide acetate tab 100 mg</i>	1	
<i>flecainide acetate tab 150 mg</i>	1	
<i>propafenone hcl cap er 12hr 225 mg</i>	1	
<i>propafenone hcl cap er 12hr 325 mg</i>	1	
<i>propafenone hcl cap er 12hr 425 mg</i>	1	
<i>propafenone hcl tab 150 mg</i>	1	
<i>propafenone hcl tab 225 mg</i>	1	
<i>propafenone hcl tab 300 mg</i>	1	
RYTHMOL SR CAP 225MG	3	
RYTHMOL SR CAP 325MG	3	
RYTHMOL SR CAP 425MG	3	
ANTIARRHYTHMICS TYPE III		
<i>amiodarone hcl tab 100 mg</i>	1	
<i>amiodarone hcl tab 200 mg</i>	1	
<i>amiodarone hcl tab 400 mg</i>	1	
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	PA
MULTAQ TAB 400MG	2	
TIKOSYN CAP 125MCG	5	PA
TIKOSYN CAP 250MCG	5	PA
TIKOSYN CAP 500MCG	5	PA
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (240 mL every 30 days)
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
DUPIXENT INJ 100/0.67	4	PA, QL (2 SYRINGES PER 28 DAYS)
DUPIXENT INJ 200/1.14	4	PA, QL (2 PFS PER 28 DAYS); LOADING DOSE: 2 PFS PER 14 DAYS
FASENRA PEN INJ 30MG/ML	4	PA, QL (1 PENS PER 56 DAYS); LOADING DOSE: 3 PENS PER 84 DAYS

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

43

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NUCALA INJ 40MG/0.4	4	PA, QL (1 SYRINGE PER 28 DAYS)
NUCALA INJ 100MG/ML	4	PA, QL (3 INJ PER 28 DAYS)
NUCALA INJ 100MG/ML	4	PA, QL (3 PFS PER 28 DAYS)
TEZSPIRE INJ 210MG	4	PA, QL (1 PEN PER 28 DAYS)
BRONCHODILATORS - ANTICHOLINERGICS		
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (120 vials every 30 days)
SPIRIVA AER 1.25MCG	2	QL (1 package every 25 days)
SPIRIVA CAP HANDIHLR	2	QL (30 caps every 30 days)
SPIRIVA SPR 2.5MCG	2	QL (1 package every 25 days)
YUPELRI SOL	2	QL (90 mL every 30 days)
LEUKOTRIENE MODULATORS		
ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	
<i>zafirlukast tab 10 mg</i>	1	
<i>zafirlukast tab 20 mg</i>	1	
ZYFLO TAB 600MG	3	
STEROID INHALANTS		
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (2 mL every 25 days)
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (3 mL every 25 days)
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (1 mL every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

44

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days); Covered for member 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125/valve)</i>	1	QL (2 packages every 25 days); Covered for members 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250/valve)</i>	1	QL (2 packages every 25 days); Covered for member 6 years of age and younger
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50/valve)</i>	1	QL (2 packages every 25 days); Covered for members 6 years of age and younger
PULMICORT INH 90MCG	2	QL (3 inhalers every 25 days)
PULMICORT INH 180MCG	2	QL (2 inhalers every 25 days)
QVAR REDIIHA AER 80MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
QVAR REDIIHAL AER 40MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

45

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SYMPATHOMIMETICS		
AIRSUPRA AER 90-80MCG	3	
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1	QL (2 packages every 25 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (120 ea every 30 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (60 mL every 30 days)
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate tab 2 mg</i>	1	
<i>albuterol sulfate tab 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 8 mg</i>	1	
ANORO ELLIPT AER 62.5-25	2	QL (60 blisters every 30 days)
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (120 mL every 30 days)
BREO ELLIPTA INH 100-25	2	QL (60 blisters every 30 days)
BREO ELLIPTA INH 200-25	2	QL (60 blisters every 30 days)
BREZTRI AERO AER SPHERE	2	QL (1 inhaler every 25 days)
COMBIVENT AER 20-100	3	QL (2 packages every 25 days)
DULERA AER 50-5MCG	3	QL (1 package every 25 days)
DULERA AER 100-5MCG	3	PA, QL (1 package every 25 days); MNPA
DULERA AER 200-5MCG	3	QL (1 package every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

46

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i>	1	QL (60 inhalations every 30 days)
<i>fluticasone-salmeterol aer powder ba 250-50 mcg/act</i>	1	QL (60 inhalations every 30 days)
<i>fluticasone-salmeterol aer powder ba 500-50 mcg/act</i>	1	QL (60 inhalations every 30 days)
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (60 mL every 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (540 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (90 ea every 30 days)
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (2 inhalers every 30 days)
PERFOROMIST NEB 20MCG	3	QL (120 mL every 30 days)
STIOLTO AER 2.5-2.5	2	QL (1 package every 25 days)
STRIVERDI AER 2.5MCG	2	QL (1 package every 25 days)
<i>terbutaline sulfate tab 2.5 mg</i>	1	
<i>terbutaline sulfate tab 5 mg</i>	1	
TRELEGY AER 100MCG	2	QL (1 inhaler every 30 days)
TRELEGY AER 200MCG	2	QL (1 inhaler every 30 days)
XOPENEX CONC NEB 1.25/0.5	3	QL (90 ea every 30 days)
XOPENEX NEB 0.31MG	3	QL (300 mL every 30 days)
XOPENEX NEB 0.63MG	3	QL (300 mL every 30 days)
XOPENEX NEB 1.25/3ML	3	QL (300 mL every 30 days)
XANTHINES		
<i>theophylline elixir 80 mg/15ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

47

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>theophylline elixir 80 mg/15ml</i>	3	
<i>theophylline tab er 12hr 300 mg</i>	1	
<i>theophylline tab er 12hr 450 mg</i>	1	
<i>theophylline tab er 24hr 400 mg</i>	1	
<i>theophylline tab er 24hr 600 mg</i>	1	

ANTICOAGULANTS**COUMARIN ANTICOAGULANTS**

<i>warfarin sodium tab 1 mg</i>	1	
<i>warfarin sodium tab 2 mg</i>	1	
<i>warfarin sodium tab 2.5 mg</i>	1	
<i>warfarin sodium tab 3 mg</i>	1	
<i>warfarin sodium tab 4 mg</i>	1	
<i>warfarin sodium tab 5 mg</i>	1	
<i>warfarin sodium tab 6 mg</i>	1	
<i>warfarin sodium tab 7.5 mg</i>	1	
<i>warfarin sodium tab 10 mg</i>	1	

DIRECT FACTOR XA INHIBITORS

ELIQUIS ST P TAB 5MG	2	
ELIQUIS TAB 2.5MG	2	
ELIQUIS TAB 5MG	2	
XARELTO STAR TAB 15/20MG	2	
XARELTO TAB 2.5MG	2	
XARELTO TAB 10MG	2	
XARELTO TAB 15MG	2	
XARELTO TAB 20MG	2	

HEPARINS AND HEPARINOID-LIKE AGENTS

ARIXTRA INJ 2.5/0.5	3	
ARIXTRA INJ 5/0.4ML	3	
ARIXTRA INJ 7.5/0.6	3	
ARIXTRA INJ 10/0.8ML	3	
<i>enoxaparin sodium inj 300 mg/3ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 30 mg/0.3ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

48

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin sodium inj soln pref syr 60 mg/0.6ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 80 mg/0.8ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 100 mg/ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 120 mg/0.8ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 150 mg/ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i>	1	
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	1	PA
LOVENOX INJ 30/0.3ML	3	
LOVENOX INJ 40/0.4ML	3	
LOVENOX INJ 60/0.6ML	3	
LOVENOX INJ 80/0.8ML	3	
LOVENOX INJ 100MG/ML	3	
LOVENOX INJ 120/0.8	3	
LOVENOX INJ 150MG/ML	3	
LOVENOX INJ 300/3ML	3	

ANTICONVULSANTS**AMPA GLUTAMATE RECEPTOR ANTAGONISTS**

FYCOMPA SUS 0.5MG/ML	2	
FYCOMPA TAB 2MG	2	
FYCOMPA TAB 4MG	2	
FYCOMPA TAB 6MG	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TAB 8MG	2	
FYCOMPA TAB 10MG	2	
FYCOMPA TAB 12MG	2	

ANTICONVULSANTS - BENZODIAZEPINES

<i>clobazam suspension 2.5 mg/ml</i>	1	
<i>clobazam tab 10 mg</i>	1	
<i>clobazam tab 20 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	
<i>clonazepam orally disintegrating tab 1 mg</i>	1	
<i>clonazepam orally disintegrating tab 2 mg</i>	1	
<i>clonazepam tab 0.5 mg</i>	1	
<i>clonazepam tab 1 mg</i>	1	
<i>clonazepam tab 2 mg</i>	1	
<i>diazepam rectal gel delivery system 2.5 mg</i>	1	
<i>diazepam rectal gel delivery system 10 mg</i>	1	
<i>diazepam rectal gel delivery system 20 mg</i>	1	
KLONOPIN TAB 0.5MG	3	
KLONOPIN TAB 1MG	3	
KLONOPIN TAB 2MG	3	
NAYZILAM SPR 5MG	2	PA, QL (10 bottles every 25 days)
VALTOCO SPR 5MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 10MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 15MG	2	PA, QL (5 ea every 25 days)
VALTOCO SPR 20MG	2	PA, QL (5 ea every 25 days)

ANTICONVULSANTS - MISC.

APTIOM TAB 200MG	2	
APTIOM TAB 400MG	2	
APTIOM TAB 600MG	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

50

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
APTIOM TAB 800MG	2	
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	
BRIVIACT TAB 75MG	3	
BRIVIACT TAB 100MG	3	
<i>carbamazepine cap er 12hr 100 mg</i>	1	
<i>carbamazepine cap er 12hr 200 mg</i>	1	
<i>carbamazepine cap er 12hr 300 mg</i>	1	
<i>carbamazepine chew tab 100 mg</i>	1	
<i>carbamazepine susp 100 mg/5ml</i>	1	
<i>carbamazepine tab 200 mg</i>	1	
<i>carbamazepine tab er 12hr 100 mg</i>	1	
<i>carbamazepine tab er 12hr 200 mg</i>	1	
<i>carbamazepine tab er 12hr 400 mg</i>	1	
CARBATROL CAP 100MG	3	
CARBATROL CAP 200MG	3	
CARBATROL CAP 300MG	3	
EPIDIOLEX SOL 100MG/ML	5	PA, QL (800 ML PER 30 DAYS)
<i>gabapentin cap 100 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 300 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 400 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin oral soln 250 mg/5ml</i>	1	
<i>gabapentin oral soln 250 mg/5ml</i>	1	QL (72 mL per day)
<i>gabapentin tab 600 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin tab 800 mg</i>	1	QL (120 tablets per 30 days)
<i>lacosamide oral solution 10 mg/ml</i>	1	
<i>lacosamide tab 50 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

51

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>lacosamide tab 100 mg</i>	1	
<i>lacosamide tab 150 mg</i>	1	
<i>lacosamide tab 200 mg</i>	1	
<i>lamotrigine orally disintegrating tab 25 mg</i>	1	
<i>lamotrigine orally disintegrating tab 50 mg</i>	1	
<i>lamotrigine orally disintegrating tab 100 mg</i>	1	
<i>lamotrigine orally disintegrating tab 200 mg</i>	1	
<i>lamotrigine tab 25 mg</i>	1	
<i>lamotrigine tab 25 mg (42) & 100 mg (7) starter kit</i>	1	
<i>lamotrigine tab 35 x 25 mg starter kit</i>	1	
<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit</i>	1	
<i>lamotrigine tab 100 mg</i>	1	
<i>lamotrigine tab 150 mg</i>	1	
<i>lamotrigine tab 200 mg</i>	1	
<i>lamotrigine tab chewable dispersible 5 mg</i>	1	
<i>lamotrigine tab chewable dispersible 25 mg</i>	1	
<i>lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit</i>	1	
<i>lamotrigine tab er 24hr 25 mg</i>	1	
<i>lamotrigine tab er 24hr 50 mg</i>	1	
<i>lamotrigine tab er 24hr 100 mg</i>	1	
<i>lamotrigine tab er 24hr 200 mg</i>	1	
<i>lamotrigine tab er 24hr 250 mg</i>	1	
<i>lamotrigine tab er 24hr 300 mg</i>	1	
<i>levetiracetam oral soln 100 mg/ml</i>	1	
<i>levetiracetam tab 250 mg</i>	1	
<i>levetiracetam tab 500 mg</i>	1	
<i>levetiracetam tab 750 mg</i>	1	
<i>levetiracetam tab 1000 mg</i>	1	
<i>levetiracetam tab er 24hr 500 mg</i>	1	
<i>levetiracetam tab er 24hr 750 mg</i>	1	
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

52

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NEURONTIN CAP 100MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 300MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 400MG	3	QL (180 capsules per 30 days)
NEURONTIN SOL 250/5ML	3	QL (72 mL per day)
NEURONTIN TAB 600MG	3	QL (180 tablets per 30 days)
NEURONTIN TAB 800MG	3	QL (120 tablets per 30 days)
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	1	
<i>oxcarbazepine tab 150 mg</i>	1	
<i>oxcarbazepine tab 300 mg</i>	1	
<i>oxcarbazepine tab 600 mg</i>	1	
OXTELLAR XR TAB 150MG	2	
OXTELLAR XR TAB 300MG	2	
OXTELLAR XR TAB 600MG	2	
<i>pregabalin cap 25 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 50 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 75 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 100 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 150 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 200 mg</i>	1	QL (90 caps every 30 days)
<i>pregabalin cap 225 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin cap 300 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin soln 20 mg/ml</i>	1	QL (1080 mL every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

53

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>primidone tab 50 mg</i>	1	
<i>primidone tab 250 mg</i>	1	
QUDEXY XR CAP 25/24HR	3	
QUDEXY XR CAP 50/24HR	3	
QUDEXY XR CAP 100/24HR	3	
QUDEXY XR CAP 150/24HR	3	
QUDEXY XR CAP 200/24HR	3	
<i>rufinamide susp 40 mg/ml</i>	1	
TOPAMAX SPR CAP 15MG	3	
TOPAMAX SPR CAP 25MG	3	
TOPAMAX TAB 25MG	3	
TOPAMAX TAB 50MG	3	
TOPAMAX TAB 100MG	3	
TOPAMAX TAB 200MG	3	
<i>topiramate cap er 24hr 200 mg</i>	1	
<i>topiramate sprinkle cap 15 mg</i>	1	
<i>topiramate sprinkle cap 25 mg</i>	1	
<i>topiramate tab 25 mg</i>	1	
<i>topiramate tab 50 mg</i>	1	
<i>topiramate tab 100 mg</i>	1	
<i>topiramate tab 200 mg</i>	1	
TROKENDI XR CAP 25MG	2	
TROKENDI XR CAP 50MG	2	
TROKENDI XR CAP 100MG	2	
TROKENDI XR CAP 200MG	2	
<i>zonisamide cap 25 mg</i>	1	
<i>zonisamide cap 50 mg</i>	1	
<i>zonisamide cap 100 mg</i>	1	
CARBAMATES		
<i>felbamate susp 600 mg/5ml</i>	1	
<i>felbamate tab 400 mg</i>	1	
<i>felbamate tab 600 mg</i>	1	
FELBATOL SUS 600/5ML	3	
FELBATOL TAB 400MG	3	
FELBATOL TAB 600MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

54

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XCOPRI PAK 12.5-25	2	
XCOPRI PAK 50-100MG	2	
XCOPRI PAK 50-200MG	2	
XCOPRI PAK 100-150	2	
XCOPRI PAK 150-200	2	
XCOPRI TAB 50MG	2	
XCOPRI TAB 100MG	2	
XCOPRI TAB 150MG	2	
XCOPRI TAB 200MG	2	
GABA MODULATORS		
GABITRIL TAB 2MG	3	
GABITRIL TAB 4MG	3	
GABITRIL TAB 12MG	3	
GABITRIL TAB 16MG	3	
<i>tiagabine hcl tab 2 mg</i>	1	
<i>tiagabine hcl tab 4 mg</i>	1	
<i>tiagabine hcl tab 12 mg</i>	1	
<i>tiagabine hcl tab 16 mg</i>	1	
<i>vigabatrin powd pack 500 mg</i>	1	PA, QL (180 PACKETS PER 30 DAYS)
<i>vigabatrin tab 500 mg</i>	1	PA, QL (180 TABLETS PER 30 DAYS)
HYDANTOINS		
<i>phenytoin chew tab 50 mg</i>	1	
<i>phenytoin sodium extended cap 100 mg</i>	1	
<i>phenytoin sodium extended cap 200 mg</i>	1	
<i>phenytoin sodium extended cap 200 mg</i>	3	
<i>phenytoin sodium extended cap 300 mg</i>	1	
<i>phenytoin sodium extended cap 300 mg</i>	3	
<i>phenytoin susp 125 mg/5ml</i>	1	
SUCCINIMIDES		
CELONTIN CAP 300MG	3	
<i>ethosuximide cap 250 mg</i>	1	
<i>ethosuximide soln 250 mg/5ml</i>	1	
ZARONTIN CAP 250MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

55

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZARONTIN SOL 250/5ML	3	
VALPROIC ACID		
<i>divalproex sodium cap delayed release sprinkle 125 mg</i>	1	
<i>divalproex sodium tab delayed release 125 mg</i>	1	
<i>divalproex sodium tab delayed release 250 mg</i>	1	
<i>divalproex sodium tab delayed release 500 mg</i>	1	
<i>divalproex sodium tab er 24 hr 250 mg</i>	1	
<i>divalproex sodium tab er 24 hr 500 mg</i>	1	
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1	
<i>valproic acid cap 250 mg</i>	1	
ANTIDEPRESSANTS		
ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)		
<i>mirtazapine orally disintegrating tab 15 mg</i>	1	
<i>mirtazapine orally disintegrating tab 30 mg</i>	1	
<i>mirtazapine orally disintegrating tab 45 mg</i>	1	
<i>mirtazapine tab 7.5 mg</i>	1	
<i>mirtazapine tab 15 mg</i>	1	
<i>mirtazapine tab 30 mg</i>	1	
<i>mirtazapine tab 45 mg</i>	1	
REMERON SLTB TAB 15MG	3	
REMERON SLTB TAB 30MG	3	
REMERON SLTB TAB 45MG	3	
REMERON TAB 15MG	3	
REMERON TAB 30MG	3	
ANTIDEPRESSANTS - MISC.		
<i>bupropion hcl tab 75 mg</i>	1	
<i>bupropion hcl tab 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 150 mg</i>	1	
<i>bupropion hcl tab er 12hr 200 mg</i>	1	
<i>bupropion hcl tab er 24hr 150 mg</i>	1	
<i>bupropion hcl tab er 24hr 300 mg</i>	1	
FORFIVO XL TAB 450MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

56

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>maprotiline hcl tab 25 mg</i>	1	
<i>maprotiline hcl tab 50 mg</i>	1	
<i>maprotiline hcl tab 75 mg</i>	1	
WELLBUTRIN TAB 100MG SR	3	
WELLBUTRIN TAB 150MG SR	3	
WELLBUTRIN TAB 200MG SR	3	
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM DIS 6MG/24HR	3	
EMSAM DIS 9MG/24HR	3	
EMSAM DIS 12MG/24H	3	
MARPLAN TAB 10MG	3	
NARDIL TAB 15MG	3	
PARNATE TAB 10MG	3	
<i>phenelzine sulfate tab 15 mg</i>	1	
<i>tranylcypromine sulfate tab 10 mg</i>	1	
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO SOL 56MG DOS	3	PA
SPRAVATO SOL 84MG DOS	3	PA
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
CELEXA TAB 10MG	3	
CELEXA TAB 20MG	3	
CELEXA TAB 40MG	3	
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1	
<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	1	
<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	1	
<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	1	
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1	
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	
<i>fluoxetine hcl cap 10 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

57

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fluoxetine hcl cap 20 mg</i>	1	
<i>fluoxetine hcl cap 40 mg</i>	1	
<i>fluoxetine hcl cap delayed release 90 mg</i>	1	
<i>fluoxetine hcl solution 20 mg/5ml</i>	1	
<i>fluoxetine hcl tab 10 mg</i>	1	
<i>fluoxetine hcl tab 20 mg</i>	1	
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	1	
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	1	
<i>fluvoxamine maleate tab 25 mg</i>	1	
<i>fluvoxamine maleate tab 50 mg</i>	1	
<i>fluvoxamine maleate tab 100 mg</i>	1	
<i>paroxetine hcl tab 10 mg</i>	1	
<i>paroxetine hcl tab 20 mg</i>	1	
<i>paroxetine hcl tab 30 mg</i>	1	
<i>paroxetine hcl tab 40 mg</i>	1	
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	1	
<i>paroxetine hcl tab er 24hr 25 mg</i>	1	
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	1	
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1	
<i>sertraline hcl tab 25 mg</i>	1	
<i>sertraline hcl tab 50 mg</i>	1	
<i>sertraline hcl tab 100 mg</i>	1	
SEROTONIN MODULATORS		
<i>nefazodone hcl tab 50 mg</i>	1	
<i>nefazodone hcl tab 100 mg</i>	1	
<i>nefazodone hcl tab 150 mg</i>	1	
<i>nefazodone hcl tab 200 mg</i>	1	
<i>nefazodone hcl tab 250 mg</i>	1	
<i>trazodone hcl tab 50 mg</i>	1	
<i>trazodone hcl tab 100 mg</i>	1	
<i>trazodone hcl tab 150 mg</i>	1	
<i>trazodone hcl tab 300 mg</i>	1	
TRINTELLIX TAB 5MG	2	
TRINTELLIX TAB 10MG	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

58

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TRINTELLIX TAB 20MG	2	
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</i>	1	
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	1	
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	1	
TRICYCLIC AGENTS		
<i>amitriptyline hcl tab 10 mg</i>	1	
<i>amitriptyline hcl tab 25 mg</i>	1	
<i>amitriptyline hcl tab 50 mg</i>	1	
<i>amitriptyline hcl tab 75 mg</i>	1	
<i>amitriptyline hcl tab 100 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

59

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>amitriptyline hcl tab 150 mg</i>	1	
<i>amoxapine tab 25 mg</i>	1	
<i>amoxapine tab 50 mg</i>	1	
<i>amoxapine tab 100 mg</i>	1	
<i>amoxapine tab 150 mg</i>	1	
ANAFRANIL CAP 25MG	3	
ANAFRANIL CAP 50MG	3	
ANAFRANIL CAP 75MG	3	
<i>clomipramine hcl cap 25 mg</i>	1	
<i>clomipramine hcl cap 50 mg</i>	1	
<i>clomipramine hcl cap 75 mg</i>	1	
<i>desipramine hcl tab 10 mg</i>	1	
<i>desipramine hcl tab 25 mg</i>	1	
<i>desipramine hcl tab 50 mg</i>	1	
<i>desipramine hcl tab 75 mg</i>	1	
<i>desipramine hcl tab 100 mg</i>	1	
<i>desipramine hcl tab 150 mg</i>	1	
<i>doxepin hcl cap 10 mg</i>	1	
<i>doxepin hcl cap 25 mg</i>	1	
<i>doxepin hcl cap 50 mg</i>	1	
<i>doxepin hcl cap 75 mg</i>	1	
<i>doxepin hcl cap 100 mg</i>	1	
<i>doxepin hcl cap 150 mg</i>	1	
<i>doxepin hcl conc 10 mg/ml</i>	1	
<i>imipramine hcl tab 10 mg</i>	1	
<i>imipramine hcl tab 25 mg</i>	1	
<i>imipramine hcl tab 50 mg</i>	1	
<i>imipramine pamoate cap 75 mg</i>	1	
<i>imipramine pamoate cap 100 mg</i>	1	
<i>imipramine pamoate cap 125 mg</i>	1	
<i>imipramine pamoate cap 150 mg</i>	1	
NORPRAMIN TAB 10MG	3	
NORPRAMIN TAB 25MG	3	
<i>nortriptyline hcl cap 10 mg</i>	1	
<i>nortriptyline hcl cap 25 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

60

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nortriptyline hcl cap 50 mg</i>	1	
<i>nortriptyline hcl cap 75 mg</i>	1	
<i>nortriptyline hcl soln 10 mg/5ml</i>	1	
PAMELOR CAP 10MG	3	
PAMELOR CAP 25MG	3	
PAMELOR CAP 50MG	3	
PAMELOR CAP 75MG	3	
<i>protriptyline hcl tab 5 mg</i>	1	
<i>protriptyline hcl tab 10 mg</i>	1	
<i>trimipramine maleate cap 25 mg</i>	1	
<i>trimipramine maleate cap 50 mg</i>	1	
<i>trimipramine maleate cap 100 mg</i>	1	

ANTIDIABETICS**ALPHA-GLUCOSIDASE INHIBITORS**

<i>acarbose tab 25 mg</i>	1	
<i>acarbose tab 50 mg</i>	1	
<i>acarbose tab 100 mg</i>	1	
<i>miglitol tab 25 mg</i>	1	
<i>miglitol tab 50 mg</i>	1	
<i>miglitol tab 100 mg</i>	1	
PRECOSE TAB 25MG	3	
PRECOSE TAB 50MG	3	
PRECOSE TAB 100MG	3	

ANTIDIABETIC - AMYLIN ANALOGS

SYMLINPEN 60 INJ 1000MCG	2	ST
SYMLNPEN 120 INJ 1000MCG	2	ST

ANTIDIABETIC COMBINATIONS

ACTOPLUS MET TAB 15-500MG	3	
ACTOPLUS MET TAB 15-850MG	3	
DUETACT TAB 30-2MG	3	
DUETACT TAB 30-4MG	3	
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	
<i>glyburide-metformin tab 1.25-250 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

61

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>glyburide-metformin tab 2.5-500 mg</i>	1	
<i>glyburide-metformin tab 5-500 mg</i>	1	
GLYXAMBI TAB 10-5 MG	2	ST
GLYXAMBI TAB 25-5 MG	2	ST
JANUMET TAB 50-500MG	2	ST
JANUMET TAB 50-1000	2	ST
JANUMET XR TAB 50-500MG	2	ST
JANUMET XR TAB 50-1000	2	ST
JANUMET XR TAB 100-1000	2	ST
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	1	
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	1	
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	1	
SOLIQUA INJ 100/33	2	ST, QL (10 pens every 30 days)
SYNJARDY TAB	2	ST
SYNJARDY TAB 5-500MG	2	ST
SYNJARDY TAB 5-1000MG	2	ST
SYNJARDY TAB 12.5-500	2	ST
SYNJARDY XR TAB	2	ST
SYNJARDY XR TAB 5-1000MG	2	ST
SYNJARDY XR TAB 10-1000	2	ST
SYNJARDY XR TAB 25-1000	2	ST
TRIJARDY XR TAB	2	ST
XIGDUO XR TAB 2.5-1000	2	ST
XIGDUO XR TAB 5-500MG	2	ST
XIGDUO XR TAB 5-1000MG	2	ST
XIGDUO XR TAB 10-500MG	2	ST
XIGDUO XR TAB 10-1000	2	ST
XULTOPHY INJ 100/3.6	2	ST, QL (5 pens every 30 days)
BIGUANIDES		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	
<i>metformin hcl tab 500 mg</i>	1	
<i>metformin hcl tab 850 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

62

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>metformin hcl tab 1000 mg</i>	1	
<i>metformin hcl tab er 24hr 500 mg</i>	1	
<i>metformin hcl tab er 24hr 750 mg</i>	1	
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
<i>diazoxide susp 50 mg/ml</i>	1	
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
GVOKE HYPO 1 INJ 1MG/.2ML	2	
GVOKE HYPO 1 INJ .5/.1ML	2	
GVOKE HYPO 2 INJ 1MG/.2ML	2	
GVOKE HYPO 2 INJ .5/.1ML	2	
GVOKE KIT SOL 1MG/0.2M	2	
GVOKE PFS INJ	2	
PROGLYCEM SUS 50MG/ML	3	
ZEGALOGUE INJ 0.6/0.6	2	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST
JANUVIA TAB 100MG	2	ST
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
MOUNJARO INJ 2.5/0.5	2	PA, QL (4 pens every 30 days)
MOUNJARO INJ 5MG/0.5	2	PA, QL (4 pens every 30 days)
MOUNJARO INJ 7.5/0.5	2	PA, QL (4 pens every 30 days)
MOUNJARO INJ 10MG/0.5	2	PA, QL (4 pens every 30 days)
MOUNJARO INJ 12.5/0.5	2	PA, QL (4 pens every 30 days)
MOUNJARO INJ 15MG/0.5	2	PA, QL (4 pens every 30 days)
OZEMPIC INJ 2/1.5ML	2	PA, QL (1 pen every 30 days); Starter Pen

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

63

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OZEMPIC INJ 2MG/3ML	2	PA, QL (1 pen every 30 days)
OZEMPIC INJ 4MG/3ML	2	PA, QL (1 pen every 30 days)
OZEMPIC INJ 8MG/3ML	2	PA, QL (1 pen every 25 days)
RYBELSUS TAB 3MG	2	PA, QL (30 tabs every 30 days)
RYBELSUS TAB 7MG	2	PA, QL (30 tabs every 30 days)
RYBELSUS TAB 14MG	2	PA, QL (30 tabs every 30 days)
TRULICITY INJ 0.75/0.5	2	PA, QL (4 pens every 30 days)
TRULICITY INJ 1.5/0.5	2	PA, QL (4 pens every 30 days)
TRULICITY INJ 3/0.5	2	PA, QL (4 pens every 30 days)
TRULICITY INJ 4.5/0.5	2	PA, QL (4 pens every 30 days)
VICTOZA INJ 18MG/3ML	2	PA, QL (3 pens every 30 days)

INSULIN

BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	
FIASP INJ 100/ML	2	
FIASP PENFIL INJ U-100	2	
HUMULIN R INJ U-500	2	
NOVOLIN INJ 70/30	2	
NOVOLIN INJ 70/30 FP	2	
NOVOLIN N INJ 100 UNIT	2	
NOVOLIN N INJ U-100	2	
NOVOLIN R INJ 100 UNIT	2	
NOVOLIN R INJ U-100	2	
NOVOLOG MIX INJ 70/30	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

64

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG MIX INJ FLEXPEN	2	
TOUJEO MAX INJ 300/ML	2	
TOUJEO SOLO INJ 300/ML	2	
TRESIBA FLEX INJ 100UNIT	2	
TRESIBA FLEX INJ 200UNIT	2	
TRESIBA INJ 100UNIT	2	
INSULIN SENSITIZING AGENTS		
AVANDIA TAB 2MG	3	
AVANDIA TAB 4MG	3	
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	
MEGLITINIDE ANALOGUES		
<i>nateglinide tab 60 mg</i>	1	
<i>nateglinide tab 120 mg</i>	1	
<i>repaglinide tab 0.5 mg</i>	1	
<i>repaglinide tab 1 mg</i>	1	
<i>repaglinide tab 2 mg</i>	1	
STARLIX TAB 120MG	3	
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB 5MG	2	ST
FARXIGA TAB 10MG	2	ST
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
SULFONYLUREAS		
AMARYL TAB 1MG	3	
AMARYL TAB 2MG	3	
AMARYL TAB 4MG	3	
<i>glimepiride tab 1 mg</i>	1	
<i>glimepiride tab 2 mg</i>	1	
<i>glimepiride tab 4 mg</i>	1	
<i>glipizide tab 5 mg</i>	1	
<i>glipizide tab 10 mg</i>	1	
<i>glipizide tab er 24hr 2.5 mg</i>	1	
<i>glipizide tab er 24hr 5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

65

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>glipizide tab er 24hr 10 mg</i>	1	
GLUCOTROL TAB 10MG	3	
GLUCOTROL XL TAB 2.5MG	3	
GLUCOTROL XL TAB 5MG	3	
GLUCOTROL XL TAB 10MG	3	
<i>glyburide micronized tab 1.5 mg</i>	1	
<i>glyburide micronized tab 3 mg</i>	1	
<i>glyburide micronized tab 6 mg</i>	1	
<i>glyburide tab 1.25 mg</i>	1	
<i>glyburide tab 2.5 mg</i>	1	
<i>glyburide tab 5 mg</i>	1	
GLYNASE TAB 1.5MG	3	
GLYNASE TAB 3MG	3	
GLYNASE TAB 6MG	3	
<i>tolbutamide tab 500 mg</i>	1	
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIPERISTALTIC AGENTS		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
LOMOTIL TAB 2.5MG	3	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP 100MG	3	
<i>deferasirox granules packet 90 mg</i>	1	PA
<i>deferasirox granules packet 180 mg</i>	1	PA
<i>deferasirox granules packet 360 mg</i>	1	PA
<i>deferasirox tab 90 mg</i>	1	PA
<i>deferasirox tab 180 mg</i>	1	PA
<i>deferasirox tab 360 mg</i>	1	PA
<i>deferasirox tab for oral susp 125 mg</i>	1	PA
<i>deferasirox tab for oral susp 250 mg</i>	1	PA
<i>deferasirox tab for oral susp 500 mg</i>	1	PA
<i>deferiprone tab 500 mg</i>	1	PA
ANTIDOTES AND SPECIFIC ANTAGONISTS		
<i>deferoxamine mesylate for inj 2 gm</i>	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

66

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	4	PA, QL (20 PACKETS PER 5 DAYS)

OPIOID ANTAGONISTS

KLOXXADO SPR 8MG	3	
<i>naloxone hcl inj 0.4 mg/ml</i>	1	
<i>naloxone hcl inj 4 mg/10ml</i>	1	
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	1	
<i>naltrexone hcl tab 50 mg</i>	0	
NARCAN SPR 4MG	3	

ANTIEMETICS**5-HT3 RECEPTOR ANTAGONISTS**

<i>granisetron hcl tab 1 mg</i>	1	QL (12 tabs every 21 days)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1	QL (200 mL every 21 days)
<i>ondansetron hcl tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 24 mg</i>	1	QL (2 ea every 21 days)
<i>ondansetron orally disintegrating tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron orally disintegrating tab 8 mg</i>	1	QL (18 tabs every 21 days)
SANCUSO DIS 3.1MG	2	QL (2 patches every 21 days)
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)

ANTIEMETICS - ANTICHOLINERGIC

<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
TIGAN CAP 300MG	3	
<i>trimethobenzamide hcl cap 300 mg</i>	1	

ANTIEMETICS - MISCELLANEOUS

BONJESTA TAB 20-20MG	3	
DICLEGIS TAB 10-10MG	3	
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	1	
<i>dronabinol cap 2.5 mg</i>	1	
<i>dronabinol cap 5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

67

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dronabinol cap 10 mg</i>	1	
MARINOL CAP 2.5MG	3	
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	

SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS

<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 ea every 21 days)
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	QL (6 caps every 21 days)

ANTIFUNGALS**ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)**

BREXAFEMME TAB 150MG	3	ST, QL (4 tabs every 7 days)
----------------------	---	------------------------------

ANTIFUNGALS

ANCOBON CAP 250MG	3	
ANCOBON CAP 500MG	3	
BIO-STATIN CAP 500000	3	
BIO-STATIN CAP 1000000	3	
<i>flucytosine cap 250 mg</i>	1	
<i>griseofulvin microsize susp 125 mg/5ml</i>	1	
<i>griseofulvin microsize tab 500 mg</i>	1	
<i>griseofulvin ultramicrosize tab 125 mg</i>	1	
<i>griseofulvin ultramicrosize tab 250 mg</i>	1	
<i>nystatin oral powder</i>	1	
<i>nystatin tab 500000 unit</i>	1	
<i>terbinafine hcl tab 250 mg</i>	1	

IMIDAZOLE-RELATED ANTIFUNGALS

DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	
DIFLUCAN TAB 100MG	3	
DIFLUCAN TAB 150MG	3	
DIFLUCAN TAB 200MG	3	
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

68

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fluconazole tab 50 mg</i>	1	
<i>fluconazole tab 100 mg</i>	1	
<i>fluconazole tab 150 mg</i>	1	
<i>fluconazole tab 200 mg</i>	1	
<i>itraconazole cap 100 mg</i>	1	
<i>itraconazole oral soln 10 mg/ml</i>	1	
<i>ketoconazole tab 200 mg</i>	1	
<i>posaconazole susp 40 mg/ml</i>	1	
VFEND SUS 40MG/ML	3	PA
VFEND TAB 50MG	3	PA
VFEND TAB 200MG	3	PA
VIVJOA CAP 150MG	3	
<i>voriconazole for susp 40 mg/ml</i>	1	PA
<i>voriconazole tab 50 mg</i>	1	PA
<i>voriconazole tab 200 mg</i>	1	PA

ANTI-HISTAMINES**ANTI-HISTAMINES - ETHANOLAMINES**

<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
<i>carbinoxamine maleate tab 4 mg</i>	1	
<i>clemastine fumarate tab 2.68 mg</i>	1	
KARBINAL ER SUS 4MG/5ML	3	

ANTI-HISTAMINES - NON-SEDATING

<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>	1	
CLARINEX TAB 5MG	3	
<i>desloratadine tab 5 mg</i>	1	
<i>desloratadine tab orally disintegrating 2.5 mg</i>	1	
<i>desloratadine tab orally disintegrating 5 mg</i>	1	
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1	
<i>levocetirizine dihydrochloride tab 5 mg</i>	1	

ANTI-HISTAMINES - PHENOTHIAZINES

<i>promethazine hcl suppos 12.5 mg</i>	1	
<i>promethazine hcl suppos 25 mg</i>	1	
<i>promethazine hcl suppos 50 mg</i>	1	
<i>promethazine hcl syrup 6.25 mg/5ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

69

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>promethazine hcl tab 12.5 mg</i>	1	
<i>promethazine hcl tab 25 mg</i>	1	
<i>promethazine hcl tab 50 mg</i>	1	
ANTIHISTAMINES - PIPERIDINES		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl tab 4 mg</i>	1	
ANTHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG	2	PA
ANTHYPERLIPIDEMICS - COMBINATIONS		
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	
NEXLIZET TAB 180/10MG	2	PA
VYTORIN TAB 10-10MG	3	
VYTORIN TAB 10-20MG	3	
VYTORIN TAB 10-40MG	3	
VYTORIN TAB 10-80MG	3	
ANTHYPERLIPIDEMICS - MISC.		
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	PA
VASCEPA CAP 0.5GM	1	PA; Tier 1 with DAW9
VASCEPA CAP 1GM	1	PA; Tier 1 with DAW9
BILE ACID SEQUESTRANTS		
<i>cholestyramine light powder 4 gm/dose</i>	1	
<i>cholestyramine light powder packets 4 gm</i>	1	
<i>cholestyramine powder 4 gm/dose</i>	1	
<i>cholestyramine powder packets 4 gm</i>	1	
<i>colesevelam hcl packet for susp 3.75 gm</i>	1	
<i>colesevelam hcl tab 625 mg</i>	1	
COLESTID FLA GRA 5/7.5GM	3	
COLESTID FLA GRA 5GM	3	
COLESTID GRA 5GM	3	
COLESTID POW 5GM	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

70

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COLESTID TAB 1GM	3	
<i>colestipol hcl granule packets 5 gm</i>	1	
<i>colestipol hcl granules 5 gm</i>	1	
<i>colestipol hcl tab 1 gm</i>	1	
QUESTRAN POW 4GM	3	
QUESTRAN POW 4GM LITE	3	
WELCHOL PAK 3.75GM	3	
WELCHOL TAB 625MG	3	
FIBRIC ACID DERIVATIVES		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	
<i>fenofibrate cap 150 mg</i>	1	
<i>fenofibrate micronized cap 43 mg</i>	1	
<i>fenofibrate micronized cap 67 mg</i>	1	
<i>fenofibrate micronized cap 134 mg</i>	1	
<i>fenofibrate micronized cap 200 mg</i>	1	
<i>fenofibrate tab 48 mg</i>	1	
<i>fenofibrate tab 54 mg</i>	1	
<i>fenofibrate tab 145 mg</i>	1	
<i>fenofibrate tab 160 mg</i>	1	
<i>fenofibric acid tab 35 mg</i>	1	
<i>fenofibric acid tab 105 mg</i>	1	
FENOGLIDE TAB 40MG	3	
FIBRICOR TAB 35MG	3	
FIBRICOR TAB 105MG	3	
<i>gemfibrozil tab 600 mg</i>	1	
LIPOFEN CAP 50MG	3	
LIPOFEN CAP 150MG	3	
LOPID TAB 600MG	3	
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

71

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	1	
<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	1	
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 80 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 5 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 20 mg</i>	1	
<i>rosuvastatin calcium tab 40 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

72

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>simvastatin tab 5 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 10 mg</i>	0	
<i>simvastatin tab 20 mg</i>	0	
<i>simvastatin tab 40 mg</i>	0	
<i>simvastatin tab 80 mg</i>	1	
ZOCOR TAB 10MG	3	
ZOCOR TAB 20MG	3	
ZOCOR TAB 40MG	3	
ZOCOR TAB 80MG	3	
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
<i>ezetimibe tab 10 mg</i>	1	
NICOTINIC ACID DERIVATIVES		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	
NIASPAN TAB 500MG ER	3	
NIASPAN TAB 750MG ER	3	
NIASPAN TAB 1000 ER	3	
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ 140MG/ML	2	PA, QL (3 SYRINGES PER 28 DAYS)
REPATHA PUSH INJ 420/3.5	2	PA, QL (1 CARTRIDGES PER 28 DAYS)
REPATHA SURE INJ 140MG/ML	2	PA, QL (3 PENS PER 28 DAYS)
ANTIHYPERTENSIVES		
ACE INHIBITORS		
ACCUPRIL TAB 5MG	3	
ACCUPRIL TAB 10MG	3	
ACCUPRIL TAB 20MG	3	
ACCUPRIL TAB 40MG	3	
ALTACE CAP 1.25MG	3	
ALTACE CAP 2.5MG	3	
ALTACE CAP 5MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

73

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ALTACE CAP 10MG	3	
<i>benazepril hcl tab 5 mg</i>	1	
<i>benazepril hcl tab 10 mg</i>	1	
<i>benazepril hcl tab 20 mg</i>	1	
<i>benazepril hcl tab 40 mg</i>	1	
<i>captopril tab 12.5 mg</i>	1	
<i>captopril tab 25 mg</i>	1	
<i>captopril tab 50 mg</i>	1	
<i>captopril tab 100 mg</i>	1	
<i>enalapril maleate oral soln 1 mg/ml</i>	1	
<i>enalapril maleate tab 2.5 mg</i>	1	
<i>enalapril maleate tab 5 mg</i>	1	
<i>enalapril maleate tab 10 mg</i>	1	
<i>enalapril maleate tab 20 mg</i>	1	
<i>fosinopril sodium tab 10 mg</i>	1	
<i>fosinopril sodium tab 20 mg</i>	1	
<i>fosinopril sodium tab 40 mg</i>	1	
<i>lisinopril tab 2.5 mg</i>	1	
<i>lisinopril tab 5 mg</i>	1	
<i>lisinopril tab 10 mg</i>	1	
<i>lisinopril tab 20 mg</i>	1	
<i>lisinopril tab 30 mg</i>	1	
<i>lisinopril tab 40 mg</i>	1	
LOTENSIN TAB 10MG	3	
LOTENSIN TAB 20MG	3	
LOTENSIN TAB 40MG	3	
<i>moexipril hcl tab 7.5 mg</i>	1	
<i>moexipril hcl tab 15 mg</i>	1	
<i>perindopril erbumine tab 2 mg</i>	1	
<i>perindopril erbumine tab 4 mg</i>	1	
<i>perindopril erbumine tab 8 mg</i>	1	
PRINIVIL TAB 20MG	3	
QBRELIS SOL 1MG/ML	3	
<i>quinapril hcl tab 5 mg</i>	1	
<i>quinapril hcl tab 10 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

74

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>quinapril hcl tab 20 mg</i>	1	
<i>quinapril hcl tab 40 mg</i>	1	
<i>ramipril cap 1.25 mg</i>	1	
<i>ramipril cap 2.5 mg</i>	1	
<i>ramipril cap 5 mg</i>	1	
<i>ramipril cap 10 mg</i>	1	
<i>trandolapril tab 1 mg</i>	1	
<i>trandolapril tab 2 mg</i>	1	
<i>trandolapril tab 4 mg</i>	1	
VASOTEC TAB 2.5MG	3	
VASOTEC TAB 5MG	3	
VASOTEC TAB 10MG	3	
VASOTEC TAB 20MG	3	
ZESTRIL TAB 2.5MG	3	
ZESTRIL TAB 5MG	3	
ZESTRIL TAB 10MG	3	
ZESTRIL TAB 20MG	3	
ZESTRIL TAB 30MG	3	
ZESTRIL TAB 40MG	3	
AGENTS FOR PHEOCHROMOCYTOMA		
DEMSER CAP 250MG	3	
DIBENZYLINE CAP 10MG	3	
<i>metirosine cap 250 mg</i>	1	
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
AVAPRO TAB 75MG	3	
AVAPRO TAB 150MG	3	
AVAPRO TAB 300MG	3	
<i>candesartan cilexetil tab 4 mg</i>	1	
<i>candesartan cilexetil tab 8 mg</i>	1	
<i>candesartan cilexetil tab 16 mg</i>	1	
<i>candesartan cilexetil tab 32 mg</i>	1	
<i>irbesartan tab 75 mg</i>	1	
<i>irbesartan tab 150 mg</i>	1	
<i>irbesartan tab 300 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

75

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>losartan potassium tab 25 mg</i>	1	
<i>losartan potassium tab 50 mg</i>	1	
<i>losartan potassium tab 100 mg</i>	1	
<i>olmesartan medoxomil tab 5 mg</i>	1	
<i>olmesartan medoxomil tab 20 mg</i>	1	
<i>olmesartan medoxomil tab 40 mg</i>	1	
<i>telmisartan tab 20 mg</i>	1	
<i>telmisartan tab 40 mg</i>	1	
<i>telmisartan tab 80 mg</i>	1	
<i>valsartan tab 40 mg</i>	1	
<i>valsartan tab 80 mg</i>	1	
<i>valsartan tab 160 mg</i>	1	
<i>valsartan tab 320 mg</i>	1	
ANTIADRENERGIC ANTIHYPERTENSIVES		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	3	
CATAPRES-TTS DIS 0.2/24HR	3	
CATAPRES-TTS DIS 0.3/24HR	3	
<i>clonidine hcl tab 0.1 mg</i>	1	
<i>clonidine hcl tab 0.2 mg</i>	1	
<i>clonidine hcl tab 0.3 mg</i>	1	
<i>clonidine td patch weekly 0.1 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.2 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.3 mg/24hr</i>	1	
<i>doxazosin mesylate tab 1 mg</i>	1	
<i>doxazosin mesylate tab 2 mg</i>	1	
<i>doxazosin mesylate tab 4 mg</i>	1	
<i>doxazosin mesylate tab 8 mg</i>	1	
<i>guanfacine hcl tab 1 mg</i>	1	
<i>guanfacine hcl tab 2 mg</i>	1	
<i>methyldopa tab 250 mg</i>	1	
<i>methyldopa tab 500 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

76

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MINIPRESS CAP 1MG	3	
MINIPRESS CAP 2MG	3	
MINIPRESS CAP 5MG	3	
<i>prazosin hcl cap 1 mg</i>	1	
<i>prazosin hcl cap 2 mg</i>	1	
<i>prazosin hcl cap 5 mg</i>	1	
<i>terazosin hcl cap 1 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 2 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 5 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1	
ANTIHYPERTENSIVE COMBINATIONS		
ACCURETIC TAB 10-12.5	3	
ACCURETIC TAB 20-12.5	3	
ACCURETIC TAB 20-25MG	3	
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

77

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	1	
<i>amlodipine besylate-valsartan tab 10-320 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	1	
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	1	
<i>atenolol & chlorthalidone tab 50-25 mg</i>	1	
<i>atenolol & chlorthalidone tab 100-25 mg</i>	1	
AVALIDE TAB 150-12.5	3	
AVALIDE TAB 300-12.5	3	
<i>benazepril & hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

78

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	
LOTENSIN HCT TAB 10-12.5	3	
LOTENSIN HCT TAB 20-12.5	3	
LOTENSIN HCT TAB 20-25MG	3	
LOTREL CAP 5-10MG	3	
LOTREL CAP 5-20MG	3	
LOTREL CAP 10-20MG	3	
LOTREL CAP 10-40MG	3	
<i>methyldopa & hydrochlorothiazide tab 250-15 mg</i>	1	
<i>methyldopa & hydrochlorothiazide tab 250-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

79

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	
<i>propranolol & hydrochlorothiazide tab 40-25 mg</i>	1	
<i>propranolol & hydrochlorothiazide tab 80-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	
TARKA TAB 2-180 CR	3	
TARKA TAB 2-240 CR	3	
TARKA TAB 4-240 CR	3	
TEKTURNA HCT TAB 150-12.5	2	
TEKTURNA HCT TAB 150-25MG	2	
TEKTURNA HCT TAB 300-12.5	2	
TEKTURNA HCT TAB 300-25MG	2	
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	
<i>telmisartan-hydrochlorothiazide tab 40-12.5 mg</i>	1	
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

80

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i>	1	
TENORETIC TAB 50	3	
TENORETIC TAB 100	3	
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	1	
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	1	
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	3	
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	1	
TRIBENZOR20- TAB 5-12.5MG	3	
TRIBENZOR40- TAB 5-12.5MG	3	
TRIBENZOR40- TAB 5-25MG	3	
TRIBENZOR40- TAB 10-12.5	3	
TRIBENZOR40- TAB 10-25MG	3	
TWYNSTA TAB 40-5MG	3	
TWYNSTA TAB 40-10MG	3	
TWYNSTA TAB 80-5MG	3	
TWYNSTA TAB 80-10MG	3	
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	1	
<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	1	
<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	1	
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	1	
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	1	
VASERETIC TAB 10-25MG	3	
ZIAC TAB 2.5/6.25	3	
ZIAC TAB 5-6.25MG	3	
ZIAC TAB 10/6.25	3	
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB 2.5MG	3	
DIRECT RENIN INHIBITORS		
<i>aliskiren fumarate tab 150 mg (base equivalent)</i>	1	
<i>aliskiren fumarate tab 300 mg (base equivalent)</i>	1	
TEKTURNA TAB 150MG	3	
TEKTURNA TAB 300MG	3	
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
<i>eplerenone tab 25 mg</i>	1	
<i>eplerenone tab 50 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

81

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INSPRA TAB 25MG	3	
INSPRA TAB 50MG	3	
VASODILATORS		
<i>hydralazine hcl tab 10 mg</i>	1	
<i>hydralazine hcl tab 25 mg</i>	1	
<i>hydralazine hcl tab 50 mg</i>	1	
<i>hydralazine hcl tab 100 mg</i>	1	
<i>minoxidil tab 2.5 mg</i>	1	
<i>minoxidil tab 10 mg</i>	1	
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
COARTEM TAB 20-120MG	3	
MALARONE TAB 62.5-25	3	
MALARONE TAB 250-100	3	
ANTIMALARIALS		
<i>chloroquine phosphate tab 250 mg</i>	1	
<i>chloroquine phosphate tab 500 mg</i>	1	
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	
<i>mefloquine hcl tab 250 mg</i>	1	
PLAQUENIL TAB 200MG	3	
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	1	
PRIMAQUINE TAB 26.3MG	3	
<i>pyrimethamine tab 25 mg</i>	1	PA
QUALAQUIN CAP 324MG	3	
<i>quinine sulfate cap 324 mg</i>	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
FIRDAPSE TAB 10MG	5	PA, QL (240 TABLETS PER 30 DAYS)
GUANIDINE TAB 125MG	3	
MESTINON TAB TIMESPAN	3	
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

82

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
RUZURGI TAB 10MG	5	PA, QL (300 TABLETS PER 30 DAYS)

ANTIMYCOBACTERIAL AGENTS**ANTIMYCOBACTERIAL AGENTS**

<i>cycloserine cap 250 mg</i>	1	
<i>ethambutol hcl tab 100 mg</i>	1	
<i>ethambutol hcl tab 400 mg</i>	1	
<i>isoniazid syrup 50 mg/5ml</i>	1	
<i>isoniazid tab 100 mg</i>	1	
<i>isoniazid tab 300 mg</i>	1	
MYAMBUTOL TAB 400MG	3	
MYCOBUTIN CAP 150MG	3	
PASER GRA 4GM	3	
PRETOMANID TAB 200MG	3	
PRIFTIN TAB 150MG	3	
<i>pyrazinamide tab 500 mg</i>	1	
<i>rifabutin cap 150 mg</i>	1	
<i>rifampin cap 150 mg</i>	1	
<i>rifampin cap 300 mg</i>	1	
SIRTURO TAB 20MG	3	
SIRTURO TAB 100MG	3	
TRECTOR TAB 250MG	3	

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES**ALKYLATING AGENTS**

ALKERAN TAB 2MG	0	
CYCLOPHOSPH TAB 25MG	0	
CYCLOPHOSPH TAB 50MG	0	
<i>cyclophosphamide cap 25 mg</i>	0	
<i>cyclophosphamide cap 50 mg</i>	0	
GLEOSTINE CAP 10MG	0	
GLEOSTINE CAP 40MG	0	
GLEOSTINE CAP 100MG	0	
LEUKERAN TAB 2MG	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

83

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>melphalan tab 2 mg</i>	0	
MYLERAN TAB 2MG	0	
TEMODAR CAP 100MG	0	PA
TEMODAR CAP 140MG	0	PA
TEMODAR CAP 180MG	0	PA
TEMODAR CAP 250MG	0	PA
<i>temozolomide cap 5 mg</i>	0	PA
<i>temozolomide cap 20 mg</i>	0	PA
<i>temozolomide cap 100 mg</i>	0	PA
<i>temozolomide cap 140 mg</i>	0	PA
<i>temozolomide cap 180 mg</i>	0	PA
<i>temozolomide cap 250 mg</i>	0	PA
ANTIMETABOLITES		
<i>azacitidine for inj 100 mg</i>	1	PA
<i>capecitabine tab 150 mg</i>	0	PA
<i>capecitabine tab 500 mg</i>	0	PA
<i>mercaptopurine tab 50 mg</i>	0	
<i>methotrexate sodium for inj 1 gm</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	0	\$0 copay based on your plan/benefit
PURIXAN SUS 20MG/ML	0	PA
TABLOID TAB 40MG	0	
TREXALL TAB 5MG	0	
TREXALL TAB 7.5MG	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

84

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TREXALL TAB 10MG	0	
TREXALL TAB 15MG	0	
VIDAZA INJ 100MG	5	PA
XATMEP SOL 2.5MG/ML	0	
XELODA TAB 150MG	0	PA, QL (120 tabs every 30 days)
XELODA TAB 500MG	0	PA, QL (300 tabs every 30 days)
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG	0	PA, QL (240 TABLETS PER 30 DAYS)
INLYTA TAB 5MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LENVIMA CAP 4MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 8 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 10 MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 12MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 14 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 18 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 20 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 24 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

85

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA TAB 10MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 100MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VENCLEXTA TAB START PK	0	PA, QL (1 PACK EVERY 28 DAYS)
ANTINEOPLASTIC - EGFR INHIBITORS		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TAGRISSE TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TAGRISSE TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TARCEVA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 150MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

86

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ODOMZO CAP 200MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
<i>abiraterone acetate tab 250 mg</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>abiraterone acetate tab 500 mg</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>anastrozole tab 1 mg</i>	0	
ARIMIDEX TAB 1MG	0	
AROMASIN TAB 25MG	0	
<i>bicalutamide tab 50 mg</i>	0	
CASODEX TAB 50MG	0	
EMCYT CAP 140MG	0	
ERLEADA TAB 60MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ERLEADA TAB 240MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>exemestane tab 25 mg</i>	0	
FARESTON TAB 60MG	0	
FEMARA TAB 2.5MG	0	
<i>flutamide cap 125 mg</i>	0	
<i>letrozole tab 2.5 mg</i>	0	
<i>leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)</i>	1	PA
LUPRON DEPOT INJ 3.75MG	5	PA
LUPRON DEPOT INJ 11.25MG	5	PA
LYSODREN TAB 500MG	0	
<i>megestrol acetate susp 40 mg/ml</i>	0	
<i>megestrol acetate tab 20 mg</i>	0	
<i>megestrol acetate tab 40 mg</i>	0	
<i>nilutamide tab 150 mg</i>	0	
NUBEQA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

87

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ORGOVYX TAB 120MG	0	PA, QL (30 TABLETS PER 30 DAYS); LOADING DOSE: FIRST MONTH: 30 PER 28 DAYS
SOLTAMOX SOL 10MG/5ML	0	
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>toremifene citrate tab 60 mg (base equivalent)</i>	0	
XTANDI CAP 40MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XTANDI TAB 40MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XTANDI TAB 80MG	0	PA, QL (60 TABLETS PER 30 DAYS)
YONSA TAB 125MG	0	PA, QL (120 tabs every 30 days)
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 2MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 3MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 4MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK 40MG	0	PA, QL (16 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 40MG	0	PA, QL (4 TABLETS PER 28 DAYS); Therapy Pack

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

88

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XPOVIO PAK 40MG	0	PA, QL (8 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 40MG	0	PA, QL (8 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 50MG	0	PA, QL (8 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 60MG	0	PA, QL (12 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 60MG	0	PA, QL (24 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 60MG	0	PA, QL (4 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 80MG	0	PA, QL (16 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 80MG	0	PA, QL (32 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 100MG	0	PA, QL (20 TABLETS PER 28 DAYS); Once Weekly

ANTINEOPLASTIC COMBINATIONS

INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (49 TABLETS PER 28 DAYS)
KISQALI 400 PAK FEMARA	0	PA, QL (70 TABLETS PER 28 DAYS)
KISQALI 600 PAK FEMARA	0	PA, QL (91 TABLETS PER 28 DAYS)
LONSURF TAB 15-6.14	0	PA, QL (100 TABLETS 28 DAYS)
LONSURF TAB 20-8.19	0	PA, QL (80 TABLETS 28 DAYS)

ANTINEOPLASTIC ENZYME INHIBITORS

ALECENSA CAP 150MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
ALUNBRIG PAK	0	PA, QL (30 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

89

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ALUNBRIG TAB 30MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ALUNBRIG TAB 90MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ALUNBRIG TAB 180MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BALVERSA TAB 3MG	0	PA, QL (84 TABLETS PER 28 DAYS)
BALVERSA TAB 4MG	0	PA, QL (56 TABLETS PER 28 DAYS)
BALVERSA TAB 5MG	0	PA, QL (28 TABLETS PER 28 DAYS)
BOSULIF CAP 50MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
BOSULIF CAP 100MG	0	PA, QL (300 CAPSULES PER 30 DAYS)
BOSULIF TAB 100MG	0	PA, QL (90 TABLETS PER 30 DAYS)
BOSULIF TAB 400MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BOSULIF TAB 500MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BRAFTOVI CAP 75MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
BRUKINSA CAP 80MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
CABOMETYX TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 60MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CALQUENCE CAP 100MG	0	PA, QL (60 caps every 30 days)
CALQUENCE TAB 100MG	0	PA, QL (60 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

90

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CAPRELSA TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
CAPRELSA TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS)
COMETRIQ KIT 60MG	0	PA, QL (84 CAPSULES PER 28 DAYS)
COMETRIQ KIT 100MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COMETRIQ KIT 140MG	0	PA, QL (112 CAPSULES PER 28 DAYS)
COPIKTRA CAP 15MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COPIKTRA CAP 25MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COTELLIC TAB 20MG	0	PA, QL (63 TABLETS 28 DAYS)
<i>everolimus tab 2.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 7.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GAVRETO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
IBRANCE CAP 75MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 100MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 125MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE TAB 75MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 100MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 125MG	0	PA, QL (21 TABLETS PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

91

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ICLUSIG TAB 10MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ICLUSIG TAB 15MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ICLUSIG TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ICLUSIG TAB 45MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
KISQALI TAB 200DOSE	0	PA, QL (21 TABLETS PER 28 DAYS)
KISQALI TAB 400DOSE	0	PA, QL (42 TABLETS 28 DAYS)
KISQALI TAB 600DOSE	0	PA, QL (63 TABLETS 28 DAYS)
KOSELUGO CAP 10MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
KOSELUGO CAP 25MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
KRAZATI TAB 200MG	0	PA, QL (180 TABLETS PER 30 DAYS)
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	0	PA, QL (180 TABLETS PER 30 DAYS)
LUMAKRAS TAB 120MG	0	PA, QL (240 TABS PER 30 DAYS)
LUMAKRAS TAB 320MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LYNPARZA TAB 100MG	0	PA, QL (120 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

92

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LYNPARZA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
MEKTOVI TAB 15MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NERLYNX TAB 40MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NINLARO CAP 2.3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 4MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
PIQRAY 200MG TAB DOSE	0	PA, QL (28 TABLETS PER 28 DAYS)
PIQRAY 250MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
PIQRAY 300MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
RETEVMO CAP 40MG	0	PA, QL (60 TABLETS PER 30 DAYS)
RETEVMO CAP 80MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ROZLYTREK PAK 50MG	0	PA, QL (8 cartons per 28 days)
ROZLYTREK CAP 100MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ROZLYTREK CAP 200MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
RYDAPT CAP 25MG	0	PA, QL (224 CAPSULES PER 28 DAYS)
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
SPRYCEL TAB 20MG	0	PA, QL (90 TABLETS PER 30 DAYS)
SPRYCEL TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

93

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL TAB 70MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
STIVARGA TAB 40MG	0	PA, QL (84 TABLETS PER 28 DAYS)
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 25 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 50 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 150MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 200MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VITRAKVI CAP 25MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
VITRAKVI CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
VITRAKVI SOL 20MG/ML	0	PA, QL (300 ML PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

94

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VONJO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XOSPATA TAB 40MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ZEJULA CAP 100MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ZEJULA TAB 100MG	0	PA, QL (30 TABS PER 30 DAYS)
ZEJULA TAB 200MG	0	PA, QL (30 TABS PER 30 DAYS)
ZEJULA TAB 300MG	0	PA, QL (30 TABS PER 30 DAYS)
ZELBORAF TAB 240MG	0	PA, QL (240 TABLETS PER 30 DAYS)
ZOLINZA CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
ZYDELIG TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYDELIG TAB 150MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ 2MU/0.5	5	PA
BESREMI SOL 500MCG	5	PA, QL (2 PFS PER 28 DAYS)
<i>bexarotene cap 75 mg</i>	0	PA
HYDREA CAP 500MG	0	
<i>hydroxyurea cap 500 mg</i>	0	
INTRON A INJ 10MU	5	PA
INTRON A INJ 18MU	5	PA
INTRON A INJ 25MU	5	PA
INTRON A INJ 50MU	5	PA
MATULANE CAP 50MG	0	
<i>tretinoin cap 10 mg</i>	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

95

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
IWILFIN TAB 192MG	0	PA
<i>leucovorin calcium tab 5 mg</i>	0	
<i>leucovorin calcium tab 10 mg</i>	0	
<i>leucovorin calcium tab 15 mg</i>	0	
<i>leucovorin calcium tab 25 mg</i>	0	
MESNEX TAB 400MG	0	
MITOTIC INHIBITORS		
<i>etoposide cap 50 mg</i>	0	
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ADJUNCTIVE THERAPY		
<i>carbidopa tab 25 mg</i>	1	
LODOSYN TAB 25MG	3	
ANTIPARKINSON ANTICHOLINERGICS		
<i>benztropine mesylate tab 0.5 mg</i>	1	
<i>benztropine mesylate tab 1 mg</i>	1	
<i>benztropine mesylate tab 2 mg</i>	1	
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl tab 2 mg</i>	1	
<i>trihexyphenidyl hcl tab 5 mg</i>	1	
ANTIPARKINSON COMT INHIBITORS		
COMTAN TAB 200MG	3	
<i>entacapone tab 200 mg</i>	1	
TASMAR TAB 100MG	3	
<i>tolcapone tab 100 mg</i>	1	
ANTIPARKINSON DOPAMINERGICS		
<i>amantadine hcl cap 100 mg</i>	1	
<i>amantadine hcl soln 50 mg/5ml</i>	1	
<i>amantadine hcl tab 100 mg</i>	1	
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

96

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	1	
<i>carbidopa & levodopa tab 10-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-250 mg</i>	1	
<i>carbidopa & levodopa tab er 25-100 mg</i>	1	
<i>carbidopa & levodopa tab er 50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	
INBRIJA CAP 42MG	4	PA, QL (300 CAPSULES PER 30 DAYS)
KYNMOBI MIS 10MG	4	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 15MG	4	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 20MG	4	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 25MG	4	PA, QL (150 FILMS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

97

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
KYNMOBI MIS 30MG	4	PA, QL (150 FILMS PER 30 DAYS)
MIRAPEX ER TAB 0.75MG	3	
MIRAPEX ER TAB 0.375MG	3	
MIRAPEX ER TAB 1.5MG	3	
MIRAPEX ER TAB 2.25MG	3	
MIRAPEX ER TAB 3.75MG	3	
MIRAPEX ER TAB 3MG	3	
MIRAPEX ER TAB 4.5MG	3	
MIRAPEX TAB 0.5MG	3	
MIRAPEX TAB 0.75MG	3	
MIRAPEX TAB 0.125MG	3	
MIRAPEX TAB 1MG	3	
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	
PARLODEL CAP 5MG	3	
PARLODEL TAB 2.5MG	3	
<i>pramipexole dihydrochloride tab 0.5 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.25 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.125 mg</i>	1	
<i>pramipexole dihydrochloride tab 1 mg</i>	1	
<i>pramipexole dihydrochloride tab 1.5 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 3 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

98

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.25 mg</i>	1	
<i>ropinirole hydrochloride tab 1 mg</i>	1	
<i>ropinirole hydrochloride tab 2 mg</i>	1	
<i>ropinirole hydrochloride tab 3 mg</i>	1	
<i>ropinirole hydrochloride tab 4 mg</i>	1	
<i>ropinirole hydrochloride tab 5 mg</i>	1	
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	1	
RYTARY CAP 95MG	2	
RYTARY CAP 145MG	2	QL (60 caps every 30 days)
RYTARY CAP 195MG	2	
RYTARY CAP 245MG	2	
SINEMET TAB 10-100MG	3	
SINEMET TAB 25-100MG	3	
STALEVO 50 TAB	3	
STALEVO 75 TAB	3	
STALEVO 100 TAB	3	
STALEVO 125 TAB	3	
STALEVO 150 TAB	3	
STALEVO 200 TAB	3	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
AZILECT TAB 0.5MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

99

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AZILECT TAB 1MG	3	
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	1	
<i>rasagiline mesylate tab 1 mg (base equiv)</i>	1	
<i>selegiline hcl cap 5 mg</i>	1	
<i>selegiline hcl tab 5 mg</i>	1	

ANTIPSYCHOTICS/ANTIMANIC AGENTS**ANTIMANIC AGENTS**

<i>lithium carbonate cap 150 mg</i>	1	
<i>lithium carbonate cap 300 mg</i>	1	
<i>lithium carbonate cap 600 mg</i>	1	
<i>lithium carbonate tab 300 mg</i>	1	
<i>lithium carbonate tab er 300 mg</i>	1	
<i>lithium carbonate tab er 450 mg</i>	1	
LITHIUM SOL 8MEQ/5ML	3	
LITHOBID TAB 300MG CR	3	

ANTIPSYCHOTICS - MISC.

EQUETRO CAP 100MG	3	
EQUETRO CAP 200MG	3	
EQUETRO CAP 300MG	3	
<i>lurasidone hcl tab 20 mg</i>	1	
<i>lurasidone hcl tab 40 mg</i>	1	
<i>lurasidone hcl tab 60 mg</i>	1	
<i>lurasidone hcl tab 80 mg</i>	1	
<i>lurasidone hcl tab 120 mg</i>	1	
NUPLAZID CAP 34MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
NUPLAZID TAB 10MG	5	PA, QL (30 TABLETS PER 30 DAYS)
VRAYLAR CAP 1.5-3MG	2	
VRAYLAR CAP 1.5MG	2	
VRAYLAR CAP 3MG	2	
VRAYLAR CAP 4.5MG	2	
VRAYLAR CAP 6MG	2	
<i>ziprasidone hcl cap 20 mg</i>	1	
<i>ziprasidone hcl cap 40 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

100

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>ziprasidone hcl cap 60 mg</i>	1	
<i>ziprasidone hcl cap 80 mg</i>	1	
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	1	
BENZISOXAZOLES		
INVEGA SUST INJ 39/0.25	3	
INVEGA SUST INJ 78/0.5ML	3	
INVEGA SUST INJ 117/0.75	3	
INVEGA SUST INJ 156MG/ML	3	
INVEGA SUST INJ 234/1.5	3	
INVEGA TAB 1.5MG	3	
INVEGA TAB 3MG	3	
INVEGA TAB 6MG	3	
INVEGA TAB 9MG	3	
<i>paliperidone tab er 24hr 1.5 mg</i>	1	
<i>paliperidone tab er 24hr 3 mg</i>	1	
<i>paliperidone tab er 24hr 6 mg</i>	1	
<i>paliperidone tab er 24hr 9 mg</i>	1	
PERSERIS INJ 90MG	2	
PERSERIS INJ 120MG	2	
RISPERDAL INJ 12.5MG	3	
RISPERDAL INJ 25MG	3	
RISPERDAL INJ 37.5MG	3	
RISPERDAL INJ 50MG	3	
RISPERDAL SOL 1MG/ML	3	
RISPERDAL TAB 0.5MG	3	
RISPERDAL TAB 1MG	3	
RISPERDAL TAB 2MG	3	
RISPERDAL TAB 3MG	3	
RISPERDAL TAB 4MG	3	
<i>risperidone orally disintegrating tab 0.5 mg</i>	1	
<i>risperidone orally disintegrating tab 0.25 mg</i>	1	
<i>risperidone orally disintegrating tab 1 mg</i>	1	
<i>risperidone orally disintegrating tab 2 mg</i>	1	
<i>risperidone orally disintegrating tab 3 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

101

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone orally disintegrating tab 4 mg</i>	1	
<i>risperidone soln 1 mg/ml</i>	1	
<i>risperidone tab 0.5 mg</i>	1	
<i>risperidone tab 0.25 mg</i>	1	
<i>risperidone tab 1 mg</i>	1	
<i>risperidone tab 2 mg</i>	1	
<i>risperidone tab 3 mg</i>	1	
<i>risperidone tab 4 mg</i>	1	
BUTYROPHENONES		
HALDOL DECAN INJ 50MG/ML	3	
HALDOL DECAN INJ 100MG/ML	3	
HALDOL INJ 5MG/ML	3	
<i>haloperidol decanoate im soln 50 mg/ml</i>	1	
<i>haloperidol decanoate im soln 100 mg/ml</i>	1	
<i>haloperidol lactate inj 5 mg/ml</i>	1	
<i>haloperidol lactate oral conc 2 mg/ml</i>	1	
<i>haloperidol tab 0.5 mg</i>	1	
<i>haloperidol tab 1 mg</i>	1	
<i>haloperidol tab 2 mg</i>	1	
<i>haloperidol tab 5 mg</i>	1	
<i>haloperidol tab 10 mg</i>	1	
<i>haloperidol tab 20 mg</i>	1	
DIBENZAPINES		
ADASUVE INH 10MG	3	
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

102

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>clozapine tab 200 mg</i>	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	
CLOZARIL TAB 200MG	3	
<i>loxapine succinate cap 5 mg</i>	1	
<i>loxapine succinate cap 10 mg</i>	1	
<i>loxapine succinate cap 25 mg</i>	1	
<i>loxapine succinate cap 50 mg</i>	1	
<i>olanzapine for im inj 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 5 mg</i>	1	
<i>olanzapine orally disintegrating tab 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 15 mg</i>	1	
<i>olanzapine orally disintegrating tab 20 mg</i>	1	
<i>olanzapine tab 2.5 mg</i>	1	
<i>olanzapine tab 5 mg</i>	1	
<i>olanzapine tab 7.5 mg</i>	1	
<i>olanzapine tab 10 mg</i>	1	
<i>olanzapine tab 15 mg</i>	1	
<i>olanzapine tab 20 mg</i>	1	
<i>quetiapine fumarate tab 25 mg</i>	1	
<i>quetiapine fumarate tab 50 mg</i>	1	
<i>quetiapine fumarate tab 100 mg</i>	1	
<i>quetiapine fumarate tab 150 mg</i>	1	
<i>quetiapine fumarate tab 200 mg</i>	1	
<i>quetiapine fumarate tab 300 mg</i>	1	
<i>quetiapine fumarate tab 400 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 50 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 150 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 200 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 300 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 400 mg</i>	1	
SAPHRIS SUB 2.5MG	3	
SAPHRIS SUB 5MG	3	
SAPHRIS SUB 10MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

103

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SEROQUEL TAB 25MG	3	
SEROQUEL TAB 50MG	3	
SEROQUEL TAB 100MG	3	
SEROQUEL TAB 200MG	3	
SEROQUEL TAB 300MG	3	
SEROQUEL TAB 400MG	3	
VERSACLOZ SUS 50MG/ML	3	
ZYPREXA INJ 10MG	3	
ZYPREXA RELP INJ 210MG	3	
ZYPREXA RELP INJ 300MG	3	
ZYPREXA RELP INJ 405MG	3	
ZYPREXA TAB 2.5MG	3	
ZYPREXA TAB 5MG	3	
ZYPREXA TAB 7.5MG	3	
ZYPREXA TAB 10MG	3	
ZYPREXA TAB 15MG	3	
ZYPREXA TAB 20MG	3	
ZYPREXA ZYDI TAB 5MG	3	
ZYPREXA ZYDI TAB 10MG	3	
ZYPREXA ZYDI TAB 15MG	3	
ZYPREXA ZYDI TAB 20MG	3	
DIHYDROINDOLONES		
<i>molindone hcl tab 5 mg</i>	1	
<i>molindone hcl tab 10 mg</i>	1	
<i>molindone hcl tab 25 mg</i>	1	
PHENOTHIAZINES		
<i>chlorpromazine hcl inj 25 mg/ml</i>	1	
<i>chlorpromazine hcl inj 50 mg/2ml</i>	1	
<i>chlorpromazine hcl tab 10 mg</i>	1	
<i>chlorpromazine hcl tab 25 mg</i>	1	
<i>chlorpromazine hcl tab 50 mg</i>	1	
<i>chlorpromazine hcl tab 100 mg</i>	1	
<i>chlorpromazine hcl tab 200 mg</i>	1	
<i>fluphenazine decanoate inj 25 mg/ml</i>	1	
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

104

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fluphenazine hcl inj 2.5 mg/ml</i>	1	
<i>fluphenazine hcl oral conc 5 mg/ml</i>	1	
<i>fluphenazine hcl tab 1 mg</i>	1	
<i>fluphenazine hcl tab 2.5 mg</i>	1	
<i>fluphenazine hcl tab 5 mg</i>	1	
<i>fluphenazine hcl tab 10 mg</i>	1	
<i>perphenazine tab 2 mg</i>	1	
<i>perphenazine tab 4 mg</i>	1	
<i>perphenazine tab 8 mg</i>	1	
<i>perphenazine tab 16 mg</i>	1	
<i>prochlorperazine edisylate inj 10 mg/2ml</i>	1	
<i>prochlorperazine edisylate inj 50 mg/10ml</i>	1	
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	1	
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	1	
<i>prochlorperazine suppos 25 mg</i>	1	
<i>thioridazine hcl tab 10 mg</i>	1	
<i>thioridazine hcl tab 25 mg</i>	1	
<i>thioridazine hcl tab 50 mg</i>	1	
<i>thioridazine hcl tab 100 mg</i>	1	
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	
QUINOLINONE DERIVATIVES		
<i>ABILIFY MAIN INJ 300MG</i>	2	
<i>ABILIFY MAIN INJ 400MG</i>	2	
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole orally disintegrating tab 10 mg</i>	1	
<i>aripiprazole orally disintegrating tab 15 mg</i>	1	
<i>aripiprazole tab 2 mg</i>	1	
<i>aripiprazole tab 5 mg</i>	1	
<i>aripiprazole tab 10 mg</i>	1	
<i>aripiprazole tab 15 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

105

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>aripiprazole tab 20 mg</i>	1	
<i>aripiprazole tab 30 mg</i>	1	
ARISTADA INJ 441MG/1.	3	
ARISTADA INJ 662MG/2	3	
ARISTADA INJ 882MG/3	3	
ARISTADA INJ 1064MG	3	
ARISTADA INJ INITIO	3	
REXULTI TAB 0.5MG	3	
REXULTI TAB 0.25MG	3	
REXULTI TAB 1MG	3	
REXULTI TAB 2MG	3	
REXULTI TAB 3MG	3	
REXULTI TAB 4MG	3	
THIOXANTHENES		
<i>thiothixene cap 1 mg</i>	1	
<i>thiothixene cap 2 mg</i>	1	
<i>thiothixene cap 5 mg</i>	1	
<i>thiothixene cap 10 mg</i>	1	
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
<i>formaldehyde solution 10%</i>	1	
GLUTARALDEHY SOL 25%	3	
<i>hydrogen peroxide soln 30%</i>	1	
CHLORINE ANTISEPTICS		
BENZALKONIUM SOL NF	3	
CHLORHEX GLU SOL 20%	3	
ANTIVIRALS		
ANTIRETROVIRALS		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	QL (900 ML PER 30 DAYS)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
ATRIPLA TAB	3	QL (30 TABLETS PER 30 DAYS)
BIKTARVY TAB	2	QL (30 TABLETS PER 30 DAYS)
CIMDUO TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
COMBIVIR TAB 150-300	3	QL (60 TABLETS PER 30 DAYS)
CRIXIVAN CAP 400MG	3	QL (180 CAPSULES PER 30 DAYS)
DESCOVY TAB 120-15MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis
DESCOVY TAB 200/25MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis
DOVATO TAB 50-300MG	2	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz cap 50 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz cap 200 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz tab 600 mg</i>	1	QL (30 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

107

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine caps 200 mg</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	0	QL (30 TABLETS PER 30 DAYS); \$0 copay for pre exposure prophylaxis
EMTRIVA CAP 200MG	2	QL (30 CAPSULES PER 30 DAYS)
EMTRIVA SOL 10MG/ML	2	QL (680 ML PER 28 DAYS)
EPIVIR SOL 10MG/ML	3	QL (960 ML PER 30 DAYS)
EPIVIR TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
EPIVIR TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
EPZICOM TAB 600-300	3	QL (30 TABLETS PER 30 DAYS)
<i>etravirine tab 100 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>etravirine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
EVOTAZ TAB 300-150	3	QL (30 TABLETS PER 30 DAYS)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	QL (120 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

108

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FUZEON INJ 90MG	2	PA, QL (60 VIALS PER 30 DAYS)
GENVOYA TAB	2	QL (30 TABLETS PER 30 DAYS)
ISENTRESS CHW 25MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS CHW 100MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS HD TAB 600MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS POW 100MG	2	QL (60 PACKETS PER 30 DAYS)
ISENTRESS TAB 400MG	2	QL (120 TABLETS PER 30 DAYS)
JULUCA TAB 50-25MG	3	QL (30 TABLETS PER 30 DAYS)
<i>lamivudine oral soln 10 mg/ml</i>	1	QL (960 ML PER 30 DAYS)
<i>lamivudine tab 150 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lamivudine tab 300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	1	QL (480 ML PER 30 DAYS)
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	QL (240 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>nevirapine susp 50 mg/5ml</i>	1	QL (1200 ML PER 30 ML DAYS)
<i>nevirapine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>nevirapine tab er 24hr 100 mg</i>	1	QL (90 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

109

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nevirapine tab er 24hr 400 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
ODEFSEY TAB	2	QL (30 TABLETS PER 30 DAYS)
PREZCOBIX TAB 800-150	3	QL (30 TABLETS PER 30 DAYS)
RETROVIR CAP 100MG	3	QL (180 CAPSULES PER 30 DAYS)
RETROVIR SYP 50MG/5ML	3	QL (1920 ML PER 30 DAYS)
<i>ritonavir tab 100 mg</i>	1	QL (360 TABLETS PER 30 DAYS)
RUKOBIA TAB 600MG ER	3	PA, QL (60 TABLETS PER 30 DAYS)
<i>stavudine cap 15 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 20 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 30 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 40 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
SUSTIVA CAP 50MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA CAP 200MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA TAB 600MG	3	QL (30 TABLETS PER 30 DAYS)
SYMFI LO TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMFI TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMTUZA TAB	2	QL (30 TABLETS PER 30 DAYS)
TEMIXYS TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

110

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>tenofovir disoproxil fumarate tab 300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
TIVICAY PD TAB 5MG	2	QL (360 TABLETS PER 30 DAYS)
TIVICAY TAB 10MG	2	QL (240 TABLETS PER 30 DAYS)
TIVICAY TAB 25MG	2	QL (60 TABLETS PER 30 DAYS)
TIVICAY TAB 50MG	2	QL (60 TABLETS PER 30 DAYS)
TRIUMEQ PD TAB	2	QL (180 TABLETS PER 30 DAYS)
TRIUMEQ TAB	2	QL (30 TABLETS PER 30 DAYS)
TRIZIVIR TAB	3	QL (60 TABLETS PER 30 DAYS)
TYBOST TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIRAMUNE SUS 50MG/5ML	3	QL (1200 ML PER 30 ML DAYS)
VIRAMUNE XR TAB 400MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD POW 40MG/GM	3	QL (240 GM PER 30 DAYS)
VIREAD TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 200MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 250MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
ZIAGEN SOL 20MG/ML	3	QL (900 ML PER 30 DAYS)
ZIAGEN TAB 300MG	3	QL (60 TABLETS PER 30 DAYS)
<i>zidovudine cap 100 mg</i>	1	QL (180 CAPSULES PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

111

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>zidovudine syrup 10 mg/ml</i>	1	QL (1920 ML PER 30 DAYS)
<i>zidovudine tab 300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100	3	QL (40 tabs every 30 days)
PAXLOVID TAB 300-100	3	QL (60 tabs every 30 days)
CMV AGENTS		
LIVTENCITY TAB 200MG	5	PA, QL (120 TABLETS PER 30 DAYS)
PREVYMIS TAB 240MG	3	QL (30 tabs per 30 days); Max 224-day supply per 365 days
PREVYMIS TAB 480MG	3	QL (30 tabs per 30 days); Max 224-day supply per 365 days
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	1	QL (1000 ML PER 30 DAYS)
<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	1	QL (120 TABLETS FOR 30 DAYS)
HEPATITIS AGENTS		
<i>adefovir dipivoxil tab 10 mg</i>	1	
BARACLUDE SOL	3	QL (630 ML PER 30 DAYS)
<i>entecavir tab 0.5 mg</i>	1	QL (30 TABS PER 30 DAYS)
<i>entecavir tab 1 mg</i>	1	QL (30 TABS PER 30 DAYS)
EPCLUSA PAK 150-37.5	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

112

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA TAB 400-100	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK	4	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG	4	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 90-400MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
<i>lamivudine tab 100 mg (hbv)</i>	1	
PEGINTRON KIT 50MCG	5	PA
<i>ribavirin cap 200 mg</i>	1	PA
<i>ribavirin tab 200 mg</i>	1	PA
SOVALDI PAK 150MG	5	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI PAK 200MG	5	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI TAB 200MG	5	PA, QL (28 TABLETS PER 28 DAYS)
SOVALDI TAB 400MG	5	PA, QL (28 TABLETS PER 28 DAYS)
VOSEVI TAB	4	PA, QL (28 TABLETS PER 28 DAYS); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

113

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HERPES AGENTS		
<i>acyclovir cap 200 mg</i>	1	
<i>acyclovir susp 200 mg/5ml</i>	1	
<i>acyclovir tab 400 mg</i>	1	
<i>acyclovir tab 800 mg</i>	1	
<i>famciclovir tab 125 mg</i>	1	
<i>famciclovir tab 250 mg</i>	1	
<i>famciclovir tab 500 mg</i>	1	
SITAVIG TAB 50MG	3	
<i>valacyclovir hcl tab 1 gm</i>	1	
<i>valacyclovir hcl tab 500 mg</i>	1	
INFLUENZA AGENTS		
<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	QL (28 caps every 90 days)
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	QL (180 mL every 90 days)
RELENZA MIS DISKHALE	2	QL (2 inhalers every 90 days)
<i>rimantadine hydrochloride tab 100 mg</i>	1	
TAMIFLU CAP 30MG	3	QL (28 caps every 90 days)
TAMIFLU CAP 45MG	3	QL (14 caps every 90 days)
TAMIFLU CAP 75MG	3	QL (14 caps every 90 days)
TAMIFLU SUS 6MG/ML	3	QL (180 mL every 90 days)
MISC. ANTIVIRALS		
FAVIPIRAVIR TAB 200MG	3	
LAGEVRIO CAP 200MG	3	QL (40 caps every 30 days)
TEMBEXA SUS 10MG/ML	3	
TEMBEXA TAB 100MG	3	
TPOXX CAP 200MG	3	
TPOXX INJ	3	
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

114

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>carvedilol phosphate cap er 24hr 20 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 40 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 80 mg</i>	1	
<i>carvedilol tab 3.125 mg</i>	1	
<i>carvedilol tab 6.25 mg</i>	1	
<i>carvedilol tab 12.5 mg</i>	1	
<i>carvedilol tab 25 mg</i>	1	
COREG TAB 3.125MG	3	
COREG TAB 6.25MG	3	
COREG TAB 12.5MG	3	
COREG TAB 25MG	3	
<i>labetalol hcl tab 100 mg</i>	1	
<i>labetalol hcl tab 200 mg</i>	1	
<i>labetalol hcl tab 300 mg</i>	1	
BETA BLOCKERS CARDIO-SELECTIVE		
<i>acebutolol hcl cap 200 mg</i>	1	
<i>acebutolol hcl cap 400 mg</i>	1	
<i>atenolol tab 25 mg</i>	1	
<i>atenolol tab 50 mg</i>	1	
<i>atenolol tab 100 mg</i>	1	
<i>betaxolol hcl tab 10 mg</i>	1	
<i>betaxolol hcl tab 20 mg</i>	1	
<i>bisoprolol fumarate tab 5 mg</i>	1	
<i>bisoprolol fumarate tab 10 mg</i>	1	
LOPRESSOR TAB 50MG	3	
LOPRESSOR TAB 100MG	3	
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	1	
<i>metoprolol tartrate tab 25 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

115

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol tartrate tab 37.5 mg</i>	1	
<i>metoprolol tartrate tab 50 mg</i>	1	
<i>metoprolol tartrate tab 75 mg</i>	1	
<i>metoprolol tartrate tab 100 mg</i>	1	
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	1	
TENORMIN TAB 25MG	3	
TENORMIN TAB 50MG	3	
TENORMIN TAB 100MG	3	
BETA BLOCKERS NON-SELECTIVE		
CORGARD TAB 20MG	3	
CORGARD TAB 40MG	3	
CORGARD TAB 80MG	3	
HEMANGEOL SOL 4.28/ML	3	
<i>nadolol tab 20 mg</i>	1	
<i>nadolol tab 40 mg</i>	1	
<i>nadolol tab 80 mg</i>	1	
<i>pindolol tab 5 mg</i>	1	
<i>pindolol tab 10 mg</i>	1	
<i>propranolol hcl cap er 24hr 60 mg</i>	1	
<i>propranolol hcl cap er 24hr 80 mg</i>	1	
<i>propranolol hcl cap er 24hr 120 mg</i>	1	
<i>propranolol hcl cap er 24hr 160 mg</i>	1	
<i>propranolol hcl oral soln 20 mg/5ml</i>	1	
<i>propranolol hcl oral soln 40 mg/5ml</i>	1	
<i>propranolol hcl tab 10 mg</i>	1	
<i>propranolol hcl tab 20 mg</i>	1	
<i>propranolol hcl tab 40 mg</i>	1	
<i>propranolol hcl tab 60 mg</i>	1	
<i>propranolol hcl tab 80 mg</i>	1	
<i>sotalol hcl (afib/afl) tab 80 mg</i>	1	
<i>sotalol hcl (afib/afl) tab 120 mg</i>	1	
<i>sotalol hcl (afib/afl) tab 160 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

116

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sotalol hcl tab 80 mg</i>	1	
<i>sotalol hcl tab 120 mg</i>	1	
<i>sotalol hcl tab 160 mg</i>	1	
<i>sotalol hcl tab 240 mg</i>	1	
SOTYLIZE SOL 5MG/ML	3	
<i>timolol maleate tab 5 mg</i>	1	
<i>timolol maleate tab 10 mg</i>	1	
<i>timolol maleate tab 20 mg</i>	1	

CALCIUM CHANNEL BLOCKERS**CALCIUM CHANNEL BLOCKERS**

<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	1	
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	1	
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	1	
CALAN SR TAB 120MG	3	
CALAN SR TAB 180MG	3	
CALAN SR TAB 240MG	3	
<i>diltiazem hcl cap er 12hr 60 mg</i>	1	
<i>diltiazem hcl cap er 12hr 90 mg</i>	1	
<i>diltiazem hcl cap er 12hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

117

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>	1	
<i>diltiazem hcl tab 30 mg</i>	1	
<i>diltiazem hcl tab 60 mg</i>	1	
<i>diltiazem hcl tab 90 mg</i>	1	
<i>diltiazem hcl tab 120 mg</i>	1	
<i>felodipine tab er 24hr 2.5 mg</i>	1	
<i>felodipine tab er 24hr 5 mg</i>	1	
<i>felodipine tab er 24hr 10 mg</i>	1	
<i>isradipine cap 2.5 mg</i>	1	
<i>isradipine cap 5 mg</i>	1	
<i>nicardipine hcl cap 20 mg</i>	1	
<i>nicardipine hcl cap 30 mg</i>	1	
<i>nifedipine cap 10 mg</i>	1	
<i>nifedipine cap 20 mg</i>	1	
<i>nifedipine tab er 24hr 30 mg</i>	1	
<i>nifedipine tab er 24hr 60 mg</i>	1	
<i>nifedipine tab er 24hr 90 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 30 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 60 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 90 mg</i>	1	
<i>nimodipine cap 30 mg</i>	1	
<i>nisoldipine tab er 24hr 8.5 mg</i>	1	
<i>nisoldipine tab er 24hr 17 mg</i>	1	
<i>nisoldipine tab er 24hr 20 mg</i>	1	
<i>nisoldipine tab er 24hr 25.5 mg</i>	1	
<i>nisoldipine tab er 24hr 30 mg</i>	1	
<i>nisoldipine tab er 24hr 34 mg</i>	1	
<i>nisoldipine tab er 24hr 40 mg</i>	1	
NYMALIZE SOL	3	
PROCARDIA CAP 10MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

118

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PROCARDIA XL TAB 30MG CR	3	
PROCARDIA XL TAB 60MG CR	3	
PROCARDIA XL TAB 90MG CR	3	
SULAR TAB 8.5MG ER	3	
SULAR TAB 17MG ER	3	
SULAR TAB 34MG ER	3	
TIAZAC CAP 120MG/24	3	
TIAZAC CAP 180MG/24	3	
TIAZAC CAP 240MG/24	3	
TIAZAC CAP 300MG/24	3	
TIAZAC CAP 360MG/24	3	
TIAZAC CAP 420MG/24	3	
<i>verapamil hcl cap er 24hr 100 mg</i>	1	
<i>verapamil hcl cap er 24hr 120 mg</i>	1	
<i>verapamil hcl cap er 24hr 180 mg</i>	1	
<i>verapamil hcl cap er 24hr 200 mg</i>	1	
<i>verapamil hcl cap er 24hr 240 mg</i>	1	
<i>verapamil hcl cap er 24hr 300 mg</i>	1	
<i>verapamil hcl cap er 24hr 360 mg</i>	1	
<i>verapamil hcl tab 40 mg</i>	1	
<i>verapamil hcl tab 80 mg</i>	1	
<i>verapamil hcl tab 120 mg</i>	1	
<i>verapamil hcl tab er 120 mg</i>	1	
<i>verapamil hcl tab er 180 mg</i>	1	
<i>verapamil hcl tab er 240 mg</i>	1	
VERELAN CAP 120MG SR	3	
VERELAN CAP 180MG SR	3	
VERELAN CAP 240MG SR	3	
VERELAN CAP 360MG SR	3	
VERELAN PM CAP 100MG ER	3	
VERELAN PM CAP 200MG ER	3	
VERELAN PM CAP 300MG ER	3	

CARDIOTONICS**CARDIAC GLYCOSIDES**

<i>digoxin oral soln 0.05 mg/ml</i>	1	
-------------------------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

119

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>digoxin tab 125 mcg (0.125 mg)</i>	1	
<i>digoxin tab 250 mcg (0.25 mg)</i>	1	
LANOXIN TAB 0.0625MG	3	

CARDIOVASCULAR AGENTS - MISC.**CARDIAC MYOSIN INHIBITORS**

CAMZYOS CAP 2.5MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 5MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 10MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 15MG	5	PA, QL (30 CAPSULES PER 30 DAYS)

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

120

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BIDIL TAB	3	
CADUET TAB 5-10MG	3	
CADUET TAB 5-20MG	3	
CADUET TAB 5-40MG	3	
CADUET TAB 5-80MG	3	
CADUET TAB 10-10MG	3	
CADUET TAB 10-20MG	3	
CADUET TAB 10-40MG	3	
CADUET TAB 10-80MG	3	
ENTRESTO TAB 24-26MG	2	
ENTRESTO TAB 49-51MG	2	
ENTRESTO TAB 97-103MG	2	
CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS		
LODOCO TAB 0.5MG	3	PA
IMPOTENCE AGENTS		
CAVERJECT IM KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
CAVERJECT INJ 40MCG	3	QL (6 vials every 30 days); Coverage is subject to your plan/benefits
CAVERJECT KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 40MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 125MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

121

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MUSE SUP 250MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 500MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 1000MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 25 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 50 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 100 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 2.5 mg</i>	1	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 5 mg</i>	1	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>ildenafil hcl orally disintegrating tab 10 mg</i>	1	QL (6 tabs every 30 days)
<i>ildenafil hcl tab 2.5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

122

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>varденаfil hcl tab 5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>varденаfil hcl tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>varденаfil hcl tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
PERIPHERAL VASODILATORS		
<i>isoxsuprine hcl tab 20 mg</i>	3	
PROSTAGLANDIN VASODILATORS		
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
ORENITRAM TAB MONTH 1	4	PA
ORENITRAM TAB MONTH 2	4	PA
ORENITRAM TAB MONTH 3	4	PA
TYVASO REFIL SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO START SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)
VENTAVIS SOL 10MCG/ML	5	PA, QL (270 AMPULES PER 30 DAYS)
VENTAVIS SOL 20MCG/ML	5	PA, QL (270 AMPULES PER 30 DAYS)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
<i>ambrisentan tab 5 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<i>ambrisentan tab 10 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

123

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>bosentan tab 62.5 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>bosentan tab 125 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
OPSUMIT TAB 10MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	PA, QL (784 ML PER 30 DAYS)
<i>sildenafil citrate tab 20 mg</i>	1	PA, QL (360 TABLETS PER 30 DAYS)
<i>tadalafil tab 20 mg (pah)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
TADLIQ SUS 20MG/5ML	4	PA, QL (300 mL per 30 days)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI PACK TAB 200/800	4	PA, QL (1 PACK EVERY 28 DAYS)
UPTRAVI TAB 200MCG	4	PA, QL (140 TABLETS PER 28 DAYS)
UPTRAVI TAB 400MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 600MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 800MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1000MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1200MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1400MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1600MCG	4	PA, QL (60 TABLETS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

124

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2MG	4	PA, QL (90 TABLETS PER 30 DAYS)
SINUS NODE INHIBITORS		
CORLANOR SOL 5MG/5ML	3	
CORLANOR TAB 5MG	2	
CORLANOR TAB 7.5MG	2	
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP 61MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
<i>cefadroxil cap 500 mg</i>	1	
<i>cefadroxil for susp 250 mg/5ml</i>	1	
<i>cefadroxil for susp 500 mg/5ml</i>	1	
<i>cefadroxil tab 1 gm</i>	1	
<i>cephalexin cap 250 mg</i>	1	
<i>cephalexin cap 500 mg</i>	1	
<i>cephalexin cap 750 mg</i>	1	
<i>cephalexin for susp 125 mg/5ml</i>	1	
<i>cephalexin for susp 250 mg/5ml</i>	1	
<i>cephalexin tab 250 mg</i>	1	
<i>cephalexin tab 500 mg</i>	1	
KEFLEX CAP 750MG	3	
CEPHALOSPORINS - 2ND GENERATION		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

125

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CEFACLOR ER TAB 500MG	3	
<i>cefaclor for susp 125 mg/5ml</i>	1	
<i>cefaclor for susp 250 mg/5ml</i>	1	
<i>cefaclor for susp 375 mg/5ml</i>	1	
<i>cefprozil for susp 125 mg/5ml</i>	1	
<i>cefprozil for susp 250 mg/5ml</i>	1	
<i>cefprozil tab 250 mg</i>	1	
<i>cefprozil tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
CEPHALOSPORINS - 3RD GENERATION		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	
<i>cefdinir for susp 250 mg/5ml</i>	1	
<i>cefixime cap 400 mg</i>	1	
<i>cefixime for susp 100 mg/5ml</i>	1	
<i>cefixime for susp 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	1	
<i>cefpodoxime proxetil tab 100 mg</i>	1	
<i>cefpodoxime proxetil tab 200 mg</i>	1	
SUPRAX CAP 400MG	2	
SUPRAX CHW 100MG	2	
SUPRAX CHW 200MG	2	
SUPRAX SUS 100/5ML	2	
SUPRAX SUS 200/5ML	2	
SUPRAX SUS 500/5ML	2	
CONTRACEPTIVES		
COMBINATION CONTRACEPTIVES - ORAL		
BALCOLTRA TAB 0.1-20	0	
<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	0	
<i>desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg</i>	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

126

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	0	
ESTROSTEP FE TAB	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	0	
GENERESS FE CHW	0	
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	0	
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	0	
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	0	
LO LOESTRIN TAB 1-10-10	0	
LOSEASONIQUE TAB	0	
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	
<i>norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg</i>	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

127

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone & ethinyl estradiol tab 0.5 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg</i>	0	
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	0	
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	0	
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	0	
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

128

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SAFYRAL TAB	0	
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	0	
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS	0	QL (1 ring every 300 days)
NUVARING MIS	1	QL (13 rings every 300 days); Tier 1 with DAW 9
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG	0	
<i>levonorgestrel tab 1.5 mg</i>	0	
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
<i>medroxyprogesterone acetate im susp 150 mg/ml</i>	0	QL (4 injections every 300 days)
<i>medroxyprogesterone acetate im susp prefilled syr 150 mg/ml</i>	0	QL (4 injections every 300 days)
PROGESTIN CONTRACEPTIVES - ORAL		
<i>norethindrone tab 0.35 mg</i>	0	
ORTHO MICRON TAB 0.35MG	0	
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
<i>budesonide delayed release particles cap 3 mg</i>	1	
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	3	
DEXAMETHASON CON 1MG/ML	3	
<i>dexamethasone elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone soln 0.5 mg/5ml</i>	1	
<i>dexamethasone tab 0.5 mg</i>	1	
<i>dexamethasone tab 0.75 mg</i>	1	
<i>dexamethasone tab 1 mg</i>	1	
<i>dexamethasone tab 1.5 mg</i>	1	
<i>dexamethasone tab 2 mg</i>	1	
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		129

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dexamethasone tab 4 mg</i>	1	
<i>dexamethasone tab 6 mg</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
ENTOCORT EC CAP 3MG DR	3	
<i>hydrocortisone tab 5 mg</i>	1	
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	
MEDROL TAB 2MG	3	
MEDROL TAB 4MG	3	
MEDROL TAB 8MG	3	
MEDROL TAB 16MG	3	
MEDROL TAB 32MG	3	
<i>methylprednisolone tab 4 mg</i>	1	
<i>methylprednisolone tab 8 mg</i>	1	
<i>methylprednisolone tab 16 mg</i>	1	
<i>methylprednisolone tab 32 mg</i>	1	
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1	
ORAPRED ODT TAB 10MG	3	
ORAPRED ODT TAB 15MG	3	
ORAPRED ODT TAB 30MG	3	
PEDIAPRED SOL 5MG/5ML	3	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i>	1	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

130

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone soln 15 mg/5ml</i>	1	
PREDNISONE CON 5MG/ML	3	
<i>prednisone oral soln 5 mg/5ml</i>	1	
<i>prednisone tab 1 mg</i>	1	
<i>prednisone tab 2.5 mg</i>	1	
<i>prednisone tab 5 mg</i>	1	
<i>prednisone tab 10 mg</i>	1	
<i>prednisone tab 20 mg</i>	1	
<i>prednisone tab 50 mg</i>	1	
<i>prednisone tab therapy pack 5 mg (21)</i>	1	
<i>prednisone tab therapy pack 5 mg (48)</i>	1	
<i>prednisone tab therapy pack 10 mg (21)</i>	1	
<i>prednisone tab therapy pack 10 mg (48)</i>	1	
SOLU-CORTEF INJ 100MG	3	PA
SOLU-CORTEF INJ 250MG	3	PA
SOLU-CORTEF INJ 500MG	3	PA
SOLU-CORTEF INJ 1000MG	3	PA
UCERIS TAB 9MG	1	Tier 1 with DAW9
MINERALOCORTICIDS		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	QL (210 mL every 30 days)
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	QL (42 tabs every 30 days)
TESSALON PER CAP 100MG	3	
COUGH/COLD/ALLERGY COMBINATIONS		
CLARINEX-D TAB 2.5-120	3	
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>	1	QL (315 mL every 30 days)
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	1	QL (420 mL every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

131

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	QL (70 mL every 30 days)
MAR-COF CG LIQ 225-7.5	3	QL (315 mL every 30 days)
NEOTUSS PLUS LIQ	3	
<i>promethazine & phenylephrine syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	QL (210 mL every 30 days)
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml</i>	1	QL (210 mL every 30 days)
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
TUSSICAPS CAP 10-8MG	3	QL (14 caps every 30 days)
MISC. RESPIRATORY INHALANTS		
HYPERSAL NEB 3.5%	3	
HYPERSAL NEB 7%	3	
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
<i>sodium chloride soln nebu 7%</i>	1	
<i>sodium chloride soln nebu 10%</i>	1	
MUCOLYTICS		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
DERMATOLOGICALS		
ACNE PRODUCTS		
ABSORICA CAP 10MG	3	
ABSORICA CAP 20MG	3	
ABSORICA CAP 25MG	3	
ABSORICA CAP 30MG	3	
ABSORICA CAP 35MG	3	
ABSORICA CAP 40MG	3	
<i>adapalene cream 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

132

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>adapalene gel 0.3%</i>	1	PA
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	1	PA
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	1	PA
AKLIEF CRE 0.005%	2	PA
BENZAMYCIN GEL 5-3%	3	QL (47 gm every 25 days)
BENZEPRO LIQ CREAMY	3	
<i>benzoyl peroxide foam 9.8%</i>	1	
<i>benzoyl peroxide liq 7%</i>	1	
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	1	QL (47 gm every 25 days)
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>	1	
CLEOCIN-T LOT 1%	3	QL (60 mL every 30 days)
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate foam 1%</i>	1	
<i>clindamycin phosphate gel 1%</i>	1	QL (60 gm every 30 days)
<i>clindamycin phosphate lotion 1%</i>	1	QL (60 mL every 30 days)
<i>clindamycin phosphate soln 1%</i>	1	QL (60 mL every 30 days)
<i>clindamycin phosphate swab 1%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	1	PA
<i>dapsone gel 5%</i>	1	
<i>dapsone gel 7.5%</i>	1	
DIFFERIN CRE 0.1%	3	PA
DIFFERIN GEL 0.1%	3	PA
DIFFERIN GEL 0.3%	3	PA
EPIDUO FORTE GEL 0.3-2.5%	2	PA
EPIDUO GEL 0.1-2.5%	2	PA
ERYGEL GEL 2%	3	QL (60 gm every 30 days)
<i>erythromycin gel 2%</i>	1	QL (60 gm every 30 days)
<i>erythromycin pads 2%</i>	1	
<i>erythromycin soln 2%</i>	1	QL (60 mL every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

133

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EVOCLIN AER 1%	3	
<i>isotretinoin cap 10 mg</i>	1	
<i>isotretinoin cap 20 mg</i>	1	
<i>isotretinoin cap 30 mg</i>	1	
<i>isotretinoin cap 40 mg</i>	1	
KLARON LOT 10%	3	
ONEXTON GEL 1.2-3.75	2	QL (50 gm every 25 days)
PR BENZOYL LIQ 7% WASH	3	
RETIN-A CRE 0.1%	3	PA
RETIN-A CRE 0.05%	3	PA
RETIN-A CRE 0.025%	3	PA
RETIN-A GEL 0.01%	3	PA
RETIN-A GEL 0.025%	3	PA
RIAX AER 5.5%	3	
RIAX AER 9.5%	3	
<i>sulfacetamide sodium lotion 10% (acne)</i>	1	
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	1	
<i>sulfacetamide sodium w/ sulfur emulsion 10-1%</i>	1	
<i>tretinoin cream 0.1%</i>	1	PA
<i>tretinoin cream 0.05%</i>	1	PA
<i>tretinoin cream 0.025%</i>	1	PA
<i>tretinoin gel 0.01%</i>	1	PA
<i>tretinoin gel 0.05%</i>	1	PA
<i>tretinoin gel 0.025%</i>	1	PA
<i>tretinoin microsphere gel 0.1%</i>	1	PA
<i>tretinoin microsphere gel 0.04%</i>	1	PA
TWYNEO CRE 0.1-3%	2	PA
WINLEVI CRE 1%	2	PA
ZACLIR LOT 8%	3	
ANTI-INFLAMMATORY AGENTS - TOPICAL		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	PA, QL (150 mL every 21 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

134

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTIBIOTICS - TOPICAL		
ALTABAX OIN 1%	3	
CENTANY OIN 2%	3	QL (30 gm every 25 days)
<i>gentamicin sulfate cream 0.1%</i>	1	QL (120 gm every 25 days)
<i>gentamicin sulfate oint 0.1%</i>	1	QL (120 gm every 25 days)
<i>mupirocin oint 2%</i>	1	QL (30 gm every 25 days)
XEPI CRE 1%	3	PA
ANTIFUNGALS - TOPICAL		
<i>ciclopirox gel 0.77%</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	QL (120 mL every 25 days)
<i>ciclopirox shampoo 1%</i>	1	QL (120 mL every 25 days)
<i>ciclopirox solution 8%</i>	1	
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	QL (60 grams per 30 days)
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	QL (60 mL per 30 days)
<i>econazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
EXELDERM CRE 1%	3	QL (60 gm every 25 days)
EXELDERM SOL 1%	3	QL (60 mL every 25 days)
EXODERM LOT 25-1%	3	
EXTINA AER 2%	3	QL (100 gm every 25 days)
<i>iodoquinol-hc cream 1-1%</i>	1	
<i>iodoquinol-hydrocortisone in aloe vehicle cream 1-1.9%</i>	1	
JUBLIA SOL 10%	3	PA, QL (4 mL every 21 days)
<i>ketoconazole cream 2%</i>	1	QL (120 gm every 25 days)
<i>ketoconazole shampoo 2%</i>	1	QL (120 mL every 25 days)
LOPROX SHA 1%	3	QL (120 mL every 25 days)
<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%</i>	1	QL (100 gm every 25 days)
<i>naftifine hcl cream 1%</i>	1	QL (60 gm every 25 days)
<i>naftifine hcl cream 2%</i>	1	QL (60 gm every 25 days)
<i>naftifine hcl gel 1%</i>	1	QL (120 gm every 25 days)
<i>nystatin cream 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin oint 100000 unit/gm</i>	1	QL (120 gm every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

135

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nystatin topical powder 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	1	QL (60 grams per 30 days)
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	QL (60 grams per 30 days)
<i>oxiconazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
<i>sulconazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
<i>sulconazole nitrate solution 1%</i>	1	QL (60 mL every 25 days)
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	PA
EFUDEX CRE 5%	3	
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
LEVULAN KERA SOL 20%	3	
PANRETIN GEL 0.1%	3	
VALCHLOR GEL 0.016%	5	PA, QL (2 TUBES PER 30 DAYS)
ANTIPRURITICS - TOPICAL		
PRUDOXIN CRE 5%	3	ST, QL (90 gm every 25 days)
ZONALON CRE 5%	3	ST, QL (90 gm every 25 days)
ANTIPSORIATICS		
<i>acitretin cap 10 mg</i>	1	
<i>acitretin cap 17.5 mg</i>	1	
<i>acitretin cap 25 mg</i>	1	
BIMZELX INJ 160MG/ML	4	PA, QL (2 Auto-Injectors Per 56 Days); Loading Dose: 10 Auto-Injectors Per 112 Days
<i>calcipotriene oint 0.005%</i>	1	PA
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

136

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COSENTYX INJ 75MG/0.5	4	PA, QL (1 SYRINGE PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:5 SYRINGES PER 35 DAYS
COSENTYX INJ 150MG/ML	4	PA, QL (1 SYRINGES PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis dependent
COSENTYX INJ 300DOSE	4	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

137

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COSENTYX PEN INJ 150MG/ML	4	PA, QL (1 PENS PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
COSENTYX PEN INJ 300DOSE	4	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
COSENTYX UNO INJ 300/2ML	4	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits.
DOVONEX CRE 0.005%	3	PA
<i>methoxsalen rapid cap 10 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

138

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI INJ 150DOSE	4	PA, QL (2 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 4 SYRINGES PER 28 DAYS
SKYRIZI INJ 150MG/ML	4	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS
SKYRIZI PEN INJ 150MG/ML	4	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS
SORIATANE CAP 10MG	3	
SORIATANE CAP 25MG	3	
SOTYKTU TAB 6MG	4	PA, QL (30 TABLETS PER 30 DAYS)
STELARA INJ 45MG/0.5	4	PA, QL (1 SYRINGES PER 12 WEEKS (84 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

139

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
STELARA INJ 45MG/0.5	4	PA, QL (1 VIALS PER 12 WEEKS); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
STELARA INJ 90MG/ML	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
TALTZ INJ 80MG/ML	4	PA, QL (1 PFS PER 28 DAYS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
TALTZ INJ 80MG/ML	4	PA, QL (1 SYRINGES PER 28 DAYS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
tazarotene cream 0.1%	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

140

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TREMFYA INJ 100MG/ML	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
VTAMA CRE 1%	2	PA
ZORYVE CRE 0.3%	2	ST, PA, QL (60 gms per 25 days)
ANTISEBORRHEIC PRODUCTS		
<i>selenium sulfide lotion 2.5%</i>	1	
SODIUM SULFA LIQ 10% WASH	3	
ZORYVE MIS 0.3%	3	ST
ANTIVIRALS - TOPICAL		
<i>acyclovir oint 5%</i>	1	
<i>penciclovir cream 1%</i>	1	
BURN PRODUCTS		
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	
SILVADENE CRE 1%	3	
<i>silver sulfadiazine cream 1%</i>	1	
SULFAMYLON CRE 85MG/GM	3	
SULFAMYLON PAK 5%	3	
CORTICOSTEROIDS - TOPICAL		
<i>alclometasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>alclometasone dipropionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>amcinonide cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>amcinonide lotion 0.1%</i>	1	QL (120 mL every 30 days)
<i>amcinonide oint 0.1%</i>	3	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	QL (120 gm every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

141

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>betamethasone dipropionate augmented gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone dipropionate augmented oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate aerosol foam 0.12%</i>	1	QL (120 gm every 30 days)
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
BRYHALI LOT 0.01%	2	QL (120 gm every 30 days)
<i>clobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate emollient base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate foam 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate shampoo 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate soln 0.05%</i>	1	QL (120 mL every 30 days)
CLOBEX LOT 0.05%	3	QL (120 mL every 30 days)
CLOBEX SHA 0.05%	3	QL (120 mL every 30 days)
CLODERM CRE 0.1%	3	QL (120 gm every 30 days)
CUTIVATE LOT 0.05%	3	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS BODY	3	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS SCLP	3	QL (120 mL every 30 days)
DESONATE GEL 0.05%	3	QL (120 gm every 30 days)
<i>desonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desonide lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>desonide oint 0.05%</i>	1	QL (120 gm every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

142

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DESOWEN CRE 0.05%	3	QL (120 gm every 30 days)
<i>desoximetasone cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone cream 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone oint 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone spray 0.25%</i>	1	QL (120 mL every 30 days)
DIPROLENE AF CRE 0.05%	3	QL (120 gm every 30 days)
DIPROLENE OIN 0.05%	3	QL (120 gm every 30 days)
ENSTILAR AER	2	PA
EPIFOAM AER 1%	3	
<i>fluocinolone acetonide cream 0.01%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide cream 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oint 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide soln 0.01%</i>	1	QL (120 mL every 30 days)
<i>fluocinonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide emulsified base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide soln 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluticasone propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate oint 0.005%</i>	1	QL (120 gm every 30 days)
<i>halobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>halobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
HC/PRAMOXINE CRE 1-2.35%	3	
<i>hydrocortisone butyrate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate soln 0.1%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone cream 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone lotion 2.5%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone oint 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate cream 0.2%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate oint 0.2%</i>	1	QL (120 gm every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

143

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LOCOID LIPO CRE 0.1%	3	QL (120 gm every 30 days)
LOCOID LOT 0.1%	3	QL (120 mL every 30 days)
<i>mometasone furoate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate solution 0.1% (lotion)</i>	1	QL (120 mL every 30 days)
OLUX AER 0.05%	3	QL (120 gm every 30 days)
PANDEL CRE 0.1%	3	QL (120 gm every 30 days)
PRAMOSONE CRE 1-1%	3	
PRAMOSONE LOT 1%	3	
PRAMOSONE LOT 2.5%	3	
<i>prednicarbate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>prednicarbate oint 0.1%</i>	1	QL (120 gm every 30 days)
SERNIVO SPR	3	QL (120 mL every 30 days)
SERNIVO SPR 0.05%	3	QL (120 mL every 30 days)
SYNALAR CRE 0.025%	3	QL (120 gm every 30 days)
SYNALAR OIN 0.025%	3	QL (120 gm every 30 days)
SYNALAR SOL 0.01%	3	QL (120 mL every 30 days)
TACLONEX OIN	2	PA
TACLONEX SUS	2	PA
TEMOVATE CRE 0.05%	3	QL (120 gm every 30 days)
TEMOVATE OIN 0.05%	3	QL (120 gm every 30 days)
TEXACORT SOL 2.5%	3	QL (120 mL every 30 days)
TOPICORT CRE 0.05%	3	QL (120 gm every 30 days)
TOPICORT CRE 0.25%	3	QL (120 gm every 30 days)
TOPICORT GEL 0.05%	3	QL (120 gm every 30 days)
TOPICORT OIN 0.05%	3	QL (120 gm every 30 days)
TOPICORT OIN 0.25%	3	QL (120 gm every 30 days)
TOPICORT SPR 0.25%	3	QL (120 mL every 30 days)
<i>triamcinolone acetonide cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide cream 0.5%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide cream 0.025%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide lotion 0.1%</i>	1	QL (120 mL every 30 days)
<i>triamcinolone acetonide lotion 0.025%</i>	1	QL (120 mL every 30 days)
<i>triamcinolone acetonide oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide oint 0.5%</i>	1	QL (120 gm every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

144

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>triamcinolone acetonide oint 0.025%</i>	1	QL (120 gm every 30 days)
TRIDESILON CRE 0.05%	3	QL (120 gm every 30 days)
ECZEMA AGENTS		
ADBRY INJ 150MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); LOADING DOSE: 4 SYRINGES PER 14 DAYS
CIBINQO TAB 50MG	4	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 100MG	4	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 200MG	4	PA, QL (30 TABLETS PER 30 DAYS)
DUPIXENT INJ 200MG	4	PA, QL (2 PENS (400 MG) PER 28 DAYS); LOADING DOSE: 2 PENS (400 MG) PER 14 DAYS
DUPIXENT INJ 300/2ML	4	PA, QL (4 PENS PER 28 DAYS)
DUPIXENT INJ 300/2ML	4	PA, QL (4 PFS PER 28 DAYS)
OPZELURA CRE 1.5%	2	PA
EMOLLIENT/KERATOLYTIC AGENTS		
<i>urea cream 39%</i>	1	
EMOLLIENTS		
LACTIC ACID LOT 10%	3	
ENZYMES - TOPICAL		
SANTYL OIN 250/GM	3	PA, QL (90 grams per 30 days)
HAIR GROWTH AGENTS		
LITFULO CAP 50MG	5	PA, QL (28 caps per 28 days)
IMMUNOMODULATING AGENTS - TOPICAL		
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	QL (21 ea every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

145

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
<i>pimecrolimus cream 1%</i>	1	ST
PROTOPIC OIN 0.1%	3	ST
PROTOPIC OIN 0.03%	3	ST
<i>tacrolimus oint 0.1%</i>	1	ST
<i>tacrolimus oint 0.03%</i>	1	ST
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL 0.5%	3	
GORDOFILM SOL	3	
<i>podofilox soln 0.5%</i>	1	
PYROGALL ACD OIN	3	
SALIMEZ FORT CRE 10%	3	
LINIMENTS		
TURPENTINE SOL SPIRITS	3	
LOCAL ANESTHETICS - TOPICAL		
ANACAINE OIN	3	
ETHYL CHLOR AER FINE PIN	3	
ETHYL CHLOR AER FN STRM	3	
ETHYL CHLOR AER MED JET	3	
ETHYL CHLOR AER MED STRM	3	
ETHYL CHLOR AER MIST	3	
<i>ethyl chloride aerosol spray</i>	1	
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel 2%</i>	1	QL (60 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (10 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (12 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (3 injections every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 25 days)
<i>lidocaine patch 5%</i>	1	QL (90 ea every 30 days)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
LIDODERM DIS 5%	3	QL (90 ea every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

146

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SYNERA DIS 70-70MG	3	QL (2 patches every 25 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 ea every 30 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 patches every 30 days)
MISC. TOPICAL		
ARNICA TIN FLOWER	3	
DRYSOL SOL 20%	3	
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2%	2	
ROSACEA AGENTS		
<i>azelaic acid gel 15%</i>	1	PA
FINACEA AER 15%	2	PA
METROCREAM CRE 0.75%	3	
METROLOTION LOT 0.75%	3	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
ORACEA CAP 40MG	1	Tier 1 with DAW9
SOOLANTRA CRE 1%	1	PA; Tier 1 with DAW9
SCABICIDES & PEDICULICIDES		
<i>crotamiton lotion 10%</i>	1	
ELIMITE CRE 5%	3	
<i>ivermectin lotion 0.5%</i>	1	
<i>lindane shampoo 1%</i>	1	
<i>malathion lotion 0.5%</i>	1	
NATROBA SUS 0.9%	3	
OVIDE LOT 0.5%	3	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
SULF LIME SOL	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

147

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TAR PRODUCTS		
coal tar soln 20%	1	
WOUND CARE PRODUCTS		
REGRANEX GEL 0.01%	3	PA, QL (60 grams per 30 days)
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC TESTS		
ACCU-CHEK GUIDE	0	QL (150 strips every 30 days)
ACCU-CHEK TES AVIVA PL	0	QL (150 strips every 30 days)
ACCU-CHEK TES COMPACT	0	QL (150 strips every 30 days)
ACCU-CHEK TES SMART	0	QL (150 strips every 30 days)
CHEMSTRIP K TES	0	
CHEMSTRIP TES UGK	0	
CVS KETONE TES CARE	0	
DIASTIX TES STRIPS	0	
FORA GTEL TES KETONE	0	
GOJJI BLOOD TES KETONE	0	
KETO-DIASTIX TES	0	
KETONE TES	0	
KETONE TEST TES	0	
KETOSTIX TES STRIP	0	
NOVA MAX PLS TES KETONE	0	
ONETOUCH TES ULTRA	0	QL (150 strips every 30 days)
ONETOUCH TES VERIO	0	QL (150 strips every 30 days)
PRECISN XTRA TES KETONE	0	
PTS PANELS TES KETONE	0	
RELION TES KETONE	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

148

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS		
DIETARY MANAGEMENT PRODUCTS		
CAMINO PRO LIQ 15PE	3	Coverage is subject to your plan/benefits
COMPLEAT LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
COMPLEAT PED LIQ ORG BLND	3	PA; Coverage is subject to your plan/benefits
CRUCIAL LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
DIABETIC TF LIQ	3	PA; Coverage is subject to your plan/benefits
DIABETISOURC LIQ	3	PA; Coverage is subject to your plan/benefits
EAA SUPPLEME POW TROPICAL	3	Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
EO28 SPLASH LIQ ORANGE	3	PA; Coverage is subject to your plan/benefits
F.A.A. LIQ	3	PA; Coverage is subject to your plan/benefits
FIBERSOUR HN LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FIBERSOURCE LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
GLUCERNA 1.0 LIQ CARB VAN	3	PA; Coverage is subject to your plan/benefits
GLUCERNA LIQ 1.2 CAL	3	PA; Coverage is subject to your plan/benefits
GLUCERNA SEL LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
GLYTACTIN PAK BTMK/DLT	3	Coverage is subject to your plan/benefits
GLYTACTIN POW BETMLK15	3	Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

149

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
GLYTACTIN POW RST LT10	3	Coverage is subject to your plan/benefits
GLYTROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
HCU EXP20 PAK UNFLAVOR	3	Coverage is subject to your plan/benefits
HCU EXPRESS PAK	3	Coverage is subject to your plan/benefits
HOMACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
ISOSOURCE HN LIQ	3	PA; Coverage is subject to your plan/benefits
ISOSOURCE LIQ	3	PA; Coverage is subject to your plan/benefits
ISOVACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
JEVITY 1 CAL LIQ	3	PA; Coverage is subject to your plan/benefits
JEVITY 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
JEVITY 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
LANAFLEX PAK	3	Coverage is subject to your plan/benefits
LIQUID HOPE LIQ	3	PA; Coverage is subject to your plan/benefits
LOPHLEX POW	3	Coverage is subject to your plan/benefits
MCT PRO-CAL PAK	3	PA; Coverage is subject to your plan/benefits
NEOCATE LIQ SPLASH	3	PA; Coverage is subject to your plan/benefits
NEOKE MCT70 POW	3	PA; Coverage is subject to your plan/benefits
NEPRO LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

150

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NOVASOURCE LIQ RENAL	3	PA; Coverage is subject to your plan/benefits
NUTRAMINE PAK	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.0 LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.5 LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
NUTREN 2.0 LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NUTREN JR LIQ	3	PA; Coverage is subject to your plan/benefits
NUTREN LIQ JUNIOR	3	PA; Coverage is subject to your plan/benefits
NUTREN RENAL LIQ	3	PA; Coverage is subject to your plan/benefits
NUTRIRENAL LIQ	3	PA; Coverage is subject to your plan/benefits
OPTIMENTAL LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE HN LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA 1.5 LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA LIQ	3	PA; Coverage is subject to your plan/benefits
PEDIASURE EN LIQ /FIBER	3	PA; Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

151

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PEDIASURE LIQ PEPTIDE	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PERATIVE LIQ	3	PA; Coverage is subject to your plan/benefits
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHLEXY-10 POW	3	PA; Coverage is subject to your plan/benefits
PIVOT LIQ 1.5 CAL	3	PA; Coverage is subject to your plan/benefits
PKU EXPLORE5 POW UNFLAVOR	3	Coverage is subject to your plan/benefits
PPA/MMA POW EXPRESS	3	Coverage is subject to your plan/benefits
PRO-PHREE POW	3	Coverage is subject to your plan/benefits
PROMACTIN AA SUS PLUS	3	Coverage is subject to your plan/benefits
PROMOTE 1.0 LIQ W/ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/FB LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

152

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
REPLETE FIBE LIQ 1 CAL	3	PA; Coverage is subject to your plan/benefits
REPLETE LIQ ULTRAPAK	3	PA; Coverage is subject to your plan/benefits
RESOURCE DIA LIQ TF	3	PA; Coverage is subject to your plan/benefits
S.O.S. 20 POW	3	Coverage is subject to your plan/benefits
S.O.S. 25 POW	3	Coverage is subject to your plan/benefits
SUPLINA LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
TOLEREX POW	3	PA; Coverage is subject to your plan/benefits
TWOCAL HN LIQ	3	PA; Coverage is subject to your plan/benefits
TYLACTIN POW BLD 20PE	3	Coverage is subject to your plan/benefits
ULTRACAL HN LIQ PLUS	3	PA; Coverage is subject to your plan/benefits
ULTRACAL LIQ	3	PA; Coverage is subject to your plan/benefits
ULTRIENT 1.5 LIQ SAFE-T	3	PA; Coverage is subject to your plan/benefits
VILACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
VITAL HN POW	3	PA; Coverage is subject to your plan/benefits
VIVONEX RTF LIQ	3	PA; Coverage is subject to your plan/benefits

DIGESTIVE AIDS***DIGESTIVE ENZYMES***

CREON CAP 3000UNIT	2
CREON CAP 6000UNIT	2

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

153

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CREON CAP 12000UNT	2	
CREON CAP 24000UNT	2	
CREON CAP 36000UNT	2	
SUCRAID SOL 8500/ML	5	PA
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 25000UNT	2	
ZENPEP CAP 40000UNT	2	
ZENPEP CAP 60000UNT	2	

DIURETICS**CARBONIC ANHYDRASE INHIBITORS**

<i>acetazolamide cap er 12hr 500 mg</i>	1	
<i>acetazolamide tab 125 mg</i>	1	
<i>acetazolamide tab 250 mg</i>	1	
<i>dichlorphenamide tab 50 mg</i>	1	PA, QL (120 tabs every 30 days)
KEVEYIS TAB 50MG	5	PA, QL (120 TABLETS PER 30 DAYS)
<i>methazolamide tab 25 mg</i>	1	
<i>methazolamide tab 50 mg</i>	1	

DIURETIC COMBINATIONS

ALDACTAZIDE TAB 25/25	3	
ALDACTAZIDE TAB 50/50	3	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	
MAXZIDE TAB 75-50	3	
MAXZIDE-25 TAB	3	
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	1	
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

154

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	
LOOP DIURETICS		
<i>bumetanide tab 0.5 mg</i>	1	
<i>bumetanide tab 1 mg</i>	1	
<i>bumetanide tab 2 mg</i>	1	
BUMEX TAB 0.5MG	3	
EDECRIN TAB 25MG	3	
<i>ethacrynic acid tab 25 mg</i>	1	
<i>furosemide oral soln 8 mg/ml</i>	1	
<i>furosemide oral soln 10 mg/ml</i>	1	
<i>furosemide tab 20 mg</i>	1	
<i>furosemide tab 40 mg</i>	1	
<i>furosemide tab 80 mg</i>	1	
LASIX TAB 20MG	3	
LASIX TAB 40MG	3	
LASIX TAB 80MG	3	
<i>toremide tab 5 mg</i>	1	
<i>toremide tab 10 mg</i>	1	
<i>toremide tab 20 mg</i>	1	
<i>toremide tab 100 mg</i>	1	
POTASSIUM SPARING DIURETICS		
ALDACTONE TAB 25MG	3	
ALDACTONE TAB 50MG	3	
ALDACTONE TAB 100MG	3	
<i>amiloride hcl tab 5 mg</i>	1	
<i>spironolactone tab 25 mg</i>	1	
<i>spironolactone tab 50 mg</i>	1	
<i>spironolactone tab 100 mg</i>	1	
<i>triamterene cap 50 mg</i>	1	
<i>triamterene cap 100 mg</i>	1	
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
<i>chlorthalidone tab 25 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

155

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>chlorthalidone tab 50 mg</i>	1	
DIURIL SUS 250/5ML	3	
<i>hydrochlorothiazide cap 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 25 mg</i>	1	
<i>hydrochlorothiazide tab 50 mg</i>	1	
<i>indapamide tab 1.25 mg</i>	1	
<i>indapamide tab 2.5 mg</i>	1	
<i>metolazone tab 2.5 mg</i>	1	
<i>metolazone tab 5 mg</i>	1	
<i>metolazone tab 10 mg</i>	1	

ENDOCRINE AND METABOLIC AGENTS - MISC.**BONE DENSITY REGULATORS**

ACTONEL TAB 35MG	3	
ACTONEL TAB 150MG	3	
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	
<i>alendronate sodium tab 5 mg</i>	1	
<i>alendronate sodium tab 10 mg</i>	1	
<i>alendronate sodium tab 35 mg</i>	1	
<i>alendronate sodium tab 70 mg</i>	1	
AELVIA TAB	3	
BINOSTO TAB 70MG	3	
BONIVA TAB 150MG	3	
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1	
FORTEO INJ 600/2.4	4	PA, QL (1 PENS FOR 28 DAYS)
FOSAMAX + D TAB 70-2800	3	
FOSAMAX + D TAB 70-5600	3	
FOSAMAX TAB 70MG	3	
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	
NATPARA INJ 25MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

156

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NATPARA INJ 75MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 100MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
<i>risedronate sodium tab 5 mg</i>	1	
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	
<i>risedronate sodium tab 150 mg</i>	1	
<i>risedronate sodium tab delayed release 35 mg</i>	1	
TYMLOS INJ	4	PA, QL (1 PEN PER 30 DAYS)

CORTICOTROPIN

ACTHAR INJ 80UNIT	5	PA, QL (35ML PER 21 DAYS)
CORTROPHIN GEL 80UNIT	5	PA, QL (35ML PER 21 DAYS)

FERTILITY REGULATORS

<i>clomiphene citrate tab 50 mg</i>	1	Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 300UNIT	4	PA, QL (15 Catridges Per 28 Days); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 600UNIT	4	PA, QL (10 Catridges Per 28 Days); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 900UNIT	4	PA, QL (7 Catridges Per 28 Days); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	4	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	4	PA; Coverage is subject to your plan/benefits

GNRH/LHRH ANTAGONISTS

GANIRELIX AC INJ 250/0.5	4	PA; Tier 1 with DAW9
--------------------------	---	----------------------

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

157

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ORLISSA TAB 150MG	2	PA
ORLISSA TAB 200MG	2	PA
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA SV INJ 2MG	5	PA, QL (30 VIALS PER 30 DAYS)
GROWTH HORMONES		
HUMATROPE INJ 6MG	4	PA
HUMATROPE INJ 12MG	4	PA
HUMATROPE INJ 24MG	4	PA
HORMONE RECEPTOR MODULATORS		
EVISTA TAB 60MG	0	
<i>raloxifene hcl tab 60 mg</i>	0	
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL SOL 2MG/ML	3	
METABOLIC MODIFIERS		
<i>calcitriol cap 0.5 mcg</i>	1	
<i>calcitriol cap 0.25 mcg</i>	1	
<i>calcitriol oral soln 1 mcg/ml</i>	1	
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
<i>doxercalciferol cap 0.5 mcg</i>	1	
<i>doxercalciferol cap 1 mcg</i>	1	
<i>doxercalciferol cap 2.5 mcg</i>	1	
GALAFOLD CAP 123MG	5	PA, QL (14 CAPSULES PER 28 DAYS)
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	
<i>levocarnitine tab 330 mg</i>	1	
MYALEPT INJ 11.3MG	5	PA, QL (30 VIALS PER 30 DAYS)
<i>nitisinone cap 2 mg</i>	1	PA
<i>nitisinone cap 5 mg</i>	1	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

158

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nitisinone cap 10 mg</i>	1	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
<i>paricalcitol cap 1 mcg</i>	1	
<i>paricalcitol cap 2 mcg</i>	1	
<i>paricalcitol cap 4 mcg</i>	1	
PHEBURANE MIS 483/GM	4	PA, QL (672 GRAMS (8 BOTTLES) PER 30 DAYS)
REVCOVI INJ 1.6MG/ML	5	PA
ROCALTROL CAP 0.5MCG	3	
ROCALTROL CAP 0.25MCG	3	
ROCALTROL SOL 1MCG/ML	3	
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	PA
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	PA
<i>sapropterin dihydrochloride tab 100 mg</i>	1	PA
SENSIPAR TAB 30MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 60MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 90MG	5	PA, QL (120 TABLETS PER 30 DAYS)
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	1	PA, QL (798 GRAMS PER 30 DAYS)
<i>sodium phenylbutyrate tab 500 mg</i>	1	PA, QL (1200 TABLETS PER 30 DAYS)
STRENSIQ INJ 18/0.45	5	PA
STRENSIQ INJ 28/0.7ML	5	PA
STRENSIQ INJ 40MG/ML	5	PA
STRENSIQ INJ 80/0.8ML	5	PA
XURIDEN POW 2GM	5	PA, QL (4 PACKETS PER DAY)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

159

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZEMPLAR CAP 1MCG	3	
ZEMPLAR CAP 2MCG	3	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG	2	PA
KERENDIA TAB 20MG	2	PA
NATRIURETIC PEPTIDES		
VOXZOGO INJ 0.4MG	5	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 0.56MG	5	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 1.2MG	5	PA, QL (30 VIALS PER 30 DAYS)
POSTERIOR PITUITARY HORMONES		
DDAVP SOL 0.01%	3	
DDAVP TAB 0.1MG	3	
DDAVP TAB 0.2MG	3	
<i>desmopressin acetate nasal spray soln 0.01%</i>	1	
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	1	
<i>desmopressin acetate tab 0.1 mg</i>	1	
<i>desmopressin acetate tab 0.2 mg</i>	1	
NOCDURNA SUB 27.7MCG	3	
NOCDURNA SUB 55.3MCG	3	
PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX TAB 200MG	3	
<i>mifepristone tab 200 mg</i>	1	\$0 copay based on your plan/benefit
PROLACTIN INHIBITORS		
<i>cabergoline tab 0.5 mg</i>	1	
SOMATOSTATIC AGENTS		
<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml)</i>	1	PA, QL (90 vials every 30 days)
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml)</i>	1	PA, QL (90 VIALS PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

160

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	1	PA, QL (45 VIALS (45,000 UNITS) PER 30 DAYS)
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml)</i>	1	PA, QL (90 AMPULES PER 30 DAYS)
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	1	PA, QL (9 VIALS (45,000) PER 30 DAYS)
SANDOSTATIN INJ 50MCG/ML	5	PA, QL (90 ampules every 30 days)
SANDOSTATIN INJ 100MCG	5	PA, QL (90 VIALS PER 30 DAYS)
SANDOSTATIN INJ 500MCG	5	PA, QL (90 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.3MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.6MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.9MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)

VASOPRESSIN RECEPTOR ANTAGONISTS

SAMSCA TAB 15MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SAMSCA TAB 30MG	5	PA, QL (30 TABLETS PER 30 DAYS)
<i>tolvaptan tab 30 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)

ESTROGENS**ESTROGEN COMBINATIONS**

ACTIVELLA TAB 1-0.5MG	3	
BIJUVA CAP 1-100MG	2	
CLIMARA PRO DIS WEEKLY	2	
COMBIPATCH DIS	2	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

161

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	
ORIAHNN CAP	2	PA
ESTROGENS		
DELESTROGEN INJ 10MG/ML	3	PA
DELESTROGEN INJ 20MG/ML	3	PA
DELESTROGEN INJ 40MG/ML	3	PA
DEPO-ESTRADI INJ 5MG/ML	3	PA
DIVIGEL GEL 0.5MG	2	
DIVIGEL GEL 0.25MG	2	
DIVIGEL GEL 0.75MG	2	
DIVIGEL GEL 1.25MG	2	
DIVIGEL GEL 1MG/GM	2	
ESTRACE TAB 0.5MG	3	
ESTRACE TAB 1MG	3	
ESTRACE TAB 2MG	3	
<i>estradiol tab 0.5 mg</i>	1	
<i>estradiol tab 1 mg</i>	1	
<i>estradiol tab 2 mg</i>	1	
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	1	
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	1	
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	1	
<i>estradiol td gel 1 mg/gm (0.1%)</i>	1	
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	1	
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.06 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.025 mg/24hr</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

162

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>estradiol td patch weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	1	
<i>estradiol valerate im in oil 20 mg/ml</i>	1	PA
<i>estradiol valerate im in oil 40 mg/ml</i>	1	PA
EVAMIST SPR 1.53MG	3	
PREMARIN INJ 25MG	3	PA

FLUOROQUINOLONES**FLUOROQUINOLONES**

BAXDELA TAB 450MG	3	
CIPRO (5%) SUS 250MG/5	3	
CIPRO (10%) SUS 500MG/5	3	
CIPRO TAB 250MG	3	
CIPRO TAB 500MG	3	
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	1	
<i>levofloxacin oral soln 25 mg/ml</i>	1	
<i>levofloxacin tab 250 mg</i>	1	
<i>levofloxacin tab 500 mg</i>	1	
<i>levofloxacin tab 750 mg</i>	1	
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1	
<i>ofloxacin tab 300 mg</i>	1	
<i>ofloxacin tab 400 mg</i>	1	

GASTROINTESTINAL AGENTS - MISC.**AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)**

TRULANCE TAB 3MG	3	
------------------	---	--

BILE ACID SYNTHESIS DISORDER AGENTS

CHOLBAM CAP 50MG	5	PA
CHOLBAM CAP 250MG	5	PA

FARNESOID X RECEPTOR (FXR) AGONISTS

OCALIVA TAB 5MG	5	PA, QL (30 TABLETS PER 30 DAYS)
-----------------	---	---------------------------------

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

163

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OCALIVA TAB 10MG	5	PA, QL (30 TABLETS PER 30 DAYS)
GALLSTONE SOLUBILIZING AGENTS		
CHENODAL TAB 250MG	5	PA
URSO 250 TAB 250MG	3	
URSO FORTE TAB 500MG	3	
<i>ursodiol cap 300 mg</i>	1	
<i>ursodiol tab 250 mg</i>	1	
<i>ursodiol tab 500 mg</i>	1	
GASTROINTESTINAL ANTIALLERGY AGENTS		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	
GASTROCROM CON 100/5ML	3	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
<i>lubiprostone cap 8 mcg</i>	1	
<i>lubiprostone cap 24 mcg</i>	1	
GASTROINTESTINAL STIMULANTS		
METOCLOPRAMI TAB 10MG ODT	3	
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	1	
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	1	
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	1	
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	1	
REGLAN TAB 5MG	3	
REGLAN TAB 10MG	3	
INFLAMMATORY BOWEL AGENTS		
APRISO CAP 0.375GM	3	
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
<i>balsalazide disodium cap 750 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

164

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CIMZIA PREFL KIT 200MG/ML	4	PA, QL (2 KITS PER 28 DAYS); Preferred agent for Non-radiographic Axial Spondyloarthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
CIMZIA START KIT 200MG/ML	4	PA, QL (1 KIT PER 28 DAYS); Preferred agent for Non-radiographic Axial Spondyloarthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
DIPENTUM CAP 250MG	3	
<i>mesalamine cap dr 400 mg</i>	1	
<i>mesalamine cap er 24hr 0.375 gm</i>	1	
<i>mesalamine cap er 500 mg</i>	1	
<i>mesalamine enema 4 gm</i>	1	
<i>mesalamine rectal enema 4 gm & cleanser wipe kit</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	
<i>mesalamine tab delayed release 800 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

165

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI INJ 180/1.2	4	PA, QL (1 CARTRIDGE PER 56 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
SKYRIZI INJ 360/2.4	4	PA, QL (1 CARTRIDGE PER 56 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
<i>sulfasalazine tab 500 mg</i>	1	
<i>sulfasalazine tab delayed release 500 mg</i>	1	
INTESTINAL ACIDIFIERS		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
<i>alosetron hcl tab 0.5 mg (base equiv)</i>	1	
<i>alosetron hcl tab 1 mg (base equiv)</i>	1	
LINZESS CAP 72MCG	2	
LINZESS CAP 145MCG	2	
LINZESS CAP 290MCG	2	
LOTRONEX TAB 0.5MG	3	
LOTRONEX TAB 1MG	3	
VIBERZI TAB 75MG	2	
VIBERZI TAB 100MG	2	
LIVE FECAL MICROBIOTA		
VOWST CAP	5	PA, QL (12 CAPSULES PER 30 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

166

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
<i>alvimopan cap 12 mg</i>	1	
ENTEREG CAP 12MG	3	
SYMPROIC TAB 0.2MG	2	PA
PHOSPHATE BINDER AGENTS		
AURYXIA TAB 210MG	2	
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	
PHOSLYRA SOL	3	
RENAGEL TAB 800MG	3	
<i>sevelamer carbonate packet 0.8 gm</i>	1	
<i>sevelamer carbonate packet 2.4 gm</i>	1	
<i>sevelamer carbonate tab 800 mg</i>	1	
<i>sevelamer hcl tab 400 mg</i>	1	
<i>sevelamer hcl tab 800 mg</i>	1	
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT 5MG	5	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB 250MG	5	PA, QL (90 TABLETS PER 30 DAYS)
GENITOURINARY AGENTS - MISCELLANEOUS		
ACIDIFIERS		
K-PHOS TAB NO 2	3	
ALKALINIZERS		
ORACIT SOL	3	
<i>pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	1	
<i>potassium citrate & citric acid powder pack 3300-1002 mg</i>	3	
<i>potassium citrate & citric acid soln 1100-334 mg/5ml</i>	1	
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		167

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sodium citrate & citric acid soln 500-334 mg/5ml</i>	1	
UROCIT-K 5 TAB	3	
UROCIT-K 10 TAB	3	
UROCIT-K 15 TAB	3	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG	4	PA
CYSTAGON CAP 150MG	4	PA
PROSTATIC HYPERTROPHY AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	
AVODART CAP 0.5MG	3	
CARDURA XL TAB 4MG	3	
CARDURA XL TAB 8MG	3	
<i>dutasteride cap 0.5 mg</i>	1	
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	
<i>finasteride tab 5 mg</i>	1	
FLOMAX CAP 0.4MG	3	
PROSCAR TAB 5MG	3	
<i>silodosin cap 4 mg</i>	1	
<i>silodosin cap 8 mg</i>	1	
<i>tamsulosin hcl cap 0.4 mg</i>	1	
URINARY ANALGESICS		
<i>phenazopyridine hcl tab 200 mg</i>	1	
URINARY STONE AGENTS		
<i>tiopronin tab 100 mg</i>	1	PA
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	
GOUT AGENTS		
<i>allopurinol tab 100 mg</i>	1	
<i>allopurinol tab 300 mg</i>	1	
<i>colchicine tab 0.6 mg</i>	1	QL (120 tabs per 30 days)
<i>febuxostat tab 40 mg</i>	1	
<i>febuxostat tab 80 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

168

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MITIGARE CAP 0.6MG	1	QL (60 caps per 30 days); Tier 1 with DAW9
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
URICOSURICS		
<i>probenecid tab 500 mg</i>	1	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ 300/2ML	5	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	1	PA, QL (45 syringes every 90 days)
COMPLEMENT INHIBITORS		
CINRYZE SOL 500 UNIT	5	PA, QL (20 VIALS PER 30 DAYS)
HAEGARDA INJ 2000UNIT	5	PA, QL (20 VIALS PER 30 DAYS)
HAEGARDA INJ 3000UNIT	5	PA, QL (20 VIALS PER 30 DAYS)
RUCONEST INJ 2100UNIT	4	PA, QL (60 VIALS PER 90 DAYS)
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB 100MG	4	PA, QL (60 TABLETS PER 30 DAYS)
TAVALISSE TAB 150MG	4	PA, QL (60 TABLETS PER 30 DAYS)
HEMATORHEOLOGIC AGENTS		
<i>pentoxifylline tab er 400 mg</i>	1	
PLASMA KALLIKREIN INHIBITORS		
KALBITOR INJ 10MG/ML	5	PA, QL (30 CARTONS (900 MG) PER 90 DAYS)
ORLADEYO CAP 110MG	4	PA, QL (28 CAPSULES PER 28 DAYS)
ORLADEYO CAP 150MG	4	PA, QL (28 CAPSULES PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

169

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TAKHZYRO INJ 150MG/ML	4	PA, QL (2 SYRINGES PER 28 DAYS)
TAKHZYRO INJ 300/2ML	4	PA, QL (2 VIALS PER 28 DAYS)
PLATELET AGGREGATION INHIBITORS		
AGRYLIN CAP 0.5MG	3	
<i>anagrelide hcl cap 0.5 mg</i>	1	
<i>anagrelide hcl cap 1 mg</i>	1	
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	1	
BRILINTA TAB 60MG	2	
BRILINTA TAB 90MG	2	
<i>cilostazol tab 50 mg</i>	1	
<i>cilostazol tab 100 mg</i>	1	
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	1	
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	1	
<i>dipyridamole tab 25 mg</i>	1	
<i>dipyridamole tab 50 mg</i>	1	
<i>dipyridamole tab 75 mg</i>	1	
EFFIENT TAB 5MG	3	
EFFIENT TAB 10MG	3	
<i>prasugrel hcl tab 5 mg (base equiv)</i>	1	
<i>prasugrel hcl tab 10 mg (base equiv)</i>	1	
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG	4	PA, QL (56 CAPSULES PER 28 DAYS)
<i>miglustat cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)
ZAVESCA CAP 100MG	5	PA, QL (90 CAPSULES PER 30 DAYS)
AGENTS FOR SICKLE CELL DISEASE		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

170

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ENDARI POW 5GM	4	PA, QL (180 PACKETS PER 30 DAYS)
SIKLOS TAB 100MG	2	
SIKLOS TAB 1000MG	2	
COBALAMINS		
<i>cyanocobalamin inj 1000 mcg/ml</i>	1	PA
NASCOBAL SPR 500MCG	3	
FOLIC ACID/FOLATES		
<i>folic acid cap 0.8 mg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 1 mg</i>	1	
<i>folic acid tab 400 mcg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 800 mcg</i>	0	\$0 copay for women younger than 55
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
DOPTELET TAB 20MG	4	PA, QL (60 tabs every 30 days)
DOPTELET TAB 20MG	4	PA, QL (90 tabs every 30 days)
FYLNETRA INJ 6MG/0.6	4	PA, QL (2 SYRINGES PER 28 DAYS)
LEUKINE INJ 250MCG	5	PA
MULPLETA TAB 3MG	5	PA, QL (7 TABLETS PER 14 DAYS)
NIVESTYM INJ 300/0.5	4	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

171

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NIVESTYM INJ 300MCG	4	PA
NIVESTYM INJ 480/0.8	4	PA
NIVESTYM INJ 480MCG	4	PA
NYVEPRIA INJ 6/0.6ML	4	PA, QL (2 SYRINGES PER 28 DAYS)
PROCRIT INJ 2000/ML	4	PA
PROCRIT INJ 3000/ML	4	PA
PROCRIT INJ 4000/ML	4	PA
PROCRIT INJ 10000/ML	4	PA
PROCRIT INJ 20000/ML	4	PA
PROCRIT INJ 40000/ML	4	PA
PROMACTA PAK 25MG	4	PA, QL (180 PACKETS PER 30 DAYS)
PROMACTA POW 12.5MG	4	PA, QL (120 PACKETS PER 30 DAYS)
PROMACTA TAB 12.5MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 25MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 50MG	4	PA, QL (60 TABLETS PER 30 DAYS)
PROMACTA TAB 75MG	4	PA, QL (60 TABLETS PER 30 DAYS)
RETACRIT INJ 2000UNIT	4	PA
RETACRIT INJ 3000UNIT	4	PA
RETACRIT INJ 4000UNIT	4	PA
RETACRIT INJ 10000UNT	4	PA
RETACRIT INJ 20000UNI	4	PA
RETACRIT INJ 40000UNT	4	PA

HEMOSTATICS**HEMOSTATICS - SYSTEMIC**

AMICAR TAB 500MG	3	
AMICAR TAB 1000MG	3	
<i>aminocaproic acid oral soln 0.25 gm/ml</i>	1	
<i>aminocaproic acid tab 500 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

172

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>aminocaproic acid tab 1000 mg</i>	1	
LYSTEDA TAB 650MG	3	
<i>tranexamic acid tab 650 mg</i>	1	
HEMOSTATICS - TOPICAL		
ARTISS SOL 2ML	3	
ARTISS SOL 4ML	3	
ARTISS SOL 10ML	3	
TACHOSIL PAD 4.8X4.8	3	
TACHOSIL PAD 9.5X4.8	3	
TISSEEL KIT 2ML	3	
TISSEEL KIT 4ML	3	
TISSEEL KIT 10ML	3	
TISSEEL SOL 2ML	3	
TISSEEL SOL 4ML	3	
TISSEEL SOL 10ML	3	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
<i>phenobarbital elixir 20 mg/5ml</i>	1	
<i>phenobarbital tab 15 mg</i>	1	
<i>phenobarbital tab 16.2 mg</i>	1	
<i>phenobarbital tab 30 mg</i>	1	
<i>phenobarbital tab 32.4 mg</i>	1	
<i>phenobarbital tab 60 mg</i>	1	
<i>phenobarbital tab 64.8 mg</i>	1	
<i>phenobarbital tab 97.2 mg</i>	1	
<i>phenobarbital tab 100 mg</i>	1	
HYPNOTICS - TRICYCLIC AGENTS		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
NON-BARBITURATE HYPNOTICS		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

173

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>estazolam tab 1 mg</i>	1	
<i>estazolam tab 2 mg</i>	1	
<i>eszopiclone tab 1 mg</i>	1	
<i>eszopiclone tab 2 mg</i>	1	
<i>eszopiclone tab 3 mg</i>	1	
<i>flurazepam hcl cap 15 mg</i>	1	
<i>flurazepam hcl cap 30 mg</i>	1	
HALCION TAB 0.25MG	3	
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	
RESTORIL CAP 22.5MG	3	
RESTORIL CAP 30MG	3	
<i>temazepam cap 7.5 mg</i>	1	
<i>temazepam cap 15 mg</i>	1	
<i>temazepam cap 22.5 mg</i>	1	
<i>temazepam cap 30 mg</i>	1	
<i>triazolam tab 0.25 mg</i>	1	
<i>triazolam tab 0.125 mg</i>	1	
<i>zaleplon cap 5 mg</i>	1	
<i>zaleplon cap 10 mg</i>	1	
<i>zolpidem tartrate tab 5 mg</i>	1	
<i>zolpidem tartrate tab 10 mg</i>	1	
<i>zolpidem tartrate tab er 6.25 mg</i>	1	
<i>zolpidem tartrate tab er 12.5 mg</i>	1	

SELECTIVE MELATONIN RECEPTOR AGONISTS

HETLIOZ CAP 20MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	5	PA, QL (5 ML PER DAY)
<i>ramelteon tab 8 mg</i>	1	
<i>tasimelteon capsule 20 mg</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)

LAXATIVES**LAXATIVE COMBINATIONS**

<i>bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit</i>	0	\$0 copay for members age 45 through 75
--	---	---

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

174

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CLENPIQ SOL	0	\$0 copay for members age 45 through 75
NULYTELY SOL LMN/LIME	3	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm</i>	1	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	
PEG-PREP KIT	0	\$0 copay for members age 45 through 75
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	0	\$0 copay for members age 45 through 75
LAXATIVES - MISCELLANEOUS		
KRISTALOSE PAK 10GM	3	
KRISTALOSE PAK 20GM	3	
<i>lactulose solution 10 gm/15ml</i>	1	
STIMULANT LAXATIVES		
CASCARA EXT SAGRADA	3	
MACROLIDES		
AZITHROMYCIN		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin powd pack for susp 1 gm</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
ZITHROMAX POW 1GM PAK	3	
ZITHROMAX SUS 100/5ML	3	
ZITHROMAX SUS 200/5ML	3	
ZITHROMAX TAB 250MG	3	
ZITHROMAX TAB 500MG	3	
ZITHROMAX TAB TRI-PAK	3	
ZITHROMAX TAB Z-PAK	3	
CLARITHROMYCIN		
<i>clarithromycin for susp 125 mg/5ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

175

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>clarithromycin for susp 250 mg/5ml</i>	1	
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
ERYTHROMYCINS		
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate tab 400 mg</i>	1	
<i>erythromycin stearate tab 250 mg</i>	1	
<i>erythromycin tab 250 mg</i>	1	
<i>erythromycin tab 500 mg</i>	1	
<i>erythromycin tab delayed release 250 mg</i>	1	
<i>erythromycin tab delayed release 333 mg</i>	1	
<i>erythromycin tab delayed release 500 mg</i>	1	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	1	
FIDAXOMICIN		
DIFICID SUS	2	
DIFICID TAB 200MG	2	
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 boxes every 25 days); OTC
FC FEMALE MIS CONDOM	0	QL (12 boxes every 25 days); OTC
FEMCAP MIS 22MM	0	QL (1 each every 300 days)
FEMCAP MIS 26MM	0	QL (1 each every 300 days)
FEMCAP MIS 30MM	0	QL (1 each every 300 days)
OMNIFLEX DPR	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 60	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 65	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 70	0	QL (1 each every 300 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

176

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
WIDE-SEAL DPR KIT 75	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 80	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 85	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 90	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 95	0	QL (1 each every 300 days)
DIABETIC SUPPLIES		
ACCU-CHEK KIT FASTCLIX	0	
ACCU-CHEK KIT SOFTCLIX	0	
ACCU-CHEK LIQ GUIDE	0	
ACCU-CHEK LIQ SMART	0	
ACCU-CHEK MIS MLTICLIX	0	
ACCU-CHEK SOL	0	
ACCU-CHEK SOL COMPACT	0	
ACCUTREND SOL GLUCOSE	0	
ACTI-LANCE MIS 28G	0	
ACTI-LANCE MIS LITE 28G	0	
ACTI-LANCE MIS SPEC 17G	0	
ACTI-LANCE MIS UNIV 23G	0	
ADJ LANCING MIS DEVICE	0	
ADV LANCING MIS DEVICE	0	
ADV TRAVEL MIS LANC 28G	0	
ADVANCE LIQ CONTROL	0	
ADVANCE LIQ INTUITIO	0	
ADVANCE NORM LIQ CONTROL	0	
ADVCATE SAFE MIS LANC 26G	0	
ADVOCATE LIQ HIGH	0	
ADVOCATE LIQ LOW	0	
ADVOCATE MIS LANC 30G	0	
ADVOCATE MIS LANC DEV	0	
ADVOCATE MIS LANCETS	0	
ADVOCATE+ SOL REDI-COD	0	
AGAMATRIX MIS 33G	0	
AGAMATRIX SOL HIGH	0	
AGAMATRIX SOL LEVEL 2	0	
AGAMATRIX SOL LEVEL 4	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

177

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AGAMATRIX SOL NORM/HGH	0	
AGAMATRIX SOL NORMAL	0	
AIMSCO TWIST MIS 32G	0	
AIMSCO TWIST MIS 33G	0	
AQUALANCE MIS 30G	0	
ASSURE 3 LIQ CONTROL	0	
ASSURE 4 LIQ LEVEL1/2	0	
ASSURE CMFRT MIS 28G	0	
ASSURE DOSE SOL NORM/HGH	0	
ASSURE DOSE SOL NORMAL	0	
ASSURE II LIQ LEVEL1/2	0	
ASSURE II LIQ LEVEL 1	0	
ASSURE LANCE MIS 21G	0	
ASSURE LANCE MIS 28G	0	
ASSURE LANCE MIS LOW FLOW	0	
ASSURE LANCE MIS MICRO	0	
ASSURE LANCE MIS SAFE 25G	0	
ASSURE LANCE MIS SAFE 30G	0	
ASSURE PLUS MIS HIGH 18G	0	
ASSURE PLUS MIS LOW 25G	0	
ASSURE PLUS MIS MCRO 28G	0	
ASSURE PLUS MIS NORM 21G	0	
ASSURE PLUS MIS PEDIATRI	0	
ASSURE PRISM SOL LEVEL1/2	0	
ASSURE PRO LIQ LEVEL1/2	0	
AURORA LANCE MIS 30G	0	
AURORA LANCE MIS THIN 23G	0	
AUTO LANCET MIS	0	
AUTO-LANCET MIS	0	
AUTO-LANCET MIS MINI	0	
AUTOLET II KIT CLINISAF	0	
AUTOLET IMPR MIS LANC DEV	0	
AUTOLET LANC MIS DEVICE	0	
AUTOLET LITE KIT	0	
AUTOLET LITE KIT CLINISAF	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

178

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AUTOLET LITE KIT STARTER	0	
AUTOLET MINI MIS	0	
AUTOLET PLAT MIS 1.8MM	0	
AUTOLET PLAT MIS 2.4MM	0	
AUTOLET PLAT MIS 3.0MM	0	
AUTOLET PLUS MIS	0	
AUTOLET PLUS MIS LANC DEV	0	
BD LANCET UF MIS 30G	0	
BD LANCET UF MIS 33G	0	
BD MICROTAIN MIS LANCETS	0	
CARDIOCOM MIS LANCING	0	
CAREONE ADV MIS LANCING	0	
CAREONE LANC MIS 30G	0	
CAREONE LANC MIS THIN 23G	0	
CARESENS 30G MIS LANCETS	0	
CARESENS SOL CONTROL	0	
CARETOUCH MIS EJECTOR	0	
CARETOUCH MIS LANC 26G	0	
CARETOUCH MIS LANC 28G	0	
CARETOUCH MIS LANC 30G	0	
CARETOUCH MIS TWIST 28	0	
CARETOUCH MIS TWIST 30	0	
CARETOUCH MIS TWIST 33	0	
CLEANLET 28G MIS LANCETS	0	
CLEVER CHECK MIS	0	
CLEVER CHECK MIS 30G	0	
CLEVR CHOICE LIQ HIGH	0	
CLEVR CHOICE LIQ LOW	0	
COAGUCHEK MIS LANCETS	0	
COMFORT ASSU MIS LANC 28G	0	
COMFORT ASSU MIS LANC 33G	0	
COMFORT EZ MIS 21G	0	
COMFORT EZ MIS 23G	0	
COMFORT EZ MIS 28G	0	
COMFORT MIS LANCETS	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

179

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COMFORT TCH MIS LANC 28G	0	
COMFORT TCH MIS LANC 31G	0	
COMFORTOUCH MIS LANCET	0	
CONTOUR HIGH LIQ CONTROL	0	
CONTOUR LOW LIQ CONTROL	0	
CONTOUR NEXT SOL LEVEL 1	0	
CONTOUR NEXT SOL LEVEL 2	0	
CONTOUR NORM LIQ CONTROL	0	
CONTROL HIGH SOL UNISTRIP	0	
CONTROL LOW SOL UNISTRIP	0	
CONTROL NORM SOL EASY STP	0	
CONTROL SOL LIQ HI/MID/L	0	
CONTROL SOL LIQ HIGH/LOW	0	
CONTROL SOL LIQ LEVEL 2	0	
CONTROL SOL LIQ MID	0	
CONTROL SOL NORMAL	0	
COOL CONTROL SOL A	0	
COOL CONTROL SOL B	0	
CVS LANCETS MIS 21G	0	
CVS LANCETS MIS 30G	0	
CVS LANCETS MIS 33G	0	
CVS LANCETS MIS ORIGINAL	0	
CVS LANCETS MIS THIN 26G	0	
CVS LANCETS MIS THIN 30G	0	
CVS LANCETS MIS THIN 33G	0	
CVS LANCING MIS DEVICE	0	
DEXCOM G6 MIS RECEIVER	0	
DEXCOM G6 MIS SENSOR	0	QL (3 sensors per month)
DEXCOM G6 MIS TRANSMIT	0	
DEXCOM G7 MIS RECEIVER	0	
DEXCOM G7 MIS SENSOR	0	QL (3 sensors per month)
DIATHRIVE LIQ CONTROL	0	
DIATHRIVE MIS LANCETS	0	
DIATHRIVE MIS LANCING	0	
DIATHRIVE MIS UT 30G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

180

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DIATRUE CONT SOL LEVEL 1	0	
DIATRUE CONT SOL LEVEL 2	0	
DIATRUE CONT SOL LEVEL 3	0	
DROPLET LANC MIS 30G	0	
DROPLET LANC MIS DEVICE	0	
DROPLET PERS MIS LANC 30G	0	
DUO-CARE LIQ LEVEL1/2	0	
E-Z JECT MIS 21G	0	
E-Z JECT MIS 21G COLR	0	
E-Z JECT MIS 30G	0	
E-Z JECT MIS 32G COLR	0	
E-Z JECT MIS LANC 21G	0	
E-Z JECT MIS THIN 26G	0	
E-ZJECT LANC MIS 33G	0	
EASY COMFORT MIS 30G	0	
EASY COMFORT MIS LANC/30G	0	
EASY COMFORT MIS TWIST	0	
EASY MINI MIS	0	
EASY MINI MIS EJECT	0	
EASY PLUS II SOL HIGH	0	
EASY PLUS II SOL LOW	0	
EASY TALK SOL HIGH	0	
EASY TALK SOL LOW	0	
EASY TALK SOL NORMAL	0	
EASY TOUCH MIS	0	
EASY TOUCH MIS LANC/21G	0	
EASY TOUCH MIS LANC/23G	0	
EASY TOUCH MIS LANC/26G	0	
EASY TOUCH MIS LANC/28G	0	
EASY TOUCH MIS LANC/30G	0	
EASY TOUCH MIS LANC/32G	0	
EASY TOUCH MIS LANC/33G	0	
EASY TOUCH SOL CONTROL	0	
EASY TOUCH SOL HIGH/LOW	0	
EASY TRAK II LIQ NORMAL	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

181

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EASY TRAK SOL HIGH	0	
EASY TRAK SOL LOW	0	
EASY TRAK SOL NORMAL	0	
EASYGLUCO SOL PLUS	0	
EASYMAX 15 LIQ LEVEL2-3	0	
EASYMAX 15 SOL LEVEL 2	0	
EASYMAX LIQ NORM/HIG	0	
EASYMAX SOL NORMAL	0	
EASYSSTEP HGH SOL CONTROL	0	
EASYSSTEP LOW SOL CONTROL	0	
ELEMENT CONT LIQ NORMAL	0	
ELEMENT LIQ HIGH	0	
ELEMENT LIQ LOW	0	
ELEMNT COMPA SOL LEVEL 2	0	
ELEMNT COMPA SOL LEVEL 3	0	
EMBRACE CNTR LIQ HIGH	0	
EMBRACE EVO LIQ LEVEL 1	0	
EMBRACE LANC MIS /EJECTOR	0	
EMBRACE LANC MIS THIN 30G	0	
EMBRACE PRO LIQ GLUCOSE	0	
EMBRACE SOL LOW	0	
EMBRACE TALK SOL HIGH/L2	0	
EMBRACE TALK SOL LOW/L1	0	
EQL LANCETS MIS 21G COLR	0	
EQL LANCETS MIS 33G COLR	0	
EQL LANCETS MIS THIN 26G	0	
EQL LANCETS MIS THIN 30G	0	
EVENCAR MINI SOL NORMAL	0	
EVENCARE G2 SOL LOW/HIGH	0	
EVENCARE G3 SOL LOW/HIGH	0	
EVENCARE SOL LIQ LOW/HIGH	0	
EVOLUTION SOL NORMAL	0	
EZ-LETS 21G MIS LANCETS	0	
EZ-LETS 26G MIS LANCETS	0	
EZ-LETS 28G MIS LANCETS	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

182

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EZ-LETS 30G MIS LANCETS	0	
FASTCLIX MIS LANCETS	0	
FIFTY50 SAFE MIS LANCETS	0	
FINE 30 MIS	0	
FINGERSTIX MIS LANCETS	0	
FORA CONTROL SOL HIGH	0	
FORA CONTROL SOL LOW	0	
FORA CONTROL SOL NORMAL	0	
FORA LANCETS MIS 30G	0	
FORA MIS LANCETS	0	
FORA MIS LANCING	0	
FORACARE GDH SOL HIGH	0	
FORACARE GDH SOL LOW	0	
FORACARE GDH SOL NORMAL	0	
FORTISCARE SOL CNTL HI	0	
FORTISCARE SOL CNTL LOW	0	
FORTISCARE SOL CNTL NML	0	
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS UNISTICK	0	
GE100 CONTRL SOL NORMAL	0	
GENTEEL LANC KIT BLUE	0	
GENTEEL MIS LANCETS	0	
GENTEEL MIS NOZZLES	0	
GENTEEL PLUS MIS BLACK	0	
GENTEEL PLUS MIS BLUE	0	
GENTEEL PLUS MIS PINK	0	
GENTEEL PLUS MIS PURPLE	0	
GENTEEL PLUS MIS WHITE	0	
GENTEEL TIPS MIS BLUE	0	
GENTEEL TIPS MIS CLEAR	0	
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

183

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
GENTEEL TIPS MIS YELLOW	0	
GENTLE-LET MIS 26G	0	
GENTLE-LET MIS 28G	0	
GENTLE-LET MIS LANCETS	0	
GENTLE-LET MIS PLATFORM	0	
GLOBAL 28G MIS LANCETS	0	
GLOBAL 30G MIS LANCETS	0	
GLOBAL LANC MIS DEVICE	0	
GLUC CONTROL LIQ NORMAL	0	
GLUC CONTROL SOL	0	
GLUC CONTROL SOL MID	0	
GLUC CONTROL SOL NORMAL	0	
GLUCOCARD 01 LIQ NORM/HGH	0	
GLUCOCARD 01 SOL NORMAL	0	
GLUCOCARD LIQ LEVEL 1	0	
GLUCOCARD SOL NORMAL	0	
GLUCOCARD SOL SHINE	0	
GLUCOCOM MIS 28G	0	
GLUCOCOM MIS 30G	0	
GLUCOCOM MIS 33G	0	
GLUCOCOM TES HIGH CON	0	
GLUCOCOM TES NORM CON	0	
GLUCOSE CONT LIQ HIGH/LOW	0	
GLUCOSE CONT SOL HIGH	0	
GLUCOSE CONT SOL NORMAL	0	
GLUCOSE CONT SOL PRECISIO	0	
GNP LANCETS MIS 21G	0	
GNP LANCETS MIS THIN	0	
GNP LANCETS MIS THIN 26G	0	
GOJJI CNTRL SOL NORMAL	0	
GOJJI LANCET MIS 30G	0	
GOJJI MIS LANC DEV	0	
GOODSENSE MIS LANC 26G	0	
GOODSENSE MIS LANC 30G	0	
GOODSENSE MIS LANC 33G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

184

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
GOODSENSE MIS LANC DVC	0	
HAEMOLANCE MIS HIGH FLO	0	
HAEMOLANCE MIS LOW FLOW	0	
HAEMOLANCE MIS PLUS	0	
HAEMOLANCE MIS PLUS LOW	0	
HAEMOLANCE MIS PLUS MAX	0	
HAEMOLANCE MIS PLUS PED	0	
HAEMOLANCE MIS RETRACT	0	
HC LANCING MIS DEVICE	0	
HLTHY ACCNTS MIS LANC 30G	0	
HYPOLANCE KIT LANCING	0	
IN TOUCH LAN MIS 30G	0	
IN TOUCH LAN MIS DEVICE	0	
IN TOUCH SOL GLUCOSE	0	
INCONTROL MIS LANC 28G	0	
INCONTROL MIS LANC 30G	0	
INCONTROL MIS LANC 33G	0	
INCONTROL MIS LANC DEV	0	
INFINITY SOL NORM CON	0	
INFNTY VOICE LIQ LEVEL 2	0	
KINNEY MIS LANCETS	0	
KINNEY THIN MIS LANCETS	0	
KROGER LANCE MIS	0	
KROGER LANCE MIS 26G	0	
KROGER LANCE MIS THIN	0	
KROGER LANCE MIS THIN 30G	0	
LANCET AUTO MIS INJECTOR	0	
LANCET CARRY MIS CASE	0	
LANCET DEVIC MIS 30G	0	
LANCET DEVIC MIS ADJUST	0	
LANCET MICRO MIS THIN 33G	0	
LANCET STAND MIS 21G	0	
LANCET SUPER MIS THIN 30G	0	
LANCET ULTRA MIS 28G	0	
LANCET ULTRA MIS THIN 30G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

185

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LANCET WITH MIS EJECTOR	0	
LANCETS MICR MIS THIN 33G	0	
LANCETS MIS	0	
LANCETS MIS 21G	0	
LANCETS MIS 21G COLR	0	
LANCETS MIS 28G	0	
LANCETS MIS 30G	0	
LANCETS MIS 33G	0	
LANCETS MIS ORANGE	0	
LANCETS MIS ORIGINAL	0	
LANCETS MIS THIN	0	
LANCETS MIS THIN 26G	0	
LANCETS MIS THIN 30G	0	
LANCETS SUPR MIS THIN 28G	0	
LANCETS THIN MIS	0	
LANCETS THIN MIS 26G	0	
LANCETS ULTR MIS THIN	0	
LANCING DEVI MIS	0	
LANCING DEVI MIS 25G	0	
LANCING DEVI MIS 30G	0	
LANCING MIS DEVICE	0	
LANZO MIS LANCING	0	
LB LANCET MIS 28G	0	
LB LANCING MIS DEVICE	0	
LIFESCAN MIS UNISTIK2	0	
LITE TOUCH MIS LANC PEN	0	
LITE TOUCH MIS LANCETS	0	
LITETOUCH MIS LANCETS	0	
LONGS LANCET MIS STANDARD	0	
LONGS LANCET MIS THIN	0	
LONGS LANCET MIS ULTRA TH	0	
MEDICHOICE MIS LANCET	0	
MEDISENSE LIQ GLUC-KET	0	
MEDISENSE LIQ GLUC/KET	0	
MEDLANCE MIS 30G PLUS	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

186

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MEDLANCE MIS EXTR 21G	0	
MEDLANCE MIS LITE 25G	0	
MEDLANCE MIS PLUS	0	
MEDLANCE MIS PLUS 30G	0	
MEDLANCE MIS UNV 21G	0	
MEDLANCE PLS MIS 0.8MM	0	
MEDLANCE PLS MIS EXTR 21G	0	
MEDLANCE PLS MIS LITE 25G	0	
MEDLANCE PLS MIS UNIV 21G	0	
MEIJER LANCE MIS COLOR	0	
MEIJER LANCE MIS UNIV 21G	0	
MEIJER LANCE MIS UNIV 30G	0	
MEIJER LANCE MIS UNIVERSA	0	
MEIJER MIS LANCETS	0	
MICRO THIN MIS LANC 33G	0	
MICRODOT CON SOL HIGH/LOW	0	
MICROLET MIS LANCETS	0	
MICROLET MIS NEXT	0	
MINI LANCING MIS DEVICE	0	
MM LANCING MIS DEVICE	0	
MM TWIST MIS LANCETS	0	
MOBILE LANCE MIS 30G	0	
MONOLET MIS LANCETS	0	
MONOLET OPD MIS LANCETS	0	
MONOLETTOR MIS LANCETS	0	
MPD SFTY LAN MIS 21G	0	
MPD SFTY LAN MIS 23G	0	
MPD SFTY LAN MIS 28G	0	
MPD SFTY LAN MIS 30G	0	
MULTI-LANCET KIT DEVICE	0	
MULTI-LANCET MIS DEVICE	0	
MYGLUCOHEALT MIS LANC 30G	0	
MYGLUCOHEALT SOL LO/NL/HI	0	
NEUTEK 2TEK SOL CONTROL	0	
NOVA MAX GLU LIQ /KET CON	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

187

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NOVA SAFETY MIS LANC 23G	0	
NOVA SAFETY MIS LANC 28G	0	
NOVA SURE MIS LANCETS	0	
NOVA SUREFLX MIS LANC DEV	0	
OMNIPOD 5 G6 KIT INTRO	0	PA, QL (1 kit per 999 days)
OMNIPOD 5 G6 MIS PODS	0	PA, QL (10 pods per month)
OMNIPOD MIS CLASSIC	0	PA, QL (10 pods per month)
OMNIPOD PDM KIT CLASSIC	0	PA, QL (1 kit per 999 days)
ON-THE-GO MIS LANC 30G	0	
ONETOUCH DEL MIS LANC DEV	0	
ONETOUCH DEL MIS PLUS 30G	0	
ONETOUCH DEL MIS PLUS 33G	0	
ONETOUCH FP MIS LANCETS	0	
ONETOUCH LIQ ULT CONT	0	
ONETOUCH LIQ VERIO	0	
ONETOUCH LIQ VERIO 4	0	
ONETOUCH MIS 30G	0	
ONETOUCH MIS LANC DEV	0	
ONETOUCH MIS LANCETS	0	
ONETOUCH SOL KIT COMPLETE	0	
ONETOUCH SOL KIT FIT	0	
ONETOUCH SOL KIT REFILL	0	
ONETOUCH US MIS LANCETS	0	
PC LANCETS MIS 30G	0	
PENLET II KIT BLOOD	0	
PENLET II MIS REPL CAP	0	
PERFECT 28G MIS LANCETS	0	
PERFECT 30G MIS LANCETS	0	
PHARMACY COU MIS LANCETS	0	
PIP LANCETS MIS 28G	0	
PIP LANCETS MIS 30G	0	
POCKETCHEM SOL EZ	0	
PRECISION LIQ CONTROL	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

188

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PRECISION LIQ GLUC/KET	0	
PRECISION LIQ NRML/MID	0	
PRESSURE ACT MIS LANCET	0	
PRESSURE ACT MIS LANCETS	0	
PRO COMFORT MIS 31G	0	
PRO COMFORT MIS LANC 30G	0	
PRO COMFORT MIS LANCETS	0	
PRODIGY MIS 26G	0	
PRODIGY MIS 28G	0	
PRODIGY MIS LANC DEV	0	
PRODIGY SOL HIGH	0	
PRODIGY SOL LOW	0	
PSS SAFE LAN MIS	0	
PSS SEL LANC MIS	0	
PSS SEL PLAT MIS	0	
PX LANCETS MIS 28G	0	
PX LANCETS MIS ULT THIN	0	
QC LANCETS MIS 28G	0	
QC LANCETS MIS 30G	0	
QC LANCING MIS DEVICE	0	
QUICKTEK LIQ SOLUTION	0	
QUINTET CONT SOL HGH/NORM	0	
RA E-ZJECT MIS 28G	0	
RA E-ZJECT MIS THIN 26G	0	
RA E-ZJECT MIS THIN 28G	0	
RA E-ZJECT MIS ULT THIN	0	
RAPID-SAFE MIS LANCING	0	
READYLANCE MIS 21G	0	
READYLANCE MIS 23G	0	
READYLANCE MIS 26G	0	
READYLANCE MIS 28G	0	
READYLANCE MIS 30G	0	
REALITY MIS LANCETS	0	
REALITY TRIG MIS LANCETS	0	
REFUAH PLUS SOL CONTROL	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

189

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RELION KIT LANCING	0	
RELION LANCE MIS THIN 26G	0	
RELION LANCE MIS THIN 30G	0	
RELION LANC MIS DEVICE	0	
RELION MICRO MIS THIN 33G	0	
RELION ULTRA MIS THIN 30G	0	
RELION ULTRA MIS THIN PLS	0	
RIGHTEST ALT MIS ADAPTOR	0	
RIGHTEST LIQ HIGH CON	0	
RIGHTEST LIQ NORM CON	0	
RIGHTEST MIS GD500	0	
RIGHTEST MIS GL300	0	
SAFE-T-LANCE MIS 21G	0	
SAFE-T-LANCE MIS 25G	0	
SAFE-T-LANCE MIS HI FLOW	0	
SAFE-T-LANCE MIS LOW FLOW	0	
SAFE-T-LANCE MIS NOR FLOW	0	
SAFE-T-PRO MIS LANCETS	0	
SAFE-T-PRO MIS PLUS	0	
SAFETY 21G MIS LANCETS	0	
SAFETY 23G MIS LANCETS	0	
SAFETY 28G MIS LANCETS	0	
SAFETY 30G MIS LANCETS	0	
SAFETY MIS LANCETS	0	
SAPS HEALTH MIS TWIST	0	
SAPS TWIST MIS 30G	0	
SAPSCARE MIS TWIST	0	
SB LANCETS MIS THIN	0	
SB LANCETS MIS ULTR THN	0	
SELECT-LITE KIT DEV/LANC	0	
SELECT-LITE MIS LANC DEV	0	
SHOPKO LANC MIS DEVICE	0	
SIDE BUTTON MIS SAFETY	0	
SIMPLE DIAG MIS LANCING	0	
SINGLE-LET MIS 23G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

190

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SM LANCETS MIS 33G	0	
SM TRUEDRAW MIS LANC DEV	0	
SMART SENSE MIS LANC 21G	0	
SMART SENSE MIS LANC 26G	0	
SMART SENSE MIS LANC 30G	0	
SMART SENSE MIS LANC 33G	0	
SMARTEST MIS LANCETS	0	
SMARTEST SOL CONTROL	0	
SOFTCLIX MIS LANCETS	0	
SOLUS V2 MIS LANC 28G	0	
SOLUS V2 MIS LANC 30G	0	
SOLUS V2 MIS LANC DEV	0	
SOLUS V2 SOL HIGH	0	
SOLUS V2 SOL LOW	0	
STERILANCE MIS 1.8MM	0	
STERILANCE MIS TL 28G	0	
STERILANCE MIS TL 30G	0	
STERILANCE MIS TL 32G	0	
SUPER THIN MIS LANC 28G	0	
SUPER THIN MIS LANCETS	0	
SUPREME II LIQ HIGH/LOW	0	
SURE COMFORT MIS LANC 18G	0	
SURE COMFORT MIS LANC 21G	0	
SURE COMFORT MIS LANC 23G	0	
SURE COMFORT MIS LANC 30G	0	
SURE COMFORT MIS LANC PEN	0	
SURE COMFORT MIS LANCETS	0	
SURE-LANCE MIS 26G	0	
SURE-LANCE MIS LANCETS	0	
SURE-PEN MIS	0	
SURE-TOUCH MIS UNV LANC	0	
SUREFLEX MIS LANCETS	0	
SURELITE MIS LANCETS	0	
SURESTEP GLU SOL	0	
SURESTEP GLU SOL HIGH/LOW	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

191

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SURESTEP PRO TES HIGH CON	0	
SURESTEP PRO TES LOW CON	0	
SURESTEP PRO TES NORM CON	0	
SURESTEP SOL CONTROL	0	
TAI DOC SOL NORM CON	0	
TECHLITE AST MIS LANCETS	0	
TECHLITE MIS LANC 30G	0	
TECHLITE MIS LANCETS	0	
TGT LANCET MIS 26G	0	
TGT LANCET MIS 30G	0	
TGT LANCET MIS 33G	0	
TGT LANCING MIS DEVICE	0	
THIN LANCETS MIS	0	
THIN LANCETS MIS 26G	0	
THIN LANCETS MIS 30G	0	
THINLETS GP MIS 26G	0	
TOPCARE MIS LANC 33G	0	
TRAVEL LANCE MIS 30G	0	
TRAVEL LANCE MIS ADV 28G	0	
TRUE METRIX SOL LEVEL 1	0	
TRUE METRIX SOL LEVEL 2	0	
TRUE METRIX SOL LEVEL 3	0	
TRUECONTROL LIQ LEVEL 0	0	
TRUECONTROL LIQ LEVEL 1	0	
TRUEDRAW MIS LANC DEV	0	
TRUPLUS LANC MIS 26G	0	
TRUPLUS LANC MIS 28G	0	
TRUPLUS LANC MIS 30G	0	
TRUPLUS LANC MIS 33G	0	
TWIST LANCET MIS 30G MULT	0	
ULTI-LANCE MIS CLR TIP	0	
ULTILET MIS 26G	0	
ULTILET MIS 28G	0	
ULTILET MIS 30G	0	
ULTILET MIS 33G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

192

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ULTILET MIS LANCETS	0	
ULTILET MIS SAFETY	0	
ULTILET SAFE MIS 21G	0	
ULTRA THIN MIS 28G	0	
ULTRA THIN MIS 30G	0	
ULTRA THIN MIS 31G	0	
ULTRA THIN MIS 33G	0	
ULTRA THIN MIS LAN 31G	0	
ULTRA THIN MIS LANC 28G	0	
ULTRA THIN MIS LANC 30G	0	
ULTRA THIN MIS LANCETS	0	
UNILET CMFR MIS TCH 28G	0	
UNILET CMFR MIS TCH 30G	0	
UNILET EX II MIS 28G	0	
UNILET EXCEL MIS 23G	0	
UNILET G.P MIS SUPR 23G	0	
UNILET G.P. MIS 21G	0	
UNILET GP 28 MIS ULT THIN	0	
UNILET LANC MIS 33G	0	
UNILET LANCE MIS 21G	0	
UNILET LANCE MIS 28G	0	
UNILET LANCE MIS 33G	0	
UNILET LANCT MIS 28G	0	
UNILET LANCT MIS 30G	0	
UNILET LANCT MIS 33G	0	
UNILET MICRO MIS 33G	0	
UNILET MIS 21G	0	
UNILET SUPER MIS 23G	0	
UNILET SUPER MIS G.P. 23G	0	
UNISTIK 1 MIS 2.4MM	0	
UNISTIK 1 MIS 3.0MM	0	
UNISTIK 2 MIS	0	
UNISTIK 2 MIS 1.8MM	0	
UNISTIK 2 MIS 2.4MM	0	
UNISTIK 2 MIS COMFORT	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

193

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
UNISTIK 2 MIS EXTRA	0	
UNISTIK 2 MIS NEONATAL	0	
UNISTIK 2 MIS NORMAL	0	
UNISTIK 2 MIS SUPER	0	
UNISTIK 3 MIS 1.8MM	0	
UNISTIK 3 MIS COMFORT	0	
UNISTIK 3 MIS EXTRA	0	
UNISTIK 3 MIS GENT 30G	0	
UNISTIK 3 MIS NEONATAL	0	
UNISTIK 3 MIS NORMAL	0	
UNISTIK 3 MIS XTR 21G	0	
UNISTIK CZT MIS COMFORT	0	
UNISTIK CZT MIS NORMAL	0	
UNISTIK II MIS LANCETS	0	
UNISTIK PRO MIS LANC 21G	0	
UNISTIK PRO MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 30G	0	
UNISTIK TOUC MIS LANC 21G	0	
UNISTIK TOUC MIS LANC 23G	0	
UNISTIK TOUC MIS LANC 28G	0	
UNISTIK TOUC MIS LANC 30G	0	
UNITSTIK PRO MIS LANC 25G	0	
UNIVERSAL 1 MIS 33G	0	
UNIVERSAL 1 MIS LANC 26G	0	
UNIVERSAL 1 MIS LANC 30G	0	
V-GO 20 KIT	0	PA, QL (30 pumps per month)
V-GO 30 KIT	0	QL (30 pumps per month)
V-GO 40 KIT	0	QL (30 pumps per month)
VANTAGE LANC MIS DEVICE	0	
VERASENS LIQ LEVEL 1	0	
VERIFINE MIS UNIV 30G	0	
VIVAGUARD LIQ CONTROL	0	
VIVAGUARD MIS 28G	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

194

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VIVAGUARD MIS 30G	0	
VIVAGUARD MIS LANCING	0	
MISC. DEVICES		
ALCOH-GLOVE PAD CONTOURE	0	
ALCOHOL PAD	0	
ALCOHOL PAD 70%	0	
ALCOHOL PAD PREP	0	
ALCOHOL PAD SWABSTIC	0	
ALCOHOL PREP PAD	0	
ALCOHOL PREP PAD 70%	0	
ALCOHOL PREP PAD MED 70%	0	
ALCOHOL PREP PAD PADS 70%	0	
ALCOHOL SWAB PAD	0	
ALCOHOL SWAB PAD 70%	0	
ALCOHOL SWAB PAD EX-THICK	0	
ALCOHOL WIPE PAD	0	
APLICARE ALC PAD SWABSTIC	0	
BD SWAB BFLY PAD SNGL USE	0	
CARETOUCH PAD ALCOHOL	0	
CURITY PREP PAD ALCOHOL	0	
CURITY SWABS PAD ALCOHOL	0	
EASY COMFORT PAD ALCOHOL	0	
FIFTY50 PREP PAD PADS	0	
GLOBAL PREP PAD PADS	0	
GNP ALCOHOL PAD SWABS	0	
HM STERILE PAD ALCHOL	0	
INCONTROL PAD ALCOHOL	0	
PREP PADS PAD	0	
PRO COMFORT PAD ALCOHOL	0	
PURE COMFORT PAD	0	
QC ALCOHOL PAD SWABS	0	
REALITY SWAB PAD	0	
SAPS CARE PAD ALCOHOL	0	
SAPS HEALTH PAD ALCOHOL	0	
SB ALCOHOL PAD PREP	0	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

195

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SM ALCOHOL PAD PREP	0	
ULTICARE PAD ALCOHOL	0	
ULTILET PAD ALCOHOL	0	
PARENTERAL THERAPY SUPPLIES		
BD U-500 MIS 31GX6MM	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
CEQR SIMPL KIT PATCH 2U	0	
INPEN 100EL MIS BLUE-HUM	0	
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS FLOW-VU	3	
AERCHMBR PLS MIS LRG MASK	3	
AERCHMBR PLS MIS MED MASK	3	
AERCHMBR PLS MIS SM MASK	3	
AERCHMBR Z- MIS STAT PLS	3	
AEROCHAMBER KIT ACTION	3	
AEROCHAMBER MIS CHAMBER	3	
AEROCHAMBER MIS FLOSIGNA	3	
AEROCHAMBER MIS MV	3	
AEROCHAMBER MIS PLUS	3	
AEROVENT MIS PLUS	3	
AIRZONE PEAK MIS FLOW MTR	3	
ASSESS METER MIS FULL	3	
ASSESS METER MIS LOW	3	
BREATHE EASE MIS LG MASK	3	
BREATHE EASE MIS MED MASK	3	
BREATHE EASE MIS METER	3	
BREATHE EASE MIS SM MASK	3	
COMPACT SPAC MIS CHAMBER	3	
COMPACT SPAC MIS LG MASK	3	
COMPACT SPAC MIS MD MASK	3	
COMPACT SPAC MIS SM MASK	3	
EASIVENT MIS	3	
EASIVENT MIS MASK LG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

196

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EASIVENT MIS MASK MED	3	
EASIVENT MIS MASK SM	3	
FLEXICHAMBER MIS	3	
FLEXICHAMBER MIS MASK LRG	3	
FLEXICHAMBER MIS MASK SM	3	
HOLD CHAMBER MIS ADLT LG	3	
HOLD CHAMBER MIS MEDIUM	3	
HOLD CHAMBER MIS SMALL	3	
INSPIRACHAMB MIS LARGE	3	
INSPIRACHAMB MIS MEDIUM	3	
INSPIRACHAMB MIS MOUTHPC	3	
INSPIRACHAMB MIS SMALL	3	
INSPIREASE MIS DD SYST	3	
INSPIREASE MIS RES BAG	3	
LUNG PERFM MIS METER	3	
MICROCHAMBER MIS	3	
MICROLIFE MIS PEAK FLO	3	
MINI WRIGHT MIS PFM	3	
MINI WRIGHT MIS PFM LOW	3	
OPTICHAMBER MIS DIA MD	3	
OPTICHAMBER MIS DIA SM	3	
OPTICHAMBER MIS DIAMOND	3	
PEAK A-I-R MIS FLW METR	3	
PEAK AIR FLO MIS ADLT/PED	3	
PEAK FLOW MIS METER	3	
PEAK FLW MTR MIS ADULT	3	
PEAK FLW MTR MIS CHILD	3	
PEAK FLW MTR MIS UNIVERSL	3	
PIKO 1 MIS ELECTRON	3	
POCKET CHAMB MIS	3	
POCKET PEAK MIS METER	3	
POCKET SPACE MIS	3	
POCKETPEAK MIS MTR LOW	3	
PROCARE MIS ADULT	3	
PROCARE MIS CHILD	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

197

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RITEFLO MIS	3	
SPACE CHAMBR MIS ANTI-STA	3	
SPACE CHAMBR MIS LARGE	3	
SPACE CHAMBR MIS MEDIUM	3	
SPACE CHAMBR MIS SMALL	3	
SPACER CHAMB MIS ADULT	3	
SPACER CHAMB MIS CHILD	3	
SPACER CHAMB MIS INFANT	3	
TRUZONE PEAK MIS FLOW MTR	3	

MIGRAINE PRODUCTS**CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG**

AJOVY INJ 225/1.5	2	ST, QL (3 auto-injectors every 75 days)
AJOVY INJ 225/1.5	2	ST, QL (3 syringes every 75 days)
EMGALITY INJ 100MG/ML	2	ST, QL (3 syringes every 25 days)
EMGALITY INJ 120MG/ML	2	ST, QL (2 pens every 25 days); Loading Dose: 2 injectors per month; Maintenance Dose: 1 injector per month
EMGALITY INJ 120MG/ML	2	ST, QL (2 syringes every 25 days); Loading Dose: 2 syringes per month; Maintenance Dose: 1 syringe per month
NURTEC TAB 75MG ODT	2	QL (16 tabs every 25 days)
QULIPTA TAB 10MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 30MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 60MG	2	ST, QL (30 tabs every 25 days)
UBRELVY TAB 50MG	2	PA, QL (16 ea every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

198

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
UBRELVY TAB 100MG	2	PA, QL (16 ea every 25 days)
MIGRAINE PRODUCTS		
ERGOMAR SUB 2MG	3	
TRUDHESA AER 0.725MG	3	
SEROTONIN AGONISTS		
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 30 days)
AMERGE TAB 1MG	3	QL (12 tabs every 30 days)
AMERGE TAB 2.5MG	3	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
FROVA TAB 2.5MG	3	QL (30 tabs every 30 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
IMITREX INJ 4MG/0.5	3	QL (12 injections every 30 days)
IMITREX INJ 4MG/0.5	3	QL (36 injections every 30 days)
IMITREX INJ 6MG/0.5	3	QL (12 injections every 30 days)
IMITREX SPR 5MG/ACT	3	QL (30 inhalers every 30 days)
IMITREX SPR 20MG/ACT	3	QL (12 inhalers every 30 days)
IMITREX TAB 25MG	3	QL (12 tabs every 30 days)
IMITREX TAB 50MG	3	QL (12 tabs every 30 days)
IMITREX TAB 100MG	3	QL (12 tabs every 30 days)
<i>naratriptan hcl tab 1 mg (base equiv)</i>	1	QL (12 tabs every 30 days)
<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	1	QL (12 tabs every 30 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

199

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ONZETRA XSAI MIS 11MG	3	QL (16 nosepieces every 25 days)
RELPAK TAB 20MG	3	QL (12 tabs every 30 days)
RELPAK TAB 40MG	3	QL (12 tabs every 30 days)
REYVOW TAB 50MG	3	ST, QL (4 tabs every 30 days)
REYVOW TAB 100MG	3	ST, QL (8 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>sumatriptan nasal spray 5 mg/act</i>	1	QL (30 inhalers every 30 days)
<i>sumatriptan nasal spray 20 mg/act</i>	1	QL (12 inhalers every 30 days)
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	1	QL (36 injections every 30 days)
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate tab 25 mg</i>	1	QL (12 tabs every 30 days)
<i>sumatriptan succinate tab 50 mg</i>	1	QL (12 tabs every 30 days)
<i>sumatriptan succinate tab 100 mg</i>	1	QL (12 tabs every 30 days)
ZEMBRACE SYM INJ 3/0.5ML	3	QL (24 injections every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

200

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	1	QL (12 inhalers every 30 days)
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	1	QL (12 bottles every 30 days)
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan orally disintegrating tab 5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan tab 2.5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan tab 5 mg</i>	1	QL (12 tabs every 30 days)
ZOMIG SPR 2.5MG	3	QL (12 inhalers every 30 days)
ZOMIG SPR 5MG	3	QL (12 bottles every 30 days)
ZOMIG TAB 2.5MG	3	QL (12 tabs every 30 days)
ZOMIG TAB 5MG	3	QL (12 tabs every 30 days)
ZOMIG ZMT TAB 2.5 MG	3	QL (12 tabs every 30 days)
ZOMIG ZMT TAB 5MG ODT	3	QL (12 tabs every 30 days)

MINERALS & ELECTROLYTES**FLUORIDE**

FLUORABON DRO	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride soln 0.25 mg/drop f (from 0.55 mg/drop naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride soln 0.125 mg/drop f (0.275 mg/drop naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply

POTASSIUM

K-TAB TAB 8MEQ CR	3	
K-TAB TAB 10MEQ CR	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

201

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
K-TAB TAB 20MEQ	3	
<i>potassium chloride cap er 8 meq</i>	1	
<i>potassium chloride cap er 10 meq</i>	1	
<i>potassium chloride microencapsulated crys er tab 10 meq</i>	1	
<i>potassium chloride microencapsulated crys er tab 15 meq</i>	1	
<i>potassium chloride microencapsulated crys er tab 20 meq</i>	1	
<i>potassium chloride oral soln 10% (20 meq/15ml)</i>	1	
<i>potassium chloride oral soln 20% (40 meq/15ml)</i>	1	
<i>potassium chloride powder packet 20 meq</i>	1	
<i>potassium chloride tab er 8 meq (600 mg)</i>	1	
<i>potassium chloride tab er 10 meq</i>	1	
<i>potassium chloride tab er 20 meq (1500 mg)</i>	1	
POTASSIUM POW CHLORIDE	3	

MISCELLANEOUS THERAPEUTIC CLASSES**CHELATING AGENTS**

DEPEN TITRA TAB 250MG	5	PA
<i>penicillamine cap 250 mg</i>	1	
<i>penicillamine tab 250 mg</i>	1	
<i>trientine hcl cap 250 mg</i>	1	

IMMUNOMODULATORS

<i>lenalidomide cap 5 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 10 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 15 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 25 mg</i>	0	PA, QL (21 CAPSULES PER 28 DAYS)
REVLIMID CAP 2.5MG	0	PA, QL (28 CAPSULES PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

202

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
REVLIMID CAP 5MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 10MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 15MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 20MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
REVLIMID CAP 25MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
THALOMID CAP 50MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
THALOMID CAP 100MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
THALOMID CAP 150MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
THALOMID CAP 200MG	0	PA, QL (56 CAPSULES PER 28 DAYS)

IMMUNOSUPPRESSIVE AGENTS

ASTAGRAF XL CAP 0.5MG	3	PA
ASTAGRAF XL CAP 1MG	3	PA
ASTAGRAF XL CAP 5MG	3	PA
azathioprine tab 50 mg	1	
azathioprine tab 75 mg	3	
azathioprine tab 100 mg	3	
CELLCEPT CAP 250MG	3	PA
CELLCEPT IV INJ 500MG	3	PA
CELLCEPT SUS 200MG/ML	3	PA
CELLCEPT TAB 500MG	3	PA
cyclosporine cap 25 mg	1	
cyclosporine cap 100 mg	1	
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	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

203

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ENSPRYNG INJ	4	PA, QL (1 PFS PER 28 DAYS); LOADING DOSE: 3 PFS PER 29 DAYS
ENVARUSUS XR TAB 0.75MG	3	PA
ENVARUSUS XR TAB 1MG	3	PA
ENVARUSUS XR TAB 4MG	3	PA
<i>everolimus tab 0.5 mg</i>	1	
<i>everolimus tab 0.25 mg</i>	1	
<i>everolimus tab 0.75 mg</i>	1	
IMURAN TAB 50MG	3	
<i>mycophenolate mofetil cap 250 mg</i>	1	
<i>mycophenolate mofetil for oral susp 200 mg/ml</i>	1	
<i>mycophenolate mofetil tab 500 mg</i>	1	
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	1	
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	1	
MYFORTIC TAB 180MG	3	PA
MYFORTIC TAB 360MG	3	PA
NEORAL CAP 25MG	3	
NEORAL CAP 100MG	3	
NEORAL SOL 100MG/ML	3	
PROGRAF CAP 0.5MG	3	PA
PROGRAF CAP 1MG	3	PA
PROGRAF CAP 5MG	3	PA
PROGRAF GRA 0.2MG	3	PA
PROGRAF GRA 1MG	3	PA
RAPAMUNE SOL 1MG/ML	3	PA
RAPAMUNE TAB 0.5MG	3	PA
RAPAMUNE TAB 1MG	3	PA
RAPAMUNE TAB 2MG	3	PA
SANDIMMUNE CAP 25MG	3	
SANDIMMUNE CAP 100MG	3	
SANDIMMUNE SOL 100MG/ML	3	
<i>sirolimus oral soln 1 mg/ml</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

204

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sirolimus tab 0.5 mg</i>	1	
<i>sirolimus tab 1 mg</i>	1	
<i>sirolimus tab 2 mg</i>	1	
<i>tacrolimus cap 0.5 mg</i>	1	
<i>tacrolimus cap 1 mg</i>	1	
<i>tacrolimus cap 5 mg</i>	1	
ZORTRESS TAB 0.5MG	3	PA
ZORTRESS TAB 0.25MG	3	PA
ZORTRESS TAB 0.75MG	3	PA
ZORTRESS TAB 1MG	3	PA
POTASSIUM REMOVING AGENTS		
<i>sodium polystyrene sulfonate oral susp 15 gm/60ml</i>	1	
<i>sodium polystyrene sulfonate powder</i>	1	
VELTASSA POW 8.4GM	2	
VELTASSA POW 16.8GM	2	
VELTASSA POW 25.2GM	2	
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP 50MG	5	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	5	PA, QL (120 CAPSULES PER 30 DAYS)
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA INJ 200MG/ML	5	PA, QL (4 INJ PER 28 DAYS); LOADING DOSE: 8 SYR PER 28 DAYS
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
<i>lidocaine hcl laryngotracheal soln 4%</i>	1	
<i>lidocaine hcl viscous soln 2%</i>	1	
ANTI-INFECTIVES - THROAT		
<i>clotrimazole troche 10 mg</i>	1	QL (90 ea every 25 days)
<i>nystatin susp 100000 unit/ml</i>	1	
ORAVIG TAB 50MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

205

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTISEPTICS - MOUTH/THROAT		
<i>chlorhexidine gluconate soln 0.12%</i>	1	
PERIDEX SOL 0.12%	3	
DENTAL PRODUCTS		
NAFRINSE DLY SOL /NEUTRAL	3	
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
<i>sodium fluoride gel 1.1% (0.5% f)</i>	1	
STEROIDS - MOUTH/THROAT/DENTAL		
<i>triamcinolone acetonide dental paste 0.1%</i>	1	
THROAT PRODUCTS - MISC.		
<i>cevimeline hcl cap 30 mg</i>	1	
EVOXAC CAP 30MG	3	
ORAFATE PST 10%	3	
<i>pilocarpine hcl tab 5 mg</i>	1	
<i>pilocarpine hcl tab 7.5 mg</i>	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	3	
SALAGEN TAB 7.5MG	3	
MULTIVITAMINS		
PRENATAL VITAMINS		
<i>prenat w/o a w/fefum-methfol-fa-dha cap 27-0.6-0.4-300 mg</i>	1	
<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg</i>	1	
<i>prenatal vit w/ fe fum-methylfolate-fa tab 27-0.6-0.4 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa chew tab 29-1 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>	1	
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	1	
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

206

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>carisoprodol tab 350 mg</i>	1	QL (84 tabs every 25 days)
<i>chlorzoxazone tab 500 mg</i>	1	
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
LYVISPAH GRA 5MG	3	
LYVISPAH GRA 10MG	3	
LYVISPAH GRA 20MG	3	
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
SKELAXIN TAB 800MG	3	
SOMA TAB 250MG	3	QL (84 tabs every 25 days)
SOMA TAB 350MG	3	QL (84 tabs every 25 days)
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	1	
ZANAFLEX CAP 2MG	3	
ZANAFLEX CAP 4MG	3	
ZANAFLEX CAP 6MG	3	
ZANAFLEX TAB 4MG	3	
DIRECT MUSCLE RELAXANTS		
DANTRIUM CAP 25MG	3	
DANTRIUM CAP 50MG	3	
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
MUSCLE RELAXANT COMBINATIONS		
<i>carisoprodol w/ aspirin & codeine tab 200-325-16 mg</i>	1	QL (168 tabs every 25 days)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

207

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 package (23gm) per 25 days)
NASAL AGENTS - MISC.		
NOZIN NASAL MIS SANITIZE	0	
NASAL ANTIALLERGY		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	1	
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 package (30.5gm) per 25 days)
PATANASE SPR 0.6%	3	QL (1 package (30.5gm) per 25 days)
NASAL ANTICHOLINERGICS		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	
NASAL STEROIDS		
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	1	QL (3 packages (25mL each) per 25 days)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	1	QL (1 package (16gm) per 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	1	QL (2 packages (17gm each) per 25 days)
NASONEX SPR 50MCG/AC	3	QL (2 packages (17gm each) per 25 days)
XHANCE MIS 93MCG	3	PA, QL (2 packages (16mL each) per 25 days)
SYMPATHOMIMETIC DECONGESTANTS		
ADRENALIN SOL 1:1000	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

208

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NEUROMUSCULAR AGENTS		
ALS AGENTS		
RADICAVA ORS SUS 105/5ML	5	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RADICAVA ORS SUS STARTER	5	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RILUTEK TAB 50MG	3	
<i>riluzole tab 50 mg</i>	1	
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOL	5	PA, QL (2 BOTTLES (120 MG) PER 24 DAYS)
OPHTHALMIC AGENTS		
BETA-BLOCKERS - OPHTHALMIC		
<i>betaxolol hcl ophth soln 0.5%</i>	1	
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	
<i>carteolol hcl ophth soln 1%</i>	1	
COSOPT SOL 2-0.5%OP	3	
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	
<i>levobunolol hcl ophth soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	
<i>timolol maleate ophth soln 0.5%</i>	1	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	
<i>timolol maleate ophth soln 0.25%</i>	1	
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	
TIMOPTIC SOL 0.5% OP	3	
TIMOPTIC SOL 0.25% OP	3	
TIMOPTIC-XE SOL 0.5% OP	3	
TIMOPTIC-XE SOL 0.25% OP	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

209

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CYCLOPLEGIC MYDRIATICS		
ATROPINE SUL SOL 1% OP	3	
CYCLOGYL SOL 0.5% OP	3	
CYCLOGYL SOL 1% OP	3	
CYCLOGYL SOL 2% OP	3	
CYCLOMYDRIL SOL OP	3	
<i>cyclopentolate hcl ophth soln 0.5%</i>	1	
<i>cyclopentolate hcl ophth soln 1%</i>	1	
<i>cyclopentolate hcl ophth soln 2%</i>	1	
ISOPTO ATROP SOL 1% OP	3	
<i>phenylephrine hcl ophth soln 2.5%</i>	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
MIOTICS		
ISOPTO CARP SOL 1% OP	3	
ISOPTO CARP SOL 2% OP	3	
ISOPTO CARP SOL 4% OP	3	
PHOSPHOLINE SOL 0.125%OP	3	
<i>pilocarpine hcl ophth soln 1%</i>	1	
<i>pilocarpine hcl ophth soln 2%</i>	1	
<i>pilocarpine hcl ophth soln 4%</i>	1	
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
<i>brimonidine tartrate ophth soln 0.2%</i>	1	
<i>brimonidine tartrate ophth soln 0.15%</i>	1	
IOPIDINE SOL 1% OP	3	
SIMBRINZA SUS 1-0.2%	2	
OPHTHALMIC ANTI-INFECTIVES		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
BETADINE SOL 5% OP	3	
BLEPH-10 SOL 10% OP	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

210

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	1	
<i>erythromycin ophth oint 5 mg/gm</i>	1	
<i>gatifloxacin ophth soln 0.5%</i>	1	
<i>gentamicin sulfate ophth oint 0.3%</i>	1	
<i>gentamicin sulfate ophth soln 0.3%</i>	1	QL (4 mL every 25 days)
<i>levofloxacin ophth soln 0.5%</i>	1	
MITOSOL KIT 0.2MG	3	
MOXEZA SOL 0.5%	3	
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
NATACYN SUS 5% OP	3	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	1	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
OCUFLOX DRO 0.3% OP	3	
<i>ofloxacin ophth soln 0.3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
POLYTRIM SOL OP	3	
POVIDONE IOD SOL 5%	3	
<i>sulfacetamide sodium ophth oint 10%</i>	1	
<i>sulfacetamide sodium ophth soln 10%</i>	1	
<i>tobramycin ophth soln 0.3%</i>	1	
TOBREX OIN 0.3% OP	3	
TOBREX SOL 0.3% OP	3	
<i>trifluridine ophth soln 1%</i>	1	
VIGAMOX DRO 0.5%	3	
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP	1	PA; Tier 1 with DAW 9
RESTASIS MUL EMU 0.05% OP	2	PA
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5%	2	PA

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

211

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OPHTHALMIC LOCAL ANESTHETICS		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
<i>proparacaine hcl ophth soln 0.5%</i>	1	
<i>tetracaine hcl ophth soln 0.5%</i>	1	
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE SOL 20MCG/ML	5	PA, QL (16 CARTONS PER 56 DAYS - ONE TIME TREATMENT)
OPHTHALMIC STEROIDS		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
DUREZOL EMU 0.05%	3	
EYSUVIS DRO 0.25%	3	PA
<i>fluorometholone ophth susp 0.1%</i>	1	
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
MAXITROL OIN 0.1% OP	3	
MAXITROL SUS 0.1% OP	3	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	
<i>neomycin-polymyxin-hc ophth susp</i>	1	
PRED SOD PHO SOL 1% OP	3	
PRED-G S.O.P OIN OP	3	
PRED-G SUS OP	3	
<i>prednisolone acetate ophth susp 1%</i>	1	
PREDNISOLONE SUS 1%	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

212

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
OPHTHALMIC SURGICAL AIDS		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
OPHTHALMICS - MISC.		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ALOCRIAL SOL 2%	3	
ALOMIDE SOL 0.1% OP	3	
<i>azelastine hcl ophth soln 0.05%</i>	1	
<i>brinzolamide ophth susp 1%</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>cromolyn sodium ophth soln 4%</i>	1	
CYSTARAN SOL 0.44%	5	PA, QL (4 BOTTLES PER 28 DAYS)
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
TRUSOPT SOL 2% OP	3	
PROSTAGLANDINS - OPHTHALMIC		
<i>bimatoprost ophth soln 0.03%</i>	1	
<i>latanoprost ophth soln 0.005%</i>	1	
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	
XALATAN SOL 0.005%	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

213

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZIOPTAN DRO 0.0015%	3	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln 2%	1	
OTIC ANTI-INFECTIVES		
CETRAXAL SOL 0.2%	3	
ciprofloxacin hcl otic soln 0.2% (base equivalent)	1	
ofloxacin otic soln 0.3%	1	
OTIC COMBINATIONS		
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
CORTISPORIN SUS -TC OTIC	3	
neomycin-polymyxin-hc otic soln 1%	1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1	
OTIC STEROIDS		
DERMOTIC OIL 0.01%	3	
fluocinolone acetonide (otic) oil 0.01%	1	
hydrocortisone w/ acetic acid otic soln 1-2%	1	
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
CERVIDIL VAG MIS 10MG INS	3	
PREPIDIL GEL 0.5MG/3G	3	
PROSTIN E2 SUP 20MG	3	
OXYTOCICS		
methylergonovine maleate tab 0.2 mg	1	PA, QL (120 tabs every 30 days)
PENICILLINS		
AMINOPENICILLINS		
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	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

214

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) tab 500 mg</i>	1	
<i>amoxicillin (trihydrate) tab 875 mg</i>	1	
<i>ampicillin cap 500 mg</i>	1	
NATURAL PENICILLINS		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	
PENICILLIN COMBINATIONS		
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML	3	
AUGMENTIN SUS 250/5ML	3	
AUGMENTIN SUS ES-600	3	
AUGMENTIN TAB 500MG	3	
PENICILLINASE-RESISTANT PENICILLINS		
<i>dicloxacillin sodium cap 250 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

215

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dicloxacillin sodium cap 500 mg</i>	1	
PROGESTINS		
PROGESTINS		
AYGESTIN TAB 5MG	3	
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	
<i>medroxyprogesterone acetate tab 5 mg</i>	1	
<i>medroxyprogesterone acetate tab 10 mg</i>	1	
<i>megestrol acetate susp 625 mg/5ml</i>	1	
<i>norethindrone acetate tab 5 mg</i>	1	
<i>progesterone cap 100 mg</i>	1	
<i>progesterone cap 200 mg</i>	1	
<i>progesterone im in oil 50 mg/ml</i>	1	
PROVERA TAB 2.5MG	3	
PROVERA TAB 5MG	3	
PROVERA TAB 10MG	3	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	
<i>disulfiram tab 250 mg</i>	1	
<i>disulfiram tab 500 mg</i>	1	
ANTI-CATAPLECTIC AGENTS		
LUMRYZ PAK 6GM	4	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PAK 7.5GM	4	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PAK 9GM	4	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PKG 4.5GM	4	PA, QL (30 PACKETS PER 30 DAYS)
XYWAV SOL 0.5GM/ML	4	PA, QL (540 ML (270 GRAMS) PER 30 DAYS)
ANTIDEMENTIA AGENTS		
ARICEPT TAB 5MG	3	
ARICEPT TAB 10MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

216

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ARICEPT TAB 23MG	3	
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	1	
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 5 mg</i>	1	
<i>donepezil hydrochloride tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 23 mg</i>	1	
EXELON DIS 4.6MG/24	3	
EXELON DIS 9.5MG/24	3	
EXELON DIS 13.3/24	3	
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	
<i>galantamine hydrobromide tab 4 mg</i>	1	
<i>galantamine hydrobromide tab 8 mg</i>	1	
<i>galantamine hydrobromide tab 12 mg</i>	1	
<i>memantine hcl cap er 24hr 7 mg</i>	1	
<i>memantine hcl cap er 24hr 14 mg</i>	1	
<i>memantine hcl cap er 24hr 21 mg</i>	1	
<i>memantine hcl cap er 24hr 28 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl tab 5 mg</i>	1	
<i>memantine hcl tab 10 mg</i>	1	
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
NAMZARIC CAP	2	
NAMZARIC CAP 7-10MG	2	
NAMZARIC CAP 14-10MG	2	
NAMZARIC CAP 21-10MG	2	
NAMZARIC CAP 28-10MG	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

217

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RAZADYNE ER CAP 8MG	3	
RAZADYNE ER CAP 16MG	3	
RAZADYNE ER CAP 24MG	3	
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	1	
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	
COMBINATION PSYCHOTHERAPEUTICS		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-50 mg</i>	1	
SYMBYAX CAP 3-25MG	3	
SYMBYAX CAP 6-25MG	3	
SYMBYAX CAP 6-50MG	3	
SYMBYAX CAP 12-50MG	3	
FIBROMYALGIA AGENTS		
SAVELLA MIS TITR PAK	3	
SAVELLA TAB 12.5MG	3	
SAVELLA TAB 25MG	3	
SAVELLA TAB 50MG	3	
SAVELLA TAB 100MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

218

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG	4	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO TAB 9MG	4	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO TAB 12MG	4	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 6MG	4	PA, QL (90 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 12MG	4	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 24MG	4	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO XR TAB TITR KIT	4	PA, QL (42 TABLETS PER 28 DAYS)
INGREZZA CAP 40-80MG	4	PA
INGREZZA CAP 40MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 60MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 80MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
tetrabenazine tab 12.5 mg	1	PA, QL (120 TABLETS PER 30 DAYS)
tetrabenazine tab 25 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
MULTIPLE SCLEROSIS AGENTS		
AMPYRA TAB 10MG	5	PA, QL (60 TABLETS PER 30 DAYS)
AVONEX PEN KIT 30MCG	4	PA, QL (4 PENS PER 28 DAYS)
AVONEX PREFL KIT 30MCG	4	PA, QL (4 SYRINGES PER 28 DAYS)
BETASERON INJ 0.3MG	4	PA, QL (14 KITS PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

219

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COPAXONE INJ 40MG/ML	4	PA, QL (12 SYRINGES PER 28 DAYS)
<i>dalfampridine tab er 12hr 10 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	PA, QL (14 CAPSULES PER 28 DAYS)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 20 mg/ml</i>	1	PA, QL (30 SYRINGES PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 40 mg/ml</i>	1	PA, QL (12 SYRINGES PER 28 DAYS)
KESIMPTA INJ 20/.4ML	4	PA, QL (1 PENS PER 28 DAYS); LOADING DOSE: 3 PENS PER 15 DAYS
MAVENCLAD PAK 10MG(4)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(5)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(6)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(7)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(8)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(9)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(10)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAYZENT PAK STARTER	4	PA, QL (7 TABLETS PER 4 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

220

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MAYZENT TAB 0.25MG	4	PA, QL (12 TABLETS PER 5 DAYS)
MAYZENT TAB 1MG	4	PA, QL (30 TABLETS PER 30 DAYS)
MAYZENT TAB 2MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PLEGRIDY INJ	5	PA, QL (1 CARTON PER 28 DAYS)
PLEGRIDY INJ	5	PA, QL (1 KIT PER 28 DAYS)
PLEGRIDY INJ PEN	5	PA, QL (2 PENS PER 28 DAYS)
PLEGRIDY INJ STARTER	5	PA, QL (1 PACK PER 28 DAYS)
PLEGRIDY PEN INJ STARTER	5	PA, QL (1 PACK PER 28 DAYS)
REBIF INJ 22/0.5	4	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF INJ 44/0.5	4	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF REBIDO INJ 22/0.5	4	PA, QL (12 SYR PER 28 DAYS)
REBIF REBIDO INJ 44/0.5	4	PA, QL (12 SYR PER 28 DAYS)
REBIF REBIDO INJ TITRATN	4	PA, QL (12 INJ PER 28 DAYS)
REBIF TITRTN INJ PACK	4	PA, QL (12 SYRINGES PER 28 DAYS)
<i>teriflunomide tab 7 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>teriflunomide tab 14 mg</i>	1	PA, QL (30 tabs every 30 days)
VUMERITY CAP 231MG	4	PA, QL (120 CAPSULES PER 30 DAYS)
ZEPOSIA 7DAY CAP STR PACK	4	PA, QL (7 TABLETS PER 7 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

221

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZEPOSIA CAP .92MG	4	PA, QL (30 TABLETS PER 30 DAYS)
ZEPOSIA CAP STR KIT	4	PA, QL (1 Starter Kit per 28 days)
ZEPOSIA CAP STR KIT	4	PA, QL (37 TABLETS PER 37 DAYS)
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
GRALISE TAB 300MG	2	QL (150 tabs every 25 days)
GRALISE TAB 450MG	2	QL (90 tablets per 25 days)
GRALISE TAB 600MG	2	QL (90 tabs every 25 days)
GRALISE TAB 750MG	2	QL (60 tablets per 25 days)
GRALISE TAB 900MG	2	QL (60 tablets per 25 days)
<i>pregabalin tab er 24hr 82.5 mg</i>	1	QL (60 tabs every 30 days)
<i>pregabalin tab er 24hr 165 mg</i>	1	QL (60 tabs every 30 days)
<i>pregabalin tab er 24hr 330 mg</i>	1	QL (60 tabs every 30 days)
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
<i>ergoloid mesylates tab 1 mg</i>	1	
<i>pimozide tab 1 mg</i>	1	
<i>pimozide tab 2 mg</i>	1	
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	0	\$0 limited to 2 treatment cycles/year
CHANTIX PAK 1MG	0	
CHANTIX TAB 0.5& 1MG	0	
CHANTIX TAB 0.5MG	0	
CHANTIX TAB 1MG	0	
NICODERM CQ DIS 7MG/24HR	3	OTC; \$0 limited to 2 treatment cycles/year
NICODERM CQ DIS 14MG/24H	3	OTC; \$0 limited to 2 treatment cycles/year
NICODERM CQ DIS 21MG/24H	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG	3	OTC; \$0 limited to 2 treatment cycles/year

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

222

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NICORETTE GUM 2MG CINN	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG MINT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG ORIG	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MGFRUIT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG CINN	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG MINT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG ORIG	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MGFRUIT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE LOZ 2MG MINT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE LOZ 4MG MINT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 2MG MINT	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 2MG ORIG	3	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 4MG ORIG	3	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

223

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nicotine td patch 24hr 7 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
NICOTROL INH	0	
NICOTROL NS SPR 10MG/ML	0	
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ 284/1.5	4	PA, QL (4 PFS PER 28 DAYS)
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP 7.5MG	3	
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
KALYDECO GRA 13.4MG	5	PA, QL (56 packets per 28 days)
KALYDECO PAK 25MG	5	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 50MG	5	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 75MG	5	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO TAB 150MG	5	PA, QL (1 CARTON (56 TABS) PER 28 DAYS)
ORKAMBI GRA 75-94MG	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 100-125	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 150-188	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI TAB 100-125	5	PA, QL (112 TABLETS PER 28 DAYS)
ORKAMBI TAB 200-125	5	PA, QL (112 TABLETS PER 28 DAYS)

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

224

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PULMOZYME SOL 1MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SYMDEKO TAB 50-75MG	5	PA, QL (56 TABLETS PER 28 DAYS)
SYMDEKO TAB 100-150	5	PA, QL (56 TABLETS PER 28 DAYS)
TRIKAFTA PAK 59.5MG	5	PA, QL (56 packets per 28 days)
TRIKAFTA PAK 75MG	5	PA, QL (56 packets per 28 days)
TRIKAFTA TAB	5	PA, QL (84 TABLETS PER 28 DAYS)
PULMONARY FIBROSIS AGENTS		
OFEV CAP 100MG	4	PA, QL (60 CAPSULES PER 30 DAYS)
OFEV CAP 150MG	4	PA, QL (60 CAPSULES PER 30 DAYS)
<i>pirfenidone tab 267 mg</i>	1	QL (270 TABLETS PER 30 DAYS)
<i>pirfenidone tab 801 mg</i>	1	QL (90 TABLETS PER 30 DAYS)
SULFONAMIDES		
SULFONAMIDES		
<i>sulfadiazine tab 500 mg</i>	3	
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB 150MG	3	
TETRACYCLINES		
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline hcl tab 300 mg</i>	1	
<i>doxycycline hyclate cap 50 mg</i>	1	
<i>doxycycline hyclate cap 100 mg</i>	1	
<i>doxycycline hyclate tab 20 mg</i>	1	
<i>doxycycline hyclate tab 100 mg</i>	1	
<i>doxycycline monohydrate cap 50 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

225

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline monohydrate cap 100 mg</i>	1	
<i>doxycycline monohydrate for susp 25 mg/5ml</i>	1	
<i>doxycycline monohydrate tab 50 mg</i>	1	
<i>doxycycline monohydrate tab 75 mg</i>	1	
<i>doxycycline monohydrate tab 100 mg</i>	1	
<i>doxycycline monohydrate tab 150 mg</i>	1	
<i>minocycline hcl cap 50 mg</i>	1	
<i>minocycline hcl cap 75 mg</i>	1	
<i>minocycline hcl cap 100 mg</i>	1	
<i>minocycline hcl tab 50 mg</i>	1	
<i>minocycline hcl tab 75 mg</i>	1	
<i>minocycline hcl tab 100 mg</i>	1	
<i>tetracycline hcl cap 250 mg</i>	1	QL (120 caps every 25 days)
<i>tetracycline hcl cap 500 mg</i>	1	QL (120 caps every 25 days)
VIBRAMYCIN CAP 100MG	3	
VIBRAMYCIN SUS 25MG/5ML	3	
VIBRAMYCIN SYP 50MG/5ML	3	

THYROID AGENTS**ANTITHYROID AGENTS**

<i>methimazole tab 5 mg</i>	1	
<i>methimazole tab 10 mg</i>	1	
<i>propylthiouracil tab 50 mg</i>	1	
TAPAZOLE TAB 5MG	3	
TAPAZOLE TAB 10MG	3	

THYROID HORMONES

ARMOUR THYRO TAB 15MG	3	
ARMOUR THYRO TAB 30MG	3	
ARMOUR THYRO TAB 60MG	3	
ARMOUR THYRO TAB 90MG	3	
ARMOUR THYRO TAB 120MG	3	
ARMOUR THYRO TAB 180MG	3	
ARMOUR THYRO TAB 240MG	3	
ARMOUR THYRO TAB 300MG	3	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

226

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>levothyroxine sodium tab 25 mcg</i>	1	
<i>levothyroxine sodium tab 50 mcg</i>	1	
<i>levothyroxine sodium tab 75 mcg</i>	1	
<i>levothyroxine sodium tab 88 mcg</i>	1	
<i>levothyroxine sodium tab 100 mcg</i>	1	
<i>levothyroxine sodium tab 112 mcg</i>	1	
<i>levothyroxine sodium tab 125 mcg</i>	1	
<i>levothyroxine sodium tab 137 mcg</i>	1	
<i>levothyroxine sodium tab 150 mcg</i>	1	
<i>levothyroxine sodium tab 175 mcg</i>	1	
<i>levothyroxine sodium tab 200 mcg</i>	1	
<i>levothyroxine sodium tab 300 mcg</i>	1	
<i>liothyronine sodium tab 5 mcg</i>	1	
<i>liothyronine sodium tab 25 mcg</i>	1	
<i>liothyronine sodium tab 50 mcg</i>	1	
NP THYROID TAB 15MG	3	
NP THYROID TAB 30MG	3	
NP THYROID TAB 60MG	3	
NP THYROID TAB 90MG	3	
NP THYROID TAB 120MG	3	
SYNTHROID TAB 25MCG	3	
SYNTHROID TAB 50MCG	3	
SYNTHROID TAB 75MCG	3	
SYNTHROID TAB 88MCG	3	
SYNTHROID TAB 100MCG	3	
SYNTHROID TAB 112MCG	3	
SYNTHROID TAB 125MCG	3	
SYNTHROID TAB 137MCG	3	
SYNTHROID TAB 150MCG	3	
SYNTHROID TAB 175MCG	3	
SYNTHROID TAB 200MCG	3	
SYNTHROID TAB 300MCG	3	

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS**ANTISPASMODICS**

ANASPAZ TAB 0.125MG	3	
---------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

227

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BELLA/OPIUM SUP 16.2-30	3	
BELLA/OPIUM SUP 16.2-60	3	
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	
CUVPOSA SOL 1MG/5ML	3	
<i>dicyclomine hcl cap 10 mg</i>	1	
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	1	
<i>dicyclomine hcl tab 20 mg</i>	1	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	1	
<i>glycopyrrolate tab 1 mg</i>	1	
<i>glycopyrrolate tab 2 mg</i>	1	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	
LEVBIID TAB 0.375 ER	3	
LEVSIN TAB 0.125MG	3	
LEVSIN/SL SUB 0.125MG	3	
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
SYMAX DUOTAB TAB	3	
H-2 ANTAGONISTS		
<i>cimetidine hcl soln 300 mg/5ml</i>	1	
<i>cimetidine tab 300 mg</i>	1	
<i>cimetidine tab 400 mg</i>	1	
<i>cimetidine tab 800 mg</i>	1	
<i>famotidine for susp 40 mg/5ml</i>	1	
<i>famotidine tab 40 mg</i>	1	
<i>nizatidine cap 150 mg</i>	1	
<i>nizatidine cap 300 mg</i>	1	
<i>nizatidine oral soln 15 mg/ml</i>	1	
PEPCID TAB 40MG	3	
MISC. ANTI-ULCER		
<i>sucralfate tab 1 gm</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

228

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PROTON PUMP INHIBITORS		
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year)
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	1	QL (90 packets every year)
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	1	QL (90 packets every year)
<i>lansoprazole cap delayed release 15 mg</i>	1	QL (90 caps every year)
<i>lansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 10 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 20 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 40 mg</i>	1	QL (90 caps every year)
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1	QL (90 tabs every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 ea every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 tabs every year)
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	1	QL (90 vials every year)
PROTONIX INJ 40MG	3	QL (90 vials every year)
RABEPRAZOLE CAP 10MG DR	3	QL (90 caps every year)
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year)
ULCER DRUGS - PROSTAGLANDINS		
CYTOTEC TAB 100MCG	3	
CYTOTEC TAB 200MCG	3	
<i>misoprostol tab 100 mcg</i>	1	\$0 copay based on your plan/benefit
<i>misoprostol tab 200 mcg</i>	1	\$0 copay based on your plan/benefit
ULCER THERAPY COMBINATIONS		
<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

229

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
OMECLAMOX- MIS PAK	3	
PYLERA CAP	3	
TALICIA CAP	2	
VOQUEZNA PAK DUAL PAK	3	
VOQUEZNA PAK TRIP PK	3	

URINARY ANTISPASMODICS**URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)**

<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	1	
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	1	
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride tab 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 10 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 15 mg</i>	1	
<i>solifenacin succinate tab 5 mg</i>	1	
<i>solifenacin succinate tab 10 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 2 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 4 mg</i>	1	
<i>tolterodine tartrate tab 1 mg</i>	1	
<i>tolterodine tartrate tab 2 mg</i>	1	
<i>trospium chloride cap er 24hr 60 mg</i>	1	
<i>trospium chloride tab 20 mg</i>	1	
VESICARE LS SUS 5MG/5ML	3	

URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS

GEMTESA TAB 75MG	2	
------------------	---	--

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

230

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
<i>flavoxate hcl tab 100 mg</i>	1	
VAGINAL AND RELATED PRODUCTS		
SPERMICIDES		
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 GEL CONTRACE	0	OTC
VCF VAGINAL MIS CONTRACP	0	OTC
VAGINAL ANTI-INFECTIVES		
CLEOCIN CRE 2% VAG	3	
CLEOCIN SUP 100MG	3	
<i>clindamycin phosphate vaginal cream 2%</i>	1	
CLINDESSE CRE 2%	3	
GYNAZOLE-1 CRE 2%	3	
<i>metronidazole vaginal gel 0.75%</i>	1	
<i>miconazole nitrate vaginal suppos 200 mg</i>	1	
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
VANDAZOLE GEL 0.75%	1	
XACIATO GEL 2%	3	
VAGINAL ESTROGENS		
ESTRACE VAG CRE 0.01%	3	
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
IMVEXXY MAIN SUP 4MCG	2	
IMVEXXY MAIN SUP 10MCG	2	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

231

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
IMVEXXY STRT SUP 4MCG	2	
IMVEXXY STRT SUP 10MCG	2	
VAGIFEM TAB 10MCG	1	Tier 1 with DAW9
VAGINAL PROGESTINS		
ENDOMETRIN SUP 100MG	2	
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
ADRENALIN INJ 1MG/ML	3	QL (6 injections every 300 days)
AUVI-Q INJ 0.1MG	2	QL (6 injections every 300 days)
AUVI-Q INJ 0.3MG	2	QL (6 injections every 300 days)
AUVI-Q INJ 0.15MG	2	QL (6 injections every 300 days)
<i>epinephrine inj 1 mg/ml (1:1000)</i>	1	QL (6 injections every 300 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	QL (6 injections every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	QL (6 injections every 300 days)
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
<i>droxidopa cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)
<i>droxidopa cap 200 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
<i>droxidopa cap 300 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
VASOPRESSORS		
EPINEPHRINE INJ 0.2MG	3	
<i>midodrine hcl tab 2.5 mg</i>	1	
<i>midodrine hcl tab 5 mg</i>	1	
<i>midodrine hcl tab 10 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

232

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VITAMINS		
OIL SOLUBLE VITAMINS		
DRISDOL CAP 50000UNT	3	
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	
MEPHYTON TAB 5MG	3	
<i>phytonadione tab 5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - Step Therapy

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. 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 the Coverage tab.

Index

A	
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	106
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	106
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	106
<i>abacavir sulfate tab 300 mg (base equiv)</i>	106
ABILIFY MAIN INJ 300MG	105
ABILIFY MAIN INJ 400MG	105
<i>abiraterone acetate tab 250 mg</i>	87
<i>abiraterone acetate tab 500 mg</i>	87
ABSORICA CAP 10MG	132
ABSORICA CAP 20MG.....	132
ABSORICA CAP 25MG.....	132
ABSORICA CAP 30MG.....	132
ABSORICA CAP 35MG.....	132
ABSORICA CAP 40MG.....	132
<i>acamprosate calcium tab delayed release 333 mg</i>	216
<i>acarbose tab 100 mg</i>	61
<i>acarbose tab 25 mg</i>	61
<i>acarbose tab 50 mg</i>	61
ACCOLATE TAB 10MG	44
ACCOLATE TAB 20MG	44
ACCU-CHEK GUIDE	148
ACCU-CHEK KIT FASTCLIX	177
ACCU-CHEK KIT SOFTCLIX	177
ACCU-CHEK LIQ GUIDE	177
ACCU-CHEK LIQ SMART	177
ACCU-CHEK MIS MLTICLIX.....	177
ACCU-CHEK SOL.....	177
ACCU-CHEK SOL COMPACT	177
ACCU-CHEK TES AVIVA PL.....	148
ACCU-CHEK TES COMPACT.....	148
ACCU-CHEK TES SMART.....	148
ACCUPRIL TAB 10MG.....	73
ACCUPRIL TAB 20MG	73
ACCUPRIL TAB 40MG.....	73
ACCUPRIL TAB 5MG	73
ACCURETIC TAB 10-12.5.....	77
ACCURETIC TAB 20-12.5	77
ACCURETIC TAB 20-25MG	77
ACCUTREND SOL GLUCOSE	177
<i>acebutolol hcl cap 200 mg</i>	115
<i>acebutolol hcl cap 400 mg</i>	115
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	33
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	33
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	33
<i>acetaminophen w/ codeine tab 300-15 mg</i>	33
<i>acetaminophen w/ codeine tab 300-30 mg</i>	33
<i>acetaminophen w/ codeine tab 300-60 mg</i>	33
<i>acetazolamide cap er 12hr 500 mg</i>	154
<i>acetazolamide tab 125 mg</i>	154
<i>acetazolamide tab 250 mg</i>	154
<i>acetic acid otic soln 2%</i>	214
<i>acetylcysteine inhal soln 10%</i>	132
<i>acetylcysteine inhal soln 20%</i>	132
<i>acitretin cap 10 mg</i>	136
<i>acitretin cap 17.5 mg</i>	136
<i>acitretin cap 25 mg</i>	136
ACTHAR INJ 80UNIT	157
ACTI-LANCE MIS 28G.....	177
ACTI-LANCE MIS LITE 28G	177
ACTI-LANCE MIS SPEC 17G.....	177
ACTI-LANCE MIS UNIV 23G.....	177
ACTIMMUNE INJ 2MU/0.5.....	95
ACTIQ LOZ 1200MCG.....	26
ACTIQ LOZ 1600MCG.....	26
ACTIQ LOZ 200MCG	26
ACTIQ LOZ 400MCG	26
ACTIQ LOZ 600MCG	26
ACTIQ LOZ 800MCG	26
ACTIVELLA TAB 1-0.5MG	161
ACTONEL TAB 150MG.....	156
ACTONEL TAB 35MG	156
ACTOPLUS MET TAB 15-500MG	61

ACTOPLUS MET TAB 15-850MG.....	61	AERCHMBR PLS MIS LRG MASK.....	196
ACULAR LS SOL 0.4%	213	AERCHMBR PLS MIS MED MASK.....	196
ACULAR SOL 0.5% OP	213	AERCHMBR PLS MIS SM MASK.....	196
<i>acyclovir cap 200 mg</i>	114	AERCHMBR Z- MIS STAT PLS.....	196
<i>acyclovir oint 5%</i>	141	AEROCHAMBER KIT ACTION.....	196
<i>acyclovir susp 200 mg/5ml</i>	114	AEROCHAMBER MIS CHAMBER	196
<i>acyclovir tab 400 mg</i>	114	AEROCHAMBER MIS FLOSIGNA	196
<i>acyclovir tab 800 mg</i>	114	AEROCHAMBER MIS MV	196
ADALIMU-ADAZ INJ 40/0.4ML	11	AEROCHAMBER MIS PLUS.....	196
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	133	AEROVENT MIS PLUS.....	196
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	133	AGAMATRIX MIS 33G	177
<i>adapalene cream 0.1%</i>	132	AGAMATRIX SOL HIGH	177
<i>adapalene gel 0.1%</i>	132	AGAMATRIX SOL LEVEL 2	177
<i>adapalene gel 0.3%</i>	133	AGAMATRIX SOL LEVEL 4	177
ADASUVE INH 10MG.....	102	AGAMATRIX SOL NORM/HGH.....	178
ADBRY INJ 150MG/ML.....	145	AGAMATRIX SOL NORMAL	178
<i>adefovir dipivoxil tab 10 mg</i>	112	AGRYLIN CAP 0.5MG	170
ADEMPAS TAB 0.5MG.....	125	AIMSCO TWIST MIS 32G.....	178
ADEMPAS TAB 1.5MG.....	125	AIMSCO TWIST MIS 33G.....	178
ADEMPAS TAB 1MG.....	125	AIRSUPRA AER 90-80MCG.....	46
ADEMPAS TAB 2.5MG	125	AIRZONE PEAK MIS FLOW MTR	196
ADEMPAS TAB 2MG	125	AJOVY INJ 225/1.5.....	198
ADIPEX-P CAP 37.5MG	3	AKLIEF CRE 0.005%	133
ADIPEX-P TAB 37.5MG	4	AKTEN GEL 3.5%.....	212
ADJ LANCING MIS DEVICE.....	177	<i>albendazole tab 200 mg</i>	37
ADRENALIN INJ 1MG/ML	232	ALBENZA TAB 200MG	37
ADRENALIN SOL 1:1000	208	<i>albuterol sulfate inhal aero 108 mcg/act</i> <i>(90mcg base equiv)</i>	46
ADVANCE LIQ CONTROL.....	177	<i>albuterol sulfate soln nebu 0.083% (2.5</i> <i>mg/3ml)</i>	46
ADVANCE LIQ INTUITIO	177	<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	46
ADVANCE NORM LIQ CONTROL	177	<i>albuterol sulfate soln nebu 0.63 mg/3ml</i> <i>(base equiv)</i>	46
ADVATE SAFE MIS LANC 26G	177	<i>albuterol sulfate soln nebu 1.25 mg/3ml</i> <i>(base equiv)</i>	46
ADV LANCING MIS DEVICE	177	<i>albuterol sulfate syrup 2 mg/5ml</i>	46
ADVOCATE+ SOL REDI-COD.....	177	<i>albuterol sulfate tab 2 mg</i>	46
ADVOCATE LIQ HIGH	177	<i>albuterol sulfate tab 4 mg</i>	46
ADVOCATE LIQ LOW	177	<i>albuterol sulfate tab er 12hr 4 mg</i>	46
ADVOCATE MIS LANC 30G	177	<i>albuterol sulfate tab er 12hr 8 mg</i>	46
ADVOCATE MIS LANC DEV	177	ALCAINE SOL 0.5% OP	212
ADVOCATE MIS LANCETS.....	177		
ADV TRAVEL MIS LANC 28G	177		
AEMCOLO TAB 194MG	37		
AERCHMBR PLS MIS FLOW-VU.....	196		

<i>alclometasone dipropionate cream 0.05%</i>	<i>alose tron hcl tab 1 mg (base equiv).....</i>	166
.....141	ALPHAGAN P SOL 0.1%	210
<i>alclometasone dipropionate oint 0.05%..</i>	ALPHAGAN P SOL 0.15%	210
141	ALPRAZOLAM CON 1 MG/ML	41
ALCOH-GLOVE PAD CONTOURE	<i>alprazolam orally disintegrating tab 0.25</i>	
ALCOHOL PAD	<i>mg</i>	41
ALCOHOL PAD 70%	<i>alprazolam orally disintegrating tab 0.5 mg</i>	
ALCOHOL PAD PREP.....	.....41	
ALCOHOL PAD SWABSTIC.....	<i>alprazolam orally disintegrating tab 1 mg..</i>	41
ALCOHOL PREP PAD.....	<i>alprazolam orally disintegrating tab 2 mg .</i>	41
ALCOHOL PREP PAD 70%	<i>alprazolam tab 0.25 mg</i>	41
ALCOHOL PREP PAD MED 70%	<i>alprazolam tab 0.5 mg</i>	41
ALCOHOL PREP PAD PADS 70%	<i>alprazolam tab 1 mg.....</i>	41
ALCOHOL SWAB PAD	<i>alprazolam tab 2 mg</i>	41
ALCOHOL SWAB PAD 70%.....	<i>alprazolam tab er 24hr 0.5 mg.....</i>	41
ALCOHOL SWAB PAD EX-THICK	<i>alprazolam tab er 24hr 1 mg</i>	41
ALCOHOL WIPE PAD.....	<i>alprazolam tab er 24hr 2 mg</i>	41
ALDACTAZIDE TAB 25/25	<i>alprazolam tab er 24hr 3 mg</i>	41
ALDACTAZIDE TAB 50/50.....	ALTABAX OIN 1%	135
ALDACTONE TAB 100MG	ALTACE CAP 1.25MG	73
ALDACTONE TAB 25MG	ALTACE CAP 10MG	74
ALDACTONE TAB 50MG.....	ALTACE CAP 2.5MG.....	73
ALECENSA CAP 150MG.....	ALTACE CAP 5MG	73
<i>alendronate sodium oral soln 70 mg/75ml</i>	ALUNBRIG PAK	89
.....156	ALUNBRIG TAB 180MG.....	90
<i>alendronate sodium tab 10 mg</i>	ALUNBRIG TAB 30MG	90
156	ALUNBRIG TAB 90MG	90
<i>alendronate sodium tab 35 mg.....</i>	<i>alvimopan cap 12 mg.....</i>	167
156	<i>amantadine hcl cap 100 mg</i>	96
<i>alendronate sodium tab 5 mg.....</i>	<i>amantadine hcl soln 50 mg/5ml</i>	96
156	<i>amantadine hcl tab 100 mg</i>	96
<i>alendronate sodium tab 70 mg</i>	AMARYL TAB 1MG	65
156	AMARYL TAB 2MG	65
<i>alfuzosin hcl tab er 24hr 10 mg</i>	AMARYL TAB 4MG	65
168	AMBIEN CR TAB 12.5MG	173
ALINIA SUS 100/5ML	AMBIEN CR TAB 6.25MG	173
38	AMBIEN TAB 10MG	173
ALINIA TAB 500MG.....	AMBIEN TAB 5MG.....	173
38	<i>ambrisentan tab 10 mg</i>	123
<i>aliskiren fumarate tab 150 mg (base</i>	<i>ambrisentan tab 5 mg</i>	123
<i>equivalent)</i>	<i>amcinonide cream 0.1%.....</i>	141
81	<i>amcinonide lotion 0.1%</i>	141
<i>aliskiren fumarate tab 300 mg (base</i>	<i>amcinonide oint 0.1%</i>	141
<i>equivalent)</i>		
81		
ALKERAN TAB 2MG.....		
83		
<i>allopurinol tab 100 mg</i>		
168		
<i>allopurinol tab 300 mg.....</i>		
168		
<i>almotriptan malate tab 12.5 mg</i>		
199		
<i>almotriptan malate tab 6.25 mg</i>		
199		
ALOCRI SOL 2%		
213		
ALOMIDE SOL 0.1% OP		
213		
<i>alose tron hcl tab 0.5 mg (base equiv)</i>		
166		

AMERGE TAB 1MG	199	amlodipine besylate-benazepril hcl cap 10-40 mg	77
AMERGE TAB 2.5MG	199	amlodipine besylate-benazepril hcl cap 2.5-10 mg	77
AMICAR TAB 1000MG	172	amlodipine besylate-benazepril hcl cap 5-10 mg	77
AMICAR TAB 500MG	172	amlodipine besylate-benazepril hcl cap 5-20 mg	77
amiloride & hydrochlorothiazide tab 5-50 mg	154	amlodipine besylate-benazepril hcl cap 5-40 mg	77
amiloride hcl tab 5 mg	155	amlodipine besylate-olmesartan medoxomil tab 10-20 mg	77
aminocaproic acid oral soln 0.25 gm/ml	172	amlodipine besylate-olmesartan medoxomil tab 10-40 mg	77
aminocaproic acid tab 1000 mg	173	amlodipine besylate-olmesartan medoxomil tab 5-20 mg	77
aminocaproic acid tab 500 mg	172	amlodipine besylate-olmesartan medoxomil tab 5-40 mg	77
amiodarone hcl tab 100 mg	43	amlodipine besylate tab 10 mg (base equivalent)	117
amiodarone hcl tab 200 mg	43	amlodipine besylate tab 2.5 mg (base equivalent)	117
amiodarone hcl tab 400 mg	43	amlodipine besylate tab 5 mg (base equivalent)	117
amitriptyline hcl tab 100 mg	59	amlodipine besylate-valsartan tab 10-160 mg	78
amitriptyline hcl tab 10 mg	59	amlodipine besylate-valsartan tab 10-320 mg	78
amitriptyline hcl tab 150 mg	60	amlodipine besylate-valsartan tab 5-160 mg	77
amitriptyline hcl tab 25 mg	59	amlodipine besylate-valsartan tab 5-320 mg	77
amitriptyline hcl tab 50 mg	59	amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	78
amitriptyline hcl tab 75 mg	59	amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 10-10 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	78
amlodipine besylate-atorvastatin calcium tab 10-20 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	78
amlodipine besylate-atorvastatin calcium tab 10-40 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 10-80 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 5-10 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 5-20 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 5-40 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-atorvastatin calcium tab 5-80 mg	120	amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	78
amlodipine besylate-benazepril hcl cap 10-20 mg	77	amoxapine tab 100 mg	60

<i>amoxapine tab 150 mg</i>	60	<i>amphetamine-dextroamphetamine cap er</i>	
<i>amoxapine tab 25 mg</i>	60	<i>24hr 15 mg</i>	1
<i>amoxapine tab 50 mg</i>	60	<i>amphetamine-dextroamphetamine cap er</i>	
<i>amoxicil cap & clarithro tab & lansopraz cap</i>		<i>24hr 20 mg</i>	1
<i>dr 500 & 500 & 30mg</i>	229	<i>amphetamine-dextroamphetamine cap er</i>	
<i>amoxicillin (trihydrate) cap 250 mg</i>	214	<i>24hr 25 mg</i>	1
<i>amoxicillin (trihydrate) cap 500 mg</i>	214	<i>amphetamine-dextroamphetamine cap er</i>	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	214	<i>24hr 30 mg</i>	1
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	214	<i>amphetamine-dextroamphetamine cap er</i>	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>		<i>24hr 5 mg</i>	1
.....	215	<i>amphetamine-dextroamphetamine tab 10</i>	
<i>amoxicillin (trihydrate) for susp 200</i>		<i>mg</i>	1
<i>mg/5ml</i>	215	<i>amphetamine-dextroamphetamine tab 12.5</i>	
<i>amoxicillin (trihydrate) for susp 250</i>		<i>mg</i>	1
<i>mg/5ml</i>	215	<i>amphetamine-dextroamphetamine tab 15</i>	
<i>amoxicillin (trihydrate) for susp 400</i>		<i>mg</i>	1
<i>mg/5ml</i>	215	<i>amphetamine-dextroamphetamine tab 20</i>	
<i>amoxicillin (trihydrate) tab 500 mg</i>	215	<i>mg</i>	1
<i>amoxicillin (trihydrate) tab 875 mg</i>	215	<i>amphetamine-dextroamphetamine tab 30</i>	
<i>amoxicillin & k clavulanate chew tab 200-</i>		<i>mg</i>	1
<i>28.5 mg</i>	215	<i>amphetamine-dextroamphetamine tab 5</i>	
<i>amoxicillin & k clavulanate chew tab 400-</i>		<i>mg</i>	1
<i>57 mg</i>	215	<i>amphetamine-dextroamphetamine tab 7.5</i>	
<i>amoxicillin & k clavulanate for susp 200-</i>		<i>mg</i>	1
<i>28.5 mg/5ml</i>	215	<i>amphetamine sulfate tab 10 mg</i>	1
<i>amoxicillin & k clavulanate for susp 250-</i>		<i>amphetamine sulfate tab 5 mg</i>	1
<i>62.5 mg/5ml</i>	215	<i>ampicillin cap 500 mg</i>	215
<i>amoxicillin & k clavulanate for susp 400-57</i>		<i>AMPYRA TAB 10MG</i>	219
<i>mg/5ml</i>	215	<i>ANACAINE OIN</i>	146
<i>amoxicillin & k clavulanate for susp 600-</i>		<i>ANAFRANIL CAP 25MG</i>	60
<i>42.9 mg/5ml</i>	215	<i>ANAFRANIL CAP 50MG</i>	60
<i>amoxicillin & k clavulanate tab 250-125 mg</i>		<i>ANAFRANIL CAP 75MG</i>	60
.....	215	<i>anagrelide hcl cap 0.5 mg</i>	170
<i>amoxicillin & k clavulanate tab 500-125 mg</i>		<i>anagrelide hcl cap 1 mg</i>	170
.....	215	<i>ANALPRAM-HC CRE 1-1%</i>	37
<i>amoxicillin & k clavulanate tab 875-125 mg</i>		<i>ANALPRAM-HC LOT 2.5%</i>	37
.....	215	<i>ANASPAZ TAB 0.125MG</i>	227
<i>amoxicillin & k clavulanate tab er 12hr 1000-</i>		<i>anastrozole tab 1 mg</i>	87
<i>62.5 mg</i>	215	<i>ANCOBON CAP 250MG</i>	68
<i>AMPHETAMI ER SUS 1.25/ML</i>	1	<i>ANCOBON CAP 500MG</i>	68
<i>amphetamine-dextroamphetamine cap er</i>		<i>ANDRODERM DIS 2MG/24HR</i>	36
<i>24hr 10 mg</i>	1	<i>ANDRODERM DIS 4MG/24HR</i>	36
		<i>ANNOVERA MIS</i>	129

ANORO ELLIPT AER 62.5-25.....	46	<i>aripiprazole tab 20 mg</i>	106
ANTARA CAP 30MG.....	71	<i>aripiprazole tab 2 mg</i>	105
ANTARA CAP 90MG.....	71	<i>aripiprazole tab 30 mg</i>	106
ANUSOL-HC CRE 2.5%.....	37	<i>aripiprazole tab 5 mg</i>	105
APLICARE ALC PAD SWABSTIC.....	195	ARISTADA INJ 1064MG.....	106
<i>apraclonidine hcl ophth soln 0.5% (base</i>		ARISTADA INJ 441MG/1.....	106
<i>equivalent)</i>	210	ARISTADA INJ 662MG/2.....	106
<i>aprepitant capsule 125 mg</i>	68	ARISTADA INJ 882MG/3.....	106
<i>aprepitant capsule 40 mg</i>	68	ARISTADA INJ INITIO.....	106
<i>aprepitant capsule 80 mg</i>	68	ARIXTRA INJ 10/0.8ML.....	48
<i>aprepitant capsule therapy pack 80 & 125</i>		ARIXTRA INJ 2.5/0.5.....	48
<i>mg</i>	68	ARIXTRA INJ 5/0.4ML.....	48
APRISO CAP 0.375GM.....	164	ARIXTRA INJ 7.5/0.6.....	48
APTIOM TAB 200MG.....	50	<i>armodafinil tab 150 mg</i>	7
APTIOM TAB 400MG.....	50	<i>armodafinil tab 200 mg</i>	7
APTIOM TAB 600MG.....	50	<i>armodafinil tab 250 mg</i>	7
APTIOM TAB 800MG.....	51	<i>armodafinil tab 50 mg</i>	7
AQUALANCE MIS 30G.....	178	ARMOUR THYRO TAB 120MG.....	226
ARANESP INJ 100MCG.....	171	ARMOUR THYRO TAB 15MG.....	226
ARANESP INJ 10MCG.....	171	ARMOUR THYRO TAB 180MG.....	226
ARANESP INJ 150MCG.....	171	ARMOUR THYRO TAB 240MG.....	226
ARANESP INJ 200MCG.....	171	ARMOUR THYRO TAB 300MG.....	226
ARANESP INJ 25MCG.....	171	ARMOUR THYRO TAB 30MG.....	226
ARANESP INJ 300MCG.....	171	ARMOUR THYRO TAB 60MG.....	226
ARANESP INJ 40MCG.....	171	ARMOUR THYRO TAB 90MG.....	226
ARANESP INJ 500MCG.....	171	ARNICA TIN FLOWER.....	147
ARANESP INJ 60MCG.....	171	AROMASIN TAB 25MG.....	87
ARAVAL TAB 10MG.....	23	ARTISS SOL 10ML.....	173
ARAVAL TAB 20MG.....	23	ARTISS SOL 2ML.....	173
<i>arformoterol tartrate soln nebu 15 mcg/2ml</i>		ARTISS SOL 4ML.....	173
<i>(base equiv)</i>	46	<i>asenapine maleate sl tab 10 mg (base</i>	
ARICEPT TAB 10MG.....	216	<i>equiv)</i>	102
ARICEPT TAB 23MG.....	217	<i>asenapine maleate sl tab 2.5 mg (base</i>	
ARICEPT TAB 5MG.....	216	<i>equiv)</i>	102
ARIKAYCE SUS.....	11	<i>asenapine maleate sl tab 5 mg (base equiv)</i>	
ARIMIDEX TAB 1MG.....	87	.....	102
<i>aripiprazole orally disintegrating tab 10 mg</i>		<i>aspirin chew tab 81 mg</i>	26
.....	105	<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	
<i>aripiprazole orally disintegrating tab 15 mg</i>		.....	170
.....	105	<i>aspirin tab delayed release 81 mg</i>	26
<i>aripiprazole oral solution 1 mg/ml</i>	105	ASSESS METER MIS FULL.....	196
<i>aripiprazole tab 10 mg</i>	105	ASSESS METER MIS LOW.....	196
<i>aripiprazole tab 15 mg</i>	105	ASSURE 3 LIQ CONTROL.....	178

ASSURE 4 LIQ LEVEL1/2	178	<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	72
ASSURE CMFRT MIS 28G.....	178	<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	72
ASSURE DOSE SOL NORM/HGH	178	<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	72
ASSURE DOSE SOL NORMAL.....	178	<i>atovaquone-proguanil hcl tab 250-100 mg</i>	
ASSURE II LIQ LEVEL 1.....	178	.....	82
ASSURE II LIQ LEVEL1/2	178	<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	
ASSURE LANCE MIS 21G	178	.....	82
ASSURE LANCE MIS 28G	178	<i>atovaquone susp 750 mg/5ml</i>	38
ASSURE LANCE MIS LOW FLOW.....	178	ATRIPLA TAB	107
ASSURE LANCE MIS MICRO.....	178	ATROPINE SUL SOL 1% OP.....	210
ASSURE LANCE MIS SAFE 25G	178	AUGMENTIN SUS 125/5ML.....	215
ASSURE LANCE MIS SAFE 30G.....	178	AUGMENTIN SUS 250/5ML.....	215
ASSURE PLUS MIS HIGH 18G.....	178	AUGMENTIN SUS ES-600	215
ASSURE PLUS MIS LOW 25G.....	178	AUGMENTIN TAB 500MG.....	215
ASSURE PLUS MIS MCRO 28G.....	178	AURORA LANCE MIS 30G.....	178
ASSURE PLUS MIS NORM 21G	178	AURORA LANCE MIS THIN 23G	178
ASSURE PLUS MIS PEDIATRI.....	178	AURYXIA TAB 210MG	167
ASSURE PRISM SOL LEVEL1/2	178	AUSTEDO TAB 12MG	219
ASSURE PRO LIQ LEVEL1/2	178	AUSTEDO TAB 6MG.....	219
ASTAGRAF XL CAP 0.5MG	203	AUSTEDO TAB 9MG.....	219
ASTAGRAF XL CAP 1MG.....	203	AUSTEDO XR TAB 12MG.....	219
ASTAGRAF XL CAP 5MG.....	203	AUSTEDO XR TAB 24MG.....	219
<i>atazanavir sulfat cap 150 mg (base equiv)</i>		AUSTEDO XR TAB 6MG.....	219
.....	107	AUSTEDO XR TAB TITR KIT	219
<i>atazanavir sulfat cap 200 mg (base equiv)</i>		AUTO LANCET MIS	178
.....	107	AUTO-LANCET MIS.....	178
<i>atazanavir sulfat cap 300 mg (base equiv)</i>		AUTO-LANCET MIS MINI	178
.....	107	AUTOLET II KIT CLINISAF.....	178
AELVIA TAB.....	156	AUTOLET IMPR MIS LANC DEV	178
<i>atenolol & chlorthalidone tab 100-25 mg..</i>	78	AUTOLET LANC MIS DEVICE.....	178
<i>atenolol & chlorthalidone tab 50-25 mg ...</i>	78	AUTOLET LITE KIT	178
<i>atenolol tab 100 mg</i>	115	AUTOLET LITE KIT CLINISAF	178
<i>atenolol tab 25 mg</i>	115	AUTOLET LITE KIT STARTER.....	179
<i>atenolol tab 50 mg</i>	115	AUTOLET MINI MIS	179
<i>atomoxetine hcl cap 100 mg (base equiv)</i> ..	6	AUTOLET PLAT MIS 1.8MM	179
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	6	AUTOLET PLAT MIS 2.4MM.....	179
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	6	AUTOLET PLAT MIS 3.0MM.....	179
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	6	AUTOLET PLUS MIS	179
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	6	AUTOLET PLUS MIS LANC DEV	179
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	6	AUVI-Q INJ 0.15MG	232
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	6		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	72		

AUVI-Q INJ 0.1MG.....	232	<i>baclofen tab 10 mg</i>	206
AUVI-Q INJ 0.3MG.....	232	<i>baclofen tab 20 mg</i>	206
AVALIDE TAB 150-12.5	78	<i>baclofen tab 5 mg</i>	206
AVALIDE TAB 300-12.5	78	BACTRIM DS TAB 800-160	38
AVANDIA TAB 2MG	65	BACTRIM TAB 400-80MG.....	38
AVANDIA TAB 4MG.....	65	BALCOLTRA TAB 0.1-20.....	126
AVAPRO TAB 150MG.....	75	<i>balsalazide disodium cap 750 mg</i>	164
AVAPRO TAB 300MG.....	75	BALVERSA TAB 3MG	90
AVAPRO TAB 75MG	75	BALVERSA TAB 4MG	90
AVODART CAP 0.5MG	168	BALVERSA TAB 5MG	90
AVONEX PEN KIT 30MCG.....	219	BAQSIMI ONE POW 3MG/DOSE	63
AVONEX PREFL KIT 30MCG.....	219	BAQSIMI TWO POW 3MG/DOSE	63
AYGESTIN TAB 5MG.....	216	BARACLUDGE SOL	112
<i>azacitidine for inj 100 mg</i>	84	BASAGLAR INJ 100UNIT	64
<i>azathioprine tab 100 mg</i>	203	BAXDELA TAB 450MG	163
<i>azathioprine tab 50 mg</i>	203	BD LANCET UF MIS 30G.....	179
<i>azathioprine tab 75 mg</i>	203	BD LANCET UF MIS 33G.....	179
<i>azelaic acid gel 15%</i>	147	BD MICROTAIN MIS LANCETS.....	179
<i>azelastine hcl-fluticasone prop nasal spray</i> <i>137-50 mcg/act</i>	208	BD SWAB BFLY PAD SNGL USE.....	195
<i>azelastine hcl nasal spray 0.1% (137</i> <i>mcg/spray)</i>	208	BD U-500 MIS 31GX6MM	196
<i>azelastine hcl nasal spray 0.15% (205.5</i> <i>mcg/spray)</i>	208	BD ULTRAFINE INSULIN SYRINGES/NEEDLES	196
<i>azelastine hcl ophth soln 0.05%</i>	213	BD ULTRAFINE PEN NEEDLES	196
AZILECT TAB 0.5MG	99	BELBUCA MIS 150MCG.....	35
AZILECT TAB 1MG.....	100	BELBUCA MIS 300MCG.....	35
<i>azithromycin for susp 100 mg/5ml</i>	175	BELBUCA MIS 450MCG.....	35
<i>azithromycin for susp 200 mg/5ml</i>	175	BELBUCA MIS 600MCG.....	35
<i>azithromycin powd pack for susp 1 gm</i> ...	175	BELBUCA MIS 750MCG.....	35
<i>azithromycin tab 250 mg</i>	175	BELBUCA MIS 75MCG	34
<i>azithromycin tab 500 mg</i>	175	BELBUCA MIS 900MCG.....	35
<i>azithromycin tab 600 mg</i>	175	BELLA/OPIUM SUP 16.2-30	228
AZSTARYS CAP 26.1-5.2	7	BELLA/OPIUM SUP 16.2-60	228
AZSTARYS CAP 39.2-7.8	7	<i>benazepril & hydrochlorothiazide tab 10-</i> <i>12.5 mg</i>	78
AZSTARYS CAP 52.3-10.....	7	<i>benazepril & hydrochlorothiazide tab 20-</i> <i>12.5 mg</i>	78
AZULFIDINE TAB 500MG.....	164	<i>benazepril & hydrochlorothiazide tab 20-25</i> <i>mg</i>	78
AZULFIDINE TAB 500MG EN.....	164	<i>benazepril & hydrochlorothiazide tab 5-</i> <i>6.25 mg</i>	78
B		<i>benazepril hcl tab 10 mg</i>	74
<i>bacitracin ophth oint 500 unit/gm</i>	210	<i>benazepril hcl tab 20 mg</i>	74
<i>bacitracin-polymyxin b ophth oint</i>	210	<i>benazepril hcl tab 40 mg</i>	74
<i>bacitracin-polymyxin-neomycin-hc ophth</i> <i>ointment 1%</i>	212		

<i>benazepril hcl tab 5 mg</i>	74	BETASERON INJ 0.3MG	219
BENLYSTA INJ 200MG/ML	205	<i>betaxolol hcl ophth soln 0.5%</i>	209
BENZALKONIUM SOL NF	106	<i>betaxolol hcl tab 10 mg</i>	115
BENZAMYCIN GEL 5-3%	133	<i>betaxolol hcl tab 20 mg</i>	115
BENZEPRO LIQ CREAMY	133	<i>bethanechol chloride tab 10 mg</i>	231
BENZNIDAZOLE TAB 100MG	37	<i>bethanechol chloride tab 25 mg</i>	231
BENZNIDAZOLE TAB 12.5MG	37	<i>bethanechol chloride tab 50 mg</i>	231
<i>benzonatate cap 100 mg</i>	131	<i>bethanechol chloride tab 5 mg</i>	231
<i>benzonatate cap 150 mg</i>	131	<i>bexarotene cap 75 mg</i>	95
<i>benzonatate cap 200 mg</i>	131	<i>bicalutamide tab 50 mg</i>	87
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	133	BIDIL TAB	121
<i>benzoyl peroxide foam 9.8%</i>	133	BIJUVA CAP 1-100MG	161
<i>benzoyl peroxide-hydrocortisone lotion 5- 0.5%</i>	133	BIKTARVY TAB	107
<i>benzoyl peroxide liq 7%</i>	133	BILTRICIDE TAB 600MG	37
<i>benzphetamine hcl tab 25 mg</i>	4	<i>bimatoprost ophth soln 0.03%</i>	213
<i>benzphetamine hcl tab 50 mg</i>	4	BIMZELX INJ 160MG/ML	136
<i>benztropine mesylate tab 0.5 mg</i>	96	BINOSTO TAB 70MG	156
<i>benztropine mesylate tab 1 mg</i>	96	BIO-STATIN CAP 1000000	68
<i>benztropine mesylate tab 2 mg</i>	96	BIO-STATIN CAP 500000	68
BESREMI SOL 500MCG	95	<i>bisacodyl tab & peg 3350-kcl-sod bicarb- nacl for soln kit</i>	174
BETADINE SOL 5% OP	210	<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	230
<i>betamethasone dipropionate augmented cream 0.05%</i>	141	<i>bisoprolol & hydrochlorothiazide tab 10- 6.25 mg</i>	78
<i>betamethasone dipropionate augmented gel 0.05%</i>	142	<i>bisoprolol & hydrochlorothiazide tab 2.5- 6.25 mg</i>	78
<i>betamethasone dipropionate augmented lotion 0.05%</i>	142	<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	78
<i>betamethasone dipropionate augmented oint 0.05%</i>	142	<i>bisoprolol fumarate tab 10 mg</i>	115
<i>betamethasone dipropionate cream 0.05%</i>	142	<i>bisoprolol fumarate tab 5 mg</i>	115
<i>betamethasone dipropionate lotion 0.05%</i>	142	BLEPH-10 SOL 10% OP	210
<i>betamethasone valerate aerosol foam 0.12%</i>	142	BLEPHAMIDE OIN S.O.P.	212
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	142	BLEPHAMIDE SUS OP	212
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	142	BONIVA TAB 150MG	156
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	142	BONJESTA TAB 20-20MG	67
		<i>bosentan tab 125 mg</i>	124
		<i>bosentan tab 62.5 mg</i>	124
		BOSULIF CAP 100MG	90
		BOSULIF CAP 50MG	90
		BOSULIF TAB 100MG	90
		BOSULIF TAB 400MG	90
		BOSULIF TAB 500MG	90

BRAFTOVI CAP 75MG.....	90	<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	35
BREATHE EASE MIS LG MASK	196	<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	35
BREATHE EASE MIS MED MASK.....	196	<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	35
BREATHE EASE MIS METER	196	<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	35
BREATHE EASE MIS SM MASK	196	<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	35
BREO ELLIPTA INH 100-25.....	46	<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	35
BREO ELLIPTA INH 200-25	46	<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	35
BREXAFEMME TAB 150MG	68	<i>buprenorphine td patch weekly 10 mcg/hr</i>	35
BREZTRI AERO AER SPHERE	46	<i>buprenorphine td patch weekly 15 mcg/hr</i>	35
BRILINTA TAB 60MG	170	<i>buprenorphine td patch weekly 20 mcg/hr</i>	35
BRILINTA TAB 90MG	170	<i>buprenorphine td patch weekly 5 mcg/hr</i>	35
<i>brimonidine tartrate ophth soln 0.15%</i>	210	<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	35
<i>brimonidine tartrate ophth soln 0.2%.....</i>	210	<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	222
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	209	<i>bupropion hcl tab 100 mg</i>	56
<i>brinzolamide ophth susp 1%</i>	213	<i>bupropion hcl tab 75 mg</i>	56
BRISDELLE CAP 7.5MG	224	<i>bupropion hcl tab er 12hr 100 mg</i>	56
BRIVIACT SOL 10MG/ML	51	<i>bupropion hcl tab er 12hr 150 mg.....</i>	56
BRIVIACT TAB 100MG	51	<i>bupropion hcl tab er 12hr 200 mg.....</i>	56
BRIVIACT TAB 10MG.....	51	<i>bupropion hcl tab er 24hr 150 mg.....</i>	56
BRIVIACT TAB 25MG	51	<i>bupropion hcl tab er 24hr 300 mg.....</i>	56
BRIVIACT TAB 50MG	51	<i>bupirone hcl tab 10 mg.....</i>	41
BRIVIACT TAB 75MG	51	<i>bupirone hcl tab 15 mg.....</i>	41
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily).....</i>	213	<i>bupirone hcl tab 30 mg</i>	41
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	96	<i>bupirone hcl tab 5 mg</i>	41
<i>bromocriptine mesylate tab 2.5 mg (base equivalent).....</i>	97	<i>bupirone hcl tab 7.5 mg</i>	41
BRUKINSA CAP 80MG	90	<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg.....</i>	26
BRYHALI LOT 0.01%	142	<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	33
<i>budesonide delayed release particles cap 3 mg.....</i>	129	<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	33
<i>budesonide inhalation susp 0.25 mg/2ml</i>	44		
<i>budesonide inhalation susp 0.5 mg/2ml ..</i>	44		
<i>budesonide inhalation susp 1 mg/2ml</i>	44		
<i>bumetanide tab 0.5 mg</i>	155		
<i>bumetanide tab 1 mg.....</i>	155		
<i>bumetanide tab 2 mg.....</i>	155		
BUMEX TAB 0.5MG.....	155		
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	35		

<i>butalbital-acetaminophen tab 50-325 mg</i>	26	<i>candesartan cilexetil-hydrochlorothiazide</i>	
<i>butalbital-aspirin-caffeine cap 50-325-40</i>		<i>tab 32-12.5 mg</i>	78
<i>mg</i>	26	<i>candesartan cilexetil-hydrochlorothiazide</i>	
<i>butalbital-aspirin-caff w/ codeine cap 50-</i>		<i>tab 32-25 mg</i>	78
<i>325-40-30 mg</i>	33	<i>candesartan cilexetil tab 16 mg</i>	75
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	35	<i>candesartan cilexetil tab 32 mg</i>	75
C		<i>candesartan cilexetil tab 4 mg</i>	75
<i>cabergoline tab 0.5 mg</i>	160	<i>candesartan cilexetil tab 8 mg</i>	75
CABOMETRYX TAB 20MG.....	90	<i>capecitabine tab 150 mg</i>	84
CABOMETRYX TAB 40MG.....	90	<i>capecitabine tab 500 mg</i>	84
CABOMETRYX TAB 60MG.....	90	CAPRELSA TAB 100MG.....	91
CADUET TAB 10-10MG.....	121	CAPRELSA TAB 300MG	91
CADUET TAB 10-20MG	121	<i>captopril & hydrochlorothiazide tab 25-15</i>	
CADUET TAB 10-40MG.....	121	<i>mg</i>	78
CADUET TAB 10-80MG	121	<i>captopril & hydrochlorothiazide tab 25-25</i>	
CADUET TAB 5-10MG.....	121	<i>mg</i>	78
CADUET TAB 5-20MG	121	<i>captopril & hydrochlorothiazide tab 50-15</i>	
CADUET TAB 5-40MG.....	121	<i>mg</i>	78
CADUET TAB 5-80MG.....	121	<i>captopril & hydrochlorothiazide tab 50-25</i>	
<i>caffeine citrate oral soln 60 mg/3ml (10</i>		<i>mg</i>	79
<i>mg/ml base equiv)</i>	3	<i>captopril tab 100 mg</i>	74
CALAN SR TAB 120MG.....	117	<i>captopril tab 12.5 mg</i>	74
CALAN SR TAB 180MG.....	117	<i>captopril tab 25 mg</i>	74
CALAN SR TAB 240MG.....	117	<i>captopril tab 50 mg</i>	74
<i>calcipotriene oint 0.005%</i>	136	<i>carbamazepine cap er 12hr 100 mg</i>	51
<i>calcipotriene soln 0.005% (50 mcg/ml)</i> .	136	<i>carbamazepine cap er 12hr 200 mg</i>	51
<i>calcitonin (salmon) nasal soln 200 unit/act</i>		<i>carbamazepine cap er 12hr 300 mg</i>	51
.....	156	<i>carbamazepine chew tab 100 mg</i>	51
<i>calcitriol cap 0.25 mcg</i>	158	<i>carbamazepine susp 100 mg/5ml</i>	51
<i>calcitriol cap 0.5 mcg</i>	158	<i>carbamazepine tab 200 mg</i>	51
<i>calcitriol oral soln 1 mcg/ml</i>	158	<i>carbamazepine tab er 12hr 100 mg</i>	51
<i>calcium acetate (phosphate binder) cap</i>		<i>carbamazepine tab er 12hr 200 mg</i>	51
<i>667 mg (169 mg ca)</i>	167	<i>carbamazepine tab er 12hr 400 mg</i>	51
CALQUENCE CAP 100MG	90	CARBATROL CAP 100MG	51
CALQUENCE TAB 100MG.....	90	CARBATROL CAP 200MG.....	51
CAMINO PRO LIQ 15PE	149	CARBATROL CAP 300MG.....	51
CAMZYOS CAP 10MG.....	120	<i>carbidopa & levodopa orally disintegrating</i>	
CAMZYOS CAP 15MG.....	120	<i>tab 10-100 mg</i>	97
CAMZYOS CAP 2.5MG.....	120	<i>carbidopa & levodopa orally disintegrating</i>	
CAMZYOS CAP 5MG	120	<i>tab 25-100 mg</i>	97
<i>candesartan cilexetil-hydrochlorothiazide</i>		<i>carbidopa & levodopa orally disintegrating</i>	
<i>tab 16-12.5 mg</i>	78	<i>tab 25-250 mg</i>	97
		<i>carbidopa & levodopa tab 10-100 mg</i>	97

<i>carbidopa & levodopa tab 25-100 mg</i>	97	<i>carvedilol phosphate cap er 24hr 10 mg</i> ..	114
<i>carbidopa & levodopa tab 25-250 mg</i>	97	<i>carvedilol phosphate cap er 24hr 20 mg</i> .	115
<i>carbidopa & levodopa tab er 25-100 mg</i> ..	97	<i>carvedilol phosphate cap er 24hr 40 mg</i> .	115
<i>carbidopa & levodopa tab er 50-200 mg</i> .	97	<i>carvedilol phosphate cap er 24hr 80 mg</i> .	115
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	97	<i>carvedilol tab 12.5 mg</i>	115
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	97	<i>carvedilol tab 25 mg</i>	115
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	97	<i>carvedilol tab 3.125 mg</i>	115
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	97	<i>carvedilol tab 6.25 mg</i>	115
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	97	CASCARA EXT SAGRADA.....	175
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	97	CASODEX TAB 50MG.....	87
<i>carbidopa tab 25 mg</i>	96	CATAPRES-TTS DIS 0.1/24HR	76
<i>carbinoxamine maleate soln 4 mg/5ml</i>	69	CATAPRES-TTS DIS 0.2/24HR	76
<i>carbinoxamine maleate tab 4 mg</i>	69	CATAPRES-TTS DIS 0.3/24HR	76
CARDIOCOM MIS LANCING.....	179	CAVERJECT IM KIT 10MCG	121
CARDURA TAB 1MG.....	76	CAVERJECT INJ 40MCG	121
CARDURA TAB 2MG.....	76	CAVERJECT KIT 20MCG.....	121
CARDURA TAB 4MG.....	76	CAYA DPR	176
CARDURA TAB 8MG.....	76	<i>cefaclor cap 250 mg</i>	125
CARDURA XL TAB 4MG	168	<i>cefaclor cap 500 mg</i>	125
CARDURA XL TAB 8MG.....	168	CEFACLOR ER TAB 500MG	126
CAREONE ADV MIS LANCING.....	179	<i>cefaclor for susp 125 mg/5ml</i>	126
CAREONE LANC MIS 30G.....	179	<i>cefaclor for susp 250 mg/5ml</i>	126
CAREONE LANC MIS THIN 23G	179	<i>cefaclor for susp 375 mg/5ml</i>	126
CARESENS 30G MIS LANCETS	179	<i>cefadroxil cap 500 mg</i>	125
CARESENS SOL CONTROL.....	179	<i>cefadroxil for susp 250 mg/5ml</i>	125
CARETOUCH MIS EJECTOR	179	<i>cefadroxil for susp 500 mg/5ml</i>	125
CARETOUCH MIS LANC 26G.....	179	<i>cefadroxil tab 1 gm</i>	125
CARETOUCH MIS LANC 28G.....	179	<i>cefdinir cap 300 mg</i>	126
CARETOUCH MIS LANC 30G	179	<i>cefdinir for susp 125 mg/5ml</i>	126
CARETOUCH MIS TWIST 28	179	<i>cefdinir for susp 250 mg/5ml</i>	126
CARETOUCH MIS TWIST 30	179	<i>cefixime cap 400 mg</i>	126
CARETOUCH MIS TWIST 33	179	<i>cefixime for susp 100 mg/5ml</i>	126
CARETOUCH PAD ALCOHOL.....	195	<i>cefixime for susp 200 mg/5ml</i>	126
<i>carisoprodol tab 350 mg</i>	207	<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	126
<i>carisoprodol w/ aspirin & codeine tab 200-325-16 mg</i>	207	<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	126
<i>carteolol hcl ophth soln 1%</i>	209	<i>cefpodoxime proxetil tab 100 mg</i>	126
		<i>cefpodoxime proxetil tab 200 mg</i>	126
		<i>cefprozil for susp 125 mg/5ml</i>	126
		<i>cefprozil for susp 250 mg/5ml</i>	126
		<i>cefprozil tab 250 mg</i>	126
		<i>cefprozil tab 500 mg</i>	126

<i>cefuroxime axetil tab 250 mg</i>	126	<i>chlordiazepoxide hcl cap 5 mg</i>	42
<i>cefuroxime axetil tab 500 mg</i>	126	<i>chlordiazepoxide hcl-clidinium bromide</i>	
<i>celecoxib cap 100 mg</i>	21	<i>cap 5-2.5 mg</i>	228
<i>celecoxib cap 200 mg</i>	21	CHLORHEX GLU SOL 20%	106
<i>celecoxib cap 400 mg</i>	21	<i>chlorhexidine gluconate soln 0.12%</i>	206
<i>celecoxib cap 50 mg</i>	21	<i>chloroquine phosphate tab 250 mg</i>	82
CELEXA TAB 10MG	57	<i>chloroquine phosphate tab 500 mg</i>	82
CELEXA TAB 20MG	57	<i>chlorpromazine hcl inj 25 mg/ml</i>	104
CELEXA TAB 40MG	57	<i>chlorpromazine hcl inj 50 mg/2ml</i>	104
CELLCEPT CAP 250MG	203	<i>chlorpromazine hcl tab 100 mg</i>	104
CELLCEPT IV INJ 500MG	203	<i>chlorpromazine hcl tab 10 mg</i>	104
CELLCEPT SUS 200MG/ML	203	<i>chlorpromazine hcl tab 200 mg</i>	104
CELLCEPT TAB 500MG	203	<i>chlorpromazine hcl tab 25 mg</i>	104
CELONTIN CAP 300MG	55	<i>chlorpromazine hcl tab 50 mg</i>	104
CENTANY OIN 2%	135	<i>chlorthalidone tab 25 mg</i>	155
<i>cephalexin cap 250 mg</i>	125	<i>chlorthalidone tab 50 mg</i>	156
<i>cephalexin cap 500 mg</i>	125	<i>chlorzoxazone tab 500 mg</i>	207
<i>cephalexin cap 750 mg</i>	125	CHOLBAM CAP 250MG	163
<i>cephalexin for susp 125 mg/5ml</i>	125	CHOLBAM CAP 50MG	163
<i>cephalexin for susp 250 mg/5ml</i>	125	<i>cholestyramine light powder 4 gm/dose</i> ..	70
<i>cephalexin tab 250 mg</i>	125	<i>cholestyramine light powder packets 4 gm</i>	
<i>cephalexin tab 500 mg</i>	125	.....	70
CEQUR SIMPL KIT PATCH 2U	196	<i>cholestyramine powder 4 gm/dose</i>	70
CERDELGA CAP 84MG	170	<i>cholestyramine powder packets 4 gm</i>	70
CERVIDIL VAG MIS 10MG INS	214	<i>choline fenofibrate cap dr 135 mg</i>	
<i>cetirizine hcl oral soln 1 mg/ml (5 mg/5ml)</i>		<i>(fenofibric acid equiv)</i>	71
.....	69	<i>choline fenofibrate cap dr 45 mg (fenofibric</i>	
CETRALAX SOL 0.2%	214	<i>acid equiv)</i>	71
<i>cevimeline hcl cap 30 mg</i>	206	CIBINQO TAB 100MG	145
CHANTIX PAK 1MG	222	CIBINQO TAB 200MG	145
CHANTIX TAB 0.5& 1MG	222	CIBINQO TAB 50MG	145
CHANTIX TAB 0.5MG	222	<i>ciclopirox gel 0.77%</i>	135
CHANTIX TAB 1MG	222	<i>ciclopirox olamine cream 0.77% (base</i>	
CHEMET CAP 100MG	66	<i>equiv)</i>	135
CHEMSTRIP K TES	148	<i>ciclopirox olamine susp 0.77% (base equiv)</i>	
CHEMSTRIP TES UGK	148	.....	135
CHENODAL TAB 250MG	164	<i>ciclopirox shampoo 1%</i>	135
<i>chlordiazepoxide-amitriptyline tab 10-25</i>		<i>ciclopirox solution 8%</i>	135
<i>mg</i>	218	<i>cilostazol tab 100 mg</i>	170
<i>chlordiazepoxide-amitriptyline tab 5-12.5</i>		<i>cilostazol tab 50 mg</i>	170
<i>mg</i>	218	CIMDUO TAB 300-300	107
<i>chlordiazepoxide hcl cap 10 mg</i>	42	<i>cimetidine hcl soln 300 mg/5ml</i>	228
<i>chlordiazepoxide hcl cap 25 mg</i>	42	<i>cimetidine tab 300 mg</i>	228

<i>cimetidine tab 400 mg</i>	228	CLENPIQ SOL.....	175
<i>cimetidine tab 800 mg</i>	228	CLEOCIN CAP 150MG	39
CIMZIA PREFL KIT 200MG/ML	165	CLEOCIN CAP 300MG	39
CIMZIA START KIT 200MG/ML.....	165	CLEOCIN CAP 75MG.....	39
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	158	CLEOCIN CRE 2% VAG.....	231
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	158	CLEOCIN PED SOL 75MG/5ML	39
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	158	CLEOCIN SUP 100MG	231
CINRYZE SOL 500 UNIT	169	CLEOCIN-T LOT 1%.....	133
CIPRO (10%) SUS 500MG/5	163	CLEVER CHECK MIS	179
CIPRO (5%) SUS 250MG/5	163	CLEVER CHECK MIS 30G.....	179
<i>ciprofloxacin-dexamethasone otic susp</i> <i>0.3-0.1%</i>	214	CLEVR CHOICE LIQ HIGH	179
<i>ciprofloxacin hcl ophth soln 0.3% (base</i> <i>equivalent)</i>	211	CLEVR CHOICE LIQ LOW	179
<i>ciprofloxacin hcl otic soln 0.2% (base</i> <i>equivalent)</i>	214	CLIMARA PRO DIS WEEKLY	161
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	163	<i>clindamycin hcl cap 150 mg</i>	39
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	163	<i>clindamycin hcl cap 300 mg</i>	39
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	163	<i>clindamycin hcl cap 75 mg</i>	39
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	163	<i>clindamycin palmitate hcl for soln 75</i> <i>mg/5ml (base equiv)</i>	39
CIPRO TAB 250MG	163	<i>clindamycin phosphate-benzoyl peroxide</i> <i>gel 1.2-2.5%</i>	133
CIPRO TAB 500MG	163	<i>clindamycin phosphate-benzoyl peroxide</i> <i>gel 1-5%</i>	133
<i>citalopram hydrobromide oral soln 10</i> <i>mg/5ml</i>	57	<i>clindamycin phosphate foam 1%</i>	133
<i>citalopram hydrobromide tab 10 mg (base</i> <i>equiv)</i>	57	<i>clindamycin phosphate gel 1%</i>	133
<i>citalopram hydrobromide tab 20 mg (base</i> <i>equiv)</i>	57	<i>clindamycin phosphate lotion 1%</i>	133
<i>citalopram hydrobromide tab 40 mg (base</i> <i>equiv)</i>	57	<i>clindamycin phosphate soln 1%</i>	133
CLARINEX-D TAB 2.5-120	131	<i>clindamycin phosphate swab 1%</i>	133
CLARINEX TAB 5MG	69	<i>clindamycin phosphate-tretinoin gel 1.2-</i> <i>0.025%</i>	133
<i>clarithromycin for susp 125 mg/5ml</i>	175	<i>clindamycin phosphate vaginal cream 2%</i>	231
<i>clarithromycin for susp 250 mg/5ml</i>	176	<i>clindamycin phosph-benzoyl peroxide</i> <i>(refrig) gel 1.2 (1)-5%</i>	133
<i>clarithromycin tab 250 mg</i>	176	CLINDESSE CRE 2%.....	231
<i>clarithromycin tab 500 mg</i>	176	<i>clobazam suspension 2.5 mg/ml</i>	50
<i>clarithromycin tab er 24hr 500 mg</i>	176	<i>clobazam tab 10 mg</i>	50
CLEANLET 28G MIS LANCETS.....	179	<i>clobazam tab 20 mg</i>	50
<i>clemastine fumarate tab 2.68 mg</i>	69	<i>clobetasol propionate cream 0.05%</i>	142
		<i>clobetasol propionate emollient base cream</i> <i>0.05%</i>	142
		<i>clobetasol propionate foam 0.05%</i>	142
		<i>clobetasol propionate gel 0.05%</i>	142
		<i>clobetasol propionate lotion 0.05%</i>	142

<i>clobetasol propionate oint 0.05%</i>	142	<i>clozapine orally disintegrating tab 100 mg</i>	102
<i>clobetasol propionate shampoo 0.05%</i> ..	142	<i>clozapine orally disintegrating tab 12.5 mg</i>	102
<i>clobetasol propionate soln 0.05%</i>	142	<i>clozapine orally disintegrating tab 150 mg</i>	102
CLOBEX LOT 0.05%	142	<i>clozapine orally disintegrating tab 200 mg</i>	102
CLOBEX SHA 0.05%	142	<i>clozapine orally disintegrating tab 25 mg</i>	102
CLODERM CRE 0.1%	142	<i>clozapine tab 100 mg</i>	102
<i>clomiphene citrate tab 50 mg</i>	157	<i>clozapine tab 200 mg</i>	103
<i>clomipramine hcl cap 25 mg</i>	60	<i>clozapine tab 25 mg</i>	102
<i>clomipramine hcl cap 50 mg</i>	60	<i>clozapine tab 50 mg</i>	102
<i>clomipramine hcl cap 75 mg</i>	60	CLOZARIL TAB 100MG	103
<i>clonazepam orally disintegrating tab 0.125</i> <i>mg</i>	50	CLOZARIL TAB 200MG	103
<i>clonazepam orally disintegrating tab 0.25</i> <i>mg</i>	50	CLOZARIL TAB 25MG	103
<i>clonazepam orally disintegrating tab 0.5 mg</i>	50	CLOZARIL TAB 50MG	103
<i>clonazepam orally disintegrating tab 1 mg</i>	50	COAGUCHEK MIS LANCETS	179
<i>clonazepam orally disintegrating tab 2 mg</i>	50	<i>coal tar soln 20%</i>	148
<i>clonazepam tab 0.5 mg</i>	50	COARTEM TAB 20-120MG	82
<i>clonazepam tab 1 mg</i>	50	<i>codeine sulfate tab 30 mg</i>	27
<i>clonazepam tab 2 mg</i>	50	CODEINE SULF TAB 15MG	26
<i>clonidine hcl tab 0.1 mg</i>	76	CODEINE SULF TAB 60MG	27
<i>clonidine hcl tab 0.2 mg</i>	76	<i>colchicine tab 0.6 mg</i>	168
<i>clonidine hcl tab 0.3 mg</i>	76	<i>colchicine w/ probenecid tab 0.5-500 mg</i>	168
<i>clonidine hcl tab er 12hr 0.1 mg</i>	6	<i>colesevelam hcl packet for susp 3.75 gm</i> 70	
<i>clonidine td patch weekly 0.1 mg/24hr</i>	76	<i>colesevelam hcl tab 625 mg</i>	70
<i>clonidine td patch weekly 0.2 mg/24hr</i>	76	COLESTID FLA GRA 5/7.5GM	70
<i>clonidine td patch weekly 0.3 mg/24hr</i>	76	COLESTID FLA GRA 5GM	70
<i>clopidogrel bisulfate tab 300 mg (base</i> <i>equiv)</i>	170	COLESTID GRA 5GM	70
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	170	COLESTID POW 5GM	70
<i>clorazepate dipotassium tab 15 mg</i>	42	COLESTID TAB 1GM	71
<i>clorazepate dipotassium tab 3.75 mg</i>	42	<i>colestipol hcl granule packets 5 gm</i>	71
<i>clorazepate dipotassium tab 7.5 mg</i>	42	<i>colestipol hcl granules 5 gm</i>	71
<i>clotrimazole troche 10 mg</i>	205	<i>colestipol hcl tab 1 gm</i>	71
<i>clotrimazole w/ betamethasone cream 1-</i> <i>0.05%</i>	135	COMBIPATCH DIS	161
<i>clotrimazole w/ betamethasone lotion 1-</i> <i>0.05%</i>	135	COMBIVENT AER 20-100	46
		COMBIVIR TAB 150-300	107
		COMETRIQ KIT 100MG	91
		COMETRIQ KIT 140MG	91
		COMETRIQ KIT 60MG	91

COMFORT ASSU MIS LANC 28G	179	CORGARD TAB 40MG	116
COMFORT ASSU MIS LANC 33G	179	CORGARD TAB 80MG	116
COMFORT EZ MIS 21G	179	CORLANOR SOL 5MG/5ML	125
COMFORT EZ MIS 23G	179	CORLANOR TAB 5MG	125
COMFORT EZ MIS 28G	179	CORLANOR TAB 7.5MG	125
COMFORT MIS LANCETS	179	CORTEF TAB 10MG	129
COMFORTOUCH MIS LANCET	180	CORTEF TAB 20MG	129
COMFORT TCH MIS LANC 28G	180	CORTEF TAB 5MG	129
COMFORT TCH MIS LANC 31G	180	CORTENEMA ENE 100MG	37
COMPACT SPAC MIS CHAMBER	196	CORTIFOAM AER 90MG	37
COMPACT SPAC MIS LG MASK	196	CORTISPORIN SUS -TC OTIC	214
COMPACT SPAC MIS MD MASK	196	CORTROPHIN GEL 80UNIT	157
COMPACT SPAC MIS SM MASK	196	COSENTYX INJ 150MG/ML	137
COMPLEAT LIQ CLS SYS	149	COSENTYX INJ 300DOSE	137
COMPLEAT PED LIQ ORG BLND	149	COSENTYX INJ 75MG/0.5	137
COMTAN TAB 200MG	96	COSENTYX PEN INJ 150MG/ML	138
CONDYLOX GEL 0.5%	146	COSENTYX PEN INJ 300DOSE	138
CONTOUR HIGH LIQ CONTROL	180	COSENTYX UNO INJ 300/2ML	138
CONTOUR LOW LIQ CONTROL	180	COSOPT SOL 2-0.5%OP	209
CONTOUR NEXT SOL LEVEL 1	180	COTELIC TAB 20MG	91
CONTOUR NEXT SOL LEVEL 2	180	CREON CAP 12000UNT	154
CONTOUR NORM LIQ CONTROL	180	CREON CAP 24000UNT	154
CONTROL HIGH SOL UNISTRIP	180	CREON CAP 3000UNIT	153
CONTROL LOW SOL UNISTRIP	180	CREON CAP 36000UNT	154
CONTROL NORM SOL EASY STP	180	CREON CAP 6000UNIT	153
CONTROL SOL LIQ HI/MID/L	180	CRIXIVAN CAP 400MG	107
CONTROL SOL LIQ HIGH/LOW	180	<i>cromolyn sodium ophth soln 4%</i>	213
CONTROL SOL LIQ LEVEL 2	180	<i>cromolyn sodium oral conc 100 mg/5ml</i>	164
CONTROL SOL LIQ MID	180	<i>cromolyn sodium soln nebu 20 mg/2ml</i>	43
CONTROL SOL NORMAL	180	<i>crotamiton lotion 10%</i>	147
CONZIP CAP 100MG	27	CRUCIAL LIQ UNFLAVOR	149
CONZIP CAP 200MG	27	CURITY PREP PAD ALCOHOL	195
CONZIP CAP 300MG	27	CURITY SWABS PAD ALCOHOL	195
COOL CONTROL SOL A	180	CUTIVATE LOT 0.05%	142
COOL CONTROL SOL B	180	CUVPOSA SOL 1MG/5ML	228
COPAXONE INJ 40MG/ML	220	CVS KETONE TES CARE	148
COPIKTRA CAP 15MG	91	CVS LANCETS MIS 21G	180
COPIKTRA CAP 25MG	91	CVS LANCETS MIS 30G	180
COREG TAB 12.5MG	115	CVS LANCETS MIS 33G	180
COREG TAB 25MG	115	CVS LANCETS MIS ORIGINAL	180
COREG TAB 3.125MG	115	CVS LANCETS MIS THIN 26G	180
COREG TAB 6.25MG	115	CVS LANCETS MIS THIN 30G	180
CORGARD TAB 20MG	116	CVS LANCETS MIS THIN 33G	180

CVS LANCING MIS DEVICE	180	dapsone tab 25 mg	39
cyanocobalamin inj 1000 mcg/ml.....	171	darifenacin hydrobromide tab er 24hr 15	
cyclobenzaprine hcl tab 10 mg	207	mg (base equiv).....	230
cyclobenzaprine hcl tab 5 mg	207	darifenacin hydrobromide tab er 24hr 7.5	
CYCLOGYL SOL 0.5% OP	210	mg (base equiv).....	230
CYCLOGYL SOL 1% OP	210	DAYPRO TAB 600MG	21
CYCLOGYL SOL 2% OP.....	210	DDAVP SOL 0.01%.....	160
CYCLOMYDRIL SOL OP	210	DDAVP TAB 0.1MG.....	160
cyclopentolate hcl ophth soln 0.5%	210	DDAVP TAB 0.2MG.....	160
cyclopentolate hcl ophth soln 1%	210	deferasirox granules packet 180 mg	66
cyclopentolate hcl ophth soln 2%.....	210	deferasirox granules packet 360 mg	66
cyclophosphamide cap 25 mg	83	deferasirox granules packet 90 mg.....	66
cyclophosphamide cap 50 mg.....	83	deferasirox tab 180 mg.....	66
CYCLOPHOSPH TAB 25MG	83	deferasirox tab 360 mg.....	66
CYCLOPHOSPH TAB 50MG.....	83	deferasirox tab 90 mg	66
cycloserine cap 250 mg	83	deferasirox tab for oral susp 125 mg	66
cyclosporine cap 100 mg	203	deferasirox tab for oral susp 250 mg	66
cyclosporine cap 25 mg.....	203	deferasirox tab for oral susp 500 mg	66
cyclosporine modified cap 100 mg	203	deferiprone tab 500 mg	66
cyclosporine modified cap 25 mg	203	deferoxamine mesylate for inj 2 gm	66
cyclosporine modified cap 50 mg.....	203	DELESTROGEN INJ 10MG/ML	162
cyclosporine modified oral soln 100 mg/ml		DELESTROGEN INJ 20MG/ML.....	162
.....	203	DELESTROGEN INJ 40MG/ML.....	162
cyproheptadine hcl syrup 2 mg/5ml	70	demeclocycline hcl tab 150 mg	225
cyproheptadine hcl tab 4 mg	70	demeclocycline hcl tab 300 mg.....	225
CYSTAGON CAP 150MG	168	DEMSEER CAP 250MG.....	75
CYSTAGON CAP 50MG.....	168	DEPEN TITRA TAB 250MG.....	202
CYSTARAN SOL 0.44%	213	DEPO-ESTRADI INJ 5MG/ML.....	162
CYTOTEC TAB 100MCG	229	DEPO-PROVERA INJ 150MG/ML.....	129
CYTOTEC TAB 200MCG.....	229	DERMA-SMOOTH OIL /FS BODY.....	142
D		DERMA-SMOOTH OIL /FS SCLP.....	142
dalfampridine tab er 12hr 10 mg	220	DERMOTIC OIL 0.01%.....	214
danazol cap 100 mg	36	DESCOVY TAB 120-15MG	107
danazol cap 200 mg	36	DESCOVY TAB 200/25MG.....	107
danazol cap 50 mg.....	36	desipramine hcl tab 100 mg	60
DANTRIUM CAP 25MG	207	desipramine hcl tab 10 mg.....	60
DANTRIUM CAP 50MG.....	207	desipramine hcl tab 150 mg	60
dantrolene sodium cap 100 mg	207	desipramine hcl tab 25 mg	60
dantrolene sodium cap 25 mg	207	desipramine hcl tab 50 mg.....	60
dantrolene sodium cap 50 mg	207	desipramine hcl tab 75 mg	60
dapsone gel 5%	133	desloratadine tab 5 mg	69
dapsone gel 7.5%	133	desloratadine tab orally disintegrating 2.5	
dapsone tab 100 mg	39	mg	69

<i>desloratadine tab orally disintegrating 5 mg</i>.....69	<i>dexamethasone tab 4 mg</i> .....130
<i>desmopressin acetate nasal spray soln</i> 0.01% .....160	<i>dexamethasone tab 6 mg</i> .....130
<i>desmopressin acetate nasal spray soln</i> 0.01% (refrigerated).....160	<i>dexamethasone tab therapy pack 1.5 mg</i> (21) .....130
<i>desmopressin acetate tab 0.1 mg</i> .....160	<i>dexamethasone tab therapy pack 1.5 mg</i> (35) .....130
<i>desmopressin acetate tab 0.2 mg</i> .....160	<i>dexamethasone tab therapy pack 1.5 mg</i> (51) .....130
<i>desogest-eth estrad & eth estrad tab 0.15-</i> 0.02/0.01 mg(21/5).....126	DEXCOM G6 MIS RECEIVER.....180
<i>desogest-ethin est tab 0.1-0.025/0.125-</i> 0.025/0.15-0.025mg-mg.....126	DEXCOM G6 MIS SENSOR.....180
<i>desogestrel & ethinyl estradiol tab 0.15 mg-</i> 30 mcg .....127	DEXCOM G6 MIS TRANSMIT .....180
DESONATE GEL 0.05% .....142	DEXCOM G7 MIS RECEIVER.....180
<i>desonide cream 0.05%</i> .....142	DEXCOM G7 MIS SENSOR.....180
<i>desonide lotion 0.05%</i>.....142	DEXEDRINE CAP 10MG CR.....1
<i>desonide oint 0.05%</i>.....142	DEXEDRINE CAP 15MG CR .....2
DESOWEN CRE 0.05% .....143	DEXEDRINE CAP 5MG CR .....1
<i>desoximetasone cream 0.05%</i> .....143	<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>.....7
<i>desoximetasone cream 0.25%</i>.....143	<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>.....7
<i>desoximetasone gel 0.05%</i> .....143	<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>.....7
<i>desoximetasone oint 0.25%</i> .....143	<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>.....7
DESOXYN TAB 5MG .....1	<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>.....7
<i>desvenlafaxine succinate tab er 24hr 100</i> <i>mg (base equiv)</i>.....59	<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>.....8
<i>desvenlafaxine succinate tab er 24hr 25 mg</i> <i>(base equiv)</i> .....59	<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>.....8
<i>desvenlafaxine succinate tab er 24hr 50 mg</i> <i>(base equiv)</i> .....59	<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i> 7
DETROL TAB 1MG.....230	<i>dexmethylphenidate hcl tab 10 mg</i>.....8
DETROL TAB 2MG.....230	<i>dexmethylphenidate hcl tab 2.5 mg</i>.....8
DEXAMETHASON CON 1MG/ML .....129	<i>dexmethylphenidate hcl tab 5 mg</i>.....8
<i>dexamethasone elixir 0.5 mg/5ml</i> .....129	<i>dextroamphetamine sulfate cap er 24hr 10</i> <i>mg</i>.....2
<i>dexamethasone sodium phosphate ophth</i> <i>soln 0.1%</i> .....212	<i>dextroamphetamine sulfate cap er 24hr 15</i> <i>mg</i>.....2
<i>dexamethasone soln 0.5 mg/5ml</i> .....129	<i>dextroamphetamine sulfate cap er 24hr 5</i> <i>mg</i>.....2
<i>dexamethasone tab 0.5 mg</i> .....129	<i>dextroamphetamine sulfate oral solution 5</i> <i>mg/5ml</i> .....2
<i>dexamethasone tab 0.75 mg</i> .....129	<i>dextroamphetamine sulfate tab 10 mg</i>.....2
<i>dexamethasone tab 1.5 mg</i> .....129	
<i>dexamethasone tab 1 mg</i> .....129	
<i>dexamethasone tab 2 mg</i>.....129	

<i>dextroamphetamine sulfate tab 15 mg</i>.....2	<i>diclofenac sodium tab er 24hr 100 mg</i> .....21
<i>dextroamphetamine sulfate tab 2.5 mg</i> .....2	<i>diclofenac w/ misoprostol tab delayed</i>
<i>dextroamphetamine sulfate tab 20 mg</i>.....2	<i>release 50-0.2 mg</i>.....21
<i>dextroamphetamine sulfate tab 30 mg</i>.....2	<i>diclofenac w/ misoprostol tab delayed</i>
<i>dextroamphetamine sulfate tab 5 mg</i> .....2	<i>release 75-0.2 mg</i> .....21
<i>dextroamphetamine sulfate tab 7.5 mg</i> .....2	<i>dicloxacillin sodium cap 250 mg</i> .....215
DIABETIC TF LIQ.....149	<i>dicloxacillin sodium cap 500 mg</i> .....216
DIABETISOURC LIQ.....149	<i>dicyclomine hcl cap 10 mg</i> .....228
DIASTIX TES STRIPS.....148	<i>dicyclomine hcl oral soln 10 mg/5ml</i>.....228
DIATHRIVE LIQ CONTROL.....180	<i>dicyclomine hcl tab 20 mg</i>.....228
DIATHRIVE MIS LANCETS .....180	<i>diethylpropion hcl tab 25 mg</i> .....4
DIATHRIVE MIS LANCING .....180	<i>diethylpropion hcl tab er 24hr 75 mg</i> .....4
DIATHRIVE MIS UT 30G .....180	DIFFERIN CRE 0.1% .....133
DIATRUE CONT SOL LEVEL 1 .....181	DIFFERIN GEL 0.1% .....133
DIATRUE CONT SOL LEVEL 2.....181	DIFFERIN GEL 0.3% .....133
DIATRUE CONT SOL LEVEL 3.....181	DIFICID SUS.....176
<i>diazepam conc 5 mg/ml</i> .....42	DIFICID TAB 200MG .....176
<i>diazepam oral soln 1 mg/ml</i>.....42	DIFLUCAN SUS 10MG/ML .....68
<i>diazepam rectal gel delivery system 10 mg</i>	DIFLUCAN SUS 40MG/ML .....68
.....50	DIFLUCAN TAB 100MG .....68
<i>diazepam rectal gel delivery system 2.5 mg</i>	DIFLUCAN TAB 150MG .....68
.....50	DIFLUCAN TAB 200MG .....68
<i>diazepam rectal gel delivery system 20 mg</i>	DIFLUCAN TAB 50MG.....68
.....50	<i>diflunisal tab 500 mg</i> .....26
<i>diazepam tab 10 mg</i>.....42	<i>difluprednate ophth emulsion 0.05%</i> .....212
<i>diazepam tab 2 mg</i> .....42	<i>digoxin oral soln 0.05 mg/ml</i>.....119
<i>diazepam tab 5 mg</i> .....42	<i>digoxin tab 125 mcg (0.125 mg)</i>.....120
<i>diazoxide susp 50 mg/ml</i>.....63	<i>digoxin tab 250 mcg (0.25 mg)</i> .....120
DIBENZYLINE CAP 10MG.....75	DILATRATE SR CAP 40MG.....40
<i>dichlorphenamide tab 50 mg</i> .....154	DILAUDID LIQ 1MG/ML .....27
DICLEGIS TAB 10-10MG.....67	DILAUDID TAB 2MG.....27
<i>diclofenac epolamine patch 1.3%</i> .....134	DILAUDID TAB 4MG .....27
<i>diclofenac potassium tab 50 mg</i> .....21	DILAUDID TAB 8MG.....27
<i>diclofenac sodium (actinic keratoses) gel</i>	<i>diltiazem hcl cap er 12hr 120 mg</i> .....117
3%.....136	<i>diltiazem hcl cap er 12hr 60 mg</i>.....117
<i>diclofenac sodium ophth soln 0.1%</i> .....213	<i>diltiazem hcl cap er 12hr 90 mg</i>.....117
<i>diclofenac sodium soln 1.5%</i> .....134	<i>diltiazem hcl cap er 24hr 120 mg</i>.....117
<i>diclofenac sodium tab delayed release 25</i>	<i>diltiazem hcl cap er 24hr 180 mg</i> .....117
<i>mg</i> .....21	<i>diltiazem hcl cap er 24hr 240 mg</i>.....117
<i>diclofenac sodium tab delayed release 50</i>	<i>diltiazem hcl coated beads cap er 24hr 120</i>
<i>mg</i> .....21	<i>mg</i>.....117
<i>diclofenac sodium tab delayed release 75</i>	<i>diltiazem hcl coated beads cap er 24hr 180</i>
<i>mg</i> .....21	<i>mg</i>.....117

<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	117	DITROPAN XL TAB 5MG.....	230
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	117	DIURIL SUS 250/5ML.....	156
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	117	<i>divalproex sodium cap delayed release sprinkle 125 mg</i>	56
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	117	<i>divalproex sodium tab delayed release 125 mg</i>	56
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	117	<i>divalproex sodium tab delayed release 250 mg</i>	56
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	117	<i>divalproex sodium tab delayed release 500 mg</i>	56
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	118	DIVIGEL GEL 0.25MG.....	162
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	118	DIVIGEL GEL 0.5MG.....	162
<i>diltiazem hcl tab 120 mg</i>	118	DIVIGEL GEL 0.75MG.....	162
<i>diltiazem hcl tab 30 mg</i>	118	DIVIGEL GEL 1.25MG.....	162
<i>diltiazem hcl tab 60 mg</i>	118	DIVIGEL GEL 1MG/GM.....	162
<i>diltiazem hcl tab 90 mg</i>	118	<i>dofetilide cap 125 mcg (0.125 mg)</i>	43
<i>dimethyl fumarate capsule delayed release 120 mg</i>	220	<i>dofetilide cap 250 mcg (0.25 mg)</i>	43
<i>dimethyl fumarate capsule delayed release 240 mg</i>	220	<i>dofetilide cap 500 mcg (0.5 mg)</i>	43
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	220	<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	217
DIPENTUM CAP 250MG.....	165	<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	217
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	66	<i>donepezil hydrochloride tab 10 mg</i>	217
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	66	<i>donepezil hydrochloride tab 23 mg</i>	217
DIPROLENE AF CRE 0.05%.....	143	<i>donepezil hydrochloride tab 5 mg</i>	217
DIPROLENE OIN 0.05%.....	143	DOPTLET TAB 20MG.....	171
<i>dipyridamole tab 25 mg</i>	170	DORAL TAB 15MG.....	173
<i>dipyridamole tab 50 mg</i>	170	<i>dorzolamide hcl ophth soln 2%</i>	213
<i>dipyridamole tab 75 mg</i>	170	<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	209
<i>disopyramide phosphate cap 100 mg</i>	42	<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	209
<i>disopyramide phosphate cap 150 mg</i>	42	DOVATO TAB 50-300MG.....	107
<i>disulfiram tab 250 mg</i>	216	DOVONEX CRE 0.005%.....	138
<i>disulfiram tab 500 mg</i>	216	<i>doxazosin mesylate tab 1 mg</i>	76
DITROPAN XL TAB 10MG.....	230	<i>doxazosin mesylate tab 2 mg</i>	76
		<i>doxazosin mesylate tab 4 mg</i>	76
		<i>doxazosin mesylate tab 8 mg</i>	76
		<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	173

<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	DROXIA CAP 400MG.....	170
.....	<i>droxidopa cap 100 mg</i>	232
<i>doxepin hcl cap 100 mg</i>	<i>droxidopa cap 200 mg</i>	232
<i>doxepin hcl cap 10 mg</i>	<i>droxidopa cap 300 mg</i>	232
<i>doxepin hcl cap 150 mg</i>	DRYSOL SOL 20%.....	147
<i>doxepin hcl cap 25 mg</i>	DUETACT TAB 30-2MG.....	61
<i>doxepin hcl cap 50 mg</i>	DUETACT TAB 30-4MG.....	61
<i>doxepin hcl cap 75 mg</i>	DUEXIS TAB 800-26.6.....	21
<i>doxepin hcl conc 10 mg/ml</i>	DULERA AER 100-5MCG.....	46
<i>doxercalciferol cap 0.5 mcg</i>	DULERA AER 200-5MCG.....	46
<i>doxercalciferol cap 1 mcg</i>	DULERA AER 50-5MCG.....	46
<i>doxercalciferol cap 2.5 mcg</i>	<i>duloxetine hcl enteric coated pellets cap 20</i>	
<i>doxycycline hyclate cap 100 mg</i>	<i>mg (base eq)</i>	59
<i>doxycycline hyclate cap 50 mg</i>	<i>duloxetine hcl enteric coated pellets cap 30</i>	
<i>doxycycline hyclate tab 100 mg</i>	<i>mg (base eq)</i>	59
<i>doxycycline hyclate tab 20 mg</i>	<i>duloxetine hcl enteric coated pellets cap 40</i>	
<i>doxycycline monohydrate cap 100 mg</i>	<i>mg (base eq)</i>	59
<i>doxycycline monohydrate cap 50 mg</i>	<i>duloxetine hcl enteric coated pellets cap 60</i>	
<i>doxycycline monohydrate for susp 25</i>	<i>mg (base eq)</i>	59
<i>mg/5ml</i>	DUO-CARE LIQ LEVEL1/2.....	181
<i>doxycycline monohydrate tab 100 mg</i>	DUPIXENT INJ 100/0.67.....	43
<i>doxycycline monohydrate tab 150 mg</i>	DUPIXENT INJ 200/1.14.....	43
<i>doxycycline monohydrate tab 50 mg</i>	DUPIXENT INJ 200MG.....	145
<i>doxycycline monohydrate tab 75 mg</i>	DUPIXENT INJ 300/2ML.....	145
<i>doxylamine-pyridoxine tab delayed release</i>	DURAGESIC DIS 100MCG/H.....	27
<i>10-10 mg</i>	DURAGESIC DIS 12MCG/HR.....	27
DRISDOL CAP 50000UNT.....	DURAGESIC DIS 25MCG/HR.....	27
<i>dronabinol cap 10 mg</i>	DURAGESIC DIS 50MCG/HR.....	27
<i>dronabinol cap 2.5 mg</i>	DURAGESIC DIS 75MCG/HR.....	27
<i>dronabinol cap 5 mg</i>	DUREZOL EMU 0.05%.....	212
DROPLET LANC MIS 30G.....	<i>dutasteride cap 0.5 mg</i>	168
DROPLET LANC MIS DEVICE.....	<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	
DROPLET PERS MIS LANC 30G.....	.....	168
<i>drospirenone-ethinyl estradiol tab 3-0.02</i>	E	
<i>mg</i>	EAA SUPPLEME POW TROPICAL.....	149
<i>drospirenone-ethinyl estradiol tab 3-0.03</i>	EASIVENT MIS.....	196
<i>mg</i>	EASIVENT MIS MASK LG.....	196
<i>drospirenone-ethinyl estrad-levomefolate</i>	EASIVENT MIS MASK MED.....	197
<i>tab 3-0.02-0.451 mg</i>	EASIVENT MIS MASK SM.....	197
<i>drospirenone-ethinyl estrad-levomefolate</i>	EASY COMFORT MIS 30G.....	181
<i>tab 3-0.03-0.451 mg</i>	EASY COMFORT MIS LANC/30G.....	181
DROXIA CAP 200MG.....	EASY COMFORT MIS TWIST.....	181
DROXIA CAP 300MG.....	EASY COMFORT PAD ALCOHOL.....	195

EASYGLUCO SOL PLUS.....	182	<i>efavirenz tab 600 mg</i>	107
EASYMAX 15 LIQ LEVEL2-3	182	EFFIENT TAB 10MG.....	170
EASYMAX 15 SOL LEVEL 2	182	EFFIENT TAB 5MG.....	170
EASYMAX LIQ NORM/HIG	182	EFUDEX CRE 5%.....	136
EASYMAX SOL NORMAL	182	EGRIFTA SV INJ 2MG.....	158
EASY MINI MIS	181	ELEMENT CONT LIQ NORMAL.....	182
EASY MINI MIS EJECT	181	ELEMENT LIQ HIGH	182
EASY PLUS II SOL HIGH	181	ELEMENT LIQ LOW	182
EASY PLUS II SOL LOW	181	ELEMNT COMPA SOL LEVEL 2	182
EASYPHASE HGH SOL CONTROL	182	ELEMNT COMPA SOL LEVEL 3	182
EASYPHASE LOW SOL CONTROL	182	<i>eletriptan hydrobromide tab 20 mg (base</i>	
EASY TALK SOL HIGH	181	<i>equivalent)</i>	199
EASY TALK SOL LOW	181	<i>eletriptan hydrobromide tab 40 mg (base</i>	
EASY TALK SOL NORMAL	181	<i>equivalent)</i>	199
EASY TOUCH MIS	181	ELIMITE CRE 5%.....	147
EASY TOUCH MIS LANC/21G.....	181	ELIQUIS ST P TAB 5MG.....	48
EASY TOUCH MIS LANC/23G	181	ELIQUIS TAB 2.5MG	48
EASY TOUCH MIS LANC/26G.....	181	ELIQUIS TAB 5MG.....	48
EASY TOUCH MIS LANC/28G.....	181	ELLA TAB 30MG	129
EASY TOUCH MIS LANC/30G.....	181	EMBRACE CNTR LIQ HIGH	182
EASY TOUCH MIS LANC/32G	181	EMBRACE EVO LIQ LEVEL 1.....	182
EASY TOUCH MIS LANC/33G	181	EMBRACE LANC MIS /EJECTOR	182
EASY TOUCH SOL CONTROL	181	EMBRACE LANC MIS THIN 30G.....	182
EASY TOUCH SOL HIGH/LOW.....	181	EMBRACE PRO LIQ GLUCOSE.....	182
EASY TRAK II LIQ NORMAL	181	EMBRACE SOL LOW	182
EASY TRAK SOL HIGH	182	EMBRACE TALK SOL HIGH/L2.....	182
EASY TRAK SOL LOW	182	EMBRACE TALK SOL LOW/L1	182
EASY TRAK SOL NORMAL	182	EMCYT CAP 140MG.....	87
EC-NAPROSYN TAB 375MG.....	21	EMGALITY INJ 100MG/ML	198
EC-NAPROSYN TAB 500MG	21	EMGALITY INJ 120MG/ML.....	198
<i>econazole nitrate cream 1%</i>	135	EMSAM DIS 12MG/24H.....	57
EDECIN TAB 25MG.....	155	EMSAM DIS 6MG/24HR.....	57
EDEX KIT 10MCG.....	121	EMSAM DIS 9MG/24HR.....	57
EDEX KIT 20MCG	121	<i>emtricitabine caps 200 mg</i>	108
EDEX KIT 40MCG.....	121	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz cap 200 mg</i>	107	<i>tab 100-150 mg</i>	108
<i>efavirenz cap 50 mg</i>	107	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz-emtricitabine-tenofovir df tab</i>		<i>tab 133-200 mg</i>	108
<i>600-200-300 mg</i>	108	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz-lamivudine-tenofovir df tab 400-</i>		<i>tab 167-250 mg</i>	108
<i>300-300 mg</i>	108	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz-lamivudine-tenofovir df tab 600-</i>		<i>tab 200-300 mg</i>	108
<i>300-300 mg</i>	108	EMTRIVA CAP 200MG	108

EMTRIVA SOL 10MG/ML.....	108	ENTRESTO TAB 97-103MG.....	121
EMVERM CHW 100MG.....	37	ENVARBUS XR TAB 0.75MG.....	204
<i>enalapril maleate & hydrochlorothiazide tab</i>		ENVARBUS XR TAB 1MG.....	204
<i>10-25 mg.....</i>	79	ENVARBUS XR TAB 4MG.....	204
<i>enalapril maleate & hydrochlorothiazide tab</i>		EO28 SPLASH LIQ ORANGE.....	149
<i>5-12.5 mg.....</i>	79	EPCLUSA PAK 150-37.5.....	112
<i>enalapril maleate oral soln 1 mg/ml.....</i>	74	EPCLUSA PAK 200-50MG.....	112
<i>enalapril maleate tab 10 mg.....</i>	74	EPCLUSA TAB 200-50MG.....	112
<i>enalapril maleate tab 2.5 mg.....</i>	74	EPCLUSA TAB 400-100.....	113
<i>enalapril maleate tab 20 mg.....</i>	74	EPIDIOLEX SOL 100MG/ML.....	51
<i>enalapril maleate tab 5 mg.....</i>	74	EPIDUO FORTE GEL 0.3-2.5%.....	133
ENBREL INJ 25/0.5ML.....	25	EPIDUO GEL 0.1-2.5%.....	133
ENBREL INJ 50MG/ML.....	25	EPIFOAM AER 1%.....	143
ENBREL MINI INJ 50MG/ML.....	25	<i>epinastine hcl ophth soln 0.05%.....</i>	213
ENBREL SRCLK INJ 50MG/ML.....	26	EPINEPHRINE INJ 0.2MG.....	232
ENCARE SUP 100MG.....	231	<i>epinephrine inj 1 mg/ml (1:1000).....</i>	232
ENDARI POW 5GM.....	171	<i>epinephrine solution auto-injector 0.15</i>	
ENDOMETRIN SUP 100MG.....	232	<i>mg/0.15ml (1:1000).....</i>	232
<i>enoxaparin sodium inj 300 mg/3ml.....</i>	48	<i>epinephrine solution auto-injector 0.3</i>	
<i>enoxaparin sodium inj soln pref syr 100</i>		<i>mg/0.3ml (1:1000).....</i>	232
<i>mg/ml.....</i>	49	EPIVIR SOL 10MG/ML.....	108
<i>enoxaparin sodium inj soln pref syr 120</i>		EPIVIR TAB 150MG.....	108
<i>mg/0.8ml.....</i>	49	EPIVIR TAB 300MG.....	108
<i>enoxaparin sodium inj soln pref syr 150</i>		<i>eplerenone tab 25 mg.....</i>	81
<i>mg/ml.....</i>	49	<i>eplerenone tab 50 mg.....</i>	81
<i>enoxaparin sodium inj soln pref syr 30</i>		EPZICOM TAB 600-300.....	108
<i>mg/0.3ml.....</i>	48	EQL LANCETS MIS 21G COLR.....	182
<i>enoxaparin sodium inj soln pref syr 40</i>		EQL LANCETS MIS 33G COLR.....	182
<i>mg/0.4ml.....</i>	48	EQL LANCETS MIS THIN 26G.....	182
<i>enoxaparin sodium inj soln pref syr 60</i>		EQL LANCETS MIS THIN 30G.....	182
<i>mg/0.6ml.....</i>	49	EQUETRO CAP 100MG.....	100
<i>enoxaparin sodium inj soln pref syr 80</i>		EQUETRO CAP 200MG.....	100
<i>mg/0.8ml.....</i>	49	EQUETRO CAP 300MG.....	100
ENSPRYNG INJ.....	204	<i>ergocalciferol cap 1.25 mg (50000 unit).233</i>	
ENSTILAR AER.....	143	<i>ergoloid mesylates tab 1 mg.....</i>	222
ENSURE PLANT LIQ CHOCOLAT.....	149	ERGOMAR SUB 2MG.....	199
<i>entacapone tab 200 mg.....</i>	96	ERIVEDGE CAP 150MG.....	86
<i>entecavir tab 0.5 mg.....</i>	112	ERLEADA TAB 240MG.....	87
<i>entecavir tab 1 mg.....</i>	112	ERLEADA TAB 60MG.....	87
ENTEREG CAP 12MG.....	167	<i>erlotinib hcl tab 100 mg (base equivalent)86</i>	
ENTOCORT EC CAP 3MG DR.....	130	<i>erlotinib hcl tab 150 mg (base equivalent)86</i>	
ENTRESTO TAB 24-26MG.....	121	<i>erlotinib hcl tab 25 mg (base equivalent) .86</i>	
ENTRESTO TAB 49-51MG.....	121	ERYGEL GEL 2%.....	133

<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	176	ESTRACE TAB 1MG	162
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	176	ESTRACE TAB 2MG.....	162
<i>erythromycin ethylsuccinate tab 400 mg</i>	176	ESTRACE VAG CRE 0.01%	231
<i>erythromycin gel 2%</i>	133	<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	161
<i>erythromycin ophth oint 5 mg/gm</i>	211	<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	161
<i>erythromycin pads 2%</i>	133	<i>estradiol tab 0.5 mg</i>	162
<i>erythromycin soln 2%</i>	133	<i>estradiol tab 1 mg</i>	162
<i>erythromycin stearate tab 250 mg</i>	176	<i>estradiol tab 2 mg</i>	162
<i>erythromycin tab 250 mg</i>	176	<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i> .	162
<i>erythromycin tab 500 mg</i>	176	<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	162
<i>erythromycin tab delayed release 250 mg</i>	176	<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i> .	162
<i>erythromycin tab delayed release 333 mg</i>	176	<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i> ...	162
<i>erythromycin tab delayed release 500 mg</i>	176	<i>estradiol td gel 1 mg/gm (0.1%)</i>	162
<i>erythromycin w/ delayed release particles cap 250 mg</i>	176	<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	162
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	57	<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	162
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	57	<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	162
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	57	<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	162
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	57	<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	162
ESGIC TAB.....	26	<i>estradiol td patch weekly 0.025 mg/24hr</i>	162
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	229	<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	163
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	229	<i>estradiol td patch weekly 0.05 mg/24hr</i> .	162
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	229	<i>estradiol td patch weekly 0.06 mg/24hr</i> .	162
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	229	<i>estradiol td patch weekly 0.075 mg/24hr</i>	163
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	229	<i>estradiol td patch weekly 0.1 mg/24hr</i>	162
<i>estazolam tab 1 mg</i>	174	<i>estradiol vaginal cream 0.1 mg/gm</i>	231
<i>estazolam tab 2 mg</i>	174	<i>estradiol valerate im in oil 20 mg/ml</i>	163
ESTRACE TAB 0.5MG	162	<i>estradiol valerate im in oil 40 mg/ml</i>	163
		ESTROSTEP FE TAB	127
		<i>eszopiclone tab 1 mg</i>	174
		<i>eszopiclone tab 2 mg</i>	174
		<i>eszopiclone tab 3 mg</i>	174
		<i>ethacrynic acid tab 25 mg</i>	155
		<i>ethambutol hcl tab 100 mg</i>	83

<i>ethambutol hcl tab 400 mg</i>	83	EXELON DIS 13.3/24.....	217
<i>ethosuximide cap 250 mg</i>	55	EXELON DIS 4.6MG/24.....	217
<i>ethosuximide soln 250 mg/5ml</i>	55	EXELON DIS 9.5MG/24.....	217
ETHYL CHLOR AER FINE PIN	146	<i>exemestane tab 25 mg</i>	87
ETHYL CHLOR AER FN STRM	146	EXODERM LOT 25-1%	135
ETHYL CHLOR AER MED JET	146	EXTINA AER 2%.....	135
ETHYL CHLOR AER MED STRM.....	146	EYSUVIS DRO 0.25%.....	212
ETHYL CHLOR AER MIST	146	<i>ezetimibe-simvastatin tab 10-10 mg</i>	70
<i>ethyl chloride aerosol spray</i>	146	<i>ezetimibe-simvastatin tab 10-20 mg</i>	70
<i>ethynodiol diacetate & ethinyl estradiol tab</i> <i>1 mg-35 mcg</i>	127	<i>ezetimibe-simvastatin tab 10-40 mg</i>	70
<i>ethynodiol diacetate & ethinyl estradiol tab</i> <i>1 mg-50 mcg</i>	127	<i>ezetimibe-simvastatin tab 10-80 mg</i>	70
<i>etodolac cap 200 mg</i>	21	<i>ezetimibe tab 10 mg</i>	73
<i>etodolac cap 300 mg</i>	21	E-ZJECT LANC MIS 33G	181
<i>etodolac tab 400 mg</i>	21	E-Z JECT MIS 21G.....	181
<i>etodolac tab 500 mg</i>	21	E-Z JECT MIS 21G COLR	181
<i>etodolac tab er 24hr 400 mg</i>	21	E-Z JECT MIS 30G.....	181
<i>etodolac tab er 24hr 500 mg</i>	21	E-Z JECT MIS 32G COLR.....	181
<i>etodolac tab er 24hr 600 mg</i>	21	E-Z JECT MIS LANC 21G	181
<i>etoposide cap 50 mg</i>	96	E-Z JECT MIS THIN 26G.....	181
<i>etravirine tab 100 mg</i>	108	EZ-LETS 21G MIS LANCETS	182
<i>etravirine tab 200 mg</i>	108	EZ-LETS 26G MIS LANCETS	182
EUCRISA OIN 2%.....	147	EZ-LETS 28G MIS LANCETS	182
EVAMIST SPR 1.53MG	163	EZ-LETS 30G MIS LANCETS	183
EVENCARE G2 SOL LOW/HIGH	182	F	
EVENCARE G3 SOL LOW/HIGH	182	F.A.A. LIQ	149
EVENCARE SOL LIQ LOW/HIGH	182	<i>famciclovir tab 125 mg</i>	114
EVENCAR MINI SOL NORMAL	182	<i>famciclovir tab 250 mg</i>	114
<i>everolimus tab 0.25 mg</i>	204	<i>famciclovir tab 500 mg</i>	114
<i>everolimus tab 0.5 mg</i>	204	<i>famotidine for susp 40 mg/5ml</i>	228
<i>everolimus tab 0.75 mg</i>	204	<i>famotidine tab 40 mg</i>	228
<i>everolimus tab 2.5 mg</i>	91	FARESTON TAB 60MG.....	87
<i>everolimus tab 5 mg</i>	91	FARXIGA TAB 10MG	65
<i>everolimus tab 7.5 mg</i>	91	FARXIGA TAB 5MG.....	65
EVISTA TAB 60MG	158	FASENRA PEN INJ 30MG/ML.....	43
EVOCLIN AER 1%.....	134	FASTCLIX MIS LANCETS.....	183
EVOLUTION SOL NORMAL	182	FAVIPIRAVIR TAB 200MG	114
EVOTAZ TAB 300-150	108	FC2 FEMALE MIS CONDOM	176
EVOXAC CAP 30MG	206	FC FEMALE MIS CONDOM	176
EVRYSDI SOL	209	<i>febuxostat tab 40 mg</i>	168
EXELDERM CRE 1%.....	135	<i>febuxostat tab 80 mg</i>	168
EXELDERM SOL 1%.....	135	<i>felbamate susp 600 mg/5ml</i>	54
		<i>felbamate tab 400 mg</i>	54
		<i>felbamate tab 600 mg</i>	54

FELBATOL SUS 600/5ML.....	54	<i>fentanyl citrate lozenge on a handle 600</i>	
FELBATOL TAB 400MG.....	54	<i>mcg</i>	27
FELBATOL TAB 600MG.....	54	<i>fentanyl citrate lozenge on a handle 800</i>	
FELDENE CAP 10MG	21	<i>mcg</i>	27
FELDENE CAP 20MG.....	21	<i>fentanyl td patch 72hr 100 mcg/hr</i>	28
<i>felodipine tab er 24hr 10 mg</i>	118	<i>fentanyl td patch 72hr 12 mcg/hr</i>	28
<i>felodipine tab er 24hr 2.5 mg</i>	118	<i>fentanyl td patch 72hr 25 mcg/hr</i>	28
<i>felodipine tab er 24hr 5 mg</i>	118	<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	28
FEMARA TAB 2.5MG	87	<i>fentanyl td patch 72hr 50 mcg/hr</i>	28
FEMCAP MIS 22MM.....	176	<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	28
FEMCAP MIS 26MM.....	176	<i>fentanyl td patch 72hr 75 mcg/hr</i>	28
FEMCAP MIS 30MM.....	176	<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	28
<i>fenofibrate cap 150 mg</i>	71	<i>fesoterodine fumarate tab er 24hr 4 mg</i> 230	
<i>fenofibrate micronized cap 134 mg</i>	71	<i>fesoterodine fumarate tab er 24hr 8 mg</i> 230	
<i>fenofibrate micronized cap 200 mg</i>	71	FIASP FLEX INJ TOUCH.....	64
<i>fenofibrate micronized cap 43 mg</i>	71	FIASP INJ 100/ML.....	64
<i>fenofibrate micronized cap 67 mg</i>	71	FIASP PENFIL INJ U-100	64
<i>fenofibrate tab 145 mg</i>	71	FIBERSOURCE LIQ CLS SYS	149
<i>fenofibrate tab 160 mg</i>	71	FIBERSOUR HN LIQ CLS SYS.....	149
<i>fenofibrate tab 48 mg</i>	71	FIBRICOR TAB 105MG.....	71
<i>fenofibrate tab 54 mg</i>	71	FIBRICOR TAB 35MG	71
<i>fenofibric acid tab 105 mg</i>	71	FIFTY50 PREP PAD PADS	195
<i>fenofibric acid tab 35 mg</i>	71	FIFTY50 SAFE MIS LANCETS	183
FENOGLIDE TAB 40MG	71	FINACEA AER 15%.....	147
<i>fentanyl citrate buccal tab 100 mcg (base</i>		<i>finasteride tab 5 mg</i>	168
<i>equiv)</i>	27	FINE 30 MIS.....	183
<i>fentanyl citrate buccal tab 200 mcg (base</i>		FINGERSTIX MIS LANCETS.....	183
<i>equiv)</i>	27	<i>ingolimod hcl cap 0.5 mg (base equiv)</i> ..	220
<i>fentanyl citrate buccal tab 400 mcg (base</i>		FIORICET CAP CODEINE.....	33
<i>equiv)</i>	27	FIRDAPSE TAB 10MG	82
<i>fentanyl citrate buccal tab 600 mcg (base</i>		FLAGYL CAP 375MG	38
<i>equiv)</i>	27	FLAGYL TAB 500MG	38
<i>fentanyl citrate buccal tab 800 mcg (base</i>		<i>flavoxate hcl tab 100 mg</i>	231
<i>equiv)</i>	27	<i>flecainide acetate tab 100 mg</i>	43
<i>fentanyl citrate lozenge on a handle 1200</i>		<i>flecainide acetate tab 150 mg</i>	43
<i>mcg</i>	28	<i>flecainide acetate tab 50 mg</i>	42
<i>fentanyl citrate lozenge on a handle 1600</i>		FLEXICHAMBER MIS.....	197
<i>mcg</i>	28	FLEXICHAMBER MIS MASK LRG	197
<i>fentanyl citrate lozenge on a handle 200</i>		FLEXICHAMBER MIS MASK SM	197
<i>mcg</i>	27	FLOMAX CAP 0.4MG.....	168
<i>fentanyl citrate lozenge on a handle 400</i>		FLOVENT HFA AER 110MCG	45
<i>mcg</i>	27	FLOVENT HFA AER 220MCG	45
		FLOVENT HFA AER 44MCG	45

<i>fluconazole for susp 10 mg/ml</i>	68	<i>fluphenazine hcl tab 2.5 mg</i>	105
<i>fluconazole for susp 40 mg/ml</i>	68	<i>fluphenazine hcl tab 5 mg</i>	105
<i>fluconazole tab 100 mg</i>	69	<i>flurazepam hcl cap 15 mg</i>	174
<i>fluconazole tab 150 mg</i>	69	<i>flurazepam hcl cap 30 mg</i>	174
<i>fluconazole tab 200 mg</i>	69	<i>flurbiprofen sodium ophth soln 0.03%</i> ...	213
<i>fluconazole tab 50 mg</i>	69	<i>flurbiprofen tab 100 mg</i>	21
<i>flucytosine cap 250 mg</i>	68	<i>flurbiprofen tab 50 mg</i>	21
<i>fludrocortisone acetate tab 0.1 mg</i>	131	<i>flutamide cap 125 mg</i>	87
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	208	<i>fluticasone propionate cream 0.05%</i>	143
<i>fluocinolone acetonide (otic) oil 0.01%</i> ...	214	<i>fluticasone propionate hfa inhal aer 110</i> <i>mcg/act (125/valve)</i>	45
<i>fluocinolone acetonide cream 0.01%</i>	143	<i>fluticasone propionate hfa inhal aer 220</i> <i>mcg/act (250/valve)</i>	45
<i>fluocinolone acetonide cream 0.025%</i> ...	143	<i>fluticasone propionate hfa inhal aero 44</i> <i>mcg/act (50/valve)</i>	45
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	143	<i>fluticasone propionate lotion 0.05%</i>	143
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	143	<i>fluticasone propionate nasal susp 50</i> <i>mcg/act</i>	208
<i>fluocinolone acetonide oint 0.025%</i>	143	<i>fluticasone propionate oint 0.005%</i>	143
<i>fluocinolone acetonide soln 0.01%</i>	143	<i>fluticasone-salmeterol aer powder ba 100-</i> <i>50 mcg/act</i>	47
<i>fluocinonide cream 0.05%</i>	143	<i>fluticasone-salmeterol aer powder ba 250-</i> <i>50 mcg/act</i>	47
<i>fluocinonide emulsified base cream 0.05%</i>	143	<i>fluticasone-salmeterol aer powder ba 500-</i> <i>50 mcg/act</i>	47
<i>fluocinonide gel 0.05%</i>	143	<i>fluvastatin sodium cap 20 mg (base</i> <i>equivalent)</i>	72
<i>fluocinonide oint 0.05%</i>	143	<i>fluvastatin sodium cap 40 mg (base</i> <i>equivalent)</i>	72
<i>fluocinonide soln 0.05%</i>	143	<i>fluvastatin sodium tab er 24 hr 80 mg (base</i> <i>equivalent)</i>	72
FLUORABON DRO	201	<i>fluvoxamine maleate cap er 24hr 100 mg</i>	58
<i>fluorometholone ophth susp 0.1%</i>	212	<i>fluvoxamine maleate cap er 24hr 150 mg</i>	58
<i>fluorouracil cream 5%</i>	136	<i>fluvoxamine maleate tab 100 mg</i>	58
<i>fluorouracil soln 2%</i>	136	<i>fluvoxamine maleate tab 25 mg</i>	58
<i>fluorouracil soln 5%</i>	136	<i>fluvoxamine maleate tab 50 mg</i>	58
<i>fluoxetine hcl cap 10 mg</i>	57	FOCALIN TAB 10MG	8
<i>fluoxetine hcl cap 20 mg</i>	58	FOCALIN TAB 2.5MG	8
<i>fluoxetine hcl cap 40 mg</i>	58	FOCALIN TAB 5MG	8
<i>fluoxetine hcl cap delayed release 90 mg</i>	58	<i>folic acid cap 0.8 mg</i>	171
<i>fluoxetine hcl solution 20 mg/5ml</i>	58	<i>folic acid tab 1 mg</i>	171
<i>fluoxetine hcl tab 10 mg</i>	58	<i>folic acid tab 400 mcg</i>	171
<i>fluoxetine hcl tab 20 mg</i>	58	<i>folic acid tab 800 mcg</i>	171
<i>fluphenazine decanoate inj 25 mg/ml</i>	104		
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	104		
<i>fluphenazine hcl inj 2.5 mg/ml</i>	105		
<i>fluphenazine hcl oral conc 5 mg/ml</i>	105		
<i>fluphenazine hcl tab 10 mg</i>	105		
<i>fluphenazine hcl tab 1 mg</i>	105		

FOLLISTIM AQ INJ 300UNIT.....	157	FREESTYLE LIQ CONTROL	183
FOLLISTIM AQ INJ 600UNIT.....	157	FREESTYLE MIS LANCETS.....	183
FOLLISTIM AQ INJ 900UNIT.....	157	FREESTYLE MIS UNISTICK.....	183
<i>fondaparinux sodium subcutaneous inj 10</i>		FROVA TAB 2.5MG.....	199
<i>mg/0.8ml.....</i>	49	<i>frovatriptan succinate tab 2.5 mg (base</i>	
<i>fondaparinux sodium subcutaneous inj 2.5</i>		<i>equivalent)</i>	199
<i>mg/0.5ml.....</i>	49	<i>furosemide oral soln 10 mg/ml</i>	155
<i>fondaparinux sodium subcutaneous inj 5</i>		<i>furosemide oral soln 8 mg/ml.....</i>	155
<i>mg/0.4ml</i>	49	<i>furosemide tab 20 mg.....</i>	155
<i>fondaparinux sodium subcutaneous inj 7.5</i>		<i>furosemide tab 40 mg</i>	155
<i>mg/0.6ml</i>	49	<i>furosemide tab 80 mg</i>	155
FORACARE GDH SOL HIGH	183	FUZEON INJ 90MG	109
FORACARE GDH SOL LOW	183	FYCOMPA SUS 0.5MG/ML	49
FORACARE GDH SOL NORMAL.....	183	FYCOMPA TAB 10MG	50
FORA CONTROL SOL HIGH	183	FYCOMPA TAB 12MG.....	50
FORA CONTROL SOL LOW	183	FYCOMPA TAB 2MG	49
FORA CONTROL SOL NORMAL.....	183	FYCOMPA TAB 4MG	49
FORA GTEL TES KETONE.....	148	FYCOMPA TAB 6MG	49
FORA LANCETS MIS 30G.....	183	FYCOMPA TAB 8MG	50
FORA MIS LANCETS	183	FYLNETRA INJ 6MG/0.6	171
FORA MIS LANCING	183	G	
FORFIVO XL TAB 450MG.....	56	<i>gabapentin cap 100 mg</i>	51
<i>formaldehyde solution 10%</i>	106	<i>gabapentin cap 300 mg.....</i>	51
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>		<i>gabapentin cap 400 mg.....</i>	51
<i>.....</i>	47	<i>gabapentin oral soln 250 mg/5ml</i>	51
FORTEO INJ 600/2.4.....	156	<i>gabapentin tab 600 mg</i>	51
FORTISCARE SOL CNTL HI.....	183	<i>gabapentin tab 800 mg.....</i>	51
FORTISCARE SOL CNTL LOW	183	GABITRIL TAB 12MG.....	55
FORTISCARE SOL CNTL NML	183	GABITRIL TAB 16MG.....	55
FOSAMAX + D TAB 70-2800	156	GABITRIL TAB 2MG	55
FOSAMAX + D TAB 70-5600.....	156	GABITRIL TAB 4MG	55
FOSAMAX TAB 70MG.....	156	GALAFOLD CAP 123MG	158
<i>fosamprenavir calcium tab 700 mg (base</i>		<i>galantamine hydrobromide cap er 24hr 16</i>	
<i>equiv).....</i>	108	<i>mg</i>	217
<i>fosfomycin tromethamine powd pack 3 gm</i>		<i>galantamine hydrobromide cap er 24hr 24</i>	
<i>(base equivalent).....</i>	39	<i>mg</i>	217
<i>fosinopril sodium & hydrochlorothiazide tab</i>		<i>galantamine hydrobromide cap er 24hr 8</i>	
<i>10-12.5 mg</i>	79	<i>mg</i>	217
<i>fosinopril sodium & hydrochlorothiazide tab</i>		<i>galantamine hydrobromide oral soln 4</i>	
<i>20-12.5 mg.....</i>	79	<i>mg/ml</i>	217
<i>fosinopril sodium tab 10 mg.....</i>	74	<i>galantamine hydrobromide tab 12 mg</i>	217
<i>fosinopril sodium tab 20 mg</i>	74	<i>galantamine hydrobromide tab 4 mg</i>	217
<i>fosinopril sodium tab 40 mg.....</i>	74	<i>galantamine hydrobromide tab 8 mg</i>	217

GANIRELIX AC INJ 250/0.5	157	GLEOSTINE CAP 40MG	83
GASTROCROM CON 100/5ML.....	164	<i>glimepiride tab 1 mg</i>	65
<i>gatifloxacin ophth soln 0.5%</i>	211	<i>glimepiride tab 2 mg</i>	65
GATTEX KIT 5MG	167	<i>glimepiride tab 4 mg</i>	65
GAVRETO CAP 100MG	91	<i>glipizide-metformin hcl tab 2.5-250 mg</i>	61
GE100 CONTRL SOL NORMAL.....	183	<i>glipizide-metformin hcl tab 2.5-500 mg</i>	61
GELFILM MIS OP.....	213	<i>glipizide-metformin hcl tab 5-500 mg</i>	61
<i>gemfibrozil tab 600 mg</i>	71	<i>glipizide tab 10 mg</i>	65
GEMTESA TAB 75MG.....	230	<i>glipizide tab 5 mg</i>	65
GENERESS FE CHW	127	<i>glipizide tab er 24hr 10 mg</i>	66
<i>gentamicin sulfate cream 0.1%</i>	135	<i>glipizide tab er 24hr 2.5 mg</i>	65
<i>gentamicin sulfate oint 0.1%</i>	135	<i>glipizide tab er 24hr 5 mg</i>	65
<i>gentamicin sulfate ophth oint 0.3%</i>	211	GLOBAL 28G MIS LANCETS	184
<i>gentamicin sulfate ophth soln 0.3%</i>	211	GLOBAL 30G MIS LANCETS.....	184
GENTEEL LANC KIT BLUE	183	GLOBAL LANC MIS DEVICE.....	184
GENTEEL MIS LANCETS.....	183	GLOBAL PREP PAD PADS.....	195
GENTEEL MIS NOZZLES	183	<i>glucagon (rdna) for inj kit 1 mg</i>	63
GENTEEL PLUS MIS BLACK.....	183	GLUC CONTROL LIQ NORMAL	184
GENTEEL PLUS MIS BLUE	183	GLUC CONTROL SOL	184
GENTEEL PLUS MIS PINK	183	GLUC CONTROL SOL MID	184
GENTEEL PLUS MIS PURPLE.....	183	GLUC CONTROL SOL NORMAL.....	184
GENTEEL PLUS MIS WHITE	183	GLUCERNA 1.0 LIQ CARB VAN.....	149
GENTEEL TIPS MIS BLUE	183	GLUCERNA LIQ 1.2 CAL.....	149
GENTEEL TIPS MIS CLEAR	183	GLUCERNA SEL LIQ VANILLA	149
GENTEEL TIPS MIS GREEN	183	GLUCOCARD 01 LIQ NORM/HGH.....	184
GENTEEL TIPS MIS ORANGE.....	183	GLUCOCARD 01 SOL NORMAL.....	184
GENTEEL TIPS MIS RAINBOW	183	GLUCOCARD LIQ LEVEL 1.....	184
GENTEEL TIPS MIS VIOLET.....	183	GLUCOCARD SOL NORMAL.....	184
GENTEEL TIPS MIS YELLOW	184	GLUCOCARD SOL SHINE.....	184
GENTLE-LET MIS 26G	184	GLUCOCOM MIS 28G	184
GENTLE-LET MIS 28G	184	GLUCOCOM MIS 30G.....	184
GENTLE-LET MIS LANCETS	184	GLUCOCOM MIS 33G	184
GENTLE-LET MIS PLATFORM	184	GLUCOCOM TES HIGH CON	184
GENVOYA TAB	109	GLUCOCOM TES NORM CON	184
GILOTRIF TAB 20MG.....	86	GLUCOSE CONT LIQ HIGH/LOW.....	184
GILOTRIF TAB 30MG.....	86	GLUCOSE CONT SOL HIGH	184
GILOTRIF TAB 40MG.....	86	GLUCOSE CONT SOL NORMAL.....	184
<i>glatiramer acetate soln prefilled syringe 20</i> <i>mg/ml</i>	220	GLUCOSE CONT SOL PRECISIO	184
<i>glatiramer acetate soln prefilled syringe 40</i> <i>mg/ml</i>	220	GLUCOTROL TAB 10MG	66
GLEOSTINE CAP 100MG.....	83	GLUCOTROL XL TAB 10MG.....	66
GLEOSTINE CAP 10MG	83	GLUCOTROL XL TAB 2.5MG	66
		GLUCOTROL XL TAB 5MG	66
		GLUTARALDEHY SOL 25%.....	106

<i>glyburide-metformin tab 1.25-250 mg</i>.....61	<i>griseofulvin ultramicrosize tab 250 mg</i>.....68
<i>glyburide-metformin tab 2.5-500 mg</i> .....62	<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>.....131
<i>glyburide-metformin tab 5-500 mg</i> .....62	<i>guaifenesin-codeine soln 100-10 mg/5ml</i> 131
<i>glyburide micronized tab 1.5 mg</i>.....66	<i>guanfacine hcl tab 1 mg</i>.....76
<i>glyburide micronized tab 3 mg</i> .....66	<i>guanfacine hcl tab 2 mg</i>.....76
<i>glyburide micronized tab 6 mg</i> .....66	<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>.....6
<i>glyburide tab 1.25 mg</i> .....66	<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>.....6
<i>glyburide tab 2.5 mg</i>.....66	<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>.....6
<i>glyburide tab 5 mg</i>.....66	<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>.....6
<i>glycopyrrolate oral soln 1 mg/5ml</i> .....228	GUANIDINE TAB 125MG.....82
<i>glycopyrrolate tab 1 mg</i>.....228	GVOKE HYPO 1 INJ .5/.1ML.....63
<i>glycopyrrolate tab 2 mg</i> .....228	GVOKE HYPO 1 INJ 1MG/.2ML.....63
GLYNASE TAB 1.5MG .....66	GVOKE HYPO 2 INJ .5/.1ML .....63
GLYNASE TAB 3MG.....66	GVOKE HYPO 2 INJ 1MG/.2ML.....63
GLYNASE TAB 6MG .....66	GVOKE KIT SOL 1MG/0.2M .....63
GLYTACTIN PAK BTMK/DLT.....149	GVOKE PFS INJ .....63
GLYTACTIN POW BETMLK15.....149	GYNAZOLE-1 CRE 2% .....231
GLYTACTIN POW RST LT10 .....150	GYNOL II GEL 3%.....231
GLYTROL LIQ PREBIO1.....150	H
GLYXAMBI TAB 10-5 MG .....62	HAEGARDA INJ 2000UNIT .....169
GLYXAMBI TAB 25-5 MG.....62	HAEGARDA INJ 3000UNIT .....169
GNP ALCOHOL PAD SWABS.....195	HAEMOLANCE MIS HIGH FLO .....185
GNP LANCETS MIS 21G.....184	HAEMOLANCE MIS LOW FLOW .....185
GNP LANCETS MIS THIN .....184	HAEMOLANCE MIS PLUS .....185
GNP LANCETS MIS THIN 26G.....184	HAEMOLANCE MIS PLUS LOW.....185
GOJJI BLOOD TES KETONE .....148	HAEMOLANCE MIS PLUS MAX.....185
GOJJI CNTRL SOL NORMAL.....184	HAEMOLANCE MIS PLUS PED.....185
GOJJI LANCET MIS 30G .....184	HAEMOLANCE MIS RETRACT.....185
GOJJI MIS LANC DEV.....184	HALCION TAB 0.25MG.....174
GOODSENSE MIS LANC 26G.....184	HALDOL DECAN INJ 100MG/ML.....102
GOODSENSE MIS LANC 30G .....184	HALDOL DECAN INJ 50MG/ML .....102
GOODSENSE MIS LANC 33G.....184	HALDOL INJ 5MG/ML .....102
GOODSENSE MIS LANC DVC.....185	<i>halobetasol propionate cream 0.05%</i> ....143
GORDOFILM SOL .....146	<i>halobetasol propionate oint 0.05%</i>.....143
GRALISE TAB 300MG.....222	<i>haloperidol decanoate im soln 100 mg/ml</i>.....102
GRALISE TAB 450MG.....222	<i>haloperidol decanoate im soln 50 mg/ml</i>.....102
GRALISE TAB 600MG .....222	
GRALISE TAB 750MG.....222	
GRALISE TAB 900MG .....222	
<i>granisetron hcl tab 1 mg</i> .....67	
<i>griseofulvin microsize susp 125 mg/5ml</i> ..68	
<i>griseofulvin microsize tab 500 mg</i> .....68	
<i>griseofulvin ultramicrosize tab 125 mg</i>.....68	

<i>haloperidol lactate inj 5 mg/ml</i>	102	HUMIRA PEDIA INJ CROHNS.....	12, 13
<i>haloperidol lactate oral conc 2 mg/ml</i>	102	HUMIRA PEN INJ 40/0.4ML	13
<i>haloperidol tab 0.5 mg</i>	102	HUMIRA PEN INJ 40MG/0.8.....	13
<i>haloperidol tab 10 mg</i>	102	HUMIRA PEN INJ 80/0.8ML	13
<i>haloperidol tab 1 mg</i>	102	HUMIRA PEN INJ CD/UC/HS	14
<i>haloperidol tab 20 mg</i>	102	HUMIRA PEN INJ PS/UV	14
<i>haloperidol tab 2 mg</i>	102	HUMIRA PEN KIT CD/UC/HS.....	14
<i>haloperidol tab 5 mg</i>	102	HUMIRA PEN KIT PED UC	14
HARVONI PAK	113	HUMIRA PEN KIT PS/UV.....	15
HARVONI PAK 45-200MG	113	HUMULIN R INJ U-500.....	64
HARVONI TAB 45-200MG	113	HYCAMTIN CAP 0.25MG.....	96
HARVONI TAB 90-400MG.....	113	HYCAMTIN CAP 1MG	96
HC/PRAMOXINE CRE 1-2.35%.....	143	<i>hydralazine hcl tab 100 mg</i>	82
HC LANCING MIS DEVICE	185	<i>hydralazine hcl tab 10 mg</i>	82
HCU EXP20 PAK UNFLAVOR	150	<i>hydralazine hcl tab 25 mg</i>	82
HCU EXPRESS PAK.....	150	<i>hydralazine hcl tab 50 mg</i>	82
HEMANGEOL SOL 4.28/ML	116	HYDREA CAP 500MG	95
HEMLIBRA INJ 300/2ML	169	<i>hydrochlorothiazide cap 12.5 mg</i>	156
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	49	<i>hydrochlorothiazide tab 12.5 mg</i>	156
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	49	<i>hydrochlorothiazide tab 25 mg</i>	156
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	49	<i>hydrochlorothiazide tab 50 mg</i>	156
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	49	<i>hydrocodone-acetaminophen soln 10-325</i> <i>mg/15ml</i>	33
<i>heparin sodium (porcine) pf inj 5000</i> <i>unit/0.5ml</i>	49	<i>hydrocodone-acetaminophen soln 7.5-325</i> <i>mg/15ml</i>	33
HETLIOZ CAP 20MG	174	<i>hydrocodone-acetaminophen tab 10-300</i> <i>mg</i>	34
HETLIOZ LQ SUS 4MG/ML.....	174	<i>hydrocodone-acetaminophen tab 10-325</i> <i>mg</i>	34
HIPREX TAB 1GM	39	<i>hydrocodone-acetaminophen tab 5-300</i> <i>mg</i>	33
HLTHY ACCNTS MIS LANC 30G.....	185	<i>hydrocodone-acetaminophen tab 5-325</i> <i>mg</i>	34
HM STERILE PAD ALCHOL	195	<i>hydrocodone-acetaminophen tab 7.5-300</i> <i>mg</i>	34
HOLD CHAMBER MIS ADLT LG	197	<i>hydrocodone-acetaminophen tab 7.5-325</i> <i>mg</i>	34
HOLD CHAMBER MIS MEDIUM.....	197	<i>hydrocodone bitart-homatropine</i> <i>methylbromide tab 5-1.5 mg</i>	131
HOLD CHAMBER MIS SMALL	197	<i>hydrocodone bitart-homatropine</i> <i>methylbrom soln 5-1.5 mg/5ml</i>	131
HOMACTIN AA LIQ PLUS.....	150	<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	28
HUMATROPE INJ 12MG.....	158	<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	28
HUMATROPE INJ 24MG.....	158		
HUMATROPE INJ 6MG.....	158		
HUMIRA INJ 10/0.1ML	11		
HUMIRA INJ 20/0.2ML	12		
HUMIRA INJ 40/0.4ML.....	12		
HUMIRA KIT 40MG/0.8	12		

hydrocodone bitartrate cap er 12hr 20 mg.....28	hydrocortisone valerate oint 0.2% .....143
hydrocodone bitartrate cap er 12hr 30 mg.....28	hydrocortisone w/ acetic acid otic soln 1- 2% .....214
hydrocodone bitartrate cap er 12hr 40 mg.....28	hydrogen peroxide soln 30% .....106
hydrocodone bitartrate cap er 12hr 50 mg.....28	hydromorphone hcl liqd 1 mg/ml .....29
hydrocodone bitartrate tab er 24hr deter 100 mg .....29	hydromorphone hcl tab 2 mg .....29
hydrocodone bitartrate tab er 24hr deter 120 mg .....29	hydromorphone hcl tab 4 mg .....29
hydrocodone bitartrate tab er 24hr deter 20 mg .....28	hydromorphone hcl tab 8 mg .....29
hydrocodone bitartrate tab er 24hr deter 30 mg .....28	hydromorphone hcl tab er 24hr 12 mg .....29
hydrocodone bitartrate tab er 24hr deter 40 mg .....28	hydromorphone hcl tab er 24hr 16 mg .....29
hydrocodone bitartrate tab er 24hr deter 60 mg .....29	hydromorphone hcl tab er 24hr 32 mg .....29
hydrocodone bitartrate tab er 24hr deter 80 mg .....29	hydromorphone hcl tab er 24hr 8 mg .....29
hydrocodone-ibuprofen tab 10-200 mg ...34	HYDROMORPHON SUP 3MG .....29
hydrocodone-ibuprofen tab 5-200 mg .....34	hydroxychloroquine sulfate tab 200 mg ...82
hydrocodone-ibuprofen tab 7.5-200 mg ..34	hydroxyurea cap 500 mg .....95
hydrocod polst-chlorphen polst er susp 10- 8 mg/5ml .....132	hydroxyzine hcl syrup 10 mg/5ml .....41
hydrocortisone acetate suppos 25 mg .....37	hydroxyzine hcl tab 10 mg .....41
hydrocortisone acetate w/ pramoxine perianal cream 1-1% .....37	hydroxyzine hcl tab 25 mg .....41
hydrocortisone butyrate cream 0.1% .....143	hydroxyzine hcl tab 50 mg .....41
hydrocortisone butyrate oint 0.1% .....143	hydroxyzine pamoate cap 100 mg .....41
hydrocortisone butyrate soln 0.1% .....143	hydroxyzine pamoate cap 25 mg .....41
hydrocortisone cream 2.5% .....143	hydroxyzine pamoate cap 50 mg .....41
hydrocortisone enema 100 mg/60ml .....37	hyoscyamine sulfate elixir 0.125 mg/5ml.....228
hydrocortisone lotion 2.5% .....143	hyoscyamine sulfate sl tab 0.125 mg .....228
hydrocortisone oint 2.5% .....143	hyoscyamine sulfate soln 0.125 mg/ml ...228
hydrocortisone perianal cream 1% .....37	hyoscyamine sulfate tab 0.125 mg .....228
hydrocortisone perianal cream 2.5% .....37	hyoscyamine sulfate tab disint 0.125 mg 228
hydrocortisone tab 10 mg .....130	HYPERSAL NEB 3.5% .....132
hydrocortisone tab 20 mg .....130	HYPERSAL NEB 7% .....132
hydrocortisone tab 5 mg .....130	HYPOLANCE KIT LANCING .....185
hydrocortisone valerate cream 0.2% .....143	HYRIMOZ .....15
	HYRIMOZ INJ 10/0.1ML .....15
	HYRIMOZ INJ 20/0.2ML .....15
	HYRIMOZ INJ 40/0.4ML .....16
	HYRIMOZ INJ 80/0.8ML .....16
	HYRIMOZ-PED INJ CROHNS .....16, 17
	HYRIMOZ-PLAQ INJ PSORIASI .....17
	I
	ibandronate sodium tab 150 mg (base equivalent) .....156
	IBRANCE CAP 100MG .....91
	IBRANCE CAP 125MG .....91

IBRANCE CAP 75MG.....	91	INCONTROL MIS LANC 30G.....	185
IBRANCE TAB 100MG	91	INCONTROL MIS LANC 33G.....	185
IBRANCE TAB 125MG.....	91	INCONTROL MIS LANC DEV	185
IBRANCE TAB 75MG	91	INCONTROL PAD ALCOHOL.....	195
<i>ibuprofen tab 400 mg</i>	21	<i>indapamide tab 1.25 mg</i>	156
<i>ibuprofen tab 600 mg</i>	21	<i>indapamide tab 2.5 mg</i>	156
<i>ibuprofen tab 800 mg</i>	21	<i>indomethacin cap 25 mg</i>	21
<i>icatibant acetate subcutaneous soln pref</i>		<i>indomethacin cap 50 mg</i>	21
<i>syr 30 mg/3ml</i>	169	<i>indomethacin cap er 75 mg</i>	21
ICLUSIG TAB 10MG.....	92	INFINITY SOL NORM CON	185
ICLUSIG TAB 15MG	92	INFNTY VOICE LIQ LEVEL 2	185
ICLUSIG TAB 30MG	92	INGREZZA CAP 40-80MG.....	219
ICLUSIG TAB 45MG	92	INGREZZA CAP 40MG	219
IDHIFA TAB 100MG.....	92	INGREZZA CAP 60MG	219
IDHIFA TAB 50MG	92	INGREZZA CAP 80MG	219
<i>imatinib mesylate tab 100 mg (base</i>		INLYTA TAB 1MG	85
<i>equivalent)</i>	92	INLYTA TAB 5MG.....	85
<i>imatinib mesylate tab 400 mg (base</i>		INPEN 100EL MIS BLUE-HUM	196
<i>equivalent)</i>	92	INQOVI TAB 35-100MG.....	89
<i>imipramine hcl tab 10 mg</i>	60	INSPIRACHAMB MIS LARGE	197
<i>imipramine hcl tab 25 mg</i>	60	INSPIRACHAMB MIS MEDIUM.....	197
<i>imipramine hcl tab 50 mg</i>	60	INSPIRACHAMB MIS MOUTHPC	197
<i>imipramine pamoate cap 100 mg</i>	60	INSPIRACHAMB MIS SMALL.....	197
<i>imipramine pamoate cap 125 mg</i>	60	INSPIREASE MIS DD SYST	197
<i>imipramine pamoate cap 150 mg</i>	60	INSPIREASE MIS RES BAG	197
<i>imipramine pamoate cap 75 mg</i>	60	INSPRA TAB 25MG	82
<i>imiquimod cream 3.75%</i>	145	INSPRA TAB 50MG.....	82
<i>imiquimod cream 5%</i>	145	IN TOUCH LAN MIS 30G	185
IMITREX INJ 4MG/0.5	199	IN TOUCH LAN MIS DEVICE	185
IMITREX INJ 6MG/0.5	199	IN TOUCH SOL GLUCOSE	185
IMITREX SPR 20MG/ACT.....	199	INTRON A INJ 10MU	95
IMITREX SPR 5MG/ACT	199	INTRON A INJ 18MU	95
IMITREX TAB 100MG	199	INTRON A INJ 25MU	95
IMITREX TAB 25MG	199	INTRON A INJ 50MU	95
IMITREX TAB 50MG	199	INVEGA SUST INJ 117/0.75.....	101
IMPAVIDO CAP 50MG	38	INVEGA SUST INJ 156MG/ML.....	101
IMURAN TAB 50MG	204	INVEGA SUST INJ 234/1.5	101
IMVEXXY MAIN SUP 10MCG.....	231	INVEGA SUST INJ 39/0.25	101
IMVEXXY MAIN SUP 4MCG	231	INVEGA SUST INJ 78/0.5ML.....	101
IMVEXXY STRT SUP 10MCG.....	232	INVEGA TAB 1.5MG.....	101
IMVEXXY STRT SUP 4MCG	232	INVEGA TAB 3MG	101
INBRIJA CAP 42MG.....	97	INVEGA TAB 6MG	101
INCONTROL MIS LANC 28G.....	185	INVEGA TAB 9MG	101

<i>iodoquinol-hc cream 1-1%</i>	135	ISOSOURCE LIQ.....	150
<i>iodoquinol-hydrocortisone in aloe vehicle cream 1-1.9%</i>	135	<i>isotretinoin cap 10 mg</i>	134
IOPIDINE SOL 1% OP.....	210	<i>isotretinoin cap 20 mg</i>	134
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	47	<i>isotretinoin cap 30 mg</i>	134
<i>ipratropium bromide inhal soln 0.02%</i>	44	<i>isotretinoin cap 40 mg</i>	134
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	208	ISOVACTIN AA LIQ PLUS.....	150
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	208	<i>isoxsuprine hcl tab 20 mg</i>	123
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	79	<i>isradipine cap 2.5 mg</i>	118
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	79	<i>isradipine cap 5 mg</i>	118
<i>irbesartan tab 150 mg</i>	75	<i>itraconazole cap 100 mg</i>	69
<i>irbesartan tab 300 mg</i>	75	<i>itraconazole oral soln 10 mg/ml</i>	69
<i>irbesartan tab 75 mg</i>	75	<i>ivermectin lotion 0.5%</i>	147
ISENTRESS CHW 100MG.....	109	<i>ivermectin tab 3 mg</i>	37
ISENTRESS CHW 25MG.....	109	IWILFIN TAB 192MG.....	96
ISENTRESS HD TAB 600MG.....	109	J	
ISENTRESS POW 100MG.....	109	JANUMET TAB 50-1000.....	62
ISENTRESS TAB 400MG.....	109	JANUMET TAB 50-500MG.....	62
<i>isoniazid syrup 50 mg/5ml</i>	83	JANUMET XR TAB 100-1000.....	62
<i>isoniazid tab 100 mg</i>	83	JANUMET XR TAB 50-1000.....	62
<i>isoniazid tab 300 mg</i>	83	JANUMET XR TAB 50-500MG.....	62
ISOPTO ATROP SOL 1% OP.....	210	JANUVIA TAB 100MG.....	63
ISOPTO CARP SOL 1% OP.....	210	JANUVIA TAB 25MG.....	63
ISOPTO CARP SOL 2% OP.....	210	JANUVIA TAB 50MG.....	63
ISOPTO CARP SOL 4% OP.....	210	JARDIANCE TAB 10MG.....	65
<i>isosorbide dinitrate tab 10 mg</i>	40	JARDIANCE TAB 25MG.....	65
<i>isosorbide dinitrate tab 20 mg</i>	40	JEVITY 1.2 LIQ CAL.....	150
<i>isosorbide dinitrate tab 30 mg</i>	40	JEVITY 1.5 LIQ CAL.....	150
<i>isosorbide dinitrate tab 5 mg</i>	40	JEVITY 1 CAL LIQ.....	150
<i>isosorbide mononitrate tab 10 mg</i>	40	JUBLIA SOL 10%.....	135
<i>isosorbide mononitrate tab 20 mg</i>	40	JULUCA TAB 50-25MG.....	109
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	40	K	
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	40	KALBITOR INJ 10MG/ML.....	169
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	40	KALYDECO GRA 13.4MG.....	224
ISOSOURCE HN LIQ.....	150	KALYDECO PAK 25MG.....	224
		KALYDECO PAK 50MG.....	224
		KALYDECO PAK 75MG.....	224
		KALYDECO TAB 150MG.....	224
		KARBINAL ER SUS 4MG/5ML.....	69
		KEFLEX CAP 750MG.....	125
		KERENDIA TAB 10MG.....	160
		KERENDIA TAB 20MG.....	160
		KESIMPTA INJ 20/.4ML.....	220
		<i>ketoconazole cream 2%</i>	135

<i>ketoconazole shampoo 2%</i>	135	KYNMOBI MIS 15MG	97
<i>ketoconazole tab 200 mg</i>	69	KYNMOBI MIS 20MG.....	97
KETO-DIASTIX TES	148	KYNMOBI MIS 25MG.....	97
KETONE TES	148	KYNMOBI MIS 30MG	98
KETONE TEST TES	148	L	
<i>ketoprofen cap 50 mg</i>	22	<i>labetalol hcl tab 100 mg</i>	115
<i>ketoprofen cap 75 mg</i>	22	<i>labetalol hcl tab 200 mg</i>	115
<i>ketorolac tromethamine ophth soln 0.4%</i>	213	<i>labetalol hcl tab 300 mg</i>	115
<i>ketorolac tromethamine ophth soln 0.5%</i>	213	<i>lacosamide oral solution 10 mg/ml</i>	51
<i>ketorolac tromethamine tab 10 mg</i>	22	<i>lacosamide tab 100 mg</i>	52
KETOSTIX TES STRIP	148	<i>lacosamide tab 150 mg</i>	52
KEVEYIS TAB 50MG.....	154	<i>lacosamide tab 200 mg</i>	52
KEVZARA INJ 150/1.14	20	<i>lacosamide tab 50 mg</i>	51
KEVZARA INJ 200/1.14	20	LACTIC ACID LOT 10%.....	145
KINNEY MIS LANCETS	185	<i>lactulose (encephalopathy) solution 10</i> <i>gm/15ml</i>	166
KINNEY THIN MIS LANCETS	185	<i>lactulose solution 10 gm/15ml</i>	175
KISQALI 200 PAK FEMARA.....	89	LAGEVRIO CAP 200MG	114
KISQALI 400 PAK FEMARA.....	89	<i>lamivudine oral soln 10 mg/ml</i>	109
KISQALI 600 PAK FEMARA.....	89	<i>lamivudine tab 100 mg (hbv)</i>	113
KISQALI TAB 200DOSE.....	92	<i>lamivudine tab 150 mg</i>	109
KISQALI TAB 400DOSE.....	92	<i>lamivudine tab 300 mg</i>	109
KISQALI TAB 600DOSE.....	92	<i>lamivudine-zidovudine tab 150-300 mg</i> .	109
KLARON LOT 10%	134	<i>lamotrigine orally disintegrating tab 100 mg</i>	52
KLONOPIN TAB 0.5MG.....	50	<i>lamotrigine orally disintegrating tab 200 mg</i>	52
KLONOPIN TAB 1MG	50	<i>lamotrigine orally disintegrating tab 25 mg</i>	52
KLONOPIN TAB 2MG	50	<i>lamotrigine orally disintegrating tab 50 mg</i>	52
KLOXXADO SPR 8MG	67	<i>lamotrigine tab 100 mg</i>	52
KOSELUGO CAP 10MG.....	92	<i>lamotrigine tab 150 mg</i>	52
KOSELUGO CAP 25MG	92	<i>lamotrigine tab 200 mg</i>	52
K-PHOS TAB NO 2.....	167	<i>lamotrigine tab 25 mg</i>	52
KRAZATI TAB 200MG	92	<i>lamotrigine tab 25 mg (42) & 100 mg (7)</i> <i>starter kit</i>	52
KRISTALOSE PAK 10GM.....	175	<i>lamotrigine tab 35 x 25 mg starter kit</i>	52
KRISTALOSE PAK 20GM	175	<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg</i> <i>starter kit</i>	52
KROGER LANCE MIS	185	<i>lamotrigine tab chewable dispersible 25 mg</i>	52
KROGER LANCE MIS 26G	185		
KROGER LANCE MIS THIN	185		
KROGER LANCE MIS THIN 30G	185		
K-TAB TAB 10MEQ CR.....	201		
K-TAB TAB 20MEQ.....	202		
K-TAB TAB 8MEQ CR	201		
KYNMOBI MIS 10MG	97		

<i>lamotrigine tab chewable dispersible 5 mg</i>	LANOXIN TAB 0.0625MG	120
.....52	<i>lansoprazole cap delayed release 15 mg</i>	229
<i>lamotrigine tab disint 25 (14) & 50 mg (14) &</i>	<i>lansoprazole cap delayed release 30 mg</i>	229
<i>100 mg (7) kit</i> .....	.....	229
.....52	LANZO MIS LANCING.....	186
<i>lamotrigine tab er 24hr 100 mg</i>	<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	92
.....52	.....	92
<i>lamotrigine tab er 24hr 200 mg</i>	LASIX TAB 20MG.....	155
.....52	LASIX TAB 40MG	155
<i>lamotrigine tab er 24hr 250 mg</i>	LASIX TAB 80MG	155
.....52	<i>latanoprost ophth soln 0.005%</i>	213
<i>lamotrigine tab er 24hr 25 mg</i>	LB LANCET MIS 28G	186
.....52	LB LANCING MIS DEVICE	186
<i>lamotrigine tab er 24hr 300 mg</i>	<i>leflunomide tab 10 mg</i>	23
.....52	<i>leflunomide tab 20 mg</i>	23
<i>lamotrigine tab er 24hr 50 mg</i>	<i>lenalidomide cap 10 mg</i>	202
.....52	<i>lenalidomide cap 15 mg</i>	202
LAMPIT TAB 120MG	<i>lenalidomide cap 25 mg</i>	202
.....38	<i>lenalidomide cap 5 mg</i>	202
LAMPIT TAB 30MG.....	LENVIMA CAP 10 MG	85
.....38	LENVIMA CAP 12MG	85
LANAFLEX PAK	LENVIMA CAP 14 MG	85
.....150	LENVIMA CAP 18 MG	85
LANCET AUTO MIS INJECTOR.....	LENVIMA CAP 20 MG	85
.....185	LENVIMA CAP 24 MG.....	85
LANCET CARRY MIS CASE	LENVIMA CAP 4MG.....	85
.....185	LENVIMA CAP 8 MG.....	85
LANCET DEVIC MIS 30G	<i>letrozole tab 2.5 mg</i>	87
.....185	<i>leucovorin calcium tab 10 mg</i>	96
LANCET DEVIC MIS ADJUST.....	<i>leucovorin calcium tab 15 mg</i>	96
.....185	<i>leucovorin calcium tab 25 mg</i>	96
LANCET MICRO MIS THIN 33G.....	<i>leucovorin calcium tab 5 mg</i>	96
.....185	LEUKERAN TAB 2MG	83
LANCETS MICR MIS THIN 33G	LEUKINE INJ 250MCG.....	171
.....186	<i>leuprolide acetate inj kit 1 mg/0.2ml (5</i>	
LANCETS MIS	<i>mg/ml)</i>	87
.....186	<i>levalbuterol hcl soln nebu 0.31 mg/3ml</i>	
LANCETS MIS 21G.....	<i>(base equiv)</i>	47
.....186	<i>levalbuterol hcl soln nebu 0.63 mg/3ml</i>	
LANCETS MIS 21G COLR.....	<i>(base equiv)</i>	47
.....186	<i>levalbuterol hcl soln nebu 1.25 mg/3ml</i>	
LANCETS MIS 28G	<i>(base equiv)</i>	47
.....186		
LANCETS MIS 30G.....		
.....186		
LANCETS MIS 33G		
.....186		
LANCETS MIS ORANGE		
.....186		
LANCETS MIS ORIGINAL		
.....186		
LANCETS MIS THIN		
.....186		
LANCETS MIS THIN 26G		
.....186		
LANCETS MIS THIN 30G.....		
.....186		
LANCETS SUPR MIS THIN 28G		
.....186		
LANCET STAND MIS 21G		
.....185		
LANCETS THIN MIS		
.....186		
LANCETS THIN MIS 26G		
.....186		
LANCETS ULTR MIS THIN.....		
.....186		
LANCET SUPER MIS THIN 30G		
.....185		
LANCET ULTRA MIS 28G		
.....185		
LANCET ULTRA MIS THIN 30G		
.....185		
LANCET WITH MIS EJECTOR.....		
.....186		
LANCING DEVI MIS.....		
.....186		
LANCING DEVI MIS 25G.....		
.....186		
LANCING DEVI MIS 30G.....		
.....186		
LANCING MIS DEVICE		
.....186		

<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	47	<i>levothyroxine sodium tab 137 mcg</i>	227
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	47	<i>levothyroxine sodium tab 150 mcg</i>	227
LEVBID TAB 0.375 ER.....	228	<i>levothyroxine sodium tab 175 mcg</i>	227
<i>levetiracetam oral soln 100 mg/ml</i>	52	<i>levothyroxine sodium tab 200 mcg</i>	227
<i>levetiracetam tab 1000 mg</i>	52	<i>levothyroxine sodium tab 25 mcg</i>	227
<i>levetiracetam tab 250 mg</i>	52	<i>levothyroxine sodium tab 300 mcg</i>	227
<i>levetiracetam tab 500 mg</i>	52	<i>levothyroxine sodium tab 50 mcg</i>	227
<i>levetiracetam tab 750 mg</i>	52	<i>levothyroxine sodium tab 75 mcg</i>	227
<i>levetiracetam tab er 24hr 500 mg</i>	52	<i>levothyroxine sodium tab 88 mcg</i>	227
<i>levetiracetam tab er 24hr 750 mg</i>	52	LEVSIN/SL SUB 0.125MG	228
<i>levobunolol hcl ophth soln 0.5%</i>	209	LEVSIN TAB 0.125MG.....	228
<i>levocarnitine oral soln 1 gm/10ml (10%)</i> ..	158	LEVULAN KERA SOL 20%	136
<i>levocarnitine tab 330 mg</i>	158	<i>lidocaine hcl laryngotracheal soln 4%</i>	205
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	69	<i>lidocaine hcl soln 4%</i>	146
<i>levocetirizine dihydrochloride tab 5 mg</i> ...	69	<i>lidocaine hcl urethral/mucosal gel 2%</i>	146
<i>levofloxacin ophth soln 0.5%</i>	211	<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	146
<i>levofloxacin oral soln 25 mg/ml</i>	163	<i>lidocaine hcl viscous soln 2%</i>	205
<i>levofloxacin tab 250 mg</i>	163	<i>lidocaine oint 5%</i>	146
<i>levofloxacin tab 500 mg</i>	163	<i>lidocaine patch 5%</i>	146
<i>levofloxacin tab 750 mg</i>	163	<i>lidocaine-prilocaine cream 2.5-2.5%</i>	146
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg</i>	127	LIDODERM DIS 5%.....	146
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	127	LIFESCAN MIS UNISTIK2.....	186
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	127	<i>lindane shampoo 1%</i>	147
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	127	<i>linezolid for susp 100 mg/5ml</i>	39
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	127	<i>linezolid tab 600 mg</i>	39
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	127	LINZESS CAP 145MCG	166
<i>levonorgestrel tab 1.5 mg</i>	129	LINZESS CAP 290MCG.....	166
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	127	LINZESS CAP 72MCG	166
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	127	<i>liothyronine sodium tab 25 mcg</i>	227
<i>levothyroxine sodium tab 100 mcg</i>	227	<i>liothyronine sodium tab 50 mcg</i>	227
<i>levothyroxine sodium tab 112 mcg</i>	227	<i>liothyronine sodium tab 5 mcg</i>	227
<i>levothyroxine sodium tab 125 mcg</i>	227	LIPOFEN CAP 150MG.....	71
		LIPOFEN CAP 50MG	71
		LIQUID HOPE LIQ	150
		<i>lisdexamfetamine dimesylate cap 10 mg</i>	2
		<i>lisdexamfetamine dimesylate cap 20 mg</i> ...	2
		<i>lisdexamfetamine dimesylate cap 30 mg</i> ...	2
		<i>lisdexamfetamine dimesylate cap 40 mg</i> ...	2
		<i>lisdexamfetamine dimesylate cap 50 mg</i> ...	2
		<i>lisdexamfetamine dimesylate cap 60 mg</i> ...	2
		<i>lisdexamfetamine dimesylate cap 70 mg</i> ...	2

<i>lisdexamfetamine dimesylate chew tab 10 mg</i>	2	LONGS LANCET MIS STANDARD.....	186
<i>lisdexamfetamine dimesylate chew tab 20 mg</i>	3	LONGS LANCET MIS THIN.....	186
<i>lisdexamfetamine dimesylate chew tab 30 mg</i>	3	LONGS LANCET MIS ULTRA TH.....	186
<i>lisdexamfetamine dimesylate chew tab 40 mg</i>	3	LONSURF TAB 15-6.14.....	89
<i>lisdexamfetamine dimesylate chew tab 50 mg</i>	3	LONSURF TAB 20-8.19.....	89
<i>lisdexamfetamine dimesylate chew tab 60 mg</i>	3	LOPHLEX POW.....	150
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	79	LOPID TAB 600MG.....	71
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	79	<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	109
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	79	<i>lopinavir-ritonavir tab 100-25 mg</i>	109
<i>lisinopril tab 10 mg</i>	74	<i>lopinavir-ritonavir tab 200-50 mg</i>	109
<i>lisinopril tab 2.5 mg</i>	74	LOPRESSOR TAB 100MG.....	115
<i>lisinopril tab 20 mg</i>	74	LOPRESSOR TAB 50MG.....	115
<i>lisinopril tab 30 mg</i>	74	LOPROX SHA 1%.....	135
<i>lisinopril tab 40 mg</i>	74	<i>lorazepam conc 2 mg/ml</i>	42
<i>lisinopril tab 5 mg</i>	74	<i>lorazepam tab 0.5 mg</i>	42
LITETOUCH MIS LANCETS.....	186	<i>lorazepam tab 1 mg</i>	42
LITE TOUCH MIS LANCETS.....	186	<i>lorazepam tab 2 mg</i>	42
LITE TOUCH MIS LANC PEN.....	186	LORTAB ELX 10-300MG.....	34
LITFULO CAP 50MG.....	145	<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	79
<i>lithium carbonate cap 150 mg</i>	100	<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	79
<i>lithium carbonate cap 300 mg</i>	100	<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	79
<i>lithium carbonate cap 600 mg</i>	100	<i>losartan potassium tab 100 mg</i>	76
<i>lithium carbonate tab 300 mg</i>	100	<i>losartan potassium tab 25 mg</i>	76
<i>lithium carbonate tab er 300 mg</i>	100	<i>losartan potassium tab 50 mg</i>	76
<i>lithium carbonate tab er 450 mg</i>	100	LOSEASONIQUE TAB.....	127
LITHIUM SOL 8MEQ/5ML.....	100	LOTENSIN HCT TAB 10-12.5.....	79
LITHOBID TAB 300MG CR.....	100	LOTENSIN HCT TAB 20-12.5.....	79
LIVTENCITY TAB 200MG.....	112	LOTENSIN HCT TAB 20-25MG.....	79
LOCOID LIPO CRE 0.1%.....	144	LOTENSIN TAB 10MG.....	74
LOCOID LOT 0.1%.....	144	LOTENSIN TAB 20MG.....	74
LODOCO TAB 0.5MG.....	121	LOTENSIN TAB 40MG.....	74
LODOSYN TAB 25MG.....	96	<i>loteprednol etabonate ophth gel 0.5%</i>	212
LO LOESTRIN TAB 1-10-10.....	127	<i>loteprednol etabonate ophth susp 0.5%</i>	212
LOMOTIL TAB 2.5MG.....	66	LOTREL CAP 10-20MG.....	79
		LOTREL CAP 10-40MG.....	79
		LOTREL CAP 5-10MG.....	79
		LOTREL CAP 5-20MG.....	79
		LOTRONEX TAB 0.5MG.....	166
		LOTRONEX TAB 1MG.....	166

<i>lovastatin tab 10 mg</i>	72	MALARONE TAB 62.5-25	82
<i>lovastatin tab 20 mg</i>	72	<i>malathion lotion 0.5%</i>	147
<i>lovastatin tab 40 mg</i>	72	<i>maprotiline hcl tab 25 mg</i>	57
LOVENOX INJ 100MG/ML.....	49	<i>maprotiline hcl tab 50 mg</i>	57
LOVENOX INJ 120/0.8	49	<i>maprotiline hcl tab 75 mg</i>	57
LOVENOX INJ 150MG/ML.....	49	MAR-COF CG LIQ 225-7.5.....	132
LOVENOX INJ 30/0.3ML	49	MARINOL CAP 10MG	68
LOVENOX INJ 300/3ML	49	MARINOL CAP 2.5MG.....	68
LOVENOX INJ 40/0.4ML.....	49	MARINOL CAP 5MG	68
LOVENOX INJ 60/0.6ML.....	49	MARPLAN TAB 10MG.....	57
LOVENOX INJ 80/0.8ML.....	49	MATULANE CAP 50MG	95
<i>loxapine succinate cap 10 mg</i>	103	MAVENCLAD PAK 10MG(10)	220
<i>loxapine succinate cap 25 mg</i>	103	MAVENCLAD PAK 10MG(4)	220
<i>loxapine succinate cap 50 mg</i>	103	MAVENCLAD PAK 10MG(5)	220
<i>loxapine succinate cap 5 mg</i>	103	MAVENCLAD PAK 10MG(6)	220
<i>lubiprostone cap 24 mcg</i>	164	MAVENCLAD PAK 10MG(7)	220
<i>lubiprostone cap 8 mcg</i>	164	MAVENCLAD PAK 10MG(8)	220
LUMAKRAS TAB 120MG	92	MAVENCLAD PAK 10MG(9)	220
LUMAKRAS TAB 320MG.....	92	MAXITROL OIN 0.1% OP.....	212
LUMRYZ PAK 6GM	216	MAXITROL SUS 0.1% OP	212
LUMRYZ PAK 7.5GM.....	216	MAXZIDE-25 TAB	154
LUMRYZ PAK 9GM	216	MAXZIDE TAB 75-50	154
LUMRYZ PKG 4.5GM	216	MAYZENT PAK STARTER	220
LUNG PERFM MIS METER.....	197	MAYZENT TAB 0.25MG.....	221
LUPRON DEPOT INJ 11.25MG	87	MAYZENT TAB 1MG	221
LUPRON DEPOT INJ 3.75MG	87	MAYZENT TAB 2MG.....	221
<i>lurasidone hcl tab 120 mg</i>	100	MCT PRO-CAL PAK	150
<i>lurasidone hcl tab 20 mg</i>	100	<i>meclofenamate sodium cap 100 mg</i>	22
<i>lurasidone hcl tab 40 mg</i>	100	<i>meclofenamate sodium cap 50 mg</i>	22
<i>lurasidone hcl tab 60 mg</i>	100	MEDICHOICE MIS LANCET.....	186
<i>lurasidone hcl tab 80 mg</i>	100	MEDISENSE LIQ GLUC/KET.....	186
LYNPARZA TAB 100MG	92	MEDISENSE LIQ GLUC-KET	186
LYNPARZA TAB 150MG	93	MEDLANCE MIS 30G PLUS.....	186
LYSODREN TAB 500MG	87	MEDLANCE MIS EXTR 21G.....	187
LYSTEDA TAB 650MG	173	MEDLANCE MIS LITE 25G.....	187
LYVISPAH GRA 10MG	207	MEDLANCE MIS PLUS	187
LYVISPAH GRA 20MG.....	207	MEDLANCE MIS PLUS 30G.....	187
LYVISPAH GRA 5MG.....	207	MEDLANCE MIS UNV 21G	187
M		MEDLANCE PLS MIS 0.8MM	187
MACROBID CAP 100MG	39	MEDLANCE PLS MIS EXTR 21G.....	187
<i>mafenide acetate packet for topical soln</i> <i>5% (50 gm)</i>	141	MEDLANCE PLS MIS LITE 25G.....	187
MALARONE TAB 250-100	82	MEDLANCE PLS MIS UNIV 21G	187
		MEDROL TAB 16MG.....	130

MEDROL TAB 2MG.....	130	<i>mercaptopurine tab 50 mg.....</i>	84
MEDROL TAB 32MG	130	<i>mesalamine cap dr 400 mg</i>	165
MEDROL TAB 4MG	130	<i>mesalamine cap er 24hr 0.375 gm</i>	165
MEDROL TAB 8MG	130	<i>mesalamine cap er 500 mg</i>	165
<i>medroxyprogesterone acetate im susp 150 mg/ml.....</i>	<i>129</i>	<i>mesalamine enema 4 gm</i>	<i>165</i>
<i>medroxyprogesterone acetate im susp prefilled syr 150 mg/ml</i>	<i>129</i>	<i>mesalamine rectal enema 4 gm & cleanser wipe kit</i>	<i>165</i>
<i>medroxyprogesterone acetate tab 10 mg</i>	<i>216</i>	<i>mesalamine suppos 1000 mg.....</i>	<i>165</i>
<i>medroxyprogesterone acetate tab 2.5 mg</i>	<i>216</i>	<i>mesalamine tab delayed release 1.2 gm .165</i>	<i>165</i>
<i>medroxyprogesterone acetate tab 5 mg</i>	<i>216</i>	<i>mesalamine tab delayed release 800 mg</i>	<i>165</i>
<i>mefenamic acid cap 250 mg</i>	<i>22</i>	MESNEX TAB 400MG	96
<i>mefloquine hcl tab 250 mg</i>	<i>82</i>	MESTINON TAB TIMESPAN	82
<i>megestrol acetate susp 40 mg/ml</i>	<i>87</i>	<i>metaxalone tab 800 mg.....</i>	<i>207</i>
<i>megestrol acetate susp 625 mg/5ml.....</i>	<i>216</i>	<i>metformin hcl oral soln 500 mg/5ml.....</i>	<i>62</i>
<i>megestrol acetate tab 20 mg</i>	<i>87</i>	<i>metformin hcl tab 1000 mg</i>	<i>63</i>
<i>megestrol acetate tab 40 mg</i>	<i>87</i>	<i>metformin hcl tab 500 mg</i>	<i>62</i>
MEIJER LANCE MIS COLOR	187	<i>metformin hcl tab 850 mg</i>	<i>62</i>
MEIJER LANCE MIS UNIV 21G	187	<i>metformin hcl tab er 24hr 500 mg.....</i>	<i>63</i>
MEIJER LANCE MIS UNIV 30G	187	<i>metformin hcl tab er 24hr 750 mg.....</i>	<i>63</i>
MEIJER LANCE MIS UNIVERSA.....	187	<i>methadone hcl conc 10 mg/ml</i>	<i>29</i>
MEIJER MIS LANCETS.....	187	<i>methadone hcl soln 10 mg/5ml.....</i>	<i>29</i>
MEKTOVI TAB 15MG.....	93	<i>methadone hcl soln 5 mg/5ml</i>	<i>29</i>
<i>meloxicam tab 15 mg.....</i>	<i>22</i>	<i>methadone hcl tab 10 mg.....</i>	<i>29</i>
<i>meloxicam tab 7.5 mg</i>	<i>22</i>	<i>methadone hcl tab 5 mg</i>	<i>29</i>
<i>melfalan tab 2 mg</i>	<i>84</i>	<i>methadone hcl tab for oral susp 40 mg</i>	<i>29</i>
<i>memantine hcl cap er 24hr 14 mg</i>	<i>217</i>	METHADOSE CON 10MG/ML	29
<i>memantine hcl cap er 24hr 21 mg</i>	<i>217</i>	METHADOSE SF CON 10MG/ML.....	29
<i>memantine hcl cap er 24hr 28 mg.....</i>	<i>217</i>	<i>methamphetamine hcl tab 5 mg</i>	<i>3</i>
<i>memantine hcl cap er 24hr 7 mg.....</i>	<i>217</i>	<i>methazolamide tab 25 mg.....</i>	<i>154</i>
<i>memantine hcl oral solution 2 mg/ml</i>	<i>217</i>	<i>methazolamide tab 50 mg</i>	<i>154</i>
<i>memantine hcl tab 10 mg</i>	<i>217</i>	<i>methenamine hippurate tab 1 gm</i>	<i>39</i>
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack.....</i>	<i>217</i>	<i>methenamine-hyos-meth blue-sod phosph sal tab 81.6 mg</i>	<i>38</i>
<i>memantine hcl tab 5 mg</i>	<i>217</i>	<i>methenamine mandelate tab 0.5 gm</i>	<i>39</i>
MEMBRANEBLUE INJ 0.15%	213	<i>methenamine mandelate tab 1 gm</i>	<i>39</i>
MENOPUR INJ 75UNIT	157	<i>methimazole tab 10 mg</i>	<i>226</i>
MEPHYTON TAB 5MG	233	<i>methimazole tab 5 mg.....</i>	<i>226</i>
<i>meprobamate tab 200 mg</i>	<i>41</i>	METHITEST TAB 10MG	36
<i>meprobamate tab 400 mg</i>	<i>41</i>	<i>methocarbamol tab 500 mg</i>	<i>207</i>
MEPRON SUS	38	<i>methocarbamol tab 750 mg.....</i>	<i>207</i>
		<i>methotrexate sodium for inj 1 gm</i>	<i>84</i>

<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	84	<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	9
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	84	<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	9
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	84	<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	9
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	84	<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	9
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	84	<i>methylphenidate hcl cap er 30 mg (cd)</i>	9
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	84	<i>methylphenidate hcl cap er 40 mg (cd)</i>	9
<i>methoxsalen rapid cap 10 mg</i>	138	<i>methylphenidate hcl cap er 50 mg (cd)</i>	9
<i>methscopolamine bromide tab 2.5 mg</i>	228	<i>methylphenidate hcl cap er 60 mg (cd)</i>	9
<i>methscopolamine bromide tab 5 mg</i>	228	<i>methylphenidate hcl chew tab 10 mg</i>	9
<i>methyldopa & hydrochlorothiazide tab 250-15 mg</i>	79	<i>methylphenidate hcl chew tab 2.5 mg</i>	9
<i>methyldopa & hydrochlorothiazide tab 250-25 mg</i>	79	<i>methylphenidate hcl chew tab 5 mg</i>	9
<i>methyldopa tab 250 mg</i>	76	<i>methylphenidate hcl soln 10 mg/5ml</i>	9
<i>methyldopa tab 500 mg</i>	76	<i>methylphenidate hcl soln 5 mg/5ml</i>	9
<i>methylergonovine maleate tab 0.2 mg</i>	214	<i>methylphenidate hcl tab 10 mg</i>	9
METHYLIN SOL 10MG/5ML.....	8	<i>methylphenidate hcl tab 20 mg</i>	9
METHYLIN SOL 5MG/5ML.....	8	<i>methylphenidate hcl tab 5 mg</i>	9
<i>methylphenidate hcl cap er 10 mg (cd)</i>	8	<i>methylphenidate hcl tab er 10 mg</i>	10
<i>methylphenidate hcl cap er 20 mg (cd)</i>	8	<i>methylphenidate hcl tab er 20 mg</i>	10
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	8	<i>methylphenidate hcl tab er 24hr 18 mg</i>	10
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	8	<i>methylphenidate hcl tab er 24hr 27 mg</i>	10
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	8	<i>methylphenidate hcl tab er 24hr 36 mg</i>	10
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	8	<i>methylphenidate hcl tab er 24hr 54 mg</i>	10
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	8	<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	10
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	8	<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	10
<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	9	<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	10
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	9	<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	10
		METHYLPHENID TAB 72MG ER.....	8
		<i>methylprednisolone tab 16 mg</i>	130
		<i>methylprednisolone tab 32 mg</i>	130
		<i>methylprednisolone tab 4 mg</i>	130
		<i>methylprednisolone tab 8 mg</i>	130
		<i>methylprednisolone tab therapy pack 4 mg (21)</i>	130
		<i>methyltestosterone cap 10 mg</i>	36

<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq).....</i>	<i>164</i>	<i>mexiletine hcl cap 200 mg.....</i>	<i>42</i>
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv).....</i>	<i>164</i>	<i>mexiletine hcl cap 250 mg.....</i>	<i>42</i>
<i>metoclopramide hcl tab 10 mg (base equivalent).....</i>	<i>164</i>	<i>miconazole nitrate vaginal suppos 200 mg.....</i>	<i>231</i>
<i>metoclopramide hcl tab 5 mg (base equivalent).....</i>	<i>164</i>	<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%.....</i>	<i>135</i>
<i>METOCLOPRAMI TAB 10MG ODT.....</i>	<i>164</i>	<i>MICROCHAMBER MIS.....</i>	<i>197</i>
<i>metolazone tab 10 mg.....</i>	<i>156</i>	<i>MICRODOT CON SOL HIGH/LOW.....</i>	<i>187</i>
<i>metolazone tab 2.5 mg.....</i>	<i>156</i>	<i>MICROLET MIS LANCETS.....</i>	<i>187</i>
<i>metolazone tab 5 mg.....</i>	<i>156</i>	<i>MICROLET MIS NEXT.....</i>	<i>187</i>
<i>metoprolol & hydrochlorothiazide tab 100-25 mg.....</i>	<i>79</i>	<i>MICROLIFE MIS PEAK FLO.....</i>	<i>197</i>
<i>metoprolol & hydrochlorothiazide tab 100-50 mg.....</i>	<i>79</i>	<i>MICRO THIN MIS LANC 33G.....</i>	<i>187</i>
<i>metoprolol & hydrochlorothiazide tab 50-25 mg.....</i>	<i>79</i>	<i>midodrine hcl tab 10 mg.....</i>	<i>232</i>
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv).....</i>	<i>115</i>	<i>midodrine hcl tab 2.5 mg.....</i>	<i>232</i>
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv).....</i>	<i>115</i>	<i>midodrine hcl tab 5 mg.....</i>	<i>232</i>
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv).....</i>	<i>115</i>	<i>MIFEPREX TAB 200MG.....</i>	<i>160</i>
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv).....</i>	<i>115</i>	<i>mifepristone tab 200 mg.....</i>	<i>160</i>
<i>metoprolol tartrate tab 100 mg.....</i>	<i>116</i>	<i>miglitol tab 100 mg.....</i>	<i>61</i>
<i>metoprolol tartrate tab 25 mg.....</i>	<i>115</i>	<i>miglitol tab 25 mg.....</i>	<i>61</i>
<i>metoprolol tartrate tab 37.5 mg.....</i>	<i>116</i>	<i>miglitol tab 50 mg.....</i>	<i>61</i>
<i>metoprolol tartrate tab 50 mg.....</i>	<i>116</i>	<i>miglustat cap 100 mg.....</i>	<i>170</i>
<i>metoprolol tartrate tab 75 mg.....</i>	<i>116</i>	<i>MINI LANCING MIS DEVICE.....</i>	<i>187</i>
<i>METROCREAM CRE 0.75%.....</i>	<i>147</i>	<i>MINIPRESS CAP 1MG.....</i>	<i>77</i>
<i>METROLOTION LOT 0.75%.....</i>	<i>147</i>	<i>MINIPRESS CAP 2MG.....</i>	<i>77</i>
<i>metronidazole cap 375 mg.....</i>	<i>38</i>	<i>MINIPRESS CAP 5MG.....</i>	<i>77</i>
<i>metronidazole cream 0.75%.....</i>	<i>147</i>	<i>MINI WRIGHT MIS PFM.....</i>	<i>197</i>
<i>metronidazole gel 0.75%.....</i>	<i>147</i>	<i>MINI WRIGHT MIS PFM LOW.....</i>	<i>197</i>
<i>metronidazole gel 1%.....</i>	<i>147</i>	<i>minocycline hcl cap 100 mg.....</i>	<i>226</i>
<i>metronidazole lotion 0.75%.....</i>	<i>147</i>	<i>minocycline hcl cap 50 mg.....</i>	<i>226</i>
<i>metronidazole tab 250 mg.....</i>	<i>38</i>	<i>minocycline hcl cap 75 mg.....</i>	<i>226</i>
<i>metronidazole tab 500 mg.....</i>	<i>38</i>	<i>minocycline hcl tab 100 mg.....</i>	<i>226</i>
<i>metronidazole vaginal gel 0.75%.....</i>	<i>231</i>	<i>minocycline hcl tab 50 mg.....</i>	<i>226</i>
<i>metyrosine cap 250 mg.....</i>	<i>75</i>	<i>minocycline hcl tab 75 mg.....</i>	<i>226</i>
<i>mexiletine hcl cap 150 mg.....</i>	<i>42</i>	<i>minoxidil tab 10 mg.....</i>	<i>82</i>
		<i>minoxidil tab 2.5 mg.....</i>	<i>82</i>
		<i>MIRAPEX ER TAB 0.375MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 0.75MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 1.5MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 2.25MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 3.75MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 3MG.....</i>	<i>98</i>
		<i>MIRAPEX ER TAB 4.5MG.....</i>	<i>98</i>
		<i>MIRAPEX TAB 0.125MG.....</i>	<i>98</i>

MIRAPEX TAB 0.5MG.....	98	<i>montelukast sodium oral granules packet 4 mg (base equiv).....</i>	44
MIRAPEX TAB 0.75MG.....	98	<i>montelukast sodium tab 10 mg (base equiv)</i>	44
MIRAPEX TAB 1MG.....	98	MONUROL PAK GRANULES.....	39
MIRCETTE TAB 28 DAY	127	<i>morphine sulfate beads cap er 24hr 120 mg</i>	30
<i>mirtazapine orally disintegrating tab 15 mg</i>	56	<i>morphine sulfate beads cap er 24hr 30 mg</i>	30
<i>mirtazapine orally disintegrating tab 30 mg</i>	56	<i>morphine sulfate beads cap er 24hr 45 mg</i>	30
<i>mirtazapine orally disintegrating tab 45 mg</i>	56	<i>morphine sulfate beads cap er 24hr 60 mg</i>	30
<i>mirtazapine tab 15 mg</i>	56	<i>morphine sulfate beads cap er 24hr 75 mg</i>	30
<i>mirtazapine tab 30 mg</i>	56	<i>morphine sulfate beads cap er 24hr 90 mg</i>	30
<i>mirtazapine tab 45 mg</i>	56	<i>morphine sulfate cap er 24hr 100 mg</i>	30
<i>mirtazapine tab 7.5 mg.....</i>	56	<i>morphine sulfate cap er 24hr 10 mg.....</i>	30
<i>misoprostol tab 100 mcg</i>	229	<i>morphine sulfate cap er 24hr 20 mg</i>	30
<i>misoprostol tab 200 mcg.....</i>	229	<i>morphine sulfate cap er 24hr 30 mg</i>	30
MITIGARE CAP 0.6MG.....	169	<i>morphine sulfate cap er 24hr 40 mg.....</i>	30
MITOSOL KIT 0.2MG.....	211	<i>morphine sulfate cap er 24hr 50 mg.....</i>	30
MM LANCING MIS DEVICE	187	<i>morphine sulfate cap er 24hr 60 mg.....</i>	30
MM TWIST MIS LANCETS.....	187	<i>morphine sulfate cap er 24hr 80 mg.....</i>	30
MOBIC TAB 15MG	22	<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml).....</i>	30
MOBIC TAB 7.5MG	22	<i>morphine sulfate oral soln 10 mg/5ml.....</i>	30
MOBILE LANCE MIS 30G	187	<i>morphine sulfate oral soln 20 mg/5ml.....</i>	30
<i>modafinil tab 100 mg.....</i>	10	<i>morphine sulfate suppos 10 mg</i>	30
<i>modafinil tab 200 mg.....</i>	10	<i>morphine sulfate suppos 20 mg</i>	31
<i>moexipril hcl tab 15 mg.....</i>	74	<i>morphine sulfate suppos 30 mg</i>	31
<i>moexipril hcl tab 7.5 mg.....</i>	74	<i>morphine sulfate suppos 5 mg.....</i>	30
<i>molindone hcl tab 10 mg</i>	104	<i>morphine sulfate tab 15 mg</i>	31
<i>molindone hcl tab 25 mg.....</i>	104	<i>morphine sulfate tab 30 mg</i>	31
<i>molindone hcl tab 5 mg.....</i>	104	<i>morphine sulfate tab er 100 mg</i>	31
<i>mometasone furoate cream 0.1%.....</i>	144	<i>morphine sulfate tab er 15 mg.....</i>	31
<i>mometasone furoate nasal susp 50 mcg/act.....</i>	208	<i>morphine sulfate tab er 200 mg</i>	31
<i>mometasone furoate oint 0.1%</i>	144	<i>morphine sulfate tab er 30 mg.....</i>	31
<i>mometasone furoate solution 0.1% (lotion)</i>	144	<i>morphine sulfate tab er 60 mg.....</i>	31
MONOLET MIS LANCETS.....	187	MOUNJARO INJ 10MG/0.5	63
MONOLET OPD MIS LANCETS.....	187	MOUNJARO INJ 12.5/0.5.....	63
MONOLETTOR MIS LANCETS.....	187	MOUNJARO INJ 15MG/0.5	63
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	44		
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	44		

MOUNJARO INJ 2.5/0.5	63	MYLERAN TAB 2MG.....	84
MOUNJARO INJ 5MG/0.5.....	63	MYSOLINE TAB 250MG.....	52
MOUNJARO INJ 7.5/0.5	63	MYSOLINE TAB 50MG	52
MOXEZA SOL 0.5%.....	211	N	
<i>moxifloxacin hcl ophth soln 0.5% (base eq)</i>		<i>nabumetone tab 500 mg</i>	22
<i>(2 times daily).....</i>	211	<i>nabumetone tab 750 mg.....</i>	22
<i>moxifloxacin hcl ophth soln 0.5% (base</i>		<i>nadolol tab 20 mg</i>	116
<i>equiv).....</i>	211	<i>nadolol tab 40 mg</i>	116
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>		<i>nadolol tab 80 mg</i>	116
<i>.....</i>	163	NAFRINSE DLY SOL /NEUTRAL	206
MPD SFTY LAN MIS 21G	187	NAFRINSE SOL DAILY.....	206
MPD SFTY LAN MIS 23G	187	NAFRINSE WK SOL 0.2%	206
MPD SFTY LAN MIS 28G	187	<i>naftifine hcl cream 1%.....</i>	135
MPD SFTY LAN MIS 30G	187	<i>naftifine hcl cream 2%</i>	135
MS CONTIN TAB 100MG ER.....	31	<i>naftifine hcl gel 1%.....</i>	135
MS CONTIN TAB 15MG ER	31	NALFON CAP 400MG	22
MS CONTIN TAB 200MG ER.....	31	NALFON TAB 600MG.....	22
MS CONTIN TAB 30MG ER	31	<i>naloxone hcl inj 0.4 mg/ml</i>	67
MS CONTIN TAB 60MG ER	31	<i>naloxone hcl inj 4 mg/10ml.....</i>	67
MULPLETA TAB 3MG	171	<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	67
MULTAQ TAB 400MG	43	<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	67
MULTI-LANCET KIT DEVICE	187	<i>naloxone hcl soln prefilled syringe 2</i>	
MULTI-LANCET MIS DEVICE	187	<i>mg/2ml</i>	67
<i>mupirocin oint 2%</i>	135	<i>naltrexone hcl tab 50 mg</i>	67
MUSE SUP 1000MCG.....	122	NAMENDA TAB 10MG.....	217
MUSE SUP 125MCG	121	NAMENDA TAB 5-10MG.....	217
MUSE SUP 250MCG.....	122	NAMENDA TAB 5MG	217
MUSE SUP 500MCG.....	122	NAMZARIC CAP.....	217
MYALEPT INJ 11.3MG	158	NAMZARIC CAP 14-10MG	217
MYAMBUTOL TAB 400MG.....	83	NAMZARIC CAP 21-10MG	217
MYCOBUTIN CAP 150MG.....	83	NAMZARIC CAP 28-10MG.....	217
<i>mycophenolate mofetil cap 250 mg</i>	204	NAMZARIC CAP 7-10MG.....	217
<i>mycophenolate mofetil for oral susp 200</i>		NAPROSYN TAB 500MG	22
<i>mg/ml.....</i>	204	<i>naproxen sodium tab 275 mg.....</i>	22
<i>mycophenolate mofetil tab 500 mg.....</i>	204	<i>naproxen sodium tab 550 mg</i>	22
<i>mycophenolate sodium tab dr 180 mg</i>		<i>naproxen tab 250 mg</i>	22
<i>(mycophenolic acid equiv)</i>	204	<i>naproxen tab 375 mg.....</i>	22
<i>mycophenolate sodium tab dr 360 mg</i>		<i>naproxen tab 500 mg</i>	22
<i>(mycophenolic acid equiv)</i>	204	<i>naproxen tab ec 375 mg</i>	22
MYFORTIC TAB 180MG	204	<i>naproxen tab ec 500 mg</i>	22
MYFORTIC TAB 360MG	204	<i>naratriptan hcl tab 1 mg (base equiv).....</i>	199
MYGLUCOHEALT MIS LANC 30G.....	187	<i>naratriptan hcl tab 2.5 mg (base equiv)...</i>	199
MYGLUCOHEALT SOL LO/NL/HI	187	NARCAN SPR 4MG.....	67

NARDIL TAB 15MG.....	57	NEOTUSS PLUS LIQ	132
NASCOBAL SPR 500MCG	171	NEPRO LIQ VANILLA	150
NASONEX SPR 50MCG/AC	208	NERLYNX TAB 40MG.....	93
NATACYN SUS 5% OP	211	NEUPRO DIS 1MG/24HR.....	98
NATAZIA TAB.....	127	NEUPRO DIS 2MG/24HR	98
<i>nateglinide tab 120 mg</i>	65	NEUPRO DIS 3MG/24HR	98
<i>nateglinide tab 60 mg</i>	65	NEUPRO DIS 4MG/24HR.....	98
NATESTO GEL 5.5MG	36	NEUPRO DIS 6MG/24HR.....	98
NATPARA INJ 100MCG	157	NEUPRO DIS 8MG/24HR.....	98
NATPARA INJ 25MCG.....	156	NEURONTIN CAP 100MG	53
NATPARA INJ 50MCG.....	156	NEURONTIN CAP 300MG.....	53
NATPARA INJ 75MCG	157	NEURONTIN CAP 400MG	53
NATROBA SUS 0.9%.....	147	NEURONTIN SOL 250/5ML.....	53
NAYZILAM SPR 5MG.....	50	NEURONTIN TAB 600MG.....	53
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	116	NEURONTIN TAB 800MG	53
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	116	NEUTEK 2TEK SOL CONTROL.....	187
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	116	<i>nevirapine susp 50 mg/5ml</i>	109
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	116	<i>nevirapine tab 200 mg</i>	109
<i>nefazodone hcl tab 100 mg</i>	58	<i>nevirapine tab er 24hr 100 mg</i>	109
<i>nefazodone hcl tab 150 mg</i>	58	<i>nevirapine tab er 24hr 400 mg</i>	110
<i>nefazodone hcl tab 200 mg</i>	58	NEXLETOL TAB 180MG.....	70
<i>nefazodone hcl tab 250 mg</i>	58	NEXLIZET TAB 180/10MG.....	70
<i>nefazodone hcl tab 50 mg</i>	58	<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	73
NEOCATE LIQ SPLASH.....	150	<i>niacin tab er 500 mg (antihyperlipidemic)</i>	73
NEOKE MCT70 POW	150	<i>niacin tab er 750 mg (antihyperlipidemic)</i>	73
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i>		NIASPAN TAB 1000 ER	73
<i>400unt-10000unt op oin</i>	211	NIASPAN TAB 500MG ER.....	73
<i>neomycin-polymy-gramicid op sol 1.75-</i>		NIASPAN TAB 750MG ER	73
<i>10000-0.025mg-unt-mg/ml</i>	211	<i>nicardipine hcl cap 20 mg</i>	118
<i>neomycin-polymyxin-dexamethasone</i>		<i>nicardipine hcl cap 30 mg</i>	118
<i>ophth oint 0.1%</i>	212	NICODERM CQ DIS 14MG/24H.....	222
<i>neomycin-polymyxin-dexamethasone</i>		NICODERM CQ DIS 21MG/24H.....	222
<i>ophth susp 0.1%</i>	212	NICODERM CQ DIS 7MG/24HR.....	222
<i>neomycin-polymyxin-hc ophth susp</i>	212	NICORETTE GUM 2MG.....	222
<i>neomycin-polymyxin-hc otic soln 1%</i>	214	NICORETTE GUM 2MG CINN	223
<i>neomycin-polymyxin-hc otic susp 3.5</i>		NICORETTE GUM 2MGFRUIT	223
<i>mg/ml-10000 unit/ml-1%</i>	214	NICORETTE GUM 2MG MINT	223
<i>neomycin sulfate tab 500 mg</i>	11	NICORETTE GUM 2MG ORIG	223
NEORAL CAP 100MG.....	204	NICORETTE GUM 4MG	223
NEORAL CAP 25MG.....	204	NICORETTE GUM 4MG CINN	223
NEORAL SOL 100MG/ML.....	204	NICORETTE GUM 4MGFRUIT	223
		NICORETTE GUM 4MG MINT	223

NICORETTE GUM 4MG ORIG	223	NITRO-DUR DIS 0.1MG/HR	40
NICORETTE LOZ 2MG MINT	223	NITRO-DUR DIS 0.2MG/HR	40
NICORETTE LOZ 4MG MINT	223	NITRO-DUR DIS 0.3MG/HR	40
NICORETTE ST GUM 2MG MINT	223	NITRO-DUR DIS 0.4MG/HR	40
NICORETTE ST GUM 2MG ORIG.....	223	NITRO-DUR DIS 0.6MG/HR	40
NICORETTE ST GUM 4MG ORIG.....	223	NITRO-DUR DIS 0.8MG/HR	40
<i>nicotine polacrilex gum 2 mg</i>	<i>223</i>	<i>nitrofurantoin macrocrystalline cap 100 mg</i>	
<i>nicotine polacrilex gum 4 mg</i>	<i>223</i>	<i>.....</i>	<i>39</i>
<i>nicotine polacrilex lozenge 2 mg</i>	<i>223</i>	<i>nitrofurantoin macrocrystalline cap 25 mg</i>	
<i>nicotine polacrilex lozenge 4 mg</i>	<i>223</i>	<i>.....</i>	<i>39</i>
<i>nicotine td patch 24hr 14 mg/24hr</i>	<i>224</i>	<i>nitrofurantoin macrocrystalline cap 50 mg</i>	
<i>nicotine td patch 24hr 21 mg/24hr</i>	<i>224</i>	<i>.....</i>	<i>39</i>
<i>nicotine td patch 24hr 7 mg/24hr.....</i>	<i>224</i>	<i>nitrofurantoin monohydrate</i>	
NICOTROL INH.....	224	<i>macrocrystalline cap 100 mg</i>	<i>39</i>
NICOTROL NS SPR 10MG/ML	224	<i>nitrofurantoin susp 25 mg/5ml</i>	<i>40</i>
<i>nifedipine cap 10 mg</i>	<i>118</i>	<i>nitroglycerin sl tab 0.3 mg</i>	<i>40</i>
<i>nifedipine cap 20 mg</i>	<i>118</i>	<i>nitroglycerin sl tab 0.4 mg</i>	<i>40</i>
<i>nifedipine tab er 24hr 30 mg.....</i>	<i>118</i>	<i>nitroglycerin sl tab 0.6 mg.....</i>	<i>40</i>
<i>nifedipine tab er 24hr 60 mg</i>	<i>118</i>	<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	<i>40</i>
<i>nifedipine tab er 24hr 90 mg</i>	<i>118</i>	<i>nitroglycerin td patch 24hr 0.2 mg/hr.....</i>	<i>40</i>
<i>nifedipine tab er 24hr osmotic release 30</i>		<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	<i>40</i>
<i>mg.....</i>	<i>118</i>	<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	<i>40</i>
<i>nifedipine tab er 24hr osmotic release 60</i>		<i>nitroglycerin tl soln 0.4 mg/spray (400</i>	
<i>mg.....</i>	<i>118</i>	<i>mcg/spray)</i>	<i>40</i>
<i>nifedipine tab er 24hr osmotic release 90</i>		NITROLINGUAL SPR 400MCG	40
<i>mg.....</i>	<i>118</i>	NITROSTAT SUB 0.3MG	41
<i>nilutamide tab 150 mg</i>	<i>87</i>	NITROSTAT SUB 0.4MG	41
<i>nimodipine cap 30 mg</i>	<i>118</i>	NITROSTAT SUB 0.6MG	41
NINLARO CAP 2.3MG.....	93	NIVESTYM INJ 300/0.5.....	171
NINLARO CAP 3MG.....	93	NIVESTYM INJ 300MCG	172
NINLARO CAP 4MG.....	93	NIVESTYM INJ 480/0.8.....	172
<i>nisoldipine tab er 24hr 17 mg</i>	<i>118</i>	NIVESTYM INJ 480MCG	172
<i>nisoldipine tab er 24hr 20 mg</i>	<i>118</i>	<i>nizatidine cap 150 mg.....</i>	<i>228</i>
<i>nisoldipine tab er 24hr 25.5 mg</i>	<i>118</i>	<i>nizatidine cap 300 mg</i>	<i>228</i>
<i>nisoldipine tab er 24hr 30 mg</i>	<i>118</i>	<i>nizatidine oral soln 15 mg/ml.....</i>	<i>228</i>
<i>nisoldipine tab er 24hr 34 mg</i>	<i>118</i>	NOCDURNA SUB 27.7MCG	160
<i>nisoldipine tab er 24hr 40 mg</i>	<i>118</i>	NOCDURNA SUB 55.3MCG	160
<i>nisoldipine tab er 24hr 8.5 mg</i>	<i>118</i>	<i>norelgestromin-ethinyl estradiol td ptwk</i>	
<i>nitazoxanide tab 500 mg</i>	<i>38</i>	<i>150-35 mcg/24hr</i>	<i>129</i>
<i>nitisinone cap 10 mg.....</i>	<i>159</i>	<i>norethindrone & ethinyl estradiol-fe chew</i>	
<i>nitisinone cap 2 mg</i>	<i>158</i>	<i>tab 0.4 mg-35 mcg</i>	<i>128</i>
<i>nitisinone cap 5 mg</i>	<i>158</i>	<i>norethindrone & ethinyl estradiol-fe chew</i>	
NITRO-BID OIN 2%.....	40	<i>tab 0.8 mg-25 mcg</i>	<i>128</i>

<i>norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg</i>	127	<i>nortriptyline hcl cap 25 mg</i>	60
<i>norethindrone & ethinyl estradiol tab 0.5 mg-35 mcg</i>	128	<i>nortriptyline hcl cap 50 mg</i>	61
<i>norethindrone & ethinyl estradiol tab 1 mg-35 mcg</i>	128	<i>nortriptyline hcl cap 75 mg</i>	61
<i>norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	128	<i>nortriptyline hcl soln 10 mg/5ml</i>	61
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	128	NOVA MAX GLU LIQ /KET CON	187
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	128	NOVA MAX PLS TES KETONE	148
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	128	NOVA SAFETY MIS LANC 23G	188
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	128	NOVA SAFETY MIS LANC 28G	188
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	128	NOVASOURCE LIQ RENAL	151
<i>norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)</i>	128	NOVA SUREFLX MIS LANC DEV	188
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	162	NOVA SURE MIS LANCETS	188
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	162	NOVOLIN INJ 70/30	64
<i>norethindrone acetate tab 5 mg</i>	216	NOVOLIN INJ 70/30 FP	64
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	128	NOVOLIN N INJ 100 UNIT	64
<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	128	NOVOLIN N INJ U-100	64
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	128	NOVOLIN R INJ 100 UNIT	64
<i>norethindrone tab 0.35 mg</i>	129	NOVOLIN R INJ U-100	64
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	128	NOVOLOG MIX INJ 70/30	64
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	128	NOVOLOG MIX INJ FLEXPEN	65
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	128	NOZIN NASAL MIS SANITIZE	208
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	128	NP THYROID TAB 120MG	227
NORPRAMIN TAB 10MG	60	NP THYROID TAB 15MG	227
NORPRAMIN TAB 25MG	60	NP THYROID TAB 30MG	227
<i>nortriptyline hcl cap 10 mg</i>	60	NP THYROID TAB 60MG	227
		NP THYROID TAB 90MG	227
		NUBEQA TAB 300MG	87
		NUCALA INJ 100MG/ML	44
		NUCALA INJ 40MG/0.4	44
		NULYTELY SOL LMN/LIME	175
		NUPLAZID CAP 34MG	100
		NUPLAZID TAB 10MG	100
		NURTEC TAB 75MG ODT	198
		NUTRAMINE PAK	151
		NUTREN 1.0 LIQ UNFLAVOR	151
		NUTREN 1.5 LIQ FIBER	151
		NUTREN 2.0 LIQ VANILLA	151
		NUTREN JR LIQ	151
		NUTREN LIQ JUNIOR	151
		NUTREN RENAL LIQ	151
		NUTRIRENAL LIQ	151
		NUVARING MIS	129
		NUZYRA TAB 150MG	225
		NYMALIZE SOL	118

<i>nystatin cream 100000 unit/gm</i>	135	<i>olanzapine orally disintegrating tab 20 mg</i>	103
<i>nystatin oint 100000 unit/gm</i>	135	<i>olanzapine orally disintegrating tab 5 mg</i>	103
<i>nystatin oral powder</i>	68	<i>olanzapine tab 10 mg</i>	103
<i>nystatin susp 100000 unit/ml</i>	205	<i>olanzapine tab 15 mg</i>	103
<i>nystatin tab 500000 unit</i>	68	<i>olanzapine tab 2.5 mg</i>	103
<i>nystatin topical powder 100000 unit/gm</i>	136	<i>olanzapine tab 20 mg</i>	103
<i>nystatin-triamcinolone cream 100000-0.1</i> <i>unit/gm-%</i>	136	<i>olanzapine tab 5 mg</i>	103
<i>nystatin-triamcinolone oint 100000-0.1</i> <i>unit/gm-%</i>	136	<i>olanzapine tab 7.5 mg</i>	103
NYVEPRIA INJ 6/0.6ML	172	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 20-5-12.5 mg</i> ..	80
○		<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-12.5 mg</i>	80
OCALIVA TAB 10MG	164	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-25 mg</i> ..	80
OCALIVA TAB 5MG	163	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-5-12.5 mg</i> ..	80
<i>octreotide acetate inj 1000 mcg/ml (1</i> <i>mg/ml)</i>	161	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-5-25 mg</i>	80
<i>octreotide acetate inj 100 mcg/ml (0.1</i> <i>mg/ml)</i>	160	<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 20-12.5 mg</i>	80
<i>octreotide acetate inj 200 mcg/ml (0.2</i> <i>mg/ml)</i>	161	<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-12.5 mg</i>	80
<i>octreotide acetate inj 500 mcg/ml (0.5</i> <i>mg/ml)</i>	161	<i>olmesartan medoxomil tab 20 mg</i>	76
<i>octreotide acetate inj 50 mcg/ml (0.05</i> <i>mg/ml)</i>	160	<i>olmesartan medoxomil tab 40 mg</i>	76
OCUFLOX DRO 0.3% OP	211	<i>olmesartan medoxomil tab 5 mg</i>	76
ODEFSEY TAB.....	110	<i>olopatadine hcl nasal soln 0.6%</i>	208
ODOMZO CAP 200MG.....	87	OLUX AER 0.05%	144
OFEV CAP 100MG.....	225	OMECLAMOX- MIS PAK.....	230
OFEV CAP 150MG	225	<i>omega-3-acid ethyl esters cap 1 gm</i>	70
<i>ofloxacin ophth soln 0.3%</i>	211	<i>omeprazole cap delayed release 10 mg</i> .	229
<i>ofloxacin otic soln 0.3%</i>	214	<i>omeprazole cap delayed release 20 mg</i> .	229
<i>ofloxacin tab 300 mg</i>	163	<i>omeprazole cap delayed release 40 mg</i> .	229
<i>ofloxacin tab 400 mg</i>	163	OMNIFLEX DPR	176
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i> ..	218	OMNIPOD 5 G6 KIT INTRO	188
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i> ..	218	OMNIPOD 5 G6 MIS PODS.....	188
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i> ...	218	OMNIPOD MIS CLASSIC	188
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i> ...	218	OMNIPOD PDM KIT CLASSIC.....	188
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i> ...	218	<i>ondansetron hcl oral soln 4 mg/5ml</i>	67
<i>olanzapine for im inj 10 mg</i>	103	<i>ondansetron hcl tab 24 mg</i>	67
<i>olanzapine orally disintegrating tab 10 mg</i>	103		
<i>olanzapine orally disintegrating tab 15 mg</i>	103		

<i>ondansetron hcl tab 4 mg</i>	67	ORENITRAM TAB 0.25MG.....	123
<i>ondansetron hcl tab 8 mg</i>	67	ORENITRAM TAB 1MG	123
<i>ondansetron orally disintegrating tab 4 mg</i>	67	ORENITRAM TAB 2.5MG	123
<i>ondansetron orally disintegrating tab 8 mg</i>	67	ORENITRAM TAB 5MG	123
ONETOUCH DEL MIS LANC DEV	188	ORENITRAM TAB MONTH 1.....	123
ONETOUCH DEL MIS PLUS 30G	188	ORENITRAM TAB MONTH 2	123
ONETOUCH DEL MIS PLUS 33G	188	ORENITRAM TAB MONTH 3	123
ONETOUCH FP MIS LANCETS	188	ORFADIN CAP 10MG.....	159
ONETOUCH LIQ ULT CONT	188	ORFADIN CAP 20MG	159
ONETOUCH LIQ VERIO.....	188	ORFADIN CAP 2MG	159
ONETOUCH LIQ VERIO 4	188	ORFADIN CAP 5MG	159
ONETOUCH MIS 30G.....	188	ORFADIN SUS 4MG/ML	159
ONETOUCH MIS LANC DEV	188	ORGOVYX TAB 120MG.....	88
ONETOUCH MIS LANCETS.....	188	ORIAHNN CAP.....	162
ONETOUCH SOL KIT COMPLETE	188	ORLISSA TAB 150MG.....	158
ONETOUCH SOL KIT FIT	188	ORLISSA TAB 200MG.....	158
ONETOUCH SOL KIT REFILL.....	188	ORKAMBI GRA 100-125	224
ONETOUCH TES ULTRA.....	148	ORKAMBI GRA 150-188	224
ONETOUCH TES VERIO.....	148	ORKAMBI GRA 75-94MG	224
ONETOUCH US MIS LANCETS	188	ORKAMBI TAB 100-125	224
ONEXTON GEL 1.2-3.75.....	134	ORKAMBI TAB 200-125	224
ON-THE-GO MIS LANC 30G.....	188	ORLADEYO CAP 110MG	169
ONZETRA XSAI MIS 11MG	200	ORLADEYO CAP 150MG.....	169
OPSUMIT TAB 10MG.....	124	<i>orlistat cap 120 mg</i>	5
OPTICHAMBER MIS DIA MD	197	<i>orphenadrine citrate tab er 12hr 100 mg</i>	207
OPTICHAMBER MIS DIAMOND.....	197	ORTHO MICRON TAB 0.35MG.....	129
OPTICHAMBER MIS DIA SM.....	197	<i>oseltamivir phosphate cap 30 mg (base</i> <i>equiv)</i>	114
OPTIMENTAL LIQ.....	151	<i>oseltamivir phosphate cap 45 mg (base</i> <i>equiv)</i>	114
OPZELURA CRE 1.5%.....	145	<i>oseltamivir phosphate cap 75 mg (base</i> <i>equiv)</i>	114
ORACEA CAP 40MG	147	<i>oseltamivir phosphate for susp 6 mg/ml</i> <i>(base equiv)</i>	114
ORACIT SOL	167	OSMOLITE 1.2 LIQ CAL.....	151
ORAFATE PST 10%.....	206	OSMOLITE 1.5 LIQ CAL.....	151
ORAPRED ODT TAB 10MG.....	130	OSMOLITE 1 LIQ CAL.....	151
ORAPRED ODT TAB 15MG.....	130	OSMOLITE HN LIQ	151
ORAPRED ODT TAB 30MG	130	OSMOLITE LIQ.....	151
ORAVIG TAB 50MG.....	205	OTEZLA TAB 10/20/30.....	23
ORENCIA CLCK INJ 125MG/ML	23	OTEZLA TAB 30MG	23
ORENCIA INJ 125MG/ML	24	OVIDE LOT 0.5%	147
ORENCIA INJ 50/0.4ML	24	OVIDREL INJ	157
ORENCIA INJ 87.5/0.7	24		
ORENITRAM TAB 0.125MG	123		

<i>oxandrolone tab 10 mg</i>	36
<i>oxandrolone tab 2.5 mg</i>	36
<i>oxaprozin tab 600 mg</i>	22
<i>oxazepam cap 10 mg</i>	42
<i>oxazepam cap 15 mg</i>	42
<i>oxazepam cap 30 mg</i>	42
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	53
<i>oxcarbazepine tab 150 mg</i>	53
<i>oxcarbazepine tab 300 mg</i>	53
<i>oxcarbazepine tab 600 mg</i>	53
<i>OXEPA 1.5 LIQ</i>	151
<i>OXEPA LIQ</i>	151
<i>OXERVATE SOL 20MCG/ML</i>	212
<i>oxiconazole nitrate cream 1%</i>	136
<i>OXTELLAR XR TAB 150MG</i>	53
<i>OXTELLAR XR TAB 300MG</i>	53
<i>OXTELLAR XR TAB 600MG</i>	53
<i>oxybutynin chloride solution 5 mg/5ml</i> ..	230
<i>oxybutynin chloride tab 5 mg</i>	230
<i>oxybutynin chloride tab er 24hr 10 mg</i> ...	230
<i>oxybutynin chloride tab er 24hr 15 mg</i>	230
<i>oxybutynin chloride tab er 24hr 5 mg</i>	230
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	34
<i>oxycodone hcl cap 5 mg</i>	31
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	31
<i>oxycodone hcl soln 5 mg/5ml</i>	31
<i>oxycodone hcl tab 10 mg</i>	31
<i>oxycodone hcl tab 15 mg</i>	32
<i>oxycodone hcl tab 20 mg</i>	32
<i>oxycodone hcl tab 30 mg</i>	32
<i>oxycodone hcl tab 5 mg</i>	31
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	32
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	32
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	34

<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	34
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	34
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	34
<i>oxymorphone hcl tab 10 mg</i>	32
<i>oxymorphone hcl tab 5 mg</i>	32
<i>OZEMPIC INJ 2/1.5ML</i>	63
<i>OZEMPIC INJ 2MG/3ML</i>	64
<i>OZEMPIC INJ 4MG/3ML</i>	64
<i>OZEMPIC INJ 8MG/3ML</i>	64

P

<i>paliperidone tab er 24hr 1.5 mg</i>	101
<i>paliperidone tab er 24hr 3 mg</i>	101
<i>paliperidone tab er 24hr 6 mg</i>	101
<i>paliperidone tab er 24hr 9 mg</i>	101
<i>PAMELOR CAP 10MG</i>	61
<i>PAMELOR CAP 25MG</i>	61
<i>PAMELOR CAP 50MG</i>	61
<i>PAMELOR CAP 75MG</i>	61
<i>PANDEL CRE 0.1%</i>	144
<i>PANRETIN GEL 0.1%</i>	136
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	229
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	229
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	229
<i>paricalcitol cap 1 mcg</i>	159
<i>paricalcitol cap 2 mcg</i>	159
<i>paricalcitol cap 4 mcg</i>	159
<i>PARLODEL CAP 5MG</i>	98
<i>PARLODEL TAB 2.5MG</i>	98
<i>PARNATE TAB 10MG</i>	57
<i>paromomycin sulfate cap 250 mg</i>	11
<i>paroxetine hcl tab 10 mg</i>	58
<i>paroxetine hcl tab 20 mg</i>	58
<i>paroxetine hcl tab 30 mg</i>	58
<i>paroxetine hcl tab 40 mg</i>	58
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	58
<i>paroxetine hcl tab er 24hr 25 mg</i>	58
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	58

PASER GRA 4GM	83	PERFECT 30G MIS LANCETS	188
PATANASE SPR 0.6%	208	PERFOROMIST NEB 20MCG	47
PAXLOVID TAB 150-100	112	PERIDEX SOL 0.12%	206
PAXLOVID TAB 300-100	112	<i>perindopril erbumine tab 2 mg</i>	74
PC LANCETS MIS 30G	188	<i>perindopril erbumine tab 4 mg</i>	74
PEAK AIR FLO MIS ADLT/PED	197	<i>perindopril erbumine tab 8 mg</i>	74
PEAK A-I-R MIS FLW METR	197	<i>permethrin cream 5%</i>	147
PEAK FLOW MIS METER	197	<i>perphenazine-amitriptyline tab 2-10 mg</i> .218	
PEAK FLW MTR MIS ADULT	197	<i>perphenazine-amitriptyline tab 2-25 mg</i> .218	
PEAK FLW MTR MIS CHILD	197	<i>perphenazine-amitriptyline tab 4-10 mg</i> .218	
PEAK FLW MTR MIS UNIVERSL	197	<i>perphenazine-amitriptyline tab 4-25 mg</i> .218	
PEDIAPRED SOL 5MG/5ML	130	<i>perphenazine-amitriptyline tab 4-50 mg</i> 218	
PEDIASURE EN LIQ /FIBER	151	<i>perphenazine tab 16 mg</i>	105
PEDIASURE LIQ PEPTIDE	152	<i>perphenazine tab 2 mg</i>	105
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>		<i>perphenazine tab 4 mg</i>	105
<i>soln 236 gm</i>	175	<i>perphenazine tab 8 mg</i>	105
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>		PERSERIS INJ 120MG	101
<i>soln 240 gm</i>	175	PERSERIS INJ 90MG	101
<i>peg 3350-kcl-sod bicarb-nacl for soln 420</i>		PHARMACY COU MIS LANCETS	188
<i>gm</i>	175	PHEBURANE MIS 483/GM	159
PEGINTRON KIT 50MCG	113	PHENACTIN AA LIQ PLUS	152
PEG-PREP KIT	175	<i>phenazopyridine hcl tab 200 mg</i>	168
<i>penciclovir cream 1%</i>	141	PHENDIMETRAZ CAP 105MG ER	4
<i>penicillamine cap 250 mg</i>	202	<i>phendimetrazine tartrate tab 35 mg</i>	4
<i>penicillamine tab 250 mg</i>	202	<i>phenelzine sulfate tab 15 mg</i>	57
<i>penicillin v potassium for soln 125 mg/5ml</i>		<i>phenobarbital elixir 20 mg/5ml</i>	173
.....	215	<i>phenobarbital tab 100 mg</i>	173
<i>penicillin v potassium for soln 250 mg/5ml</i>		<i>phenobarbital tab 15 mg</i>	173
.....	215	<i>phenobarbital tab 16.2 mg</i>	173
<i>penicillin v potassium tab 250 mg</i>	215	<i>phenobarbital tab 30 mg</i>	173
<i>penicillin v potassium tab 500 mg</i>	215	<i>phenobarbital tab 32.4 mg</i>	173
PENLET II KIT BLOOD	188	<i>phenobarbital tab 60 mg</i>	173
PENLET II MIS REPL CAP	188	<i>phenobarbital tab 64.8 mg</i>	173
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>		<i>phenobarbital tab 97.2 mg</i>	173
.....	35	<i>phenoxybenzamine hcl cap 10 mg</i>	75
<i>pentoxifylline tab er 400 mg</i>	169	<i>phentermine hcl cap 15 mg</i>	4
PEPCID TAB 40MG	228	<i>phentermine hcl cap 30 mg</i>	4
PEPTAMEN LIQ PREBIO1	152	<i>phentermine hcl cap 37.5 mg</i>	4
PEPTAMEN LIQ UNFLAVOR	152	<i>phentermine hcl tab 37.5 mg</i>	4
PEPTINEX DT LIQ	152	<i>phenylephrine hcl ophth soln 10%</i>	210
PEPTINEX DT LIQ VANILLA	152	<i>phenylephrine hcl ophth soln 2.5%</i>	210
PERATIVE LIQ	152	<i>phenytoin chew tab 50 mg</i>	55
PERFECT 28G MIS LANCETS	188	<i>phenytoin sodium extended cap 100 mg</i> .55	

<i>phenytoin sodium extended cap 200 mg</i>.....55	POCKET CHAMB MIS .....197
<i>phenytoin sodium extended cap 300 mg</i>.....55	POCKETCHEM SOL EZ .....188
<i>phenytoin susp 125 mg/5ml</i> .....55	POCKET PEAK MIS METER.....197
PHLEXY-10 POW .....152	POCKETPEAK MIS MTR LOW.....197
PHOSLYRA SOL .....167	POCKET SPACE MIS .....197
PHOSPHOLINE SOL 0.125%OP .....210	<i>podofilox soln 0.5%</i> .....146
<i>phytonadione tab 5 mg</i> .....233	<i>polymyxin b-trimethoprim ophth soln</i>
PIKO 1 MIS ELECTRON .....197	10000 unit/ml-0.1% .....211
<i>pilocarpine hcl ophth soln 1%</i> .....210	POLYTRIM SOL OP .....211
<i>pilocarpine hcl ophth soln 2%</i> .....210	POMALYST CAP 1MG.....88
<i>pilocarpine hcl ophth soln 4%</i> .....210	POMALYST CAP 2MG .....88
<i>pilocarpine hcl tab 5 mg</i> .....206	POMALYST CAP 3MG .....88
<i>pilocarpine hcl tab 7.5 mg</i> .....206	POMALYST CAP 4MG .....88
<i>pimecrolimus cream 1%</i> .....146	<i>posaconazole susp 40 mg/ml</i> .....69
<i>pimozide tab 1 mg</i> .....222	<i>pot & sod citrates w/ cit ac soln 550-500-</i>
<i>pimozide tab 2 mg</i> .....222	334 mg/5ml .....167
<i>pindolol tab 10 mg</i> .....116	<i>potassium chloride cap er 10 meq</i>.....202
<i>pindolol tab 5 mg</i>.....116	<i>potassium chloride cap er 8 meq</i> .....202
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>.....62	<i>potassium chloride microencapsulated crys</i>
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i> 62	<i>er tab 10 meq</i> .....202
<i>pioglitazone hcl-metformin hcl tab 15-500</i>	<i>potassium chloride microencapsulated crys</i>
<i>mg</i> .....62	<i>er tab 15 meq</i> .....202
<i>pioglitazone hcl-metformin hcl tab 15-850</i>	<i>potassium chloride microencapsulated crys</i>
<i>mg</i> .....62	<i>er tab 20 meq</i> .....202
<i>pioglitazone hcl tab 15 mg (base equiv)</i> ...65	<i>potassium chloride oral soln 10% (20</i>
<i>pioglitazone hcl tab 30 mg (base equiv)</i> ...65	<i>meq/15ml)</i> .....202
<i>pioglitazone hcl tab 45 mg (base equiv)</i> ...65	<i>potassium chloride oral soln 20% (40</i>
PIP LANCETS MIS 28G .....188	<i>meq/15ml)</i> .....202
PIP LANCETS MIS 30G .....188	<i>potassium chloride powder packet 20 meq</i>
PIQRAY 200MG TAB DOSE .....93	.....202
PIQRAY 250MG TAB DOSE .....93	<i>potassium chloride tab er 10 meq</i> .....202
PIQRAY 300MG TAB DOSE .....93	<i>potassium chloride tab er 20 meq (1500</i>
<i>pirfenidone tab 267 mg</i> .....225	<i>mg)</i> .....202
<i>pirfenidone tab 801 mg</i> .....225	<i>potassium chloride tab er 8 meq (600 mg)</i>
<i>piroxicam cap 10 mg</i> .....22	.....202
<i>piroxicam cap 20 mg</i> .....22	<i>potassium citrate & citric acid powder pack</i>
PIVOT LIQ 1.5 CAL .....152	3300-1002 mg.....167
PKU EXPLORE5 POW UNFLAVOR .....152	<i>potassium citrate & citric acid soln 1100-</i>
PLAQUENIL TAB 200MG .....82	334 mg/5ml .....167
PLEGRIDY INJ .....221	<i>potassium citrate tab er 10 meq (1080 mg)</i>
PLEGRIDY INJ PEN.....221	.....167
PLEGRIDY INJ STARTER .....221	<i>potassium citrate tab er 15 meq (1620 mg)</i>
PLEGRIDY PEN INJ STARTER.....221	.....167

<i>potassium citrate tab er 5 meq (540 mg)</i> 167	PRECISION LIQ NRML/MID .....189
POTASSIUM POW CHLORIDE .....202	PRECISN XTRA TES KETONE .....148
POVIDONE IOD SOL 5%.....211	PRECOSE TAB 100MG .....61
PPA/MMA POW EXPRESS.....152	PRECOSE TAB 25MG .....61
<i>pramipexole dihydrochloride tab 0.125 mg</i>	PRECOSE TAB 50MG .....61
.....98	PRED-G S.O.P OIN OP.....212
<i>pramipexole dihydrochloride tab 0.25 mg</i>	PRED-G SUS OP.....212
.....98	<i>prednicarbate cream 0.1%</i>.....144
<i>pramipexole dihydrochloride tab 0.5 mg</i> .98	<i>prednicarbate oint 0.1%</i> .....144
<i>pramipexole dihydrochloride tab 0.75 mg</i>	<i>prednisolone acetate ophth susp 1%</i>.....212
.....98	<i>prednisolone sodium phosphate oral soln</i>
<i>pramipexole dihydrochloride tab 1.5 mg</i> ..98	25 mg/5ml (base eq).....130
<i>pramipexole dihydrochloride tab 1 mg</i> ....98	<i>prednisolone sod phos orally disintegr tab</i>
<i>pramipexole dihydrochloride tab er 24hr</i>	10 mg (base eq).....130
0.375 mg .....98	<i>prednisolone sod phos orally disintegr tab</i>
<i>pramipexole dihydrochloride tab er 24hr</i>	15 mg (base eq).....130
0.75 mg.....98	<i>prednisolone sod phos orally disintegr tab</i>
<i>pramipexole dihydrochloride tab er 24hr 1.5</i>	30 mg (base eq).....130
mg .....98	<i>prednisolone sod phosphate oral soln 15</i>
<i>pramipexole dihydrochloride tab er 24hr</i>	mg/5ml (base equiv) .....130
2.25 mg .....98	<i>prednisolone sod phosph oral soln 6.7</i>
<i>pramipexole dihydrochloride tab er 24hr</i>	mg/5ml (5 mg/5ml base) .....130
3.75 mg.....99	<i>prednisolone soln 15 mg/5ml</i> .....131
<i>pramipexole dihydrochloride tab er 24hr 3</i>	PREDNISOLONE SUS 1% .....212
mg .....98	PREDNISONONE CON 5MG/ML.....131
<i>pramipexole dihydrochloride tab er 24hr</i>	<i>prednisone oral soln 5 mg/5ml</i>.....131
4.5 mg .....99	<i>prednisone tab 10 mg</i> .....131
PRAMOSONE CRE 1-1% .....144	<i>prednisone tab 1 mg</i>.....131
PRAMOSONE LOT 1%.....144	<i>prednisone tab 2.5 mg</i> .....131
PRAMOSONE LOT 2.5%.....144	<i>prednisone tab 20 mg</i>.....131
<i>prasugrel hcl tab 10 mg (base equiv)</i>.....170	<i>prednisone tab 50 mg</i>.....131
<i>prasugrel hcl tab 5 mg (base equiv)</i> .....170	<i>prednisone tab 5 mg</i> .....131
<i>pravastatin sodium tab 10 mg</i> .....72	<i>prednisone tab therapy pack 10 mg (21)</i> ..131
<i>pravastatin sodium tab 20 mg</i>.....72	<i>prednisone tab therapy pack 10 mg (48)</i> .131
<i>pravastatin sodium tab 40 mg</i>.....72	<i>prednisone tab therapy pack 5 mg (21)</i> ....131
<i>pravastatin sodium tab 80 mg</i>.....72	<i>prednisone tab therapy pack 5 mg (48)</i> ...131
<i>praziquantel tab 600 mg</i> .....37	PRED SOD PHO SOL 1% OP .....212
<i>prazosin hcl cap 1 mg</i>.....77	<i>pregabalin cap 100 mg</i> .....53
<i>prazosin hcl cap 2 mg</i>.....77	<i>pregabalin cap 150 mg</i> .....53
<i>prazosin hcl cap 5 mg</i>.....77	<i>pregabalin cap 200 mg</i> .....53
PR BENZOYL LIQ 7% WASH.....134	<i>pregabalin cap 225 mg</i>.....53
PRECISION LIQ CONTROL.....188	<i>pregabalin cap 25 mg</i>.....53
PRECISION LIQ GLUC/KET .....189	<i>pregabalin cap 300 mg</i> .....53

<i>pregabalin cap 50 mg</i>	53	<i>prochlorperazine edisylate inj 10 mg/2ml</i>	105
<i>pregabalin cap 75 mg</i>	53	<i>prochlorperazine edisylate inj 50 mg/10ml</i>	105
<i>pregabalin soln 20 mg/ml</i>	53	<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	105
<i>pregabalin tab er 24hr 165 mg</i>	222	<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	105
<i>pregabalin tab er 24hr 330 mg</i>	222	<i>prochlorperazine suppos 25 mg</i>	105
<i>pregabalin tab er 24hr 82.5 mg</i>	222	PRO COMFORT MIS 31G	189
PREMARIN INJ 25MG.....	163	PRO COMFORT MIS LANC 30G.....	189
<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg</i>	206	PRO COMFORT MIS LANCETS.....	189
<i>prenatal vit w/ fe fumarate-fa chew tab 29-1 mg</i>	206	PRO COMFORT PAD ALCOHOL	195
<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>	206	PROCRIT INJ 10000/ML.....	172
<i>prenatal vit w/ fe fum-methylfolate-fa tab 27-0.6-0.4 mg</i>	206	PROCRIT INJ 2000/ML	172
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	206	PROCRIT INJ 20000/ML.....	172
<i>prenat w/o a w/fefum-methfol-fa-dha cap 27-0.6-0.4-300 mg</i>	206	PROCRIT INJ 3000/ML	172
PREPIDIL GEL 0.5MG/3G.....	214	PROCRIT INJ 4000/ML	172
PREP PADS PAD.....	195	PROCRIT INJ 40000/ML.....	172
PRESSURE ACT MIS LANCET	189	PROCTOFOAM AER HC 1%	37
PRESSURE ACT MIS LANCETS	189	PRODIGY MIS 26G	189
PRETOMANID TAB 200MG.....	83	PRODIGY MIS 28G	189
PREVYMIS TAB 240MG.....	112	PRODIGY MIS LANC DEV	189
PREVYMIS TAB 480MG.....	112	PRODIGY SOL HIGH.....	189
PREZCOBIX TAB 800-150.....	110	PRODIGY SOL LOW	189
PRIFTIN TAB 150MG.....	83	<i>progesterone cap 100 mg</i>	216
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	82	<i>progesterone cap 200 mg</i>	216
PRIMAQUINE TAB 26.3MG.....	82	<i>progesterone im in oil 50 mg/ml</i>	216
<i>primidone tab 250 mg</i>	54	PROGLYCEM SUS 50MG/ML.....	63
<i>primidone tab 50 mg</i>	54	PROGRAF CAP 0.5MG.....	204
PRIMSOL SOL 50MG/5ML	38	PROGRAF CAP 1MG	204
PRINIVIL TAB 20MG	74	PROGRAF CAP 5MG	204
<i>probenecid tab 500 mg</i>	169	PROGRAF GRA 0.2MG.....	204
PROCARDIA CAP 10MG.....	118	PROGRAF GRA 1MG	204
PROCARDIA XL TAB 30MG CR.....	119	PROMACTA PAK 25MG.....	172
PROCARDIA XL TAB 60MG CR.....	119	PROMACTA POW 12.5MG.....	172
PROCARDIA XL TAB 90MG CR.....	119	PROMACTA TAB 12.5MG	172
PROCARE MIS ADULT	197	PROMACTA TAB 25MG.....	172
PROCARE MIS CHILD	197	PROMACTA TAB 50MG.....	172
		PROMACTA TAB 75MG.....	172
		PROMACTIN AA SUS PLUS.....	152
		<i>promethazine & phenylephrine syrup 6.25- 5 mg/5ml</i>	132

<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	132	PROSOURCE LIQ TF	153
.....	132	PROSTIN E2 SUP 20MG.....	214
<i>promethazine hcl suppos 12.5 mg</i>	69	PROTHELIAL PST 10%.....	206
<i>promethazine hcl suppos 25 mg</i>	69	PROTONIX INJ 40MG	229
<i>promethazine hcl suppos 50 mg</i>	69	PROTOPIC OIN 0.03%.....	146
<i>promethazine hcl syrup 6.25 mg/5ml</i>	69	PROTOPIC OIN 0.1%.....	146
<i>promethazine hcl tab 12.5 mg</i>	70	<i>protriptyline hcl tab 10 mg</i>	61
<i>promethazine hcl tab 25 mg</i>	70	<i>protriptyline hcl tab 5 mg</i>	61
<i>promethazine hcl tab 50 mg</i>	70	PROVERA TAB 10MG	216
<i>promethazine-phenylephrine-codeine</i>		PROVERA TAB 2.5MG.....	216
<i>syrup 6.25-5-10 mg/5ml</i>	132	PROVERA TAB 5MG	216
<i>promethazine w/ codeine syrup 6.25-10</i>		PRUDOXIN CRE 5%.....	136
<i>mg/5ml</i>	132	<i>pseudoephed-bromphen-dm syrup 30-2-10</i>	
PROMOTE/ LIQ FIBER	152	<i>mg/5ml</i>	132
PROMOTE 1.0 LIQ W/ FIBER.....	152	PSS SAFE LAN MIS.....	189
PROMOTE LIQ VANILLA.....	152	PSS SEL LANC MIS.....	189
PROMOTE W/FB LIQ VANILLA.....	152	PSS SEL PLAT MIS	189
PROMOTE W/ LIQ FIBER.....	152	PTS PANELS TES KETONE.....	148
<i>propafenone hcl cap er 12hr 225 mg</i>	43	PULMICORT INH 180MCG.....	45
<i>propafenone hcl cap er 12hr 325 mg</i>	43	PULMICORT INH 90MCG	45
<i>propafenone hcl cap er 12hr 425 mg</i>	43	PULMOZYME SOL 1MG/ML	225
<i>propafenone hcl tab 150 mg</i>	43	PURE COMFORT PAD	195
<i>propafenone hcl tab 225 mg</i>	43	PURIXAN SUS 20MG/ML.....	84
<i>propafenone hcl tab 300 mg</i>	43	PX LANCETS MIS 28G	189
<i>proparacaine hcl ophth soln 0.5%</i>	212	PX LANCETS MIS ULT THIN	189
PRO-PHREE POW.....	152	PYLERA CAP	230
<i>propranolol & hydrochlorothiazide tab 40-</i>		<i>pyrazinamide tab 500 mg</i>	83
<i>25 mg</i>	80	<i>pyridostigmine bromide oral soln 60</i>	
<i>propranolol & hydrochlorothiazide tab 80-</i>		<i>mg/5ml</i>	82
<i>25 mg</i>	80	<i>pyridostigmine bromide tab 60 mg</i>	83
<i>propranolol hcl cap er 24hr 120 mg</i>	116	<i>pyridostigmine bromide tab er 180 mg</i>	83
<i>propranolol hcl cap er 24hr 160 mg</i>	116	<i>pyrimethamine tab 25 mg</i>	82
<i>propranolol hcl cap er 24hr 60 mg</i>	116	PYROGALL ACD OIN	146
<i>propranolol hcl cap er 24hr 80 mg</i>	116	Q	
<i>propranolol hcl oral soln 20 mg/5ml</i>	116	QBRELIS SOL 1MG/ML.....	74
<i>propranolol hcl oral soln 40 mg/5ml</i>	116	QBREXZA PAD 2.4%	147
<i>propranolol hcl tab 10 mg</i>	116	QC ALCOHOL PAD SWABS	195
<i>propranolol hcl tab 20 mg</i>	116	QC LANCETS MIS 28G.....	189
<i>propranolol hcl tab 40 mg</i>	116	QC LANCETS MIS 30G	189
<i>propranolol hcl tab 60 mg</i>	116	QC LANCING MIS DEVICE	189
<i>propranolol hcl tab 80 mg</i>	116	QSYMIA CAP 11.25-69	5
<i>propylthiouracil tab 50 mg</i>	226	QSYMIA CAP 15-92MG.....	5
PROSCAR TAB 5MG	168	QSYMIA CAP 3.75-23	4

QSYMIA CAP 7.5-46MG.....5
 QUALAQUIN CAP 324MG.....82
 QUDEXY XR CAP 100/24HR.....54
 QUDEXY XR CAP 150/24HR.....54
 QUDEXY XR CAP 200/24HR.....54
 QUDEXY XR CAP 25/24HR.....54
 QUDEXY XR CAP 50/24HR.....54
 QUESTRAN POW 4GM.....71
 QUESTRAN POW 4GM LITE.....71
quetiapine fumarate tab 100 mg103
quetiapine fumarate tab 150 mg103
quetiapine fumarate tab 200 mg.....103
quetiapine fumarate tab 25 mg103
quetiapine fumarate tab 300 mg.....103
quetiapine fumarate tab 400 mg103
quetiapine fumarate tab 50 mg103
quetiapine fumarate tab er 24hr 150 mg.103
quetiapine fumarate tab er 24hr 200 mg 103
quetiapine fumarate tab er 24hr 300 mg 103
quetiapine fumarate tab er 24hr 400 mg 103
quetiapine fumarate tab er 24hr 50 mg ..103
 QUICKTEK LIQ SOLUTION189
quinapril hcl tab 10 mg74
quinapril hcl tab 20 mg.....75
quinapril hcl tab 40 mg.....75
quinapril hcl tab 5 mg74
quinapril-hydrochlorothiazide tab 10-12.5 mg80
quinapril-hydrochlorothiazide tab 20-12.5 mg80
quinapril-hydrochlorothiazide tab 20-25 mg80
quinidine gluconate tab er 324 mg42
quinidine sulfate tab 200 mg.....42
quinidine sulfate tab 300 mg.....42
quinine sulfate cap 324 mg.....82
 QUINTET CONT SOL HGH/NORM189
 QULIPTA TAB 10MG.....198
 QULIPTA TAB 30MG.....198
 QULIPTA TAB 60MG.....198
 QVAR REDIIHA AER 80MCG45
 QVAR REDIIHAL AER 40MCG45

R
 RABEPRAZOLE CAP 10MG DR.....229
rabeprazole sodium ec tab 20 mg229
 RADICAVA ORS SUS 105/5ML209
 RADICAVA ORS SUS STARTER209
 RADIOGARDASE CAP 0.5GM67
 RA E-ZJECT MIS 28G189
 RA E-ZJECT MIS THIN 26G.....189
 RA E-ZJECT MIS THIN 28G.....189
 RA E-ZJECT MIS ULT THIN189
raloxifene hcl tab 60 mg158
ramelteon tab 8 mg174
ramipril cap 1.25 mg.....75
ramipril cap 10 mg.....75
ramipril cap 2.5 mg75
ramipril cap 5 mg75
 RANEXA TAB 1000MG.....40
 RANEXA TAB 500MG.....40
ranolazine tab er 12hr 1000 mg40
ranolazine tab er 12hr 500 mg.....40
 RAPAMUNE SOL 1MG/ML.....204
 RAPAMUNE TAB 0.5MG.....204
 RAPAMUNE TAB 1MG.....204
 RAPAMUNE TAB 2MG204
 RAPID-SAFE MIS LANCING189
rasagiline mesylate tab 0.5 mg (base equiv)100
rasagiline mesylate tab 1 mg (base equiv)100
 RASUVO INJ 10MG19
 RASUVO INJ 12.5MG20
 RASUVO INJ 15MG20
 RASUVO INJ 17.5MG20
 RASUVO INJ 20MG.....20
 RASUVO INJ 22.5MG.....20
 RASUVO INJ 25MG.....20
 RASUVO INJ 30MG20
 RASUVO INJ 7.5MG.....19
 RAZADYNE ER CAP 16MG.....218
 RAZADYNE ER CAP 24MG218
 RAZADYNE ER CAP 8MG218
 READYLANCE MIS 21G.....189
 READYLANCE MIS 23G189

READYLANCE MIS 26G	189	RESOURCE DIA LIQ TF	153
READYLANCE MIS 28G	189	RESTASIS EMU 0.05% OP	211
READYLANCE MIS 30G	189	RESTASIS MUL EMU 0.05% OP	211
REALITY MIS LANCETS	189	RESTORIL CAP 15MG	174
REALITY SWAB PAD	195	RESTORIL CAP 22.5MG	174
REALITY TRIG MIS LANCETS	189	RESTORIL CAP 30MG	174
REBIF INJ 22/0.5	221	RESTORIL CAP 7.5MG	174
REBIF INJ 44/0.5	221	RETACRIT INJ 10000UNT	172
REBIF REBIDO INJ 22/0.5.....	221	RETACRIT INJ 20000UNI	172
REBIF REBIDO INJ 44/0.5	221	RETACRIT INJ 2000UNIT	172
REBIF REBIDO INJ TITRATN	221	RETACRIT INJ 3000UNIT	172
REBIF TITRTN INJ PACK.....	221	RETACRIT INJ 40000UNT	172
RECTIV OIN 0.4%.....	37	RETACRIT INJ 4000UNIT	172
REFUAH PLUS SOL CONTROL	189	RETEVMO CAP 40MG	93
REGIMEX TAB 25MG	5	RETEVMO CAP 80MG	93
REGLAN TAB 10MG.....	164	RETIN-A CRE 0.025%	134
REGLAN TAB 5MG	164	RETIN-A CRE 0.05%	134
REGRANEX GEL 0.01%	148	RETIN-A CRE 0.1%	134
RELENZA MIS DISKHALE.....	114	RETIN-A GEL 0.01%	134
RELION KIT LANCING.....	190	RETIN-A GEL 0.025%	134
RELION LANCE MIS THIN 26G	190	RETROVIR CAP 100MG	110
RELION LANCE MIS THIN 30G.....	190	RETROVIR SYP 50MG/5ML.....	110
RELION LANCI MIS DEVICE	190	REVCovi INJ 1.6MG/ML	159
RELION MICRO MIS THIN 33G.....	190	REVLIMID CAP 10MG	203
RELION TES KETONE.....	148	REVLIMID CAP 15MG	203
RELION ULTRA MIS THIN 30G	190	REVLIMID CAP 2.5MG	202
RELION ULTRA MIS THIN PLS.....	190	REVLIMID CAP 20MG	203
RELPAx TAB 20MG.....	200	REVLIMID CAP 25MG	203
RELPAx TAB 40MG.....	200	REVLIMID CAP 5MG.....	203
REMERON SLTB TAB 15MG	56	REXULTI TAB 0.25MG	106
REMERON SLTB TAB 30MG.....	56	REXULTI TAB 0.5MG.....	106
REMERON SLTB TAB 45MG.....	56	REXULTI TAB 1MG.....	106
REMERON TAB 15MG.....	56	REXULTI TAB 2MG	106
REMERON TAB 30MG.....	56	REXULTI TAB 3MG	106
RENAGEL TAB 800MG	167	REXULTI TAB 4MG	106
<i>repaglinide tab 0.5 mg</i>	65	REYVOW TAB 100MG	200
<i>repaglinide tab 1 mg</i>	65	REYVOW TAB 50MG.....	200
<i>repaglinide tab 2 mg</i>	65	RIAX AER 5.5%	134
REPATHA INJ 140MG/ML.....	73	RIAX AER 9.5%	134
REPATHA PUSH INJ 420/3.5	73	<i>ribavirin cap 200 mg</i>	113
REPATHA SURE INJ 140MG/ML.....	73	<i>ribavirin tab 200 mg</i>	113
REPLETE FIBE LIQ 1 CAL.....	153	RIDAURA CAP 3MG	20
REPLETE LIQ ULTRAPAK	153	<i>rifabutin cap 150 mg</i>	83

<i>rifampin cap 150 mg</i>	83	<i>risperidone tab 1 mg</i>	102
<i>rifampin cap 300 mg</i>	83	<i>risperidone tab 2 mg</i>	102
RIGHTEST ALT MIS ADAPTOR.....	190	<i>risperidone tab 3 mg</i>	102
RIGHTEST LIQ HIGH CON.....	190	<i>risperidone tab 4 mg</i>	102
RIGHTEST LIQ NORM CON.....	190	RITALIN LA CAP 10MG	10
RIGHTEST MIS GD500	190	RITALIN LA CAP 20MG.....	10
RIGHTEST MIS GL300	190	RITALIN LA CAP 30MG.....	10
RILUTEK TAB 50MG.....	209	RITALIN LA CAP 40MG.....	10
<i>riluzole tab 50 mg</i>	209	RITALIN TAB 10MG	10
<i>rimantadine hydrochloride tab 100 mg</i>	114	RITALIN TAB 20MG.....	10
RINVOQ TAB 15MG ER	17	RITALIN TAB 5MG	10
RINVOQ TAB 30MG ER	17	RITEFLO MIS	198
RINVOQ TAB 45MG ER	18	<i>ritonavir tab 100 mg</i>	110
<i>risedronate sodium tab 150 mg</i>	157	<i>rivastigmine tartrate cap 1.5 mg (base</i> <i>equivalent)</i>	218
<i>risedronate sodium tab 30 mg</i>	157	<i>rivastigmine tartrate cap 3 mg (base</i> <i>equivalent)</i>	218
<i>risedronate sodium tab 35 mg</i>	157	<i>rivastigmine tartrate cap 4.5 mg (base</i> <i>equivalent)</i>	218
<i>risedronate sodium tab 5 mg</i>	157	<i>rivastigmine tartrate cap 6 mg (base</i> <i>equivalent)</i>	218
<i>risedronate sodium tab delayed release 35</i> <i>mg</i>	157	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	218
RISPERDAL INJ 12.5MG	101	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	.218
RISPERDAL INJ 25MG.....	101	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i> ..	218
RISPERDAL INJ 37.5MG	101	<i>rizatriptan benzoate oral disintegrating tab</i> <i>10 mg (base eq)</i>	200
RISPERDAL INJ 50MG	101	<i>rizatriptan benzoate oral disintegrating tab</i> <i>5 mg (base eq)</i>	200
RISPERDAL SOL 1MG/ML.....	101	<i>rizatriptan benzoate tab 10 mg (base</i> <i>equivalent)</i>	200
RISPERDAL TAB 0.5MG	101	<i>rizatriptan benzoate tab 5 mg (base</i> <i>equivalent)</i>	200
RISPERDAL TAB 1MG	101	ROCALTROL CAP 0.25MCG.....	159
RISPERDAL TAB 2MG.....	101	ROCALTROL CAP 0.5MCG	159
RISPERDAL TAB 3MG.....	101	ROCALTROL SOL 1MCG/ML	159
RISPERDAL TAB 4MG	101	<i>ropinirole hydrochloride tab 0.25 mg</i>	99
<i>risperidone orally disintegrating tab 0.25</i> <i>mg</i>	101	<i>ropinirole hydrochloride tab 0.5 mg</i>	99
<i>risperidone orally disintegrating tab 0.5 mg</i>	101	<i>ropinirole hydrochloride tab 1 mg</i>	99
<i>risperidone orally disintegrating tab 1 mg</i>	101	<i>ropinirole hydrochloride tab 2 mg</i>	99
<i>risperidone orally disintegrating tab 2 mg</i>	101	<i>ropinirole hydrochloride tab 3 mg</i>	99
<i>risperidone orally disintegrating tab 3 mg</i>	101	<i>ropinirole hydrochloride tab 4 mg</i>	99
<i>risperidone orally disintegrating tab 4 mg</i>	102	<i>ropinirole hydrochloride tab 5 mg</i>	99
<i>risperidone soln 1 mg/ml</i>	102		
<i>risperidone tab 0.25 mg</i>	102		
<i>risperidone tab 0.5 mg</i>	102		

<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	99	SAFE-T-PRO MIS LANCETS	190
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	99	SAFE-T-PRO MIS PLUS	190
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	99	SAFETY 21G MIS LANCETS.....	190
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	99	SAFETY 23G MIS LANCETS	190
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	99	SAFETY 28G MIS LANCETS	190
<i>rosuvastatin calcium tab 10 mg</i>	72	SAFETY 30G MIS LANCETS.....	190
<i>rosuvastatin calcium tab 20 mg</i>	72	SAFETY MIS LANCETS	190
<i>rosuvastatin calcium tab 40 mg</i>	72	SAFYRAL TAB	129
<i>rosuvastatin calcium tab 5 mg</i>	72	SALAGEN TAB 5MG	206
ROXICODONE TAB 15MG	32	SALAGEN TAB 7.5MG.....	206
ROXICODONE TAB 30MG	32	SALIMEZ FORT CRE 10%.....	146
ROXICODONE TAB 5MG.....	32	salsalate tab 500 mg	26
ROZLYTREK CAP 100MG.....	93	salsalate tab 750 mg.....	26
ROZLYTREK CAP 200MG	93	SAMSCA TAB 15MG.....	161
ROZLYTREK PAK 50MG.....	93	SAMSCA TAB 30MG.....	161
RUCONEST INJ 2100UNIT	169	SANCUSO DIS 3.1MG.....	67
<i>rufinamide susp 40 mg/ml</i>	54	SANDIMMUNE CAP 100MG.....	204
RUKOBIA TAB 600MG ER.....	110	SANDIMMUNE CAP 25MG.....	204
RUZURGI TAB 10MG	83	SANDIMMUNE SOL 100MG/ML.....	204
RYBELSUS TAB 14MG	64	SANDOSTATIN INJ 100MCG.....	161
RYBELSUS TAB 3MG.....	64	SANDOSTATIN INJ 500MCG	161
RYBELSUS TAB 7MG	64	SANDOSTATIN INJ 50MCG/ML	161
RYDAPT CAP 25MG	93	SANTYL OIN 250/GM	145
RYTARY CAP 145MG	99	SAPHRIS SUB 10MG.....	103
RYTARY CAP 195MG	99	SAPHRIS SUB 2.5MG	103
RYTARY CAP 245MG	99	SAPHRIS SUB 5MG	103
RYTARY CAP 95MG	99	<i>sapropterin dihydrochloride powder packet 100 mg</i>	159
RYTHMOL SR CAP 225MG.....	43	<i>sapropterin dihydrochloride powder packet 500 mg</i>	159
RYTHMOL SR CAP 325MG.....	43	<i>sapropterin dihydrochloride tab 100 mg</i>	159
RYTHMOL SR CAP 425MG.....	43	SAPSCARE MIS TWIST	190
S		SAPS CARE PAD ALCOHOL	195
S.O.S. 20 POW	153	SAPS HEALTH MIS TWIST	190
S.O.S. 25 POW.....	153	SAPS HEALTH PAD ALCOHOL.....	195
SAFE-T-LANCE MIS 21G.....	190	SAPS TWIST MIS 30G.....	190
SAFE-T-LANCE MIS 25G.....	190	SAVELLA MIS TITR PAK	218
SAFE-T-LANCE MIS HI FLOW	190	SAVELLA TAB 100MG.....	218
SAFE-T-LANCE MIS LOW FLOW	190	SAVELLA TAB 12.5MG	218
SAFE-T-LANCE MIS NOR FLOW	190	SAVELLA TAB 25MG.....	218
		SAVELLA TAB 50MG.....	218
		SAXENDA INJ 18MG/3ML.....	5
		SB ALCOHOL PAD PREP	195

SB LANCETS MIS THIN	190	<i>silodosin cap 4 mg</i>	168
SB LANCETS MIS ULTR THN.....	190	<i>silodosin cap 8 mg</i>	168
<i>scopolamine td patch 72hr 1 mg/3days</i>	67	SILVADENE CRE 1%.....	141
SELECT-LITE KIT DEV/LANC	190	<i>silver sulfadiazine cream 1%</i>	141
SELECT-LITE MIS LANC DEV	190	SIMBRINZA SUS 1-0.2%	210
<i>selegiline hcl cap 5 mg</i>	100	SIMPLE DIAG MIS LANCING	190
<i>selegiline hcl tab 5 mg</i>	100	<i>simvastatin tab 10 mg</i>	73
<i>selenium sulfide lotion 2.5%</i>	141	<i>simvastatin tab 20 mg</i>	73
SENSIPAR TAB 30MG.....	159	<i>simvastatin tab 40 mg</i>	73
SENSIPAR TAB 60MG.....	159	<i>simvastatin tab 5 mg</i>	73
SENSIPAR TAB 90MG.....	159	<i>simvastatin tab 80 mg</i>	73
SERNIVO SPR.....	144	SINEMET TAB 10-100MG.....	99
SERNIVO SPR 0.05%.....	144	SINEMET TAB 25-100MG	99
SEROQUEL TAB 100MG	104	SINGLE-LET MIS 23G.....	190
SEROQUEL TAB 200MG.....	104	<i>sirolimus oral soln 1 mg/ml</i>	204
SEROQUEL TAB 25MG	104	<i>sirolimus tab 0.5 mg</i>	205
SEROQUEL TAB 300MG.....	104	<i>sirolimus tab 1 mg</i>	205
SEROQUEL TAB 400MG	104	<i>sirolimus tab 2 mg</i>	205
SEROQUEL TAB 50MG.....	104	SIRTURO TAB 100MG.....	83
<i>sertraline hcl oral concentrate for solution</i>		SIRTURO TAB 20MG.....	83
<i>20 mg/ml</i>	58	SITAVIG TAB 50MG	114
<i>sertraline hcl tab 100 mg</i>	58	SIVEXTRO TAB 200MG.....	39
<i>sertraline hcl tab 25 mg</i>	58	SKELAXIN TAB 800MG.....	207
<i>sertraline hcl tab 50 mg</i>	58	SKYRIZI INJ 150DOSE	139
<i>sevelamer carbonate packet 0.8 gm</i>	167	SKYRIZI INJ 150MG/ML	139
<i>sevelamer carbonate packet 2.4 gm</i>	167	SKYRIZI INJ 180/1.2.....	166
<i>sevelamer carbonate tab 800 mg</i>	167	SKYRIZI INJ 360/2.4	166
<i>sevelamer hcl tab 400 mg</i>	167	SKYRIZI PEN INJ 150MG/ML.....	139
<i>sevelamer hcl tab 800 mg</i>	167	SM ALCOHOL PAD PREP	196
SHOPKO LANC MIS DEVICE.....	190	SMARTEST MIS LANCETS	191
SHUR-SEAL GEL 2%.....	231	SMARTEST SOL CONTROL	191
SIDE BUTTON MIS SAFETY.....	190	SMART SENSE MIS LANC 21G	191
SIGNIFOR INJ 0.3MG/ML	161	SMART SENSE MIS LANC 26G.....	191
SIGNIFOR INJ 0.6MG/ML	161	SMART SENSE MIS LANC 30G	191
SIGNIFOR INJ 0.9MG/ML	161	SMART SENSE MIS LANC 33G.....	191
SIKLOS TAB 1000MG.....	171	SM LANCETS MIS 33G	191
SIKLOS TAB 100MG	171	SM TRUEDRAW MIS LANC DEV	191
<i>sildenafil citrate for suspension 10 mg/ml</i>		<i>sodium chloride soln nebu 0.9%</i>	132
.....	124	<i>sodium chloride soln nebu 10%</i>	132
<i>sildenafil citrate tab 100 mg</i>	122	<i>sodium chloride soln nebu 3%</i>	132
<i>sildenafil citrate tab 20 mg</i>	124	<i>sodium chloride soln nebu 7%</i>	132
<i>sildenafil citrate tab 25 mg</i>	122	<i>sodium citrate & citric acid soln 500-334</i>	
<i>sildenafil citrate tab 50 mg</i>	122	<i>mg/5ml</i>	168

<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	201	<i>sotalol hcl (afib/afl) tab 120 mg</i>	116
<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	201	<i>sotalol hcl (afib/afl) tab 160 mg</i>	116
<i>sodium fluoride gel 1.1% (0.5% f)</i>	206	<i>sotalol hcl (afib/afl) tab 80 mg</i>	116
<i>sodium fluoride soln 0.125 mg/drop f (0.275 mg/drop naf)</i>	201	<i>sotalol hcl tab 120 mg</i>	117
<i>sodium fluoride soln 0.25 mg/drop f (from 0.55 mg/drop naf)</i>	201	<i>sotalol hcl tab 160 mg</i>	117
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	201	<i>sotalol hcl tab 240 mg</i>	117
<i>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</i>	201	<i>sotalol hcl tab 80 mg</i>	117
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	159	SOTYKTU TAB 6MG	139
<i>sodium phenylbutyrate tab 500 mg</i>	159	SOTYLIZE SOL 5MG/ML	117
<i>sodium polystyrene sulfonate oral susp 15 gm/60ml</i>	205	SOVALDI PAK 150MG	113
<i>sodium polystyrene sulfonate powder</i> ...	205	SOVALDI PAK 200MG	113
SODIUM SULFA LIQ 10% WASH	141	SOVALDI TAB 200MG	113
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	175	SOVALDI TAB 400MG	113
SOFTCLIX MIS LANCETS	191	SPACE CHAMBR MIS ANTI-STA	198
<i>solifenacin succinate tab 10 mg</i>	230	SPACE CHAMBR MIS LARGE	198
<i>solifenacin succinate tab 5 mg</i>	230	SPACE CHAMBR MIS MEDIUM	198
SOLIQUA INJ 100/33	62	SPACE CHAMBR MIS SMALL	198
SOLTAMOX SOL 10MG/5ML	88	SPACER CHAMB MIS ADULT	198
SOLU-CORTEF INJ 1000MG	131	SPACER CHAMB MIS CHILD	198
SOLU-CORTEF INJ 100MG	131	SPACER CHAMB MIS INFANT	198
SOLU-CORTEF INJ 250MG	131	<i>spinosad susp 0.9%</i>	147
SOLU-CORTEF INJ 500MG	131	SPIRIVA AER 1.25MCG	44
SOLUS V2 MIS LANC 28G	191	SPIRIVA CAP HANDIHLR	44
SOLUS V2 MIS LANC 30G	191	SPIRIVA SPR 2.5MCG	44
SOLUS V2 MIS LANC DEV	191	<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	154
SOLUS V2 SOL HIGH	191	<i>spironolactone tab 100 mg</i>	155
SOLUS V2 SOL LOW	191	<i>spironolactone tab 25 mg</i>	155
SOMA TAB 250MG	207	<i>spironolactone tab 50 mg</i>	155
SOMA TAB 350MG	207	SPRAVATO SOL 56MG DOS.....	57
SOOLANTRA CRE 1%.....	147	SPRAVATO SOL 84MG DOS.....	57
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	93	SPRYCEL TAB 100MG	94
SORIATANE CAP 10MG	139	SPRYCEL TAB 140MG	94
SORIATANE CAP 25MG.....	139	SPRYCEL TAB 20MG	93
		SPRYCEL TAB 50MG.....	93
		SPRYCEL TAB 70MG.....	94
		SPRYCEL TAB 80MG.....	94
		STALEVO 100 TAB	99
		STALEVO 125 TAB.....	99
		STALEVO 150 TAB	99
		STALEVO 200 TAB	99
		STALEVO 50 TAB.....	99
		STALEVO 75 TAB	99

STARLIX TAB 120MG.....	65	<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	38
<i>stavudine cap 15 mg</i>	110	<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	38
<i>stavudine cap 20 mg</i>	110	<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	38
<i>stavudine cap 30 mg</i>	110	SULFAMYLON CRE 85MG/GM	141
<i>stavudine cap 40 mg</i>	110	SULFAMYLON PAK 5%	141
STELARA INJ 45MG/0.5	139, 140	<i>sulfasalazine tab 500 mg.....</i>	166
STELARA INJ 90MG/ML	140	<i>sulfasalazine tab delayed release 500 mg</i>	166
STERILANCE MIS 1.8MM.....	191	SULF LIME SOL	147
STERILANCE MIS TL 28G.....	191	<i>sulindac tab 150 mg</i>	22
STERILANCE MIS TL 30G.....	191	<i>sulindac tab 200 mg</i>	22
STERILANCE MIS TL 32G.....	191	<i>sumatriptan nasal spray 20 mg/act</i>	200
STIOLTO AER 2.5-2.5	47	<i>sumatriptan nasal spray 5 mg/act</i>	200
STIVARGA TAB 40MG.....	94	<i>sumatriptan succinate inj 6 mg/0.5ml....</i>	200
STRATTERA CAP 100MG	7	<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml.....</i>	200
STRATTERA CAP 10MG	6	<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml.....</i>	200
STRATTERA CAP 18MG.....	6	<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	200
STRATTERA CAP 25MG.....	6	<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	200
STRATTERA CAP 40MG.....	6	<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	200
STRATTERA CAP 60MG.....	6	<i>sumatriptan succinate tab 100 mg.....</i>	200
STRATTERA CAP 80MG.....	6	<i>sumatriptan succinate tab 25 mg.....</i>	200
STRENSIQ INJ 18/0.45	159	<i>sumatriptan succinate tab 50 mg</i>	200
STRENSIQ INJ 28/0.7ML	159	<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	94
STRENSIQ INJ 40MG/ML	159	<i>sunitinib malate cap 25 mg (base equivalent)</i>	94
STRENSIQ INJ 80/0.8ML	159	<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	94
STRIVERDI AER 2.5MCG	47	<i>sunitinib malate cap 50 mg (base equivalent)</i>	94
STROMECTOL TAB 3MG	37	SUNOSI TAB 150MG	7
SUCRAID SOL 8500/ML.....	154	SUNOSI TAB 75MG	7
<i>sucrafate tab 1 gm.....</i>	228	SUPER THIN MIS LANC 28G.....	191
SULAR TAB 17MG ER	119	SUPER THIN MIS LANCETS	191
SULAR TAB 34MG ER	119	SUPLENA LIQ VANILLA	153
SULAR TAB 8.5MG ER	119		
<i>sulconazole nitrate cream 1%</i>	136		
<i>sulconazole nitrate solution 1%</i>	136		
<i>sulfacetamide sodium lotion 10% (acne).....</i>	134		
<i>sulfacetamide sodium ophth oint 10%</i>	211		
<i>sulfacetamide sodium ophth soln 10%</i>	211		
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	213		
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	134		
<i>sulfacetamide sodium w/ sulfur emulsion 10-1%</i>	134		
<i>sulfadiazine tab 500 mg.....</i>	225		

SUPRAX CAP 400MG	126	SYNALAR SOL 0.01%	144
SUPRAX CHW 100MG.....	126	SYNAREL SOL 2MG/ML	158
SUPRAX CHW 200MG.....	126	SYNERA DIS 70-70MG	147
SUPRAX SUS 100/5ML	126	SYNJARDY TAB	62
SUPRAX SUS 200/5ML.....	126	SYNJARDY TAB 12.5-500	62
SUPRAX SUS 500/5ML	126	SYNJARDY TAB 5-1000MG.....	62
SUPREME II LIQ HIGH/LOW	191	SYNJARDY TAB 5-500MG	62
SURE COMFORT MIS LANC 18G.....	191	SYNJARDY XR TAB.....	62
SURE COMFORT MIS LANC 21G.....	191	SYNJARDY XR TAB 10-1000	62
SURE COMFORT MIS LANC 23G	191	SYNJARDY XR TAB 25-1000	62
SURE COMFORT MIS LANC 30G	191	SYNJARDY XR TAB 5-1000MG.....	62
SURE COMFORT MIS LANCETS	191	SYNTHROID TAB 100MCG	227
SURE COMFORT MIS LANC PEN	191	SYNTHROID TAB 112MCG	227
SUREFLEX MIS LANCETS	191	SYNTHROID TAB 125MCG.....	227
SURE-LANCE MIS 26G	191	SYNTHROID TAB 137MCG.....	227
SURE-LANCE MIS LANCETS	191	SYNTHROID TAB 150MCG	227
SURELITE MIS LANCETS.....	191	SYNTHROID TAB 175MCG.....	227
SURE-PEN MIS.....	191	SYNTHROID TAB 200MCG	227
SURESTEP GLU SOL	191	SYNTHROID TAB 25MCG	227
SURESTEP GLU SOL HIGH/LOW	191	SYNTHROID TAB 300MCG	227
SURESTEP PRO TES HIGH CON.....	192	SYNTHROID TAB 50MCG.....	227
SURESTEP PRO TES LOW CON.....	192	SYNTHROID TAB 75MCG	227
SURESTEP PRO TES NORM CON.....	192	SYNTHROID TAB 88MCG	227
SURESTEP SOL CONTROL.....	192	T	
SURE-TOUCH MIS UNV LANC	191	TABLOID TAB 40MG	84
SUSTIVA CAP 200MG	110	TACHOSIL PAD 4.8X4.8	173
SUSTIVA CAP 50MG.....	110	TACHOSIL PAD 9.5X4.8	173
SUSTIVA TAB 600MG	110	TACLONEX OIN	144
SYMAX DUOTAB TAB	228	TACLONEX SUS.....	144
SYMBYAX CAP 12-50MG	218	<i>tacrolimus cap 0.5 mg</i>	205
SYMBYAX CAP 3-25MG.....	218	<i>tacrolimus cap 1 mg</i>	205
SYMBYAX CAP 6-25MG.....	218	<i>tacrolimus cap 5 mg</i>	205
SYMBYAX CAP 6-50MG.....	218	<i>tacrolimus oint 0.03%</i>	146
SYMDEKO TAB 100-150.....	225	<i>tacrolimus oint 0.1%</i>	146
SYMDEKO TAB 50-75MG.....	225	<i>tadalafil tab 10 mg</i>	122
SYMFI LO TAB	110	<i>tadalafil tab 2.5 mg</i>	122
SYMFI TAB	110	<i>tadalafil tab 20 mg</i>	122
SYMLINPEN 60 INJ 1000MCG	61	<i>tadalafil tab 20 mg (pah)</i>	124
SYMLNPEN 120 INJ 1000MCG.....	61	<i>tadalafil tab 5 mg</i>	122
SYMPROIC TAB 0.2MG	167	TADLIQ SUS 20MG/5ML.....	124
SYMTUZA TAB.....	110	<i>tafluprost preservative free (pf) ophth soln</i>	
SYNALAR CRE 0.025%	144	<i>0.0015%</i>	213
SYNALAR OIN 0.025%.....	144	TAGRISO TAB 40MG.....	86

TAGRISSO TAB 80MG.....	86	<i>telmisartan-hydrochlorothiazide tab 40-</i>	
TAI DOC SOL NORM CON.....	192	<i>12.5 mg</i>	80
TAKHZYRO INJ 150MG/ML	170	<i>telmisartan-hydrochlorothiazide tab 80-12.5</i>	
TAKHZYRO INJ 300/2ML	170	<i>mg</i>	80
TALICIA CAP	230	<i>telmisartan-hydrochlorothiazide tab 80-25</i>	
TALTZ INJ 80MG/ML	140	<i>mg</i>	81
TAMIFLU CAP 30MG	114	<i>telmisartan tab 20 mg</i>	76
TAMIFLU CAP 45MG	114	<i>telmisartan tab 40 mg</i>	76
TAMIFLU CAP 75MG	114	<i>telmisartan tab 80 mg</i>	76
TAMIFLU SUS 6MG/ML.....	114	<i>temazepam cap 15 mg.....</i>	174
<i>tamoxifen citrate tab 10 mg (base</i>		<i>temazepam cap 22.5 mg.....</i>	174
<i>equivalent)</i>	88	<i>temazepam cap 30 mg.....</i>	174
<i>tamoxifen citrate tab 20 mg (base</i>		<i>temazepam cap 7.5 mg</i>	174
<i>equivalent)</i>	88	TEMBEXA SUS 10MG/ML	114
<i>tamsulosin hcl cap 0.4 mg</i>	168	TEMBEXA TAB 100MG	114
TAPAZOLE TAB 10MG.....	226	TEMIXYS TAB 300-300.....	110
TAPAZOLE TAB 5MG	226	TEMODAR CAP 100MG.....	84
TARCEVA TAB 100MG	86	TEMODAR CAP 140MG.....	84
TARCEVA TAB 150MG	86	TEMODAR CAP 180MG.....	84
TARCEVA TAB 25MG	86	TEMODAR CAP 250MG	84
TARKA TAB 2-180 CR.....	80	TEMOVATE CRE 0.05%.....	144
TARKA TAB 2-240 CR.....	80	TEMOVATE OIN 0.05%	144
TARKA TAB 4-240 CR.....	80	<i>temozolomide cap 100 mg</i>	84
<i>tasimelteon capsule 20 mg</i>	174	<i>temozolomide cap 140 mg</i>	84
TASMAR TAB 100MG	96	<i>temozolomide cap 180 mg</i>	84
TAVALISSE TAB 100MG	169	<i>temozolomide cap 20 mg</i>	84
TAVALISSE TAB 150MG	169	<i>temozolomide cap 250 mg.....</i>	84
<i>tazarotene cream 0.1%.....</i>	140	<i>temozolomide cap 5 mg</i>	84
TECHLITE AST MIS LANCETS	192	<i>tenofovir disoproxil fumarate tab 300 mg</i>	111
TECHLITE MIS LANC 30G	192	TENORETIC TAB 100	81
TECHLITE MIS LANCETS.....	192	TENORETIC TAB 50.....	81
TEGSEDI INJ 284/1.5.....	224	TENORMIN TAB 100MG.....	116
TEKTURNA HCT TAB 150-12.5.....	80	TENORMIN TAB 25MG.....	116
TEKTURNA HCT TAB 150-25MG.....	80	TENORMIN TAB 50MG.....	116
TEKTURNA HCT TAB 300-12.5.....	80	<i>terazosin hcl cap 10 mg (base equivalent)</i>	77
TEKTURNA HCT TAB 300-25MG	80	<i>terazosin hcl cap 1 mg (base equivalent) ..</i>	77
TEKTURNA TAB 150MG.....	81	<i>terazosin hcl cap 2 mg (base equivalent) .</i>	77
TEKTURNA TAB 300MG	81	<i>terazosin hcl cap 5 mg (base equivalent) .</i>	77
<i>telmisartan-amlodipine tab 40-10 mg.....</i>	80	<i>terbinafine hcl tab 250 mg.....</i>	68
<i>telmisartan-amlodipine tab 40-5 mg</i>	80	<i>terbutaline sulfate tab 2.5 mg.....</i>	47
<i>telmisartan-amlodipine tab 80-10 mg.....</i>	80	<i>terbutaline sulfate tab 5 mg.....</i>	47
<i>telmisartan-amlodipine tab 80-5 mg</i>	80	<i>terconazole vaginal cream 0.4%</i>	231
		<i>terconazole vaginal cream 0.8%</i>	231

<i>terconazole vaginal suppos 80 mg</i>	231	THIN LANCETS MIS 30G	192
<i>teriflunomide tab 14 mg</i>	221	THINLETS GP MIS 26G	192
<i>teriflunomide tab 7 mg</i>	221	<i>thioridazine hcl tab 100 mg</i>	105
TESSALON PER CAP 100MG	131	<i>thioridazine hcl tab 10 mg</i>	105
TESTOST CYP INJ 200MG/ML	36	<i>thioridazine hcl tab 25 mg</i>	105
<i>testosterone cypionate im inj in oil 100</i> <i>mg/ml</i>	36	<i>thioridazine hcl tab 50 mg</i>	105
<i>testosterone cypionate im inj in oil 200</i> <i>mg/ml</i>	36	<i>thiothixene cap 10 mg</i>	106
<i>testosterone enanthate im inj in oil 200</i> <i>mg/ml</i>	36	<i>thiothixene cap 1 mg</i>	106
<i>testosterone td gel 10mg/act (2%)</i>	36	<i>thiothixene cap 2 mg</i>	106
<i>testosterone td gel 12.5 mg/act (1%)</i>	36	<i>thiothixene cap 5 mg</i>	106
<i>testosterone td gel 20.25 mg/1.25gm</i> <i>(1.62%)</i>	36	<i>tiagabine hcl tab 12 mg</i>	55
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	36	<i>tiagabine hcl tab 16 mg</i>	55
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	36	<i>tiagabine hcl tab 2 mg</i>	55
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	36	<i>tiagabine hcl tab 4 mg</i>	55
<i>testosterone td gel 50 mg/5gm (1%)</i>	36	TIAZAC CAP 120MG/24	119
<i>testosterone td soln 30 mg/act</i>	36	TIAZAC CAP 180MG/24	119
<i>tetrabenazine tab 12.5 mg</i>	219	TIAZAC CAP 240MG/24	119
<i>tetrabenazine tab 25 mg</i>	219	TIAZAC CAP 300MG/24	119
<i>tetracaine hcl ophth soln 0.5%</i>	212	TIAZAC CAP 360MG/24	119
<i>tetracycline hcl cap 250 mg</i>	226	TIAZAC CAP 420MG/24	119
<i>tetracycline hcl cap 500 mg</i>	226	TIBSOVO TAB 250MG	94
TEXACORT SOL 2.5%	144	TIGAN CAP 300MG	67
TEZSPIRE INJ 210MG	44	TIKOSYN CAP 125MCG	43
TGT LANCET MIS 26G	192	TIKOSYN CAP 250MCG	43
TGT LANCET MIS 30G	192	TIKOSYN CAP 500MCG	43
TGT LANCET MIS 33G	192	<i>timolol maleate ophth gel forming soln</i> <i>0.25%</i>	209
TGT LANCING MIS DEVICE	192	<i>timolol maleate ophth gel forming soln</i> <i>0.5%</i>	209
THALOMID CAP 100MG	203	<i>timolol maleate ophth soln 0.25%</i>	209
THALOMID CAP 150MG	203	<i>timolol maleate ophth soln 0.5%</i>	209
THALOMID CAP 200MG	203	<i>timolol maleate ophth soln 0.5% (once-</i> <i>daily)</i>	209
THALOMID CAP 50MG	203	<i>timolol maleate preservative free ophth soln</i> <i>0.5%</i>	209
<i>theophylline elixir 80 mg/15ml</i>	47, 48	<i>timolol maleate tab 10 mg</i>	117
<i>theophylline tab er 12hr 300 mg</i>	48	<i>timolol maleate tab 20 mg</i>	117
<i>theophylline tab er 12hr 450 mg</i>	48	<i>timolol maleate tab 5 mg</i>	117
<i>theophylline tab er 24hr 400 mg</i>	48	TIMOPTIC SOL 0.25% OP	209
<i>theophylline tab er 24hr 600 mg</i>	48	TIMOPTIC SOL 0.5% OP	209
THIN LANCETS MIS	192	TIMOPTIC-XE SOL 0.25% OP	209
THIN LANCETS MIS 26G	192	TIMOPTIC-XE SOL 0.5% OP	209
		<i>tinidazole tab 250 mg</i>	38

<i>tinidazole tab 500 mg</i>	38	TOPAMAX TAB 200MG	54
<i>tiopronin tab 100 mg</i>	168	TOPAMAX TAB 25MG.....	54
TISSEEL KIT 10ML.....	173	TOPAMAX TAB 50MG.....	54
TISSEEL KIT 2ML	173	TOPCARE MIS LANC 33G	192
TISSEEL KIT 4ML	173	TOPICORT CRE 0.05%	144
TISSEEL SOL 10ML	173	TOPICORT CRE 0.25%	144
TISSEEL SOL 2ML.....	173	TOPICORT GEL 0.05%	144
TISSEEL SOL 4ML.....	173	TOPICORT OIN 0.05%.....	144
TIVICAY PD TAB 5MG	111	TOPICORT OIN 0.25%.....	144
TIVICAY TAB 10MG.....	111	TOPICORT SPR 0.25%	144
TIVICAY TAB 25MG	111	<i>topiramate cap er 24hr 200 mg</i>	54
TIVICAY TAB 50MG.....	111	<i>topiramate sprinkle cap 15 mg</i>	54
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	207	<i>topiramate sprinkle cap 25 mg</i>	54
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	207	<i>topiramate tab 100 mg</i>	54
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	207	<i>topiramate tab 200 mg</i>	54
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	207	<i>topiramate tab 25 mg</i>	54
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	207	<i>topiramate tab 50 mg</i>	54
<i>tobramycin-dexamethasone ophth susp</i> 0.3-0.1%	213	<i>toremifene citrate tab 60 mg (base equivalent)</i>	88
<i>tobramycin nebu soln 300 mg/4ml</i>	11	<i>toremide tab 100 mg</i>	155
<i>tobramycin nebu soln 300 mg/5ml</i>	11	<i>toremide tab 10 mg</i>	155
<i>tobramycin ophth soln 0.3%</i>	211	<i>toremide tab 20 mg</i>	155
TOBEX OIN 0.3% OP	211	<i>toremide tab 5 mg</i>	155
TOBEX SOL 0.3% OP.....	211	TOUJEO MAX INJ 300/ML.....	65
TODAY SPONGE MIS	231	TOUJEO SOLO INJ 300/ML	65
<i>tolbutamide tab 500 mg</i>	66	TPOXX CAP 200MG	114
<i>tolcapone tab 100 mg</i>	96	TPOXX INJ.....	114
TOLEREX POW.....	153	<i>tramadol-acetaminophen tab 37.5-325 mg</i>	34
<i>tolmetin sodium cap 400 mg</i>	22	<i>tramadol hcl tab 50 mg</i>	32
<i>tolmetin sodium tab 600 mg</i>	22	<i>tramadol hcl tab er 24hr 100 mg</i>	32
<i>tolterodine tartrate cap er 24hr 2 mg</i>	230	<i>tramadol hcl tab er 24hr 200 mg</i>	32
<i>tolterodine tartrate cap er 24hr 4 mg</i>	230	<i>tramadol hcl tab er 24hr 300 mg</i>	33
<i>tolterodine tartrate tab 1 mg</i>	230	<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	33
<i>tolterodine tartrate tab 2 mg</i>	230	<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	33
<i>tolvaptan tab 30 mg</i>	161	<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	33
TOPAMAX SPR CAP 15MG.....	54	<i>trandolapril tab 1 mg</i>	75
TOPAMAX SPR CAP 25MG	54	<i>trandolapril tab 2 mg</i>	75
TOPAMAX TAB 100MG.....	54	<i>trandolapril tab 4 mg</i>	75

<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	81	<i>triamcinolone acetone dental paste 0.1%</i>	206
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	81	<i>triamcinolone acetone lotion 0.025%</i> ..	144
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	81	<i>triamcinolone acetone lotion 0.1%</i>	144
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	81	<i>triamcinolone acetone oint 0.025%</i>	145
<i>tranexamic acid tab 650 mg</i>	173	<i>triamcinolone acetone oint 0.1%</i>	144
TRANXENE T TAB 7.5MG.....	42	<i>triamcinolone acetone oint 0.5%</i>	144
<i>tranylcypromine sulfate tab 10 mg</i>	57	<i>triamterene & hydrochlorothiazide cap</i> 37.5-25 mg	154
TRAVEL LANCE MIS 30G	192	<i>triamterene & hydrochlorothiazide tab 37.5-</i> 25 mg.....	155
TRAVEL LANCE MIS ADV 28G.....	192	<i>triamterene & hydrochlorothiazide tab 75-</i> 50 mg	155
<i>travoprost ophth soln 0.004%</i> (benzalkonium free) (bak free).....	213	<i>triamterene cap 100 mg</i>	155
<i>trazodone hcl tab 100 mg</i>	58	<i>triamterene cap 50 mg</i>	155
<i>trazodone hcl tab 150 mg</i>	58	<i>triazolam tab 0.125 mg</i>	174
<i>trazodone hcl tab 300 mg</i>	58	<i>triazolam tab 0.25 mg</i>	174
<i>trazodone hcl tab 50 mg</i>	58	TRIBENZOR20- TAB 5-12.5MG.....	81
TRECATOR TAB 250MG	83	TRIBENZOR40- TAB 10-12.5	81
TRELEGY AER 100MCG.....	47	TRIBENZOR40- TAB 10-25MG.....	81
TRELEGY AER 200MCG.....	47	TRIBENZOR40- TAB 5-12.5MG.....	81
TREMFYA INJ 100MG/ML	141	TRIBENZOR40- TAB 5-25MG	81
TRESIBA FLEX INJ 100UNIT	65	TRIDESILON CRE 0.05%	145
TRESIBA FLEX INJ 200UNIT.....	65	<i>trientine hcl cap 250 mg</i>	202
TRESIBA INJ 100UNIT	65	<i>trifluoperazine hcl tab 10 mg (base</i> equivalent)	105
<i>tretinoin cap 10 mg</i>	95	<i>trifluoperazine hcl tab 1 mg (base</i> equivalent)	105
<i>tretinoin cream 0.025%</i>	134	<i>trifluoperazine hcl tab 2 mg (base</i> equivalent)	105
<i>tretinoin cream 0.05%</i>	134	<i>trifluoperazine hcl tab 5 mg (base</i> equivalent)	105
<i>tretinoin cream 0.1%</i>	134	<i>trifluridine ophth soln 1%</i>	211
<i>tretinoin gel 0.01%</i>	134	<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i> ...	96
<i>tretinoin gel 0.025%</i>	134	<i>trihexyphenidyl hcl tab 2 mg</i>	96
<i>tretinoin gel 0.05%</i>	134	<i>trihexyphenidyl hcl tab 5 mg</i>	96
<i>tretinoin microsphere gel 0.04%</i>	134	TRIJARDY XR TAB	62
<i>tretinoin microsphere gel 0.1%</i>	134	TRIKAFTA PAK 59.5MG.....	225
TREXALL TAB 10MG.....	85	TRIKAFTA PAK 75MG	225
TREXALL TAB 15MG	85	TRIKAFTA TAB	225
TREXALL TAB 5MG	84	TRILIPIX CAP 135MG.....	71
TREXALL TAB 7.5MG	84	TRILIPIX CAP 45MG	71
<i>triamcinolone acetone cream 0.025%</i> 144		<i>trimethobenzamide hcl cap 300 mg</i>	67
<i>triamcinolone acetone cream 0.1%</i>	144		
<i>triamcinolone acetone cream 0.5%</i>	144		

<i>trimethoprim tab 100 mg</i>	38	TWYNSTA TAB 80-10MG	81
<i>trimipramine maleate cap 100 mg</i>	61	TWYNSTA TAB 80-5MG.....	81
<i>trimipramine maleate cap 25 mg</i>	61	TYBOST TAB 150MG	111
<i>trimipramine maleate cap 50 mg</i>	61	TYKERB TAB 250MG.....	94
TRINTELLIX TAB 10MG	58	TYLACTIN POW BLD 20PE	153
TRINTELLIX TAB 20MG.....	59	TYMLOS INJ.....	157
TRINTELLIX TAB 5MG.....	58	TYVASO REFIL SOL 0.6MG/ML.....	123
TRIUMEQ PD TAB	111	TYVASO SOL 0.6MG/ML.....	123
TRIUMEQ TAB.....	111	TYVASO START SOL 0.6MG/ML.....	123
TRIZIVIR TAB	111	U	
TROKENDI XR CAP 100MG	54	UBRELVY TAB 100MG	199
TROKENDI XR CAP 200MG.....	54	UBRELVY TAB 50MG	198
TROKENDI XR CAP 25MG	54	UCERIS TAB 9MG.....	131
TROKENDI XR CAP 50MG.....	54	ULTICARE PAD ALCOHOL	196
<i>tropium chloride cap er 24hr 60 mg</i>	230	ULTI-LANCE MIS CLR TIP	192
<i>tropium chloride tab 20 mg</i>	230	ULTILET MIS 26G.....	192
TRUDHESA AER 0.725MG.....	199	ULTILET MIS 28G.....	192
TRUECONTROL LIQ LEVEL 0.....	192	ULTILET MIS 30G.....	192
TRUECONTROL LIQ LEVEL 1.....	192	ULTILET MIS 33G.....	192
TRUEDRAW MIS LANC DEV	192	ULTILET MIS LANCETS.....	193
TRUE METRIX SOL LEVEL 1.....	192	ULTILET MIS SAFETY	193
TRUE METRIX SOL LEVEL 2	192	ULTILET PAD ALCOHOL	196
TRUE METRIX SOL LEVEL 3	192	ULTILET SAFE MIS 21G	193
TRULANCE TAB 3MG.....	163	ULTRACAL HN LIQ PLUS.....	153
TRULICITY INJ 0.75/0.5	64	ULTRACAL LIQ.....	153
TRULICITY INJ 1.5/0.5	64	ULTRACET TAB 37.5-325	34
TRULICITY INJ 3/0.5	64	ULTRAM TAB 50MG	33
TRULICITY INJ 4.5/0.5.....	64	ULTRA THIN MIS 28G	193
TRUPLUS LANC MIS 26G	192	ULTRA THIN MIS 30G	193
TRUPLUS LANC MIS 28G	192	ULTRA THIN MIS 31G	193
TRUPLUS LANC MIS 30G.....	192	ULTRA THIN MIS 33G	193
TRUPLUS LANC MIS 33G	192	ULTRA THIN MIS LAN 31G	193
TRUSOPT SOL 2% OP.....	213	ULTRA THIN MIS LANC 28G.....	193
TRUZONE PEAK MIS FLOW MTR.....	198	ULTRA THIN MIS LANC 30G.....	193
TUKYSA TAB 150MG	85	ULTRA THIN MIS LANCETS	193
TUKYSA TAB 50MG.....	85	ULTRIENT 1.5 LIQ SAFE-T.....	153
TURPENTINE SOL SPIRITS	146	UNILET CMFR MIS TCH 28G.....	193
TUSSICAPS CAP 10-8MG	132	UNILET CMFR MIS TCH 30G	193
TWIST LANCET MIS 30G MULT	192	UNILET EXCEL MIS 23G.....	193
TWOCAL HN LIQ	153	UNILET EX II MIS 28G.....	193
TWYNEO CRE 0.1-3%	134	UNILET G.P. MIS 21G.....	193
TWYNSTA TAB 40-10MG	81	UNILET G.P MIS SUPR 23G	193
TWYNSTA TAB 40-5MG.....	81	UNILET GP 28 MIS ULT THIN	193

UNILET LANCE MIS 21G	193	UPTRAVI PACK TAB 200/800.....	124
UNILET LANCE MIS 28G.....	193	UPTRAVI TAB 1000MCG	124
UNILET LANCE MIS 33G.....	193	UPTRAVI TAB 1200MCG	124
UNILET LANC MIS 33G	193	UPTRAVI TAB 1400MCG	124
UNILET LANCT MIS 28G.....	193	UPTRAVI TAB 1600MCG	124
UNILET LANCT MIS 30G	193	UPTRAVI TAB 200MCG	124
UNILET LANCT MIS 33G.....	193	UPTRAVI TAB 400MCG.....	124
UNILET MICRO MIS 33G.....	193	UPTRAVI TAB 600MCG.....	124
UNILET MIS 21G	193	UPTRAVI TAB 800MCG.....	124
UNILET SUPER MIS 23G	193	<i>urea cream 39%</i>	145
UNILET SUPER MIS G.P. 23G	193	UROCIT-K 10 TAB	168
UNISTIK 1 MIS 2.4MM	193	UROCIT-K 15 TAB	168
UNISTIK 1 MIS 3.0MM	193	UROCIT-K 5 TAB.....	168
UNISTIK 2 MIS.....	193	URSO 250 TAB 250MG.....	164
UNISTIK 2 MIS 1.8MM	193	<i>ursodiol cap 300 mg</i>	164
UNISTIK 2 MIS 2.4MM	193	<i>ursodiol tab 250 mg</i>	164
UNISTIK 2 MIS COMFORT	193	<i>ursodiol tab 500 mg</i>	164
UNISTIK 2 MIS EXTRA.....	194	URSO FORTE TAB 500MG	164
UNISTIK 2 MIS NEONATAL	194	V	
UNISTIK 2 MIS NORMAL	194	VAGIFEM TAB 10MCG.....	232
UNISTIK 2 MIS SUPER.....	194	<i>valacyclovir hcl tab 1 gm</i>	114
UNISTIK 3 MIS 1.8MM.....	194	<i>valacyclovir hcl tab 500 mg</i>	114
UNISTIK 3 MIS COMFORT	194	VALCHLOR GEL 0.016%.....	136
UNISTIK 3 MIS EXTRA.....	194	<i>valganciclovir hcl for soln 50 mg/ml (base</i> <i>equiv)</i>	112
UNISTIK 3 MIS GENT 30G	194	<i>valganciclovir hcl tab 450 mg (base</i> <i>equivalent)</i>	112
UNISTIK 3 MIS NEONATAL	194	VALIUM TAB 10MG	42
UNISTIK 3 MIS NORMAL	194	VALIUM TAB 2MG.....	42
UNISTIK 3 MIS XTR 21G	194	VALIUM TAB 5MG.....	42
UNISTIK CZT MIS COMFORT.....	194	<i>valproate sodium oral soln 250 mg/5ml</i> <i>(base equiv)</i>	56
UNISTIK CZT MIS NORMAL	194	<i>valproic acid cap 250 mg</i>	56
UNISTIK II MIS LANCETS.....	194	<i>valsartan-hydrochlorothiazide tab 160-12.5</i> <i>mg</i>	81
UNISTIK PRO MIS LANC 21G	194	<i>valsartan-hydrochlorothiazide tab 160-25</i> <i>mg</i>	81
UNISTIK PRO MIS LANC 28G	194	<i>valsartan-hydrochlorothiazide tab 320-12.5</i> <i>mg</i>	81
UNISTIK SAFE MIS LANC 28G	194	<i>valsartan-hydrochlorothiazide tab 320-25</i> <i>mg</i>	81
UNISTIK SAFE MIS LANC 30G.....	194	<i>valsartan-hydrochlorothiazide tab 80-12.5</i> <i>mg</i>	81
UNISTIK TOUC MIS LANC 21G.....	194		
UNISTIK TOUC MIS LANC 23G.....	194		
UNISTIK TOUC MIS LANC 28G.....	194		
UNISTIK TOUC MIS LANC 30G.....	194		
UNITSTIK PRO MIS LANC 25G	194		
UNIVERSAL 1 MIS 33G	194		
UNIVERSAL 1 MIS LANC 26G.....	194		
UNIVERSAL 1 MIS LANC 30G	194		

<i>valsartan tab 160 mg</i>	76	<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	59
<i>valsartan tab 320 mg</i>	76	<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	59
<i>valsartan tab 40 mg</i>	76	<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	59
<i>valsartan tab 80 mg</i>	76	<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	59
VALTOCO SPR 10MG	50	<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	59
VALTOCO SPR 15MG	50	<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	59
VALTOCO SPR 20MG.....	50	<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	59
VALTOCO SPR 5MG.....	50	<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	59
VANCOCIN CAP 125MG.....	38	<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	59
VANCOCIN CAP 250MG.....	38	VENTAVIS SOL 10MCG/ML	123
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	38	VENTAVIS SOL 20MCG/ML.....	123
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	38	<i>verapamil hcl cap er 24hr 100 mg</i>	119
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	39	<i>verapamil hcl cap er 24hr 120 mg</i>	119
VANDAZOLE GEL 0.75%	231	<i>verapamil hcl cap er 24hr 180 mg</i>	119
VANTAGE LANC MIS DEVICE.....	194	<i>verapamil hcl cap er 24hr 200 mg</i>	119
<i>ardenafil hcl orally disintegrating tab 10 mg</i>	122	<i>verapamil hcl cap er 24hr 240 mg</i>	119
<i>ardenafil hcl tab 10 mg</i>	123	<i>verapamil hcl cap er 24hr 300 mg</i>	119
<i>ardenafil hcl tab 2.5 mg</i>	122	<i>verapamil hcl cap er 24hr 360 mg</i>	119
<i>ardenafil hcl tab 20 mg</i>	123	<i>verapamil hcl tab 120 mg</i>	119
<i>ardenafil hcl tab 5 mg</i>	123	<i>verapamil hcl tab 40 mg</i>	119
VASCEPA CAP 0.5GM.....	70	<i>verapamil hcl tab 80 mg</i>	119
VASCEPA CAP 1GM.....	70	<i>verapamil hcl tab er 120 mg</i>	119
VASERETIC TAB 10-25MG.....	81	<i>verapamil hcl tab er 180 mg</i>	119
VASOTEC TAB 10MG.....	75	<i>verapamil hcl tab er 240 mg</i>	119
VASOTEC TAB 2.5MG	75	VERASENS LIQ LEVEL 1.....	194
VASOTEC TAB 20MG	75	VERELAN CAP 120MG SR	119
VASOTEC TAB 5MG	75	VERELAN CAP 180MG SR	119
VCF VAGINAL AER CONTRACP	231	VERELAN CAP 240MG SR	119
VCF VAGINAL GEL CONTRACE	231	VERELAN CAP 360MG SR	119
VCF VAGINAL MIS CONTRACP.....	231	VERELAN PM CAP 100MG ER	119
VECAMYL TAB 2.5MG	81	VERELAN PM CAP 200MG ER	119
VELTASSA POW 16.8GM	205	VERELAN PM CAP 300MG ER	119
VELTASSA POW 25.2GM	205	VERIFINE MIS UNIV 30G.....	194
VELTASSA POW 8.4GM	205	VERSACLOZ SUS 50MG/ML	104
VENCLEXTA TAB 100MG.....	86		
VENCLEXTA TAB 10MG	86		
VENCLEXTA TAB 50MG	86		
VENCLEXTA TAB START PK	86		

VERZENIO TAB 100MG	94	VIVAGUARD MIS 30G	195
VERZENIO TAB 150MG	94	VIVAGUARD MIS LANCING	195
VERZENIO TAB 200MG.....	94	VIVJOA CAP 150MG.....	69
VERZENIO TAB 50MG.....	94	VIVONEX RTF LIQ.....	153
VESICARE LS SUS 5MG/5ML.....	230	VONJO CAP 100MG	95
VFEND SUS 40MG/ML.....	69	VOQUEZNA PAK DUAL PAK	230
VFEND TAB 200MG.....	69	VOQUEZNA PAK TRIP PK.....	230
VFEND TAB 50MG	69	<i>voriconazole for susp 40 mg/ml</i>	69
V-GO 20 KIT	194	<i>voriconazole tab 200 mg</i>	69
V-GO 30 KIT	194	<i>voriconazole tab 50 mg</i>	69
V-GO 40 KIT	194	VOSEVI TAB	113
VIBERZI TAB 100MG	166	VOWST CAP.....	166
VIBERZI TAB 75MG	166	VOXZOGO INJ 0.4MG	160
VIBRAMYCIN CAP 100MG.....	226	VOXZOGO INJ 0.56MG	160
VIBRAMYCIN SUS 25MG/5ML	226	VOXZOGO INJ 1.2MG.....	160
VIBRAMYCIN SYP 50MG/5ML	226	VRAYLAR CAP 1.5-3MG	100
VICTOZA INJ 18MG/3ML.....	64	VRAYLAR CAP 1.5MG.....	100
VIDAZA INJ 100MG.....	85	VRAYLAR CAP 3MG	100
<i>vigabatrin powd pack 500 mg</i>	55	VRAYLAR CAP 4.5MG	100
<i>vigabatrin tab 500 mg</i>	55	VRAYLAR CAP 6MG	100
VIGAMOX DRO 0.5%	211	VTAMA CRE 1%	141
VILACTIN AA LIQ PLUS	153	VUMERITY CAP 231MG.....	221
VIMOVO TAB 375-20MG	22	VYNDAMAX CAP 61MG.....	125
VIMOVO TAB 500-20MG.....	22	VYTORIN TAB 10-10MG	70
VIOKACE TAB 10440	154	VYTORIN TAB 10-20MG.....	70
VIOKACE TAB 20880.....	154	VYTORIN TAB 10-40MG	70
VIRAMUNE SUS 50MG/5ML	111	VYTORIN TAB 10-80MG	70
VIRAMUNE XR TAB 400MG	111	VYVANSE CAP 10MG.....	3
VIREAD POW 40MG/GM	111	VYVANSE CAP 20MG	3
VIREAD TAB 150MG	111	VYVANSE CAP 30MG.....	3
VIREAD TAB 200MG.....	111	VYVANSE CAP 40MG.....	3
VIREAD TAB 250MG.....	111	VYVANSE CAP 50MG.....	3
VIREAD TAB 300MG.....	111	VYVANSE CAP 60MG.....	3
VISIONBLUE INJ 0.06%.....	213	VYVANSE CAP 70MG	3
VISTARIL CAP 25MG.....	41	VYVANSE CHW 10MG	3
VISTARIL CAP 50MG	41	VYVANSE CHW 20MG.....	3
VISTOGARD PAK 10GM	67	VYVANSE CHW 30MG	3
VITAL HN POW	153	VYVANSE CHW 40MG	3
VITRAKVI CAP 100MG	94	VYVANSE CHW 50MG	3
VITRAKVI CAP 25MG	94	VYVANSE CHW 60MG	3
VITRAKVI SOL 20MG/ML	94	W	
VIVAGUARD LIQ CONTROL.....	194	WAKIX TAB 17.8MG	7
VIVAGUARD MIS 28G	194	WAKIX TAB 4.45MG	7

<i>warfarin sodium tab 10 mg</i>	48	XCOPRI TAB 150MG	55
<i>warfarin sodium tab 1 mg</i>	48	XCOPRI TAB 200MG	55
<i>warfarin sodium tab 2.5 mg</i>	48	XCOPRI TAB 50MG	55
<i>warfarin sodium tab 2 mg</i>	48	XELJANZ SOL 1MG/ML	18
<i>warfarin sodium tab 3 mg</i>	48	XELJANZ TAB 10MG	19
<i>warfarin sodium tab 4 mg</i>	48	XELJANZ TAB 5MG	18
<i>warfarin sodium tab 5 mg</i>	48	XELJANZ XR TAB 11MG	19
<i>warfarin sodium tab 6 mg</i>	48	XELJANZ XR TAB 22MG	19
<i>warfarin sodium tab 7.5 mg</i>	48	XELODA TAB 150MG	85
WEGOVY INJ 0.25MG	5	XELODA TAB 500MG	85
WEGOVY INJ 0.5MG	5	XENICAL CAP 120MG	6
WEGOVY INJ 1.7MG	5	XENLETA TAB 600MG	39
WEGOVY INJ 1MG	5	XEPI CRE 1%	135
WEGOVY INJ 2.4MG	5	XERAC-AC SOL 6.25%	147
WELCHOL PAK 3.75GM	71	XERMELO TAB 250MG	167
WELCHOL TAB 625MG	71	XHANCE MIS 93MCG	208
WELLBUTRIN TAB 100MG SR	57	XIFAXAN TAB 550MG	38
WELLBUTRIN TAB 150MG SR	57	XIGDUO XR TAB 10-1000	62
WELLBUTRIN TAB 200MG SR	57	XIGDUO XR TAB 10-500MG	62
WIDE-SEAL DPR KIT 60	176	XIGDUO XR TAB 2.5-1000	62
WIDE-SEAL DPR KIT 65	176	XIGDUO XR TAB 5-1000MG	62
WIDE-SEAL DPR KIT 70	176	XIGDUO XR TAB 5-500MG	62
WIDE-SEAL DPR KIT 75	177	XIIDRA DRO 5%	211
WIDE-SEAL DPR KIT 80	177	XOPENEX CONC NEB 1.25/0.5	47
WIDE-SEAL DPR KIT 85	177	XOPENEX NEB 0.31MG	47
WIDE-SEAL DPR KIT 90	177	XOPENEX NEB 0.63MG	47
WIDE-SEAL DPR KIT 95	177	XOPENEX NEB 1.25/3ML	47
WINLEVI CRE 1%	134	XOSPATA TAB 40MG	95
X		XPOVIO PAK 100MG	89
XACIATO GEL 2%	231	XPOVIO PAK 40MG	88, 89
XALATAN SOL 0.005%	213	XPOVIO PAK 50MG	89
XARELTO STAR TAB 15/20MG	48	XPOVIO PAK 60MG	89
XARELTO TAB 10MG	48	XPOVIO PAK 80MG	89
XARELTO TAB 15MG	48	XTANDI CAP 40MG	88
XARELTO TAB 2.5MG	48	XTANDI TAB 40MG	88
XARELTO TAB 20MG	48	XTANDI TAB 80MG	88
XATMEP SOL 2.5MG/ML	85	XULTOPHY INJ 100/3.6	62
XCOPRI PAK 100-150	55	XURIDEN POW 2GM	159
XCOPRI PAK 12.5-25	55	XYOSTED INJ 100/0.5	36
XCOPRI PAK 150-200	55	XYOSTED INJ 50/0.5	36
XCOPRI PAK 50-100MG	55	XYOSTED INJ 75/0.5	36
XCOPRI PAK 50-200MG	55	XYWAV SOL 0.5GM/ML	216
XCOPRI TAB 100MG	55		

Y	
YONSA TAB 125MG	88
YUPELRI SOL	44
Z	
ZACLIR LOT 8%	134
<i>zafirlukast tab 10 mg</i>	44
<i>zafirlukast tab 20 mg</i>	44
<i>zaleplon cap 10 mg</i>	174
<i>zaleplon cap 5 mg</i>	174
ZANAFLEX CAP 2MG	207
ZANAFLEX CAP 4MG	207
ZANAFLEX CAP 6MG	207
ZANAFLEX TAB 4MG	207
ZARONTIN CAP 250MG	55
ZARONTIN SOL 250/5ML	56
ZAVESCA CAP 100MG	170
ZEGALOGUE INJ 0.6/0.6	63
ZEJULA CAP 100MG	95
ZEJULA TAB 100MG	95
ZEJULA TAB 200MG	95
ZEJULA TAB 300MG	95
ZELBORAF TAB 240MG	95
ZEMBRACE SYM INJ 3/0.5ML	200
ZEMPLAR CAP 1MCG	160
ZEMPLAR CAP 2MCG	160
ZENPEP CAP 10000UNT	154
ZENPEP CAP 15000UNT	154
ZENPEP CAP 20000UNT	154
ZENPEP CAP 25000UNT	154
ZENPEP CAP 3000UNIT	154
ZENPEP CAP 40000UNT	154
ZENPEP CAP 5000UNIT	154
ZENPEP CAP 60000UNT	154
ZEPOSIA 7DAY CAP STR PACK	221
ZEPOSIA CAP .92MG	222
ZEPOSIA CAP STR KIT	222
ZESTRIL TAB 10MG	75
ZESTRIL TAB 2.5MG	75
ZESTRIL TAB 20MG	75
ZESTRIL TAB 30MG	75
ZESTRIL TAB 40MG	75
ZESTRIL TAB 5MG	75
ZIAC TAB 10/6.25	81
ZIAC TAB 2.5/6.25	81
ZIAC TAB 5-6.25MG	81
ZIAGEN SOL 20MG/ML	111
ZIAGEN TAB 300MG	111
<i>zidovudine cap 100 mg</i>	111
<i>zidovudine syrup 10 mg/ml</i>	112
<i>zidovudine tab 300 mg</i>	112
ZIOPTAN DRO 0.0015%	214
<i>ziprasidone hcl cap 20 mg</i>	100
<i>ziprasidone hcl cap 40 mg</i>	100
<i>ziprasidone hcl cap 60 mg</i>	101
<i>ziprasidone hcl cap 80 mg</i>	101
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	101
ZITHROMAX POW 1GM PAK	175
ZITHROMAX SUS 100/5ML	175
ZITHROMAX SUS 200/5ML	175
ZITHROMAX TAB 250MG	175
ZITHROMAX TAB 500MG	175
ZITHROMAX TAB TRI-PAK	175
ZITHROMAX TAB Z-PAK	175
ZOCOR TAB 10MG	73
ZOCOR TAB 20MG	73
ZOCOR TAB 40MG	73
ZOCOR TAB 80MG	73
ZOFRAN TAB 4MG	67
ZOKINVY CAP 50MG	205
ZOKINVY CAP 75MG	205
ZOLINZA CAP 100MG	95
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	201
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	201
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	201
<i>zolmitriptan orally disintegrating tab 5 mg</i>	201
<i>zolmitriptan tab 2.5 mg</i>	201
<i>zolmitriptan tab 5 mg</i>	201
<i>zolpidem tartrate tab 10 mg</i>	174
<i>zolpidem tartrate tab 5 mg</i>	174
<i>zolpidem tartrate tab er 12.5 mg</i>	174
<i>zolpidem tartrate tab er 6.25 mg</i>	174
ZOMIG SPR 2.5MG	201

ZOMIG SPR 5MG	201	ZUBSOLV SUB 8.6-2.1.....	36
ZOMIG TAB 2.5MG.....	201	ZYDELIG TAB 100MG	95
ZOMIG TAB 5MG	201	ZYDELIG TAB 150MG	95
ZOMIG ZMT TAB 2.5 MG	201	ZYFLO TAB 600MG	44
ZOMIG ZMT TAB 5MG ODT	201	ZYKADIA TAB 150MG.....	95
ZONALON CRE 5%.....	136	ZYLOPRIM TAB 100MG	169
<i>zonisamide cap 100 mg</i>	54	ZYLOPRIM TAB 300MG	169
<i>zonisamide cap 25 mg</i>	54	ZYPREXA INJ 10MG	104
<i>zonisamide cap 50 mg</i>	54	ZYPREXA RELP INJ 210MG.....	104
ZORTRESS TAB 0.25MG.....	205	ZYPREXA RELP INJ 300MG.....	104
ZORTRESS TAB 0.5MG.....	205	ZYPREXA RELP INJ 405MG.....	104
ZORTRESS TAB 0.75MG.....	205	ZYPREXA TAB 10MG.....	104
ZORTRESS TAB 1MG	205	ZYPREXA TAB 15MG.....	104
ZORYVE CRE 0.3%.....	141	ZYPREXA TAB 2.5MG	104
ZORYVE MIS 0.3%	141	ZYPREXA TAB 20MG	104
ZTLIDO PAD 1.8%	147	ZYPREXA TAB 5MG	104
ZUBSOLV SUB 0.7-0.18	35	ZYPREXA TAB 7.5MG	104
ZUBSOLV SUB 1.4-0.36	35	ZYPREXA ZYDI TAB 10MG	104
ZUBSOLV SUB 11.4-2.9	36	ZYPREXA ZYDI TAB 15MG	104
ZUBSOLV SUB 2.9-0.71	36	ZYPREXA ZYDI TAB 20MG.....	104
ZUBSOLV SUB 5.7-1.4.....	36	ZYPREXA ZYDI TAB 5MG.....	104

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **[carefirst.com/rxgroup](https://www.carefirst.com/rxgroup)**.



10455 Mill Run Circle
Owings Mills, MD 21117

[carefirst.com/rxgroup](https://www.carefirst.com/rxgroup)

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SUM6874-1S (4/24) ■ For self-insured plans only

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 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 ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላሉ። ይኸን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ አገዛ 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) Ìtètíléko: Àkíyèsí yíì ní iwífún nípa isẹ́ adójútòfò rẹ. Ó le ní àwọn déèti pátó o sì le ní láti gbé ìgbésẹ́ ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yíì àti irànlówó ní èdè rẹ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̀bà fòò̀nù tó wà lẹ̀yìn káàdì idánimò wòn. Àwọn mírà̀n le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjìròrò tí tí a ó fì sọ fún ọ láti tẹ 0. Nígbatí așojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì sọ ọ pò mò ògbufò 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 nasasaklawang 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।

Bàsòò-wùdù (Bassa) Tò Dùù Cáo! Bǎ nìà kè bá nyo bǎ kè m̄ gbo kpá bó nì fùà-fúá-tiìn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bǎ bǎ m̄ kè dε wa m̄ m̄ kè nyuεε nyu hwè bǎ wé bǎa kè zi. ɔ m̄ nì kpé bǎ m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ m̄ dyé dε nì bídí-wùdù mú bǎ m̄ kè se wídí dò péè. Kpooò nyo bǎ m̄ dá fúùn-nòbà nìà dε waa I.D. káàò dεín nyε. Nyo tòò séín m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ fò tee bǎ wa kèε m̄ gbo cǎ bǎ m̄ kè nòbà m̄à 0 kèε dyi pàdàìn hwè. ɔ jǔ kè nyo dò dyi m̄ gǎ jǔìn, po wuqu m̄ m̄ poε dyie, kè nyo dò mu bó nììn bǎ ɔ kè nì wuquò 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 855-258-6518 پر 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 شناسایی شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518 تماس 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 للأخريين 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) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozu niile nwere ike ikpo 855-258-6518 wee chere ububu ahuru roo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa 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 아닌 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 íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ní'íst'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkaálígíí dóo t'áadoo le'é ádadoolyí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'í'íh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náána'á' éí kojí' dahóoolnih 855-258-6518 dóo yii dii'łts'í'íł yałtí'ígíí t'áa níléj'í' áádóo éí bikéé'dóo naasbaqas bił adidiilchíł. Áká'anidaalwó'ígíí neidiitáqgo, saad bee yáníłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowól.