

# CareFirst Formulary 1

---

## 2023

**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](https://carefirst.com).

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit [carefirst.com/rxgroup](https://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 three 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](http://carefirst.com/myaccount) and clicking on *Tools* and *Drug Pricing Tool* or by reviewing their annual summary of benefits.

<b>Tier 0: \$0 Drugs</b>	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ 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.</li> </ul>
<b>Tier 1: Generic Drugs \$</b>	<ul style="list-style-type: none"> <li>■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.</li> <li>■ Generic drugs generally cost less than brand-name drugs.</li> </ul>
<b>Tier 2: Preferred Brand Drugs \$\$</b>	<ul style="list-style-type: none"> <li>■ 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.</li> </ul>
<b>Tier 3: Non-preferred Brand Drugs \$\$\$</b>	<ul style="list-style-type: none"> <li>■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.</li> </ul>

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS</b>		
<b>AMPHETAMINES</b>		
ADDERALL TAB 5MG	3	QL (120 tabs every 30 days); MNPA
ADDERALL TAB 7.5MG	3	QL (120 tabs every 30 days); MNPA
ADDERALL TAB 10MG	3	QL (120 tabs every 30 days); MNPA
ADDERALL TAB 12.5MG	3	QL (120 tabs every 30 days); MNPA
ADDERALL TAB 15MG	3	QL (60 tabs every 30 days); MNPA
ADDERALL TAB 20MG	3	QL (60 tabs every 30 days); MNPA
ADDERALL TAB 30MG	3	QL (30 tabs every 30 days); MNPA
ADDERALL XR CAP 5MG	3	QL (120 caps every 30 days); MNPA
ADDERALL XR CAP 10MG	3	QL (120 caps every 30 days); MNPA
ADDERALL XR CAP 15MG	3	QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 20MG	3	QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 25MG	3	QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 30MG	3	QL (30 caps every 30 days); MNPA
ADZENYS ER SUS 1.25MG	3	QL (540 mL every 30 days); MNPA
ADZENYS XR TAB 3.1MG	3	QL (60 ea every 30 days); MNPA
ADZENYS XR TAB 6.3MG	3	QL (60 ea every 30 days); MNPA
ADZENYS XR TAB 9.4MG	3	QL (60 ea every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ADZENYS XR TAB 12.5MG	3	QL (30 ea every 30 days); MNPA
ADZENYS XR TAB 15.7 MG	3	QL (30 ea every 30 days); MNPA
ADZENYS XR TAB 18.8MG	3	QL (30 ea every 30 days); MNPA
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 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1	QL (120 caps every 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1	QL (30 caps every 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1	QL (30 caps every 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	1	QL (30 caps every 30 days)
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	1	QL (30 caps every 30 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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DEXEDRINE CAP 5MG CR	3	QL (150 caps every 30 days)
DEXEDRINE CAP 10MG CR	3	QL (150 caps every 30 days)
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 2.5 mg</i>	3	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 7.5 mg</i>	3	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 15 mg</i>	3	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	3	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	1	QL (30 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	3	QL (30 tabs every 30 days)
DYANAVEL XR CHW 5MG	3	QL (60 tabs every 25 days)
DYANAVEL XR CHW 10MG	3	QL (60 tabs every 25 days)
DYANAVEL XR CHW 15MG	3	QL (30 tabs every 25 days)
DYANAVEL XR CHW 20MG	3	QL (30 tabs every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DYANAVEL XR SUS 2.5MG/ML	3	QL (300 mL every 30 days)
EVEKEO ODT TAB 5MG	3	QL (150 tabs every 30 days)
EVEKEO ODT TAB 10MG	3	QL (150 tabs every 30 days)
EVEKEO ODT TAB 15MG	3	QL (60 tabs every 30 days)
EVEKEO ODT TAB 20MG	3	QL (60 tabs every 30 days)
EVEKEO TAB 5MG	3	QL (150 tabs every 30 days); MNPA
EVEKEO TAB 10MG	3	QL (150 tabs every 30 days); MNPA
<i>methamphetamine hcl tab 5 mg</i>	1	QL (180 tabs every 30 days)
MYDAYIS CAP 12.5MG	2	QL (60 caps every 30 days)
MYDAYIS CAP 25MG	2	QL (60 caps every 30 days)
MYDAYIS CAP 37.5MG	2	QL (30 caps every 30 days)
MYDAYIS CAP 50MG	2	QL (30 caps 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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
<b>ANALEPTICS</b>		
<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	1	
<b>ANTI-OBESITY AGENTS</b>		
WEGOVY INJ 0.5MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 0.25MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1.7MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 2.4MG	2	PA; Coverage is subject to your plan/benefits
<b>ANTIOBESITY AGENTS, INJECTABLE</b>		
SAXENDA INJ 18MG/3ML	2	PA; Coverage is subject to your plan/benefits
<b>ANTIOBESITY AGENTS, ORAL</b>		
ADIPEX-P CAP 37.5MG	3	PA; Coverage is subject to your plan/benefits
ADIPEX-P TAB 37.5MG	3	PA; Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 25 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 50 mg</i>	1	PA; Coverage is subject to your plan/benefits
CONTRAVE TAB 8-90MG	3	PA; Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab 25 mg</i>	1	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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA; Coverage is subject to your plan/benefits
LOMAIRA TAB 8MG	3	Coverage is subject to your plan/benefits
<i>orlistat cap 120 mg</i>	1	PA; Coverage is subject to your plan/benefits
PHENDIMETRAZ CAP 105MG ER	1	PA; Coverage is subject to your plan/benefits
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 15 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 30 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl tab 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 3.75-23	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 7.5-46MG	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 11.25-69	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 15-92MG	2	PA; Coverage is subject to your plan/benefits
REGIMEX TAB 25MG	3	PA; Coverage is subject to your plan/benefits
XENICAL CAP 120MG	3	PA; Coverage is subject to your plan/benefits
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS</b>		
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
INTUNIV TAB 1MG	3	MNPA
INTUNIV TAB 2MG	3	MNPA
INTUNIV TAB 3MG	3	MNPA
INTUNIV TAB 4MG	3	MNPA
KAPVAY TAB 0.1 MG	3	
QELBREE CAP 100MG ER	2	
QELBREE CAP 150MG ER	2	
QELBREE CAP 200MG ER	2	
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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STRATTERA CAP 100MG	3	QL (30 caps every 30 days)
<b>DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)</b>		
SUNOSI TAB 75MG	2	
SUNOSI TAB 150MG	2	
<b>HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS</b>		
WAKIX TAB 4.45MG	2	PA, QL (60 TABLETS PER 30 DAYS)
WAKIX TAB 17.8MG	2	PA, QL (60 TABLETS PER 30 DAYS)
<b>STIMULANTS - MISC.</b>		
ADHANSIA XR CAP 25MG	3	QL (60 caps every 30 days)
ADHANSIA XR CAP 35MG	3	QL (60 caps every 30 days)
ADHANSIA XR CAP 45MG	3	QL (60 caps every 30 days)
ADHANSIA XR CAP 55MG	3	QL (30 caps every 30 days)
ADHANSIA XR CAP 70MG	3	QL (30 caps every 30 days)
ADHANSIA XR CAP 85MG	3	QL (30 caps every 30 days)
APTENSIO XR CAP 10MG	3	QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 15MG	3	QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 20MG	3	QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 30MG	3	QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 40MG	3	QL (30 caps every 30 days); MNPA
APTENSIO XR CAP 50MG	3	QL (30 caps every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
APTENSIO XR CAP 60MG	3	QL (30 caps every 30 days); MNPA
<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	
CONCERTA TAB 18MG	3	QL (60 tabs every 30 days); MNPA
CONCERTA TAB 27MG	3	QL (60 tabs every 30 days); MNPA
CONCERTA TAB 36MG	3	QL (60 tabs every 30 days); MNPA
CONCERTA TAB 54MG	3	QL (30 tabs every 30 days); MNPA
COTEMPLA XR TAB 8.6MG	3	QL (60 ea every 30 days)
COTEMPLA XR TAB 17.3MG	3	QL (60 ea every 30 days)
COTEMPLA XR TAB 25.9MG	3	QL (60 ea every 30 days)
DAYTRANA DIS 10MG/9HR	3	QL (30 patches every 30 days); MNPA
DAYTRANA DIS 15MG/9HR	3	QL (30 patches every 30 days); MNPA
DAYTRANA DIS 20MG/9HR	3	QL (30 patches every 30 days); MNPA
DAYTRANA DIS 30MG/9HR	3	QL (30 patches every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
dexmethylphenidate hcl cap er 24 hr 15 mg	1	QL (60 caps every 30 days)
dexmethylphenidate hcl cap er 24 hr 20 mg	1	QL (60 caps every 30 days)
dexmethylphenidate hcl cap er 24 hr 25 mg	1	QL (30 caps every 30 days)
dexmethylphenidate hcl cap er 24 hr 30 mg	1	QL (30 caps every 30 days)
dexmethylphenidate hcl cap er 24 hr 35 mg	1	QL (30 caps every 30 days)
dexmethylphenidate hcl cap er 24 hr 40 mg	1	QL (30 caps every 30 days)
dexmethylphenidate hcl tab 2.5 mg	1	QL (150 tabs every 30 days)
dexmethylphenidate hcl tab 5 mg	1	QL (150 tabs every 30 days)
dexmethylphenidate hcl tab 10 mg	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)
FOCALIN XR CAP 5MG	3	QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 10MG	3	QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 15MG	3	QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 20MG	3	QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 25MG	3	QL (30 caps every 30 days); MNPA
FOCALIN XR CAP 30MG	3	QL (30 caps every 30 days); MNPA
FOCALIN XR CAP 35MG	3	QL (30 caps every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FOCALIN XR CAP 40MG	3	QL (30 caps every 30 days); MNPA
JORNAY PM CAP 20MG ER	3	QL (60 caps every 30 days)
JORNAY PM CAP 40MG ER	3	QL (60 caps every 30 days)
JORNAY PM CAP 60MG ER	3	QL (30 caps every 30 days)
JORNAY PM CAP 80MG ER	3	QL (30 caps every 30 days)
JORNAY PM CAP 100MG ER	3	QL (30 caps 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 45MG ER	3	QL (30 tabs every 25 days)
METHYLPHENID TAB 63MG ER	3	QL (30 tabs every 25 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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<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 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	1	QL (30 tabs every 30 days)
<i>methylphenidate td patch 10 mg/9hr</i>	1	QL (30 ea every 30 days)
<i>methylphenidate td patch 15 mg/9hr</i>	1	QL (30 ea every 30 days)
<i>methylphenidate td patch 20 mg/9hr</i>	1	QL (30 ea every 30 days)
<i>methylphenidate td patch 30 mg/9hr</i>	1	QL (30 ea every 30 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)
NUVIGIL TAB 50MG	3	PA, QL (60 tabs every 30 days); MNPA
NUVIGIL TAB 150MG	3	PA, QL (30 tabs every 30 days); MNPA
NUVIGIL TAB 200MG	3	PA, QL (30 tabs every 30 days); MNPA
NUVIGIL TAB 250MG	3	PA, QL (30 tabs every 30 days); MNPA
PROVIGIL TAB 100MG	3	PA, QL (60 tabs every 30 days); MNPA
PROVIGIL TAB 200MG	3	PA, QL (60 tabs every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QUILLICHEW CHW 20MG ER	3	QL (60 tabs every 30 days); MNPA
QUILLICHEW CHW 30MG ER	3	QL (60 tabs every 30 days); MNPA
QUILLICHEW CHW 40MG ER	3	QL (30 tabs every 30 days); MNPA
QUILLIVANT SUS 25MG/5ML	3	QL (420 mL every 30 days); MNPA
RELEXXII TAB 72MG	3	QL (30 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)

**ALLERGENIC EXTRACTS/BIOLOGICALS MISC****ALLERGENIC EXTRACTS**

ALTERNARIA SOL ALTERNAT	3
GRASTEK SUB 2800BAU	2
ODACTRA SUB	3
ORALAIR SUB 300 IR	2
PALFORZIA CAP ESCALAT	3
PALFORZIA CAP LEVEL 1	3
PALFORZIA CAP LEVEL 2	3
PALFORZIA CAP LEVEL 3	3
PALFORZIA CAP LEVEL 4	3
PALFORZIA CAP LEVEL 5	3

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PALFORZIA CAP LEVEL 6	3	
PALFORZIA CAP LEVEL 7	3	
PALFORZIA CAP LEVEL 8	3	
PALFORZIA CAP LEVEL 9	3	
PALFORZIA CAP LEVEL 10	3	
PALFORZIA POW LEVEL 11	3	
RAGWITEK SUB	2	
<b>AMEBICIDES</b>		
<b>AMEBICIDES</b>		
SOLOSEC GRA 2GM	3	
<b>AMINOGLYCOSIDES</b>		
<b>AMINOGLYCOSIDES</b>		
ARIKAYCE SUS	3	PA
BETHKIS NEB 300/4ML	3	PA, QL (56 AMPULES PER 28 DAYS)
KITABIS PAK NEB 300/5ML	2	PA, QL (56 AMPULES PER 28 DAYS)
<i>neomycin sulfate tab 500 mg</i>	1	
<i>paromomycin sulfate cap 250 mg</i>	1	
TOBI NEB 300/5ML	3	PA, QL (56 AMPULES PER 28 DAYS); MNPA
TOBI PODHALR CAP 28MG	2	PA, QL (224 CAPSULES PER 28 DAYS); MNPA
<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)
<b>ANALGESICS - ANTI-INFLAMMATORY</b>		
<b>ANALGESICS - ANTI-INFLAMMATORY COMBINATIONS</b>		
LEFLUNICLO PAK 20MG-1%	3	
<b>ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES</b>		
ADALIMU-ADAZ INJ 40/0.4ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ADALIMU-ADAZ INJ 40/0.4ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
ADALIMU-FKJP KIT 20/0.4ML	2	PA, QL (4 syringes per 28 days)
ADALIMU-FKJP KIT 40/0.8ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
ADALIMU-FKJP KIT 40/0.8ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
AMJEVITA INJ 10/0.2ML	3	PA, QL (2 syringes per 28 days)
AMJEVITA INJ 20/0.4ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
AMJEVITA INJ 40/0.8ML	3	PA, QL (4 PENS PER 28 DAYS); Loading dose: 8 per 14 days
AMJEVITA INJ 40/0.8ML	3	PA, QL (4 SYRINGES PER 28 DAYS); Loading dose: 8 per 14 days
CYLTEZO INJ 10/0.2ML	3	PA, QL (2 syringes per 28 days)
CYLTEZO INJ 20/0.4ML	3	PA, QL (4 syringes per 28 days)
CYLTEZO INJ 40/0.8ML	3	QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
CYLTEZO INJ 40/0.8ML	3	PA, QL (4 syringes per 28 days)
CYLTEZO INJ CROHNS	3	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 6 pens per 28 days
CYLTEZO INJ PSORIASI	3	QL (NOT FOR DAILY USE); LOADING DOSE: 4 pens per 28 days

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HADLIMA INJ 40/0.4ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HADLIMA INJ 40/0.8ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HADLIMA PUSH INJ 40/0.4ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HADLIMA PUSH INJ 40/0.8ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HULIO INJ 40/0.8ML	3	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HULIO INJ 40/0.8ML	3	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HULIO KIT 20/0.4ML	3	PA, QL (4 syringes per 28 days)
HUMIRA INJ 10/0.1ML	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA INJ 20/0.2ML	2	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	2	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	2	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	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEDIA INJ CROHNS	2	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	2	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	2	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	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEN INJ CD/UC/HS	2	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	2	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	2	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	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEN KIT PS/UV	2	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	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
HYRIMOZ INJ 10/0.1ML	2	PA, QL (2 syringes per 28 days)
HYRIMOZ INJ 20/0.2ML	2	PA, QL (4 syringes per 28 days)
HYRIMOZ INJ 40/0.4ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HYRIMOZ INJ 40/0.4ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HYRIMOZ INJ 40/0.8ML	2	QL (4 pen autoinjectors per 28 days)
HYRIMOZ INJ 40/0.8ML	2	QL (4 syringes per 28 days)
HYRIMOZ INJ 80/0.8ML	2	PA, QL (2 pens PER 28 days); LOADING DOSE: 4 pens per 14 days
HYRIMOZ-PED INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 2 syringes per 28 days
HYRIMOZ-PED INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HYRIMOZ-PLAQ INJ PSORIASI	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
IDACIO CROHN INJ DISEASE	3	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 6 pens per 28 days
IDACIO INJ 40/0.8ML	3	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
IDACIO INJ 40/0.8ML	3	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
IDACIO PLAQU INJ PSORIASI	3	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 4 pens per 28 days
SIMPONI INJ 50/0.5ML	2	PA, QL (1 SYRINGES PER 28 DAYS); MNPA
SIMPONI INJ 100MG/ML	2	PA, QL (1 SYRINGES PER 28 DAYS); LOADING DOSE: 3 PFS PER 28 DAYS
SIMPONI INJ 100MG/ML	2	PA, QL (1 SYRINGES PER 28 DAYS); LOADING DOSE: 3 SYRINGES PER 28 DAYS
YUFLYMA 1PEN KIT 40/0.4ML	3	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
YUFLYMA 2SYR KIT 40/0.4ML	3	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
YUSIMRY INJ 40/0.8ML	3	PA
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>		
OLUMIANT TAB 1MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OLUMIANT TAB 2MG	3	PA, QL (30 TABLETS PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RINVOQ TAB 15MG ER	2	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	2	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 45MG ER	2	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XELJANZ SOL 1MG/ML	2	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	2	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 TAB 10MG	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XELJANZ XR TAB 11MG	2	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	2	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**

OTREXUP INJ 10MG	3	PA, QL (4 INJ PER 28 DAYS)
OTREXUP INJ 12.5/0.4	3	PA, QL (4 INJ PER 28 DAYS)
OTREXUP INJ 15MG	3	PA, QL (4 PENS PER 28 DAYS)
OTREXUP INJ 17.5/0.4	3	PA, QL (4 INJ PER 28 DAYS)
OTREXUP INJ 20MG	3	PA, QL (4 PENS PER 28 DAYS)
OTREXUP INJ 22.5/0.4	3	PA, QL (4 INJ PER 28 DAYS)
OTREXUP INJ 25MG	3	PA, QL (4 PENS 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RASUVO INJ 7.5MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 10MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 12.5MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 15MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 17.5MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 20MG	2	PA, QL (4 PENS PER 28 DAYS)
RASUVO INJ 22.5MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 25MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 30MG	2	PA, QL (4 INJ PER 28 DAYS)
REDITREX INJ 7.5/.3ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 10/.4ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 12.5/0.5	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 15/.6ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 17.5/0.7	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 20/.8ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 22.5/0.9	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 25MG/ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
<b>GOLD COMPOUNDS</b>		
RIDAURA CAP 3MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>INTERLEUKIN-1 BLOCKERS</b>		
ARCALYST INJ 220MG	3	PA, QL (8 VIALS PER 28 DAYS); MNPA
<b>INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)</b>		
KINERET INJ	3	PA, QL (30 SYRINGES PER 30 DAYS); MNPA
<b>INTERLEUKIN-6 RECEPTOR INHIBITORS</b>		
ACTEMRA INJ 162/0.9	3	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
ACTEMRA INJ ACTPEN	3	PA, QL (4 PENS PER 28 DAYS); MNPA
KEVZARA INJ 150/1.14	2	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	2	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.
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		
ARTHROTEC 50 TAB	3	MNPA
ARTHROTEC 75 TAB	3	MNPA
CELEBREX CAP 50MG	3	MNPA
CELEBREX CAP 100MG	3	MNPA
CELEBREX CAP 200MG	3	MNPA
CELEBREX CAP 400MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
DICLOFENAC CAP 35MG	3	PA
<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>fenoprofen calcium cap 400 mg</i>	1	PA; MNPA
<i>fenoprofen calcium tab 600 mg</i>	1	PA; MNPA
FENOPROFEN CAP 200MG	1	PA; MNPA
FENOPROFEN CAP 200MG	3	PA; MNPA
FENORTHO CAP 200MG	3	PA
<i>flurbiprofen tab 50 mg</i>	1	
<i>flurbiprofen tab 100 mg</i>	1	
<i>ibuprofen tab 400 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ibuprofen tab 600 mg</i>	1	
<i>ibuprofen tab 800 mg</i>	1	
INDOCIN SUS 25MG/5ML	3	PA; MNPA
<i>indomethacin cap 20 mg</i>	1	PA; MNPA
<i>indomethacin cap 25 mg</i>	1	
<i>indomethacin cap 50 mg</i>	1	
<i>indomethacin cap er 75 mg</i>	1	
<i>indomethacin suppos 50 mg</i>	3	PA; MNPA
<i>ketoprofen cap 25 mg</i>	1	PA; MNPA
<i>ketoprofen cap 50 mg</i>	1	
<i>ketoprofen cap 75 mg</i>	1	
<i>ketoprofen cap er 24hr 200 mg</i>	1	PA; MNPA
KETOR TROMET SPR 15.75MG	3	PA
<i>ketorolac tromethamine tab 10 mg</i>	1	
LODINE TAB 400MG	3	
<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>mefenamic acid cap 250 mg</i>	1	PA; MNPA
<i>meloxicam cap 5 mg</i>	1	MNPA
<i>meloxicam cap 10 mg</i>	1	MNPA
<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	
NAPRELAN TAB 375MG CR	3	PA; MNPA
NAPRELAN TAB 500MG CR	3	PA; MNPA
NAPRELAN TAB 750MG CR	3	MNPA
NAPROSYN SUS 125/5ML	3	
NAPROSYN TAB 500MG	3	
<i>naproxen sodium tab 275 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>naproxen sodium tab 550 mg</i>	1	
<i>naproxen sodium tab er 24hr 375 mg (base equiv)</i>	1	PA; MNPA
<i>naproxen sodium tab er 24hr 500 mg (base equiv)</i>	1	PA; MNPA
<i>naproxen sodium tab er 24hr 750 mg (base equiv)</i>	1	MNPA
<i>naproxen susp 125 mg/5ml</i>	1	PA; MNPA
<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>naproxen-esomeprazole magnesium tab dr 375-20 mg</i>	1	PA; MNPA
<i>naproxen-esomeprazole magnesium tab dr 500-20 mg</i>	1	PA; MNPA
<i>oxaprozin tab 600 mg</i>	1	
<i>piroxicam cap 10 mg</i>	1	
<i>piroxicam cap 20 mg</i>	1	
QMIIZ ODT TAB 7.5MG	3	
QMIIZ ODT TAB 15 MG	3	
RELAFEN DS TAB 1000MG	3	
SPRIX SPR 15.75MG	3	PA; MNPA
<i>sulindac tab 150 mg</i>	1	
<i>sulindac tab 200 mg</i>	1	
TIVORBEX CAP 20MG	3	
<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	
VIVLODEX CAP 5MG	3	
VIVLODEX CAP 10MG	3	
ZIPSOR CAP 25MG	3	
ZORVOLEX CAP 18MG	3	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZORVOLEX CAP 35MG	3	PA; MNPA
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
OTEZLA TAB 10/20/30	2	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	2	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.
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>		
ARAVA TAB 10MG	2	
ARAVA TAB 20MG	2	
<i>leflunomide tab 10 mg</i>	1	
<i>leflunomide tab 20 mg</i>	1	
<b>SELECTIVE COSTIMULATION MODULATORS</b>		
ORENCIA CLCK INJ 125MG/ML	3	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. MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ORENCIA INJ 50/0.4ML	3	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. MNPA
ORENCIA INJ 87.5/0.7	3	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. MNPA
ORENCIA INJ 125MG/ML	3	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. MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS</b>		
ENBREL INJ 25/0.5ML	2	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 25MG	2	PA, QL (8 VIALS PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:16 VIALS PER 28 DAYS
ENBREL INJ 50MG/ML	2	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ENBREL MINI INJ 50MG/ML	2	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
ENBREL SRCLK INJ 50MG/ML	2	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**

ALLZITAL TAB 25-325MG	3	
BUT/ASA/CAF TAB	3	
<i>butalbital-acetaminophen cap 50-300 mg</i>	1	MNPA
<i>butalbital-acetaminophen tab 25-325 mg</i>	1	
<i>butalbital-acetaminophen tab 50-300 mg</i>	1	PA; MNPA
<i>butalbital-acetaminophen tab 50-325 mg</i>	1	
<i>butalbital-acetaminophen-caffeine cap 50-300-40 mg</i>	1	MNPA
<i>butalbital-acetaminophen-caffeine cap 50-325-40 mg</i>	1	
<i>butalbital-acetaminophen-caffeine cap 50-325-40 mg</i>	1	MNPA
<i>butalbital-acetaminophen-caffeine soln 50-325-40 mg/15ml</i>	1	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
FIORICET CAP	3	MNPA
<b>SALICYLATES</b>		
<i>aspirin chew tab 81 mg</i>	0	
<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	
<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	
<b>ANALGESICS - OPIOID</b>		
<b>OPIOID AGONISTS</b>		
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)
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
FENTORA TAB 100MCG	3	PA
FENTORA TAB 200MCG	3	PA
FENTORA TAB 400MCG	3	PA
FENTORA TAB 600MCG	3	PA
FENTORA TAB 800MCG	3	PA
<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)
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
HYSINGLA ER TAB 20 MG	3	PA, QL (30 tabs every 25 days); MNPA
HYSINGLA ER TAB 30 MG	3	PA, QL (30 tabs every 25 days); MNPA
HYSINGLA ER TAB 40 MG	3	PA, QL (30 tabs every 25 days); MNPA
HYSINGLA ER TAB 60 MG	3	PA, QL (30 tabs every 25 days); MNPA
HYSINGLA ER TAB 80 MG	3	PA, QL (30 tabs every 25 days); MNPA
HYSINGLA ER TAB 100 MG	3	PA; MNPA
HYSINGLA ER TAB 120 MG	3	PA; MNPA
LAZANDA SPR 100MCG	3	PA; MNPA
LAZANDA SPR 400MCG	3	PA; MNPA
<i>levorphanol tartrate tab 2 mg</i>	1	PA, QL (120 tabs every 25 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>levorphanol tartrate tab 3 mg</i>	1	PA, QL (60 tabs every 25 days); MNPA
<i>meperidine hcl oral soln 50 mg/5ml</i>	1	PA
<i>meperidine hcl tab 50 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 (1 tab per day)
<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)
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
<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
<i>morphine sulfate tab er 100 mg</i>	1	PA
<i>morphine sulfate tab er 200 mg</i>	1	PA
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MS CONTIN TAB 60MG ER	3	PA
MS CONTIN TAB 100MG ER	3	PA
MS CONTIN TAB 200MG ER	3	PA
NUCYNTA ER TAB 50MG	2	PA, QL (60 tabs every 25 days); MNPA
NUCYNTA ER TAB 100MG	2	PA, QL (60 tabs every 25 days); MNPA
NUCYNTA ER TAB 150MG	2	PA; MNPA
NUCYNTA ER TAB 200MG	2	PA; MNPA
NUCYNTA ER TAB 250MG	2	PA; MNPA
NUCYNTA TAB 50MG	2	PA, QL (120 tabs every 25 days); MNPA
NUCYNTA TAB 75MG	2	PA, QL (90 tabs every 25 days); MNPA
NUCYNTA TAB 100MG	2	PA, QL (60 tabs every 25 days); MNPA
OLINVYK SOL 1MG/ML	3	
OLINVYK SOL 2MG/2ML	3	
OLINVYK SOL 30MG/30	3	
OXAYDO TAB 5MG	3	PA, QL (180 tabs every 25 days)
OXAYDO TAB 7.5MG	3	PA, QL (180 tabs every 25 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 25 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)
<i>oxycodone hcl tab 15 mg</i>	1	PA, QL (120 tabs every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
OXYCONTIN TAB 10MG ER	3	PA, QL (60 tabs every 25 days); MNPA
OXYCONTIN TAB 15MG ER	3	PA, QL (60 tabs every 25 days); MNPA
OXYCONTIN TAB 20MG ER	3	PA, QL (60 tabs every 25 days); MNPA
OXYCONTIN TAB 30MG ER	3	PA, QL (60 tabs every 25 days); MNPA
OXYCONTIN TAB 40MG ER	3	PA, QL (120 tabs every 30 days); MNPA
OXYCONTIN TAB 60MG ER	3	PA, QL (60 tabs every 25 days); MNPA
OXYCONTIN TAB 80MG ER	3	PA, QL (60 tabs every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxymorphone hcl tab er 12hr 5 mg</i>	1	PA, QL (60 tabs every 25 days); MNPA
<i>oxymorphone hcl tab er 12hr 7.5 mg</i>	1	PA, QL (60 tabs every 25 days); MNPA
<i>oxymorphone hcl tab er 12hr 10 mg</i>	1	PA, QL (60 tabs every 25 days); MNPA
<i>oxymorphone hcl tab er 12hr 15 mg</i>	1	PA, QL (60 tabs every 25 days); MNPA
<i>oxymorphone hcl tab er 12hr 20 mg</i>	1	PA; MNPA
<i>oxymorphone hcl tab er 12hr 30 mg</i>	1	PA; MNPA
<i>oxymorphone hcl tab er 12hr 40 mg</i>	1	PA; MNPA
QDOLO SOL 5MG/ML	3	
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)
ROXYBOND TAB 5MG	3	
SUBSYS SPR 100MCG	3	PA; MNPA
SUBSYS SPR 200MCG	3	PA; MNPA
SUBSYS SPR 400MCG	3	PA; MNPA
SUBSYS SPR 600MCG	3	PA; MNPA
SUBSYS SPR 800MCG	3	PA; MNPA
SUBSYS SPR 1200MCG	3	PA; MNPA
SUBSYS SPR 1600MCG	3	PA; MNPA
<i>tramadol hcl tab 50 mg</i>	1	PA, QL (180 tabs every 25 days)
<i>tramadol hcl tab 100 mg</i>	1	PA, QL (90 tabs every 25 days); MNPA
<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)
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA, QL (30 tabs every 25 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA
ULTRAM TAB 50MG	3	PA, QL (180 tabs every 25 days)
XTAMPZA ER CAP 9MG	2	PA, QL (60 caps every 25 days)
XTAMPZA ER CAP 13.5MG	2	PA, QL (60 caps every 25 days)
XTAMPZA ER CAP 18MG	2	PA, QL (60 caps every 25 days)
XTAMPZA ER CAP 27MG	2	PA, QL (60 caps every 25 days)
XTAMPZA ER CAP 36MG	2	PA, QL (60 caps every 25 days)
ZOHYDRO ER CAP 10MG	3	PA, QL (60 caps every 25 days); MNPA
ZOHYDRO ER CAP 15MG	3	PA, QL (60 caps every 25 days); MNPA
ZOHYDRO ER CAP 20MG	3	PA, QL (60 caps every 25 days); MNPA
ZOHYDRO ER CAP 30MG	3	PA, QL (60 caps every 25 days); MNPA
ZOHYDRO ER CAP 40MG	3	PA, QL (60 caps every 25 days); MNPA
ZOHYDRO ER CAP 50MG	3	PA, QL (60 caps every 30 days); MNPA
<b>OPIOID COMBINATIONS</b>		
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
APADAZ TAB 4.08-325	3	PA, QL (360 tabs every 30 days)
APADAZ TAB 6.12-325	3	PA, QL (360 tabs every 30 days)
APADAZ TAB 8.16-325	3	PA, QL (360 tabs every 30 days)
BENZHY/ACETA TAB 4.08-325	3	PA, QL (360 tabs every 30 days); MNPA
BENZHY/ACETA TAB 6.12-325	3	PA, QL (360 tabs every 30 days); MNPA
BENZHY/ACETA TAB 8.16-325	3	PA, QL (360 tabs every 30 days); MNPA
<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)
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 30 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
NALOCET TAB 2.5-300	3	PA, QL (360 tabs every 30 days)
OXYCOD-APAP TAB 2.5-300	3	PA, QL (360 tabs every 30 days)
OXYCOD/ACETA SOL 10/300MG	3	QL (900 mL every 30 days)
OXYCOD/APAP TAB 5-300MG	3	PA, QL (360 tabs every 30 days)
OXYCOD/APAP TAB 10-300MG	3	PA, QL (180 tabs every 30 days)
<i>oxycodone w/ acetaminophen soln 5-325 mg/5ml</i>	3	
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	1	PA, QL (360 tabs every 30 days)
PERCOCET TAB 2.5-325	3	PA, QL (360 tabs every 30 days); MNPA
PERCOCET TAB 5-325MG	3	PA, QL (360 tabs every 30 days); MNPA
PERCOCET TAB 7.5-325	3	PA, QL (240 tabs every 30 days); MNPA
PERCOCET TAB 10-325MG	3	PA, QL (180 tabs every 30 days); MNPA
PROLATE SOL 10/300MG	3	QL (900 mL every 30 days)
PROLATE TAB 5-300MG	3	PA, QL (360 tabs every 30 days)
PROLATE TAB 7.5-300	3	PA, QL (240 tabs every 30 days)
PROLATE TAB 10-300MG	3	PA, QL (180 tabs every 30 days)
SEGLENTIS TAB 56-44MG	3	PA, QL (120 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)
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
BUNAVAIL MIS 4.2-0.7	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BUNAVAIL MIS 6.3-1MG	2	
<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)
BUTRANS DIS 5MCG/HR	3	PA, QL (4 patches every 25 days); MNPA
BUTRANS DIS 7.5/HR	3	PA, QL (4 patches every 25 days); MNPA
BUTRANS DIS 10MCG/HR	3	PA, QL (4 patches every 25 days); MNPA
BUTRANS DIS 15MCG/HR	3	PA; MNPA
BUTRANS DIS 20MCG/HR	3	PA; MNPA
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA
SUBOXONE MIS 2-0.5MG	3	MNPA
SUBOXONE MIS 4-1MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SUBOXONE MIS 8-2MG	3	MNPA
SUBOXONE MIS 12-3MG	3	MNPA
ZUBSOLV SUB 0.7-0.18	2	
ZUBSOLV SUB 1.4-0.36	2	
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
ANDROGEL GEL 1%(25MG)	3	PA; MNPA
ANDROGEL GEL 1%(50MG)	3	PA; MNPA
ANDROGEL GEL 1.62%	3	PA; MNPA
<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	
FORTESTA GEL 10MG/ACT	3	PA; MNPA
JATENZO CAP 158MG	3	PA
JATENZO CAP 198MG	3	PA
JATENZO CAP 237MG	3	PA
METHITEST TAB 10MG	3	
<i>methyltestosterone cap 10 mg</i>	1	
NATESTO GEL 5.5MG	2	PA
TESTIM GEL 1%(50MG)	3	PA; MNPA
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

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

49

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
VOGELXO GEL 1%(50MG)	3	PA; MNPA
VOGELXO GEL PUMP 1%	3	PA; MNPA
XYOSTED INJ 50/0.5	3	PA
XYOSTED INJ 75/0.5	3	PA
XYOSTED INJ 100/0.5	3	PA

**ANORECTAL AND RELATED PRODUCTS****INTRARECTAL STEROIDS**

CORTENEMA ENE 100MG	3	
CORTIFOAM AER 90MG	2	
<i>hydrocortisone enema 100 mg/60ml</i>	1	
UCERIS AER 2MG/ACT	3	

**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	
PROCORT CRE	3	
PROCTOFOAM AER HC 1%	2	

**RECTAL STEROIDS**

ANUSOL-HC CRE 2.5%	2	
<i>hydrocortisone acetate suppos 25 mg</i>	1	
<i>hydrocortisone perianal cream 1%</i>	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
PROCTOCORT CRE 1%	3	
PROCTOCORT SUP 30MG	3	

**VASODILATING AGENTS**

RECTIV OIN 0.4%	3	
-----------------	---	--

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



Drug Name	Drug Tier	Requirements/Limits
<b>ANTHELMINTICS</b>		
<b>ANTHELMINTICS</b>		
<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	2	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)
STROMEKTOL TAB 3MG	3	PA, QL (9 tabs every 90 days)
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
AEMCOLO TAB 194MG	3	
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 200MG	3	QL (9 tabs every 25 days)
XIFAXAN TAB 550MG	2	PA
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>		
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
<b>ANTIPROTOZOAL AGENTS</b>		
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	3	
<i>nitazoxanide tab 500 mg</i>	1	
<b>GLYCOPEPTIDES</b>		
FIRVANQ SOL 25MG/ML	3	QL (450 mL every 10 days)
FIRVANQ SOL 50MG/ML	3	QL (450 mL every 10 days)
VANCOCIN CAP 125MG	2	QL (80 caps every 10 days)
VANCOCIN CAP 250MG	2	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)
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	3	QL (450 mL every 10 days)
<b>LEPROSTATICS</b>		
<i>dapsone tab 25 mg</i>	1	
<i>dapsone tab 100 mg</i>	1	
<b>LINCOSAMIDES</b>		
CLEOCIN CAP 75MG	2	
CLEOCIN CAP 150MG	2	
CLEOCIN CAP 300MG	2	
CLEOCIN PED SOL 75MG/5ML	2	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MONOBACTAMS</b>		
CAYSTON INH 75MG	3	PA, QL (84 VIALS PER 28 DAYS); MNPA
<b>OXAZOLIDINONES</b>		
<i>linezolid for susp 100 mg/5ml</i>	1	PA
<i>linezolid tab 600 mg</i>	1	PA
SIVEXTRO TAB 200MG	3	
ZYVOX SUS 100MG/5M	3	PA
ZYVOX TAB 600MG	3	PA
<b>PLEUROMUTILINS</b>		
XENLETA TAB 600MG	3	
<b>URINARY ANTI-INFECTIVES</b>		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	2	
MACRODANTIN CAP 25MG	3	PA; MNPA
MACRODANTIN CAP 50MG	3	PA; MNPA
MACRODANTIN CAP 100MG	3	PA; MNPA
<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	
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
<b>ANTIANGINAL AGENTS</b>		
<b>ANTIANGINALS-OTHER</b>		
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NITRATES</b>		
DILATRATE SR CAP 40MG	3	
GONITRO POW 400MCG	3	MNPA
ISORDIL TAB 5MG	3	
ISORDIL TAB 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 dinitrate tab 40 mg</i>	1	PA; MNPA
<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	2	
NITRO-DUR DIS 0.2MG/HR	2	
NITRO-DUR DIS 0.3MG/HR	2	
NITRO-DUR DIS 0.4MG/HR	2	
NITRO-DUR DIS 0.6MG/HR	2	
NITRO-DUR DIS 0.8MG/HR	2	
<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 PUMPSRA	3	
NITROMIST AER 400MCG	3	
NITROSTAT SUB 0.3MG	3	
NITROSTAT SUB 0.4MG	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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NITROSTAT SUB 0.6MG	3	
<b>ANTIAXIETY AGENTS</b>		
<b>ANTIAXIETY AGENTS - MISC.</b>		
<i>bupirone hcl tab 5 mg</i>	1	
<i>bupirone hcl tab 7.5 mg</i>	1	
<i>bupirone hcl tab 10 mg</i>	1	
<i>bupirone hcl tab 15 mg</i>	1	
<i>bupirone 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	
<b>BENZODIAZEPINES</b>		
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	
ATIVAN TAB 0.5MG	3	MNPA
ATIVAN TAB 1MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ATIVAN TAB 2MG	3	MNPA
<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	
XANAX TAB 0.5MG	3	MNPA
XANAX TAB 0.25MG	3	MNPA
XANAX TAB 1MG	3	MNPA
XANAX TAB 2MG	3	MNPA
XANAX XR TAB 0.5MG	3	MNPA
XANAX XR TAB 1MG	3	MNPA
XANAX XR TAB 2MG	3	MNPA
XANAX XR TAB 3MG	3	MNPA

**ANTIARRHYTHMICS****ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i>	1	
<i>disopyramide phosphate cap 150 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NORPACE CAP 100MG	3	MNPA
NORPACE CAP 100MG CR	2	
NORPACE CAP 150MG	3	MNPA
NORPACE CAP 150MG CR	2	
<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	
<b>ANTIARRHYTHMICS TYPE I-B</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	
<b>ANTIARRHYTHMICS TYPE I-C</b>		
<i>flecainide acetate tab 50 mg</i>	1	
<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	2	
RYTHMOL SR CAP 325MG	2	
RYTHMOL SR CAP 425MG	2	
<b>ANTIARRHYTHMICS TYPE III</b>		
<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	MNPA
TIKOSYN CAP 125MCG	2	PA
TIKOSYN CAP 250MCG	2	PA
TIKOSYN CAP 500MCG	2	PA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

Drug Name	Drug Tier	Requirements/Limits
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>		
<b>ANTI-INFLAMMATORY AGENTS</b>		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (240 mL every 30 days)
<b>ANTIASTHMATIC - MONOCLONAL ANTIBODIES</b>		
DUPIXENT INJ 100/0.67	2	PA, QL (2 SYRINGES PER 28 DAYS)
DUPIXENT INJ 200/1.14	2	PA, QL (2 PFS PER 28 DAYS); LOADING DOSE: 2 PFS PER 14 DAYS
FASENRA PEN INJ 30MG/ML	2	PA, QL (1 PENS PER 56 DAYS); LOADING DOSE: 3 PENS PER 84 DAYS
NUCALA INJ 40MG/0.4	2	PA, QL (1 SYRINGE PER 28 DAYS)
NUCALA INJ 100MG/ML	2	PA, QL (3 INJ PER 28 DAYS)
NUCALA INJ 100MG/ML	2	PA, QL (3 PFS PER 28 DAYS)
TEZSPIRE INJ 210MG	2	PA, QL (1 PEN PER 28 DAYS)
<b>BRONCHODILATORS - ANTICHOLINERGICS</b>		
ATROVENT HFA AER 17MCG	2	QL (2 packages every 25 days)
INCRUSE ELPT INH 62.5MCG	2	QL (30 blisters every 30 days); MNPA
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (120 vials every 30 days)
LONHALA MAGN SOL 25MCG	3	QL (60 mL every 30 days)
SEEBRI NEOHA CAP 15.6MCG	3	QL (60 ea 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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TUDORZA PRES AER 400/ACT	3	QL (1 inhaler every 30 days); MNPA
YUPELRI SOL	2	QL (90 mL every 30 days)
<b>LEUKOTRIENE MODULATORS</b>		
ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
montelukast sodium chew tab 4 mg (base equiv)	1	
montelukast sodium chew tab 5 mg (base equiv)	1	
montelukast sodium oral granules packet 4 mg (base equiv)	1	
montelukast sodium tab 10 mg (base equiv)	1	
SINGULAIR CHW 4MG	3	MNPA
SINGULAIR CHW 5MG	3	MNPA
SINGULAIR GRA 4MG	3	MNPA
SINGULAIR TAB 10MG	3	MNPA
zafirlukast tab 10 mg	1	
zafirlukast tab 20 mg	1	
zileuton tab er 12hr 600 mg	1	PA; MNPA
ZYFLO TAB 600MG	3	
<b>SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
DALIRESP TAB 250MCG	3	MNPA
DALIRESP TAB 500MCG	3	MNPA
roflumilast tab 250 mcg	1	
roflumilast tab 500 mcg	1	
<b>STEROID INHALANTS</b>		
ALVESCO AER 80MCG	3	QL (3 packages every 25 days); MNPA
ALVESCO AER 160MCG	3	QL (2 inhalers every 25 days); MNPA
ARMONAIR DIG AER 55MCG	3	QL (1 inhaler every 25 days)
ARMONAIR DIG AER 113MCG	3	QL (1 inhaler every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARMONAIR DIG AER 232MCG	3	QL (1 inhaler every 25 days)
ARNUITY ELPT INH 50MCG	2	QL (1 inhaler every 30 days); MNPA
ARNUITY ELPT INH 100MCG	2	QL (30 blisters every 30 days); MNPA
ARNUITY ELPT INH 200MCG	2	QL (30 blisters every 30 days); MNPA
ASMANEX 7 AER 110MCG	3	QL (2 inhalers every 25 days); MNPA
ASMANEX 14 AER 220MCG	3	MNPA
ASMANEX 30 AER 110MCG	3	QL (2 inhalers every 25 days); MNPA
ASMANEX 30 AER 220MCG	3	QL (4 inhalers every 25 days); MNPA
ASMANEX 60 AER 220MCG	3	QL (2 inhalers every 25 days); MNPA
ASMANEX 120 AER 220MCG	3	QL (1 inhaler every 25 days); MNPA
ASMANEX HFA AER 50MCG	3	QL (1 package every 25 days); MNPA
ASMANEX HFA AER 100 MCG	3	QL (1 inhaler every 25 days); MNPA
ASMANEX HFA AER 200 MCG	3	QL (1 inhaler every 25 days); MNPA
<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)
FLOVENT DISK AER 50MCG	2	QL (3 inhalations every 25 days); MNPA
FLOVENT DISK AER 100MCG	2	QL (4 inhalations every 25 days); MNPA
FLOVENT DISK AER 250MCG	2	QL (4 inhalations every 25 days); MNPA
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days)
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days)
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125/valve)</i>	3	QL (2 packages every 25 days)
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250/valve)</i>	3	QL (2 packages every 25 days)
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50/valve)</i>	3	QL (2 packages every 25 days)
PULMICORT INH 90MCG	2	QL (3 inhalers every 25 days)
PULMICORT INH 180MCG	2	QL (2 inhalers every 25 days)
PULMICORT SUS 0.5MG/2	3	QL (2 mL every 25 days)
PULMICORT SUS 0.25MG/2	3	QL (3 mL every 25 days)
PULMICORT SUS 1MG/2ML	3	QL (1 mL every 25 days)
QVAR REDIIHA AER 80MCG	2	QL (2 packages every 25 days); MNPA, Covered for members 6 years of age and younger
QVAR REDIIHAL AER 40MCG	2	QL (2 packages every 25 days); MNPA, Covered for members 6 years of age and younger

**SYMPATHOMIMETICS**

ADVAIR DISKU AER 100/50	2	QL (60 inhalations every 30 days)
ADVAIR DISKU AER 250/50	2	QL (60 inhalations every 30 days)
ADVAIR DISKU AER 500/50	2	QL (60 inhalations every 30 days)
ADVAIR HFA AER 45/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 115/21	2	QL (1 package every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ADVAIR HFA AER 230/21	2	QL (1 package every 25 days)
AIRDUO DGHLR INH 55-14	3	QL (60 inhalers every 25 days)
AIRDUO DGHLR INH 113-14	3	QL (60 inhalers every 25 days)
AIRDUO DGHLR INH 232-14	3	QL (60 inhalers every 25 days)
AIRDUO RESPI INH 55-14	3	QL (1 inhaler every 30 days)
AIRDUO RESPI INH 113-14	3	QL (1 inhaler every 30 days)
AIRDUO RESPI INH 232-14	3	QL (1 inhaler every 30 days)
AIRSUPRA AER 90-80MCG	2	QL (3 packages per 30 days)
ALBUTEROL NEB 0.5%	3	QL (60 mL every 30 days)
<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 (60 mL every 30 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BEVESPI AER 9-4.8MCG	2	QL (1 package every 25 days); MNPA
BREO ELLIPTA INH 50-25MCG	2	QL (60 blisters 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)
BROVANA NEB 15MCG	3	QL (120 mL every 30 days)
<i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i>	1	QL (3 packages every 25 days)
<i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i>	3	
<i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</i>	1	QL (3 packages every 25 days)
<i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</i>	3	
COMBIVENT AER 20-100	3	QL (2 packages every 25 days)
DUAKLIR AER 400/12	3	QL (1 inhaler every 30 days)
DULERA AER 50-5MCG	3	QL (1 package every 25 days); MNPA
DULERA AER 100-5MCG	3	QL (1 package every 25 days); MNPA
DULERA AER 200-5MCG	3	QL (1 package every 25 days); MNPA
<i>fluticasone furoate-vilanterol aero powd ba 100-25 mcg/act</i>	3	
<i>fluticasone furoate-vilanterol aero powd ba 200-25 mcg/act</i>	3	
<i>fluticasone-salmeterol aer powder ba 55-14 mcg/act</i>	1	QL (1 inhaler every 30 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fluticasone-salmeterol aer powder ba 100-50 mcg/act</i>	1	QL (60 inhalations every 30 days)
<i>fluticasone-salmeterol aer powder ba 113-14 mcg/act</i>	1	QL (1 inhaler every 30 days)
<i>fluticasone-salmeterol aer powder ba 232-14 mcg/act</i>	1	QL (1 inhaler 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>fluticasone-salmeterol inhal aerosol 45-21 mcg/act</i>	1	QL (1 package every 25 days)
<i>fluticasone-salmeterol inhal aerosol 115-21 mcg/act</i>	1	QL (1 package every 25 days)
<i>fluticasone-salmeterol inhal aerosol 230-21 mcg/act</i>	1	QL (1 package every 25 days)
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (120 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)
PROAIR DIGIH AER	3	QL (2 packages every 25 days)
PROAIR HFA AER	3	QL (2 packages every 25 days); MNPA
PROAIR RESPI AER	3	QL (2 packages every 25 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROVENTIL AER HFA	3	QL (2 packages every 25 days); MNPA
SEREVENT DIS AER 50MCG	2	QL (60 inhalations 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)
SYMBICORT AER 80-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
SYMBICORT AER 160-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
<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)
UTIBRON CAP NEOHALER	3	QL (60 ea every 30 days)
VENTOLIN HFA AER	3	QL (2 packages every 25 days); MNPA
VENTOLIN HFA AER	3	QL (6 packages every 25 days); MNPA
XOPENEX CONC NEB 1.25/0.5	3	QL (90 ea every 30 days)
XOPENEX HFA AER	3	QL (2 inhalers every 30 days); MNPA
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)
<b>XANTHINES</b>		
THEO-24 CAP 100MG CR	3	PA; MNPA
THEO-24 CAP 200MG CR	3	PA; MNPA
THEO-24 CAP 300MG CR	3	PA; MNPA
THEO-24 CAP 400MG ER	3	PA; MNPA
<i>theophylline elixir 80 mg/15ml</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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>theophylline elixir 80 mg/15ml</i>	3	
<i>theophylline tab er 12hr 100 mg</i>	3	
<i>theophylline tab er 12hr 200 mg</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	
SAVAYSA TAB 15MG	3	
SAVAYSA TAB 30MG	3	
SAVAYSA TAB 60MG	3	
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	2	
ARIXTRA INJ 5/0.4ML	2	
ARIXTRA INJ 7.5/0.6	2	
ARIXTRA INJ 10/0.8ML	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<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	
ENOXILUV KIT INJ 40/0.4ML	3	
<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	
FRAGMIN INJ 2500/0.2	2	
FRAGMIN INJ 2500/ML	2	
FRAGMIN INJ 5000/0.2	2	
FRAGMIN INJ 7500/0.3	2	
FRAGMIN INJ 10000/ML	2	
FRAGMIN INJ 12500UNT	2	
FRAGMIN INJ 15000UNT	2	
FRAGMIN INJ 18000UNT	2	
FRAGMIN INJ 95000UNT	2	
HEPARIN SOD INJ 5000/0.5	3	PA
HEPARIN SOD INJ 5000/ML	3	PA
<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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>THROMBIN INHIBITORS</b>		
PRADAXA CAP 75MG	3	MNPA
PRADAXA CAP 110MG	3	MNPA
PRADAXA CAP 150MG	3	MNPA
<b>ANTICONSULSANTS</b>		
<b>AMPA GLUTAMATE RECEPTOR ANTAGONISTS</b>		
FYCOMPA SUS 0.5MG/ML	2	
FYCOMPA TAB 2MG	2	
FYCOMPA TAB 4MG	2	
FYCOMPA TAB 6MG	2	
FYCOMPA TAB 8MG	2	
FYCOMPA TAB 10MG	2	
FYCOMPA TAB 12MG	2	
<b>ANTICONSULSANTS - BENZODIAZEPINES</b>		
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DIASTAT ACDL GEL 5-10MG	3	
DIASTAT ACDL GEL 12.5-20	3	
DIASTAT PED GEL 2.5M GEL	3	
<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	3	PA, QL (10 bottles every 25 days)
ONFI SUS 2.5MG/ML	3	MNPA
ONFI TAB 10MG	3	MNPA
ONFI TAB 20MG	3	MNPA
SYMPAZAN MIS 5MG	3	
SYMPAZAN MIS 10MG	3	
SYMPAZAN MIS 20MG	3	
VALTOCO SPR 5MG	3	QL (5 sprays every 25 days)
VALTOCO SPR 10MG	3	QL (5 sprays every 25 days)
VALTOCO SPR 15MG	3	QL (5 ea every 25 days)
VALTOCO SPR 20MG	3	QL (5 ea every 25 days)
<b>ANTICONVULSANTS - MISC.</b>		
APTIOM TAB 200MG	3	
APTIOM TAB 400MG	3	
APTIOM TAB 600MG	3	
APTIOM TAB 800MG	3	
BANZEL SUS 40MG/ML	3	MNPA
BANZEL TAB 200MG	3	
BANZEL TAB 400MG	3	
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
DIACOMIT CAP 250MG	3	QL (360 CAPSULES PER 30 DAYS)
DIACOMIT CAP 500MG	3	QL (180 CAPSULES PER 30 DAYS)
DIACOMIT PAK 250MG	3	QL (360 PACKETS PER 30 DAYS)
DIACOMIT PAK 500MG	3	QL (180 PACKETS PER 30 DAYS)
ELEPSIA XR TAB 1000MG	3	
ELEPSIA XR TAB 1500MG	3	
EPIDIOLEX SOL 100MG/ML	3	PA, QL (800 ML PER 30 DAYS)
EPRONTIA SOL 25MG/ML	3	
FINTEPLA SOL 2.2MG/ML	3	PA, QL (360ML 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	QL (72 mL per day)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>gabapentin tab 600 mg</i>	1	QL (180 tablets per 30 days)
<i>gabapentin tab 800 mg</i>	1	QL (120 tablets per 30 days)
KEPPRA SOL 100MG/ML	3	MNPA
KEPPRA TAB 250MG	3	MNPA
KEPPRA TAB 500MG	3	MNPA
KEPPRA TAB 750MG	3	MNPA
KEPPRA TAB 1000MG	3	MNPA
KEPPRA XR TAB 500MG	3	MNPA
KEPPRA XR TAB 750MG	3	MNPA
<i>lacosamide oral solution 10 mg/ml</i>	3	
<i>lacosamide tab 50 mg</i>	3	
<i>lacosamide tab 100 mg</i>	3	
<i>lacosamide tab 150 mg</i>	3	
<i>lacosamide tab 200 mg</i>	3	
LAMICTAL CHW 5MG	3	MNPA
LAMICTAL CHW 25MG	3	MNPA
LAMICTAL KIT START 35	3	MNPA
LAMICTAL KIT START 49	3	MNPA
LAMICTAL KIT START 98	3	MNPA
LAMICTAL ODT KIT	3	MNPA
LAMICTAL ODT TAB 25MG	3	MNPA
LAMICTAL ODT TAB 50MG	3	MNPA
LAMICTAL ODT TAB 100MG	3	MNPA
LAMICTAL ODT TAB 200MG	3	MNPA
LAMICTAL TAB 25MG	3	MNPA
LAMICTAL TAB 100MG	3	MNPA
LAMICTAL TAB 150MG	3	MNPA
LAMICTAL TAB 200MG	3	MNPA
LAMICTAL XR KIT	3	MNPA
LAMICTAL XR TAB 25MG	3	MNPA
LAMICTAL XR TAB 50MG	3	MNPA
LAMICTAL XR TAB 100MG	3	MNPA
LAMICTAL XR TAB 200MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LAMICTAL XR TAB 250MG	3	MNPA
LAMICTAL XR TAB 300MG	3	MNPA
<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) &amp; 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 &amp; 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) &amp; 50 mg (14) &amp; 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	
LYRICA CAP 25MG	3	QL (120 caps every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LYRICA CAP 50MG	3	QL (120 caps every 30 days); MNPA
LYRICA CAP 75MG	3	QL (120 caps every 30 days); MNPA
LYRICA CAP 100MG	3	QL (120 caps every 30 days); MNPA
LYRICA CAP 150MG	3	QL (120 caps every 30 days); MNPA
LYRICA CAP 200MG	3	QL (90 caps every 30 days); MNPA
LYRICA CAP 225MG	3	QL (60 caps every 30 days); MNPA
LYRICA CAP 300MG	3	QL (60 caps every 30 days); MNPA
LYRICA SOL 20MG/ML	3	QL (1080 mL every 30 days); MNPA
MOTPOLY XR CAP 100MG	3	
MOTPOLY XR CAP 150MG	3	
MOTPOLY XR CAP 200MG	3	
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	
NEURONTIN CAP 100MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 300MG	3	QL (180 tablets 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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
<i>primidone tab 50 mg</i>	1	
<i>primidone tab 125 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	
SPRITAM TAB 250MG	3	
SPRITAM TAB 500MG	3	
SPRITAM TAB 750MG	3	
SPRITAM TAB 1000MG	3	
TEGRETOL SUS 100/5ML	3	MNPA
TEGRETOL TAB 200MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TEGRETOL-XR TAB 100MG	3	MNPA
TEGRETOL-XR TAB 200MG	3	MNPA
TEGRETOL-XR TAB 400MG	3	MNPA
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 cap er 24hr sprinkle 25 mg</i>	1	PA; MNPA
<i>topiramate cap er 24hr sprinkle 50 mg</i>	1	PA; MNPA
<i>topiramate cap er 24hr sprinkle 100 mg</i>	1	PA; MNPA
<i>topiramate cap er 24hr sprinkle 150 mg</i>	1	PA; MNPA
<i>topiramate cap er 24hr sprinkle 200 mg</i>	1	PA; MNPA
<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	
TRILEPTAL SUS 300MG/5M	3	MNPA
TRILEPTAL TAB 150MG	3	MNPA
TRILEPTAL TAB 300MG	3	MNPA
TRILEPTAL TAB 600MG	3	MNPA
TROKENDI XR CAP 25MG	2	
TROKENDI XR CAP 50MG	2	
TROKENDI XR CAP 100MG	2	
TROKENDI XR CAP 200MG	2	
VIMPAT SOL 10MG/ML	3	
VIMPAT TAB 50MG	3	
VIMPAT TAB 100MG	3	
VIMPAT TAB 150MG	3	
VIMPAT TAB 200MG	3	
ZONEGRAN CAP 25MG	3	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZONEGRAN CAP 100MG	3	PA; MNPA
<i>zonisamide cap 25 mg</i>	1	
<i>zonisamide cap 50 mg</i>	1	
<i>zonisamide cap 100 mg</i>	1	
<b>CARBAMATES</b>		
<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	
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	
<b>GABA MODULATORS</b>		
GABITRIL TAB 2MG	3	
GABITRIL TAB 4MG	3	
GABITRIL TAB 12MG	3	
GABITRIL TAB 16MG	3	
SABRIL POW 500MG	3	PA, QL (180 PACKETS PER 30 DAYS); MNPA
SABRIL TAB 500MG	3	PA, QL (180 TABLETS PER 30 DAYS); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>vigabatrin tab 500 mg</i>	1	PA, QL (180 TABLETS PER 30 DAYS)
<b>HYDANTOINS</b>		
DILANTIN CAP 30MG	3	MNPA
DILANTIN CAP 100MG	3	MNPA
DILANTIN CHW 50MG	3	MNPA
DILANTIN-125 SUS 125/5ML	3	MNPA
<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	
<b>SUCCINIMIDES</b>		
CELONTIN CAP 300MG	3	
<i>ethosuximide cap 250 mg</i>	1	
<i>ethosuximide soln 250 mg/5ml</i>	1	
ZARONTIN CAP 250MG	3	
ZARONTIN SOL 250/5ML	3	
<b>VALPROIC ACID</b>		
DEPAKOTE ER TAB 250MG	3	MNPA
DEPAKOTE ER TAB 500MG	3	MNPA
DEPAKOTE SPR CAP 125MG	3	MNPA
DEPAKOTE TAB 125MG DR	3	MNPA
DEPAKOTE TAB 250MG DR	3	MNPA
DEPAKOTE TAB 500MG DR	3	MNPA
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	

**ANTIDEPRESSANT COMBINATIONS**

AUVELITY TAB 45-105MG	3	ST, PA, QL (60 tabs per 25 days)
-----------------------	---	----------------------------------

**ANTIDEPRESSANTS - MISC.**

APLENZIN TAB 174MG	3	
APLENZIN TAB 348MG	3	
APLENZIN TAB 522MG	3	
<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	
<i>bupropion hcl tab er 24hr 450 mg</i>	1	PA; MNPA
FORFIVO XL TAB 450MG	3	
<i>maprotiline hcl tab 25 mg</i>	1	
<i>maprotiline hcl tab 50 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>maprotiline hcl tab 75 mg</i>	1	
WELLBUTRIN TAB 100MG SR	3	
WELLBUTRIN TAB 150MG SR	3	
WELLBUTRIN TAB 200MG SR	3	
WELLBUTRIN TAB XL 150MG	3	
WELLBUTRIN TAB XL 300MG	3	
<b>MONOAMINE OXIDASE INHIBITORS (MAOIS)</b>		
EMSAM DIS 6MG/24HR	3	
EMSAM DIS 9MG/24HR	3	
EMSAM DIS 12MG/24H	3	
MARPLAN TAB 10MG	3	
NARDIL TAB 15MG	2	
PARNATE TAB 10MG	2	
<i>phenelzine sulfate tab 15 mg</i>	1	
<i>tranylcypromine sulfate tab 10 mg</i>	1	
<b>N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS</b>		
SPRAVATO SOL 56MG DOS	3	PA
SPRAVATO SOL 84MG DOS	3	PA
<b>SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)</b>		
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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>fluoxetine hcl tab 60 mg</i>	1	PA; MNPA
<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	
LEXAPRO TAB 5MG	3	MNPA
LEXAPRO TAB 10MG	3	MNPA
LEXAPRO TAB 20MG	3	MNPA
<i>paroxetine hcl oral susp 10 mg/5ml (base equiv)</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	
PAXIL CR TAB 12.5MG	3	MNPA
PAXIL CR TAB 25MG	3	MNPA
PAXIL CR TAB 37.5MG	3	MNPA
PAXIL SUS 10MG/5ML	3	MNPA
PAXIL TAB 10MG	3	MNPA
PAXIL TAB 20MG	3	MNPA
PAXIL TAB 30MG	3	MNPA
PAXIL TAB 40MG	3	MNPA
PEXEVA TAB 10MG	3	MNPA
PEXEVA TAB 20MG	3	MNPA
PEXEVA TAB 30MG	3	MNPA
PEXEVA TAB 40MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROZAC CAP 10MG	3	MNPA
PROZAC CAP 20MG	3	MNPA
PROZAC CAP 40MG	3	MNPA
<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	
ZOLOFT CON 20MG/ML	3	MNPA
ZOLOFT TAB 25MG	3	MNPA
ZOLOFT TAB 50MG	3	MNPA
ZOLOFT TAB 100MG	3	MNPA
<b>SEROTONIN MODULATORS</b>		
<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	
TRINTELLIX TAB 20MG	2	
VIIBRYD KIT STARTER	2	MNPA
VIIBRYD TAB 10MG	2	MNPA
VIIBRYD TAB 20MG	2	MNPA
VIIBRYD TAB 40MG	2	MNPA
<i>vilazodone hcl tab 10 mg</i>	1	
<i>vilazodone hcl tab 20 mg</i>	1	
<i>vilazodone hcl tab 40 mg</i>	1	
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
CYMBALTA CAP 20MG	3	MNPA
CYMBALTA CAP 30MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CYMBALTA CAP 60MG	3	MNPA
DESVENLAFAX TAB 50MG ER	3	
DESVENLAFAX TAB 100MG ER	3	
<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	
DRIZALMA CAP 20MG DR	3	
DRIZALMA CAP 30MG DR	3	
DRIZALMA CAP 40MG DR	3	
DRIZALMA CAP 60MG DR	3	
<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	
EFFEXOR XR CAP 37.5MG	3	MNPA
EFFEXOR XR CAP 75MG	3	MNPA
EFFEXOR XR CAP 150MG	3	MNPA
FETZIMA CAP 20MG	2	
FETZIMA CAP 40MG	2	
FETZIMA CAP 80MG	2	
FETZIMA CAP 120MG	2	
FETZIMA CAP TITRATIO	2	
PRISTIQ TAB 25MG	3	MNPA
PRISTIQ TAB 50MG	3	MNPA
PRISTIQ TAB 100MG	3	MNPA
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 37.5 mg (base equivalent)</i>	1	MNPA
<i>venlafaxine hcl tab er 24hr 75 mg (base equivalent)</i>	1	MNPA
<i>venlafaxine hcl tab er 24hr 150 mg (base equivalent)</i>	1	MNPA
<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	
<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	2	
ANAFRANIL CAP 50MG	2	
ANAFRANIL CAP 75MG	2	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	2	
NORPRAMIN TAB 25MG	2	
<i>nortriptyline hcl cap 10 mg</i>	1	
<i>nortriptyline hcl cap 25 mg</i>	1	
<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	2	
PAMELOR CAP 25MG	2	
PAMELOR CAP 50MG	2	
PAMELOR CAP 75MG	2	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIDIABETICS</b>		
<b>ALPHA-GLUCOSIDASE INHIBITORS</b>		
<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	2	
PRECOSE TAB 50MG	2	
PRECOSE TAB 100MG	2	
<b>ANTIDIABETIC - AMYLIN ANALOGS</b>		
SYMLINPEN 60 INJ 1000MCG	2	ST
SYMLNPEN 120 INJ 1000MCG	2	ST
<b>ANTIDIABETIC COMBINATIONS</b>		
ACTOPLUS MET TAB 15-500MG	3	
ACTOPLUS MET TAB 15-850MG	3	
<i>alogliptin-metformin hcl tab 12.5-500 mg</i>	1	ST
<i>alogliptin-metformin hcl tab 12.5-1000 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 12.5-15 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 12.5-30 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 12.5-45 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 25-15 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 25-30 mg</i>	1	ST
<i>alogliptin-pioglitazone tab 25-45 mg</i>	1	ST
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	
<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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INVOKAMET TAB 50-500MG	2	ST; MNPA
INVOKAMET TAB 50-1000	2	ST; MNPA
INVOKAMET TAB 150-500	2	ST; MNPA
INVOKAMET TAB 150-1000	2	ST; MNPA
INVOKAMET XR TAB 50-500MG	2	ST; MNPA
INVOKAMET XR TAB 50-1000	2	ST; MNPA
INVOKAMET XR TAB 150-500	2	ST; MNPA
INVOKAMET XR TAB 150-1000	2	ST; MNPA
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
JENTADUETO TAB 2.5-500	2	MNPA
JENTADUETO TAB 2.5-850	2	MNPA
JENTADUETO TAB 2.5-1000	2	MNPA
JENTADUETO TAB XR	2	MNPA
KAZANO 12.5- TAB 500MG	3	ST; MNPA
KAZANO 12.5- TAB 1000MG	3	ST; MNPA
KOMBIGLYZ XR TAB 2.5-1000	3	ST; MNPA
KOMBIGLYZ XR TAB 5-500MG	3	ST; MNPA
KOMBIGLYZ XR TAB 5-1000MG	3	ST; MNPA
OSENI TAB 12.5-15	3	ST; MNPA
OSENI TAB 12.5-30	3	ST; MNPA
OSENI TAB 12.5-45	3	ST; MNPA
OSENI TAB 25-15MG	3	ST; MNPA
OSENI TAB 25-30MG	3	ST; MNPA
OSENI TAB 25-45MG	3	ST; MNPA
<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	
QTERN TAB 5-5MG	2	ST; MNPA
QTERN TAB 10-5MG	2	ST; MNPA
SEGLUROMET TAB 2.5-500	3	ST

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SEGLUROMET TAB 2.5-1000	3	ST
SEGLUROMET TAB 7.5-500	3	ST; MNPA
SEGLUROMET TAB 7.5-1000	3	ST
SOLIQUA INJ 100/33	2	ST, QL (10 pens every 30 days)
STEGLUJAN TAB 5-100MG	3	ST
STEGLUJAN TAB 15-100MG	3	ST
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**

FORTAMET TAB 500MG	3	PA; MNPA
FORTAMET TAB 1000MG	3	PA; MNPA
GLUMETZA TAB 500MG	3	PA; MNPA
GLUMETZA TAB 1000MG	3	PA; MNPA
<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	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>metformin hcl tab er 24hr modified release 500 mg</i>	1	PA; MNPA
<i>metformin hcl tab er 24hr modified release 1000 mg</i>	1	PA; MNPA
<i>metformin hcl tab er 24hr osmotic 500 mg</i>	1	PA; MNPA
<i>metformin hcl tab er 24hr osmotic 1000 mg</i>	1	PA; MNPA
METFORMIN TAB 625MG	3	
RIOMET SOL 500/5ML	3	MNPA
<b>DIABETIC OTHER</b>		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
<i>diazoxide susp 50 mg/ml</i>	1	
GLUCAGEN INJ HYPOKIT	2	MNPA
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
GLUCAGON EMR SOL 1MG	3	MNPA
GLUCAGON KIT 1MG	3	MNPA
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	
KORLYM TAB 300MG	3	PA, QL (120 TABLETS PER 30 DAYS)
PROGLYCEM SUS 50MG/ML	3	
ZEGALOGUE INJ 0.6/0.6	2	
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>		
<i>alogliptin benzoate tab 6.25 mg (base equiv)</i>	1	ST
<i>alogliptin benzoate tab 12.5 mg (base equiv)</i>	1	ST
<i>alogliptin benzoate tab 25 mg (base equiv)</i>	1	ST
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST
JANUVIA TAB 100MG	2	ST
NESINA TAB 6.25MG	3	ST; MNPA
NESINA TAB 12.5MG	3	ST; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NESINA TAB 25MG	3	ST; MNPA
ONGLYZA TAB 2.5MG	3	ST; MNPA
ONGLYZA TAB 5MG	3	ST; MNPA
TRADJENTA TAB 5MG	2	ST; MNPA
<b>DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC</b>		
CYCLOSET TAB 0.8MG	3	
<b>INCRETIN MIMETIC AGENTS</b>		
BYDUREON PEN INJ 2MG	3	ST, QL (4 pens every 28 days)
OZEMPIC INJ 2MG/3ML	2	ST, QL (1 pen every 30 days)
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>		
ADLYXIN INJ 10/20MCG	3	ST, QL (1 injection every 30 days)
ADLYXIN INJ 20MCG	3	ST, QL (2 pens every 30 days)
BYDUREON BC INJ 2/0.85ML	3	ST, QL (4 auto-injectors every 30 days); MNPA
BYETTA INJ 5MCG	3	ST, QL (1 pen every 30 days); MNPA
BYETTA INJ 10MCG	3	ST, QL (1 pen every 30 days); MNPA
MOUNJARO INJ 2.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 5MG/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 7.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 10MG/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 12.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 15MG/0.5	2	ST, QL (4 pens every 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OZEMPIC INJ 2/1.5ML	2	ST, QL (1 pen every 30 days); Starter Pen
OZEMPIC INJ 4MG/3ML	2	ST, QL (1 pen every 30 days)
OZEMPIC INJ 8MG/3ML	2	ST, QL (1 pen every 30 days)
RYBELSUS TAB 3MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 7MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 14MG	2	ST, QL (30 tabs every 30 days)
TRULICITY INJ 0.75/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 1.5/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 3/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 4.5/0.5	2	ST, QL (4 pens every 30 days)
VICTOZA INJ 18MG/3ML	2	ST, QL (3 pens every 30 days)
<b>INSULIN</b>		
ADMELOG INJ 100U/ML	3	
ADMELOG SOLO INJ 100U/ML	3	
AFREZZA POW 4-8 UNIT	3	
AFREZZA POW 4-8-12	3	
AFREZZA POW 4UNIT	3	
AFREZZA POW 8 UNIT	3	
AFREZZA POW 8-12UNIT	3	
AFREZZA POW 12 UNIT	3	
APIDRA INJ SOLOSTAR	3	MNPA
APIDRA INJ U-100	3	MNPA
BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FIASP INJ 100/ML	2	
FIASP PENFIL INJ U-100	2	
HUMALOG INJ 100/ML	2	MNPA
HUMALOG JR INJ 100/ML	3	MNPA
HUMALOG KWIK INJ 100/ML	2	MNPA
HUMALOG KWIK INJ 200/ML	2	MNPA
HUMALOG MIX INJ 50/50	2	MNPA
HUMALOG MIX INJ 50/50KWP	2	MNPA
HUMALOG MIX INJ 75/25KWP	2	MNPA
HUMALOG MIX SUS 75/25	2	MNPA
HUMULIN INJ 70/30	2	MNPA
HUMULIN INJ 70/30KWP	2	MNPA
HUMULIN N INJ U-100	2	MNPA
HUMULIN N INJ U-100KWP	2	MNPA
HUMULIN R INJ U-100	2	MNPA
HUMULIN R INJ U-500	2	
INS ASP PROT INJ FLEXPEN	2	
INSULIN ASPA INJ 70/30	2	
INSULIN ASPA INJ 100/ML	2	
INSULIN ASPA INJ FLEXPEN	2	
INSULIN ASPA INJ PENFILL	2	
INSULIN LISP INJ 100/ML	2	
INSULIN LISP INJ JUNIOR	2	
INSULIN LISP INJ PROTAMIN	2	
LANTUS INJ 100/ML	2	MNPA
LANTUS SOLOS INJ 100/ML	2	MNPA
LEVEMIR INJ	2	
LEVEMIR INJ FLEXPEN	2	
LEVEMIR INJ FLEXTOUC	2	
LYUMJEV INJ 100OUT/ML	2	
LYUMJEV KWPN INJ 100OUT/ML	2	
LYUMJEV KWPN INJ 200OUT/ML	2	
MYXREDLIN SOL 1UNIT/ML	3	
NOVOLIN70/30 INJ RELION	3	MNPA
NOVOLIN INJ 70/30	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NOVOLIN INJ 70/30 FP	2	
NOVOLIN INJ 70/30 FP	3	MNPA
NOVOLIN N INJ 100 UNIT	2	
NOVOLIN N INJ 100 UNIT	3	MNPA
NOVOLIN N INJ RELION	3	MNPA
NOVOLIN N INJ U-100	2	
NOVOLIN R INJ 100 UNIT	2	
NOVOLIN R INJ 100 UNIT	3	MNPA
NOVOLIN R INJ RELION	3	MNPA
NOVOLIN R INJ U-100	2	
NOVOLOG INJ 100/ML	2	
NOVOLOG INJ FLEX REL	3	
NOVOLOG INJ FLEXPEN	2	
NOVOLOG INJ PENFILL	2	
NOVOLOG INJ RELION	3	
NOVOLOG MIX INJ 70/30	2	
NOVOLOG MIX INJ FLEX REL	3	
NOVOLOG MIX INJ FLEXPEN	2	
NOVOLOG RELI INJ 70/30	3	
REZVOGLAR INJ 100UT/ML	3	
SEMGLEE INJ 100U/ML	3	
SEMGLEE SOL 100U/ML	3	
TOUJEO MAX INJ 300IU/ML	2	
TOUJEO SOLO INJ 300IU/ML	2	
TRESIBA FLEX INJ 100UNIT	2	
TRESIBA FLEX INJ 200UNIT	2	
TRESIBA INJ 100UNIT	2	
<b>INSULIN SENSITIZING AGENTS</b>		
ACTOS TAB 15MG	3	MNPA
ACTOS TAB 30MG	3	MNPA
ACTOS TAB 45MG	3	MNPA
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	
<b>MEGLITINIDE ANALOGUES</b>		
<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	
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		
BRENZAVVY TAB 20MG	3	ST
FARXIGA TAB 5MG	2	ST
FARXIGA TAB 10MG	2	ST
INVOKANA TAB 100MG	2	ST; MNPA
INVOKANA TAB 300MG	2	ST; MNPA
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
STEGLATRO TAB 5MG	3	ST
STEGLATRO TAB 15MG	3	ST
<b>SULFONYLUREAS</b>		
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	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS</b>		
<b>ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS</b>		
MYTESI TAB 125MG	3	PA; MNPA
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.</b>		
PRODIGEN CAP	3	PA; MNPA
PROVAD CAP	3	PA
ZELAC CAP	3	PA; MNPA
<b>ANTIDIARRHEAL/PROBIOTIC COMBINATIONS</b>		
RESTORA RX CAP 60-1.25	3	
<b>ANTIPERISTALTIC AGENTS</b>		
<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	2	
MOTOFEN TAB 1-0.025	3	
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>deferasirox tab for oral susp 500 mg</i>	1	PA
<i>deferiprone tab 500 mg</i>	1	PA
EXJADE TAB 125MG	3	PA; MNPA
EXJADE TAB 250MG	3	PA; MNPA
EXJADE TAB 500MG	3	PA; MNPA
FERPRX 2-DAY TAB 1000MG	3	PA; MNPA
FERRIPROX SOL 100MG/ML	3	PA; MNPA
FERRIPROX TAB 500MG	3	PA; MNPA
FERRIPROX TAB 1000MG	3	PA; MNPA
JADENU SPRKL GRA 90MG	3	PA; MNPA
JADENU SPRKL GRA 180MG	3	PA; MNPA
JADENU SPRKL GRA 360MG	3	PA; MNPA
JADENU TAB 90MG	3	PA; MNPA
JADENU TAB 180MG	3	PA; MNPA
JADENU TAB 360MG	3	PA; MNPA
PENTETATE CA SOL 200MG/ML	3	
PENTETATE ZI SOL 200MG/ML	3	
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<i>deferoxamine mesylate for inj 2 gm</i>	1	PA
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	2	QL (20 PACKETS PER 5 DAYS)
<b>OPIOID ANTAGONISTS</b>		
KLOXXADO SPR 8MG	2	
<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	
OPVEE SPR 2.7/0.1	3	
<b>ANTIEMETICS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
ANZEMET TAB 50MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ANZEMET TAB 50MG	3	QL (6 tabs every 21 days)
ANZEMET TAB 100MG	3	QL (6 tabs every 21 days)
<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)
SUSTOL INJ 10/0.4ML	3	QL (2.5 injections every 21 days)
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)
ZUPLENZ MIS 4MG	3	QL (18 films every 21 days); MNPA
ZUPLENZ MIS 8MG	3	QL (18 films every 21 days); MNPA

**ANTIEMETICS - ANTICHOLINERGIC**

MECLIZINE TAB 50MG	3	
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
TIGAN CAP 300MG	3	
TRANSDERM SC DIS 1MG/3DAY	3	MNPA
TRANSDERM-SC DIS 1MG/3DAY	3	MNPA
<i>trimethobenzamide hcl cap 300 mg</i>	1	

**ANTIEMETICS - MISCELLANEOUS**

AKYNZEO CAP 300-0.5	3	QL (2 caps every 21 days)
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	
<i>dronabinol cap 10 mg</i>	1	
MARINOL CAP 2.5MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	
SYNDROS SOL 5MG/ML	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 &amp; 125 mg</i>	1	QL (6 caps every 21 days)
EMEND CAP 80MG	3	QL (4 caps every 21 days)
EMEND SUS 125MG	3	QL (6 kits every 21 days)
EMEND TRIPAC PAK 80 & 125	3	QL (6 caps every 21 days)
VARUBI TAB 90MG	2	QL (4 tabs 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	MNPA
BIO-STATIN CAP 500000	3	
BIO-STATIN CAP 1000000	3	
<i>flucytosine cap 250 mg</i>	1	
<i>flucytosine cap 500 mg</i>	1	PA; MNPA
<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**

CRESEMBA CAP 186 MG	3	MNPA
DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
<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	
NOXAFIL SUS 40MG/ML	3	PA; MNPA
NOXAFIL TAB 100MG	3	PA; MNPA
<i>posaconazole susp 40 mg/ml</i>	1	
<i>posaconazole tab delayed release 100 mg</i>	1	PA; MNPA
SPORANOX CAP 100MG	3	
SPORANOX CAP PULSEPAK	3	
SPORANOX SOL 10MG/ML	3	
TOLSURA CAP 65MG	3	
VFEND SUS 40MG/ML	2	PA
VFEND TAB 50MG	2	PA
VFEND TAB 200MG	2	PA
VIVJOA CAP 150MG	3	PA
<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 - ALKYLAMINES**

<i>dexchlorpheniramine maleate oral soln 2 mg/5ml</i>	1	PA; MNPA
---	---	----------

**ANTI-HISTAMINES - ETHANOLAMINES**

CARBINOXAMIN TAB 6MG	3	PA; MNPA
<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
<i>carbinoxamine maleate tab 4 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clemastine fumarate syrup 0.67 mg/5ml (0.5 mg/5ml base eq)</i>	1	
<i>clemastine fumarate tab 2.68 mg</i>	1	
<i>diphenhydramine hcl elixir 12.5 mg/5ml</i>	1	PA; MNPA
KARBINAL ER SUS 4MG/5ML	3	
RYVENT TAB 6MG	3	
<b>ANTIHISTAMINES - NON-SEDATING</b>		
QUZYTIR INJ 10MG/ML	3	
<b>ANTIHISTAMINES - PHENOTHIAZINES</b>		
<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	
<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	
<b>ANTIHISTAMINES - PIPERIDINES</b>		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl tab 4 mg</i>	1	
<b>ANTIHYPERLIPIDEMICS</b>		
<b>ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS</b>		
NEXLETOL TAB 180MG	2	PA
<b>ANTIHYPERLIPIDEMICS - COMBINATIONS</b>		
EZETIM/ATORV TAB 10-10MG	3	
EZETIM/ATORV TAB 10-20MG	3	
EZETIM/ATORV TAB 10-40MG	3	
EZETIM/ATORV TAB 10-80MG	3	
<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
ROSZET TAB 5-10MG	3	
ROSZET TAB 10-10MG	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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ROSZET TAB 20-10MG	3	
ROSZET TAB 40-10MG	3	
VYTORIN TAB 10-10MG	3	
VYTORIN TAB 10-20MG	3	
VYTORIN TAB 10-40MG	3	
VYTORIN TAB 10-80MG	3	
<b>ANTIHYPERTENSIVES - MISC.</b>		
<i>icosapent ethyl cap 0.5 gm</i>	1	PA
<i>icosapent ethyl cap 1 gm</i>	1	PA
LOVAZA CAP 1GM	3	PA
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	PA
VASCEPA CAP 0.5GM	2	PA
VASCEPA CAP 1GM	2	PA
<b>BILE ACID SEQUESTRANTS</b>		
<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	
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	
<b>FIBRIC ACID DERIVATIVES</b>		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 50 mg</i>	1	PA; MNPA
<i>fenofibrate cap 150 mg</i>	1	
<i>fenofibrate micronized cap 30 mg</i>	1	MNPA
<i>fenofibrate micronized cap 43 mg</i>	1	
<i>fenofibrate micronized cap 67 mg</i>	1	
<i>fenofibrate micronized cap 90 mg</i>	1	MNPA
<i>fenofibrate micronized cap 130 mg</i>	1	PA; MNPA
<i>fenofibrate micronized cap 134 mg</i>	1	
<i>fenofibrate micronized cap 200 mg</i>	1	
<i>fenofibrate tab 40 mg</i>	1	PA; MNPA
<i>fenofibrate tab 48 mg</i>	1	
<i>fenofibrate tab 54 mg</i>	1	
<i>fenofibrate tab 120 mg</i>	1	PA; MNPA
<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	
FENOGLIDE TAB 120MG	3	PA; MNPA
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	
TRICOR TAB 48MG	3	MNPA
TRICOR TAB 145MG	3	MNPA
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	
<b>HMG COA REDUCTASE INHIBITORS</b>		
ALTOPREV TAB 20MG ER	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ALTOPREV TAB 40MG ER	3	MNPA
ALTOPREV TAB 60MG ER	3	MNPA
ATORVALIQ SUS 20MG/5ML	3	
<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	
CRESTOR TAB 5MG	3	MNPA
CRESTOR TAB 10MG	3	MNPA
CRESTOR TAB 20MG	3	MNPA
CRESTOR TAB 40MG	3	MNPA
EZALLOR SPR CAP 5MG	3	
EZALLOR SPR CAP 10MG	3	
EZALLOR SPR CAP 20MG	3	
EZALLOR SPR CAP 40MG	3	
FLOLIPID SUS 20MG/5ML	3	
FLOLIPID SUS 40MG/5ML	3	
<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
LESCOL XL TAB 80MG	3	MNPA
LIPITOR TAB 10MG	3	MNPA
LIPITOR TAB 20MG	3	MNPA
LIPITOR TAB 40MG	3	MNPA
LIPITOR TAB 80MG	3	MNPA
LIVALO TAB 1MG	3	MNPA
LIVALO TAB 2MG	3	MNPA
LIVALO TAB 4MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<i>simvastatin tab 5 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 80 mg</i>	1	
ZOCOR TAB 10MG	3	
ZOCOR TAB 20MG	3	
ZOCOR TAB 40MG	3	
ZOCOR TAB 80MG	3	
ZYPITAMAG TAB 2MG	3	
ZYPITAMAG TAB 4MG	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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>		
<i>ezetimibe tab 10 mg</i>	1	
ZETIA TAB 10MG	3	MNPA
<b>MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS</b>		
JUXTAPID CAP 5MG	3	PA, QL (28 CAPSULES PER 28 DAYS); MNPA
JUXTAPID CAP 10MG	3	PA, QL (28 CAPSULES PER 28 DAYS); MNPA
JUXTAPID CAP 20MG	3	PA, QL (56 CAPSULES PER 28 DAYS); MNPA
JUXTAPID CAP 30MG	3	PA, QL (56 CAPSULES PER 28 DAYS); MNPA
<b>NICOTINIC ACID DERIVATIVES</b>		
<i>niacin (antihyperlipidemic) tab 500 mg</i>	1	PA; MNPA
<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	
<b>PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS</b>		
PRALUENT INJ 75MG/ML	2	PA, QL (2 PENS PER 28 DAYS)
PRALUENT INJ 150MG/ML	2	PA, QL (2 PENS PER 28 DAYS)
REPATHA INJ 140MG/ML	2	PA, QL (3 SYRINGES PER 28 DAYS); MNPA
REPATHA PUSH INJ 420/3.5	2	PA, QL (1 CARTRIDGES PER 28 DAYS); MNPA
REPATHA SURE INJ 140MG/ML	2	PA, QL (3 PENS PER 28 DAYS); MNPA
<b>ANTIHYPERTENSIVES</b>		
<b>ACE INHIBITORS</b>		
ACCUPRIL TAB 5MG	3	
ACCUPRIL TAB 10MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ACCUPRIL TAB 20MG	3	
ACCUPRIL TAB 40MG	3	
ALTACE CAP 1.25MG	3	
ALTACE CAP 2.5MG	3	
ALTACE CAP 5MG	3	
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	QL (3 tabs every 25 days)
<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	
EPANED SOL 1MG/ML	3	MNPA
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<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	
<b>AGENTS FOR PHEOCHROMOCYTOMA</b>		
DEMSEER CAP 250MG	3	
DIBENZYLINE CAP 10MG	3	
<i>metyrosine cap 250 mg</i>	1	
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
ATACAND TAB 4MG	3	MNPA
ATACAND TAB 8MG	3	MNPA
ATACAND TAB 16MG	3	MNPA
ATACAND TAB 32MG	3	MNPA

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

106

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AVAPRO TAB 75MG	3	
AVAPRO TAB 150MG	3	
AVAPRO TAB 300MG	3	
BENICAR TAB 5MG	3	MNPA
BENICAR TAB 20MG	3	MNPA
BENICAR TAB 40MG	3	MNPA
<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	
COZAAR TAB 25MG	3	MNPA
COZAAR TAB 50MG	3	MNPA
COZAAR TAB 100MG	3	MNPA
DIOVAN TAB 40MG	3	MNPA
DIOVAN TAB 80MG	3	MNPA
DIOVAN TAB 160MG	3	MNPA
DIOVAN TAB 320MG	3	MNPA
EDARBI TAB 40MG	3	MNPA
EDARBI TAB 80MG	3	MNPA
<i>irbesartan tab 75 mg</i>	1	
<i>irbesartan tab 150 mg</i>	1	
<i>irbesartan tab 300 mg</i>	1	
<i>losartan potassium tab 25 mg</i>	1	
<i>losartan potassium tab 50 mg</i>	1	
<i>losartan potassium tab 100 mg</i>	1	
MICARDIS TAB 20MG	3	MNPA
MICARDIS TAB 40MG	3	MNPA
MICARDIS TAB 80MG	3	MNPA
<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	
VALSARTAN SOL 20MG/5ML	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	2	
CATAPRES-TTS DIS 0.2/24HR	2	
CATAPRES-TTS DIS 0.3/24HR	2	
<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	
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1	
<b>ANTIHYPERTENSIVE COMBINATIONS</b>		
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	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	1	
ATACAND HCT TAB 16-12.5	3	MNPA
ATACAND HCT TAB 32-12.5	3	MNPA
ATACAND HCT TAB 32-25MG	3	MNPA
<i>atenolol &amp; chlorthalidone tab 50-25 mg</i>	1	
<i>atenolol &amp; chlorthalidone tab 100-25 mg</i>	1	
AVALIDE TAB 150-12.5	3	
AVALIDE TAB 300-12.5	3	
AZOR TAB 5-20MG	3	MNPA
AZOR TAB 5-40MG	3	MNPA
AZOR TAB 10-20MG	3	MNPA
AZOR TAB 10-40MG	3	MNPA
<i>benazepril &amp; hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>benazepril &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>benazepril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>benazepril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	
BENICAR HCT TAB 20-12.5	3	MNPA
BENICAR HCT TAB 40-12.5	3	MNPA
BENICAR HCT TAB 40-25MG	3	MNPA
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg</i>	1	
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>bisoprolol &amp; 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 &amp; hydrochlorothiazide tab 25-15 mg</i>	1	
<i>captopril &amp; hydrochlorothiazide tab 25-25 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>captopril &amp; hydrochlorothiazide tab 50-15 mg</i>	1	
<i>captopril &amp; hydrochlorothiazide tab 50-25 mg</i>	1	
DIOVAN HCT TAB 80/12.5	3	MNPA
DIOVAN HCT TAB 160-12.5	3	MNPA
DIOVAN HCT TAB 160-25MG	3	MNPA
DIOVAN HCT TAB 320-12.5	3	MNPA
DIOVAN HCT TAB 320-25MG	3	MNPA
DUTOPROL TAB 25-12.5	3	PA; MNPA
DUTOPROL TAB 50-12.5	3	PA; MNPA
DUTOPROL TAB 100-12.5	3	PA; MNPA
EDARBYCLOR TAB 40-12.5	3	MNPA
EDARBYCLOR TAB 40-25MG	3	MNPA
<i>enalapril maleate &amp; hydrochlorothiazide tab 5-12.5 mg</i>	1	
<i>enalapril maleate &amp; hydrochlorothiazide tab 10-25 mg</i>	1	
EXFORGE HCT TAB 5-160-12.5	3	MNPA
EXFORGE HCT TAB 5-160-25	3	MNPA
EXFORGE HCT TAB 10-160-12.5	3	MNPA
EXFORGE HCT TAB 10-160-25	3	MNPA
EXFORGE HCT TAB 10-320-25	3	MNPA
EXFORGE TAB 5-160MG	3	MNPA
EXFORGE TAB 5-320MG	3	MNPA
EXFORGE TAB 10-160MG	3	MNPA
EXFORGE TAB 10-320MG	3	MNPA
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	
HYZAAR TAB 50-12.5	3	MNPA
HYZAAR TAB 100-12.5	3	MNPA
HYZAAR TAB 100-25	3	MNPA
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril &amp; hydrochlorothiazide tab 20-25 mg</i>	1	
<i>losartan potassium &amp; hydrochlorothiazide tab 50-12.5 mg</i>	1	
<i>losartan potassium &amp; hydrochlorothiazide tab 100-12.5 mg</i>	1	
<i>losartan potassium &amp; 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	2	
LOTREL CAP 5-20MG	2	
LOTREL CAP 10-20MG	2	
LOTREL CAP 10-40MG	2	
<i>methyldopa &amp; hydrochlorothiazide tab 250-15 mg</i>	1	
<i>methyldopa &amp; hydrochlorothiazide tab 250-25 mg</i>	1	
<i>metoprolol &amp; hydrochlorothiazide tab 50-25 mg</i>	1	
<i>metoprolol &amp; hydrochlorothiazide tab 100-25 mg</i>	1	
<i>metoprolol &amp; hydrochlorothiazide tab 100-50 mg</i>	1	
MICARDIS HCT TAB 40/12.5	3	MNPA
MICARDIS HCT TAB 80-25MG	3	MNPA
MICARDIS HCT TAB 80/12.5	3	MNPA
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
PRESTALIA TAB 3.5-2.5	3	
PRESTALIA TAB 7-5MG	3	
PRESTALIA TAB 14-10MG	3	
<i>propranolol &amp; hydrochlorothiazide tab 40-25 mg</i>	1	
<i>propranolol &amp; 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	2	
TARKA TAB 2-240 CR	2	
TARKA TAB 4-240 CR	2	
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	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
ZESTORETIC TAB 10-12.5	3	MNPA
ZESTORETIC TAB 20-12.5	3	MNPA
ZESTORETIC TAB 20-25MG	3	MNPA
ZIAC TAB 2.5/6.25	2	
ZIAC TAB 5-6.25MG	2	
ZIAC TAB 10/6.25	2	
<b>ANTIHYPERTENSIVES - MISC.</b>		
VECAMYL TAB 2.5MG	3	
<b>DIRECT RENIN INHIBITORS</b>		
<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	
<b>SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)</b>		
<i>eplerenone tab 25 mg</i>	1	
<i>eplerenone tab 50 mg</i>	1	
INSPIRA TAB 25MG	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSPIRA TAB 50MG	2	
<b>VASODILATORS</b>		
<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	
<b>ANTIMALARIALS</b>		
<b>ANTIMALARIAL COMBINATIONS</b>		
<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	2	
MALARONE TAB 250-100	2	
PYRIME/LEUCO CAP 12.5/2.5	3	
PYRIME/LEUCO CAP 25/5MG	3	
PYRIME/LEUCO CAP 25/10MG	3	
PYRIME/LEUCO CAP 50/10MG	3	
PYRIME/LEUCO CAP 50/20MG	3	
PYRIME/LEUCO CAP 50/25MG	3	
PYRIME/LEUCO CAP 75/25MG	3	
<b>ANTIMALARIALS</b>		
ARAKODA TAB 100MG	3	
<i>chloroquine phosphate tab 250 mg</i>	1	
<i>chloroquine phosphate tab 500 mg</i>	1	
DARAPRIM TAB 25MG	3	PA; MNPA
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	
KRINTAFEL TAB 150MG	3	
<i>mefloquine hcl tab 250 mg</i>	1	
PLAQUENIL TAB 200MG	2	
<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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QUALAQUIN CAP 324MG	3	
<i>quinine sulfate cap 324 mg</i>	1	

**ANTIMYASTHENIC/CHOLINERGIC AGENTS****ANTIMYASTHENIC/CHOLINERGIC AGENTS**

FIRDAPSE TAB 10MG	3	PA, QL (240 TABLETS PER 30 DAYS)
GUANIDINE TAB 125MG	3	
MESTINON SOL 60MG/5ML	3	
MESTINON TAB 60MG	3	
MESTINON TAB TIMESPAN	3	
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	
<i>pyridostigmine bromide tab 30 mg</i>	1	
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
RUZURGI TAB 10MG	3	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	2	
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TRECATOR TAB 250MG	3	
<b>ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES</b>		
<b>ALKYLATING AGENTS</b>		
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	
<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
<b>ANTIMETABOLITES</b>		
<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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
ONUREG TAB 200MG	0	PA, QL (14 TABLETS PER 28 DAYS)
ONUREG TAB 300MG	0	PA, QL (14 TABLETS PER 28 DAYS)
PURIXAN SUS 20MG/ML	0	PA
TABLOID TAB 40MG	0	
TREXALL TAB 5MG	0	
TREXALL TAB 7.5MG	0	
TREXALL TAB 10MG	0	
TREXALL TAB 15MG	0	
VIDAZA INJ 100MG	3	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)
<b>ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS</b>		
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
<b>ANTINEOPLASTIC - ANTI-HER2 AGENTS</b>		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTIC - BCL-2 INHIBITORS</b>		
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)
<b>ANTINEOPLASTIC - EGFR INHIBITORS</b>		
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IRESSA TAB 250MG	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)
VIZIMPRO TAB 15MG	0	PA, QL (30 TABLETS PER 30 DAYS)
VIZIMPRO TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
VIZIMPRO TAB 45MG	0	PA, QL (30 TABLETS PER 30 DAYS)

**ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS**

DAURISMO TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
DAURISMO TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
LEUPROLIDE INJ 22.5MG	3	PA
LUPRON DEPOT INJ 3.75MG	3	PA
LUPRON DEPOT INJ 11.25MG	3	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	
NILANDRON TAB 150MG	0	PA; MNPA
<i>nilutamide tab 150 mg</i>	0	
NUBEQA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ORGOVYX TAB 120MG	0	PA, QL (30 TABLETS PER 30 DAYS); LOADING DOSE: FIRST MONTH: 30 PER 28 DAYS
ORSERDU TAB 86MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ORSERDU TAB 345MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SOLTAMOX SOL 10MG/5ML	0	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
ZYTIGA TAB 250MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
ZYTIGA TAB 500MG	0	PA, QL (60 TABLETS PER 30 DAYS); MNPA
<b>ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS</b>		
WELIREG TAB 40MG	0	PA, QL (90 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTIC - IMMUNOMODULATORS</b>		
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)
<b>ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS</b>		
AYVAKIT TAB 25MG	0	PA, QL (30 TABLETS PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AYVAKIT TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 200MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTIC - XPO1 INHIBITORS</b>		
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
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
<b>ANTINEOPLASTIC COMBINATIONS</b>		
INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (49 TABLETS PER 28 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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**

AFINITOR DIS TAB 2MG	0	PA, QL (60 TABLETS PER 30 DAYS); MNPA
AFINITOR DIS TAB 3MG	0	PA, QL (90 TABLETS PER 30 DAYS); MNPA
AFINITOR DIS TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS); MNPA
AFINITOR TAB 2.5MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AFINITOR TAB 5MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AFINITOR TAB 7.5MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AFINITOR TAB 10MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
ALECENSA CAP 150MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
ALUNBRIG PAK	0	PA, QL (30 TABLETS PER 30 DAYS)
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BALVERSA TAB 4MG	0	PA, QL (56 TABLETS PER 28 DAYS)
BALVERSA TAB 5MG	0	PA, QL (28 TABLETS PER 28 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)
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
FARYDAK CAP 10MG	0	PA, QL (6 CAPSULES PER 21 DAYS)
FARYDAK CAP 15MG	0	PA, QL (6 CAPSULES PER 21 DAYS)
FARYDAK CAP 20MG	0	PA, QL (6 CAPSULES PER 21 DAYS)
FOTIVDA CAP 0.89MG	0	PA, QL (21 PER 28 DAYS)
FOTIVDA CAP 1.34MG	0	PA, QL (21 PER 28 DAYS)
GAVRETO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
GLEEVEC TAB 100MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
GLEEVEC TAB 400MG	0	PA, QL (60 TABLETS PER 30 DAYS); MNPA
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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ICLUSIG TAB 10MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
ICLUSIG TAB 15MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
ICLUSIG TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
ICLUSIG TAB 45MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
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)
IMBRUVICA CAP 70MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
IMBRUVICA CAP 140MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
IMBRUVICA SUS 70MG/ML	0	PA, QL (216 ML PER 36 DAYS)
IMBRUVICA TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 280MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 420MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 560MG	0	PA, QL (30 TABLETS PER 30 DAYS)
INREBIC CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
JAKAFI TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 10MG	0	PA, QL (60 TABLETS PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
JAKAFI TAB 15MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 20MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAYPIRCA TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
JAYPIRCA TAB 100MG	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)
LORBRENA TAB 25MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LORBRENA TAB 100MG	0	PA, QL (30 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)
LYNPARZA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LYTGOBI TAB 4MG	0	PA, QL (112 TABLETS PER 28 DAYS)
LYTGOBI TAB 4MG	0	PA, QL (140 TABLETS PER 28 DAYS)
LYTGOBI TAB 4MG	0	PA, QL (84 TABLETS PER 28 DAYS)
MEKINIST SOL 0.05/ML	0	PA, QL (12 bottles per 28 days)
MEKINIST TAB 0.5MG	0	PA, QL (90 TABLETS PER 30 DAYS); MNPA
MEKINIST TAB 2MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
MEKTOVI TAB 15MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NERLYNX TAB 40MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NEXAVAR TAB 200MG	0	PA, QL (120 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)
PEMAZYRE TAB 4.5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
PEMAZYRE TAB 9MG	0	PA, QL (30 TABLETS PER 30 DAYS)
PEMAZYRE TAB 13.5MG	0	PA, QL (30 TABLETS PER 30 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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QINLOCK TAB 50MG	0	PA, QL (90 TABLETS PER 30 DAYS)
RETEVMO CAP 40MG	0	PA, QL (60 TABLETS PER 30 DAYS)
RETEVMO CAP 80MG	0	PA, QL (120 TABLETS PER 30 DAYS)
REZLIDHIA CAP 150MG	0	PA, QL (60 CAP PER 30 DAYS)
ROZLYTREK CAP 100MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ROZLYTREK CAP 200MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
RUBRACA TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
RUBRACA TAB 250MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
RUBRACA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
RYDAPT CAP 25MG	0	PA, QL (224 CAPSULES PER 28 DAYS)
SCEMBLIX TAB 40MG	0	QL (300 TABLETS PER 30 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)
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
SUTENT CAP 12.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
SUTENT CAP 25MG	0	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
SUTENT CAP 37.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
SUTENT CAP 50MG	0	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
TABRECTA TAB 150MG	0	PA, QL (112 TABLETS PER 28 DAYS)
TABRECTA TAB 200MG	0	PA, QL (112 TABLETS PER 28 DAYS)
TAFINLAR CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TAFINLAR CAP 75MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TAFINLAR TAB 10MG	0	PA, QL (4 bottles (210 tabs per bottle) per 28 days)
TALZENNA CAP 0.1MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
TALZENNA CAP 0.5MG	0	PA
TALZENNA CAP 0.25MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
TALZENNA CAP 0.35MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
TALZENNA CAP 0.75MG	0	PA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TALZENNA CAP 1MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
TASIGNA CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TASIGNA CAP 150MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TASIGNA CAP 200MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TAZVERIK TAB 200MG	0	PA, QL (240 TABLETS PER 30 DAYS)
TEPMETKO TAB 225MG	0	PA, QL (60 tabs every 30 days)
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TRUSELTIQ CAP 50MG	0	PA, QL (42 CAPS PER 28 DAYS)
TRUSELTIQ CAP 75MG	0	PA, QL (63 CAPS PER 28 DAYS)
TRUSELTIQ CAP 100MG	0	PA, QL (21 CAPS PER 28 DAYS)
TRUSELTIQ CAP 125MG	0	PA, QL (42 CAPS PER 28 DAYS)
TURALIO CAP 125MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TURALIO CAP 200MG	0	PA, QL (120 caps every 30 days)
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
UKONIQ TAB 200MG	0	PA, QL (120 TABS PER 30 DAYS)
VANFLYTA TAB 17.7MG	3	PA
VANFLYTA TAB 26.5MG	3	PA
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
VONJO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
VOTRIENT TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS); MNPA
XALKORI CAP 200MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
XALKORI CAP 250MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTICS MISC.</b>		
ACTIMMUNE INJ 2MU/0.5	3	PA
BESREMI SOL 500MCG	3	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	2	PA
INTRON A INJ 18MU	2	PA
INTRON A INJ 25MU	2	PA
INTRON A INJ 50MU	2	PA
MATULANE CAP 50MG	0	
TARGRETIN CAP 75MG	0	PA; MNPA
<i>tretinoin cap 10 mg</i>	0	
<b>CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS</b>		
<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	
<b>MITOTIC INHIBITORS</b>		
<i>etoposide cap 50 mg</i>	0	
<b>TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
<b>ANTIPARKINSON AND RELATED THERAPY AGENTS</b>		
<b>ANTIPARKINSON ADJUNCTIVE THERAPY</b>		
<i>carbidopa tab 25 mg</i>	1	
LODOSYN TAB 25MG	3	
NOURIANZ TAB 20MG	3	MNPA
NOURIANZ TAB 40MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIPARKINSON ANTICHOLINERGICS</b>		
<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	
<b>ANTIPARKINSON COMT INHIBITORS</b>		
COMTAN TAB 200MG	3	
<i>entacapone tab 200 mg</i>	1	
ONGENTYS CAP 25MG	3	
ONGENTYS CAP 50MG	3	
TASMAR TAB 100MG	3	
<i>tolcapone tab 100 mg</i>	1	
<b>ANTIPARKINSON DOPAMINERGICS</b>		
<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	
APOKYN INJ 10MG/ML	3	PA, QL (20 CARTRIDGES PER 30 DAYS); MNPA
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	
<i>carbidopa &amp; levodopa orally disintegrating tab 10-100 mg</i>	1	
<i>carbidopa &amp; levodopa orally disintegrating tab 25-100 mg</i>	1	
<i>carbidopa &amp; levodopa orally disintegrating tab 25-250 mg</i>	1	
<i>carbidopa &amp; levodopa tab 10-100 mg</i>	1	
<i>carbidopa &amp; levodopa tab 25-100 mg</i>	1	
<i>carbidopa &amp; levodopa tab 25-250 mg</i>	1	
<i>carbidopa &amp; levodopa tab er 25-100 mg</i>	1	
<i>carbidopa &amp; levodopa tab er 50-200 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	
GOCOVRI CAP 68.5MG	3	
GOCOVRI CAP 137MG	3	
INBRIJA CAP 42MG	2	PA, QL (300 CAPSULES PER 30 DAYS)
KYNMOBI MIS 10MG	3	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 15MG	3	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 20MG	3	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 25MG	3	PA, QL (150 FILMS PER 30 DAYS)
KYNMOBI MIS 30MG	3	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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
OSMOLEX ER TAB	3	
OSMOLEX ER TAB 129MG	3	
OSMOLEX ER TAB 193MG	3	
OSMOLEX ER TAB 258MG	3	
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	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
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	
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
AZILECT TAB 0.5MG	3	
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	
XADAGO TAB 50MG	3	
XADAGO TAB 100MG	3	
ZELAPAR TAB 1.25MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>		
<b>ANTIMANIC AGENTS</b>		
<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	2	
<b>ANTIPSYCHOTICS - MISC.</b>		
CAPLYTA CAP 10.5MG	2	
CAPLYTA CAP 21MG	2	
CAPLYTA CAP 42MG	3	
EQUETRO CAP 100MG	3	
EQUETRO CAP 200MG	3	
EQUETRO CAP 300MG	3	
GEODON CAP 20MG	3	
GEODON CAP 40MG	3	
GEODON CAP 60MG	3	
GEODON CAP 80MG	3	
GEODON INJ 20MG	3	
LATUDA TAB 20MG	3	
LATUDA TAB 40MG	3	
LATUDA TAB 60MG	3	
LATUDA TAB 80MG	3	
LATUDA TAB 120MG	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	3	PA, QL (30 CAPSULES PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NUPLAZID TAB 10MG	3	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	
<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	
<b>BENZISOXAZOLES</b>		
FANAPT PAK	3	PA; MNPA
FANAPT TAB 1MG	3	PA; MNPA
FANAPT TAB 2MG	3	PA; MNPA
FANAPT TAB 4MG	3	PA; MNPA
FANAPT TAB 6MG	3	PA; MNPA
FANAPT TAB 8MG	3	PA; MNPA
FANAPT TAB 10MG	3	PA; MNPA
FANAPT TAB 12MG	3	PA; MNPA
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	
INVEGA TRINZ INJ 273MG	3	
INVEGA TRINZ INJ 410MG	3	
INVEGA TRINZ INJ 546MG	3	
INVEGA TRINZ INJ 819MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	3	
PERSERIS INJ 120MG	3	
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	
<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	
RYKINDO INJ 25MG	3	
RYKINDO INJ 37.5MG	3	
RYKINDO INJ 50MG	3	
UZEDY INJ 50MG	3	
UZEDY INJ 75MG	3	
UZEDY INJ 100MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UZEDY INJ 125MG	3	
UZEDY INJ 150MG	3	
UZEDY INJ 200MG	3	
UZEDY INJ 250MG	3	
<b>BUTYROPHENONES</b>		
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	
<b>DIBENZAPINES</b>		
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	
<i>clozapine tab 200 mg</i>	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 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	
SECUADO DIS 3.8MG	3	
SECUADO DIS 5.7MG	3	
SECUADO DIS 7.6MG	3	
SEROQUEL TAB 25MG	3	
SEROQUEL TAB 50MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SEROQUEL TAB 100MG	3	
SEROQUEL TAB 200MG	3	
SEROQUEL TAB 300MG	3	
SEROQUEL TAB 400MG	3	
SEROQUEL XR TAB 50MG	3	MNPA
SEROQUEL XR TAB 150MG	3	MNPA
SEROQUEL XR TAB 200MG	3	MNPA
SEROQUEL XR TAB 300MG	3	MNPA
SEROQUEL XR TAB 400MG	3	MNPA
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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<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	
<b>QUINOLINONE DERIVATIVES</b>		
<i>ABILIFY ASIM INJ 720MG</i>	2	
<i>ABILIFY ASIM INJ 960MG</i>	2	
<i>ABILIFY MAIN INJ 300MG</i>	2	
<i>ABILIFY MAIN INJ 400MG</i>	2	
<i>ABILIFY MYCI TAB 2MG</i>	3	
<i>ABILIFY MYCI TAB 2MG MANT</i>	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ABILIFY MYCI TAB 2MG STRT	3	
ABILIFY MYCI TAB 5MG	3	
ABILIFY MYCI TAB 5MG MANT	3	
ABILIFY MYCI TAB 5MG STRT	3	
ABILIFY MYCI TAB 10MG	3	
ABILIFY MYCI TAB 10MG MNT	3	
ABILIFY MYCI TAB 10MG STR	3	
ABILIFY MYCI TAB 15MG	3	
ABILIFY MYCI TAB 15MG MNT	3	
ABILIFY MYCI TAB 15MG STR	3	
ABILIFY MYCI TAB 20MG	3	
ABILIFY MYCI TAB 20MG MNT	3	
ABILIFY MYCI TAB 20MG STR	3	
ABILIFY MYCI TAB 30MG	3	
ABILIFY MYCI TAB 30MG MNT	3	
ABILIFY MYCI TAB 30MG STR	3	
ABILIFY TAB 2MG	3	MNPA
ABILIFY TAB 5MG	3	MNPA
ABILIFY TAB 10MG	3	MNPA
ABILIFY TAB 15MG	3	MNPA
ABILIFY TAB 20MG	3	MNPA
ABILIFY TAB 30MG	3	MNPA
<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	
<i>aripiprazole tab 20 mg</i>	1	
<i>aripiprazole tab 30 mg</i>	1	
ARISTADA INJ 441MG/1.	2	
ARISTADA INJ 662MG/2	2	
ARISTADA INJ 882MG/3	2	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARISTADA INJ 1064MG	2	QL (23.077 injections every year)
ARISTADA INJ INITIO	2	
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	
<b>THIOXANTHENES</b>		
<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	
<b>ANTISEPTICS &amp; DISINFECTANTS</b>		
<b>ANTISEPTICS &amp; DISINFECTANTS</b>		
<i>formaldehyde solution 10%</i>	1	
GLUTARALDEHY SOL 25%	3	
<i>hydrogen peroxide soln 30%</i>	1	
<b>CHLORINE ANTISEPTICS</b>		
BENZALKONIUM SOL NF	3	
CHLORHEX GLU SOL 20%	3	
<b>ANTIVIRALS</b>		
<b>ANTIRETROVIRALS</b>		
<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)
APTIVUS CAP 250MG	3	QL (120 CAPSULES PER 30 DAYS); MNPA
APTIVUS SOL	3	QL (285 ML PER 28 DAYS); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
atazanavir sulfate cap 150 mg (base equiv)	1	QL (30 CAPSULES PER 30 DAYS)
atazanavir sulfate cap 200 mg (base equiv)	1	QL (60 CAPSULES PER 30 DAYS)
atazanavir sulfate cap 300 mg (base equiv)	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)
CABENUVA SUS 400-600	3	PA, QL (1 KIT PER 30 DAYS)
CABENUVA SUS 600-900	3	PA, QL (1 KIT 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)
COMPLERA TAB	3	QL (30 TABLETS PER 30 DAYS); MNPA
CONJUPRI TAB 5MG	2	QL (60 TABLETS PER 30 DAYS)
CRIXIVAN CAP 400MG	3	QL (180 CAPSULES PER 30 DAYS)
DELSTRIGO TAB	3	QL (30 TABLETS 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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
EDURANT TAB 25MG	2	QL (60 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)
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	2	QL (30 TABLETS PER 30 DAYS)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	QL (120 TABLETS PER 30 DAYS)
FUZEON INJ 90MG	2	PA, QL (60 VIALS PER 30 DAYS)
GENVOYA TAB	2	QL (30 TABLETS PER 30 DAYS)
INTELENCE TAB 25MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 100MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 200MG	2	QL (60 tabs every 30 days)
INVIRASE TAB 500MG	3	QL (120 TABLETS PER 30 DAYS); MNPA
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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
JULUCA TAB 50-25MG	3	QL (30 TABLETS PER 30 DAYS)
KALETRA SOL	3	QL (480 ML PER 30 DAYS)
KALETRA TAB 100-25MG	3	QL (240 TABLETS PER 30 DAYS)
KALETRA TAB 200-50MG	3	QL (120 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)
LEXIVA SUS 50MG/ML	3	QL (1575 ML PER 28 DAYS); MNPA
LEXIVA TAB 700MG	3	QL (120 TABLETS PER 30 DAYS); MNPA
<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)
<i>nevirapine tab er 24hr 400 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
NORVIR POW 100MG	2	QL (360 PACKETS PER 30 DAYS)
NORVIR SOL 80MG/ML	2	QL (480 ML PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NORVIR TAB 100MG	2	QL (360 TABLETS PER 30 DAYS)
ODEFSEY TAB	2	QL (30 TABLETS PER 30 DAYS)
PIFELTRO TAB 100MG	3	QL (60 TABLETS PER 30 DAYS)
PREZCOBIX TAB 800-150	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA SUS 100MG/ML	2	QL (400 ML PER 30 DAYS)
PREZISTA TAB 75MG	2	QL (300 TABLETS PER 30 DAYS)
PREZISTA TAB 150MG	2	QL (180 TABLETS PER 30 DAYS)
PREZISTA TAB 600MG	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA TAB 800MG	2	QL (60 TABLETS PER 30 DAYS)
RETROVIR CAP 100MG	2	QL (180 CAPSULES PER 30 DAYS)
RETROVIR SYP 50MG/5ML	2	QL (1920 ML PER 30 DAYS)
REYATAZ CAP 150MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ CAP 200MG	3	QL (60 CAPSULES PER 30 DAYS)
REYATAZ CAP 300MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ POW 50MG	3	QL (180 PACKETS PER 30 DAYS)
<i>ritonavir tab 100 mg</i>	1	QL (360 TABLETS PER 30 DAYS)
RUKOBIA TAB 600MG ER	3	QL (60 TABLETS PER 30 DAYS)
SELZENTRY SOL 20MG/ML	3	QL (1840 ML PER 30 DAYS); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SELZENTRY TAB 25MG	3	QL (240 TABLETS PER 30 DAYS); MNPA
SELZENTRY TAB 75MG	3	QL (60 TABLETS PER 30 DAYS); MNPA
SELZENTRY TAB 150MG	3	QL (60 TABLETS PER 30 DAYS); MNPA
SELZENTRY TAB 300MG	3	QL (120 TABLETS PER 30 DAYS); MNPA
<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)
STRIBILD TAB	2	QL (30 TABLETS PER 30 DAYS)
SUNLENCA TAB 300MG	3	PA, QL (4 tablets per 2 days)
SUNLENCA TAB 300MG	3	PA, QL (5 TABLETS PER 8 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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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)
TRUVADA TAB 100-150	3	QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 133-200	3	QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 167-250	3	QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 200-300	3	QL (30 TABLETS PER 30 DAYS); MNPA
TYBOST TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIRACEPT TAB 250MG	3	QL (300 TABLETS PER 30 DAYS); MNPA
VIRACEPT TAB 625MG	3	QL (120 TABLETS PER 30 DAYS); MNPA
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	2	QL (240 GM PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIREAD TAB 150MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 200MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 250MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 300MG	2	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)
<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)
<b>ANTIVIRAL COMBINATIONS</b>		
PAXLOVID TAB 150-100	3	QL (40 tabs every 30 days)
PAXLOVID TAB 300-100	3	QL (60 tabs every 30 days)
<b>CMV AGENTS</b>		
LIVTENCITY TAB 200MG	3	PA, QL (120 TABLETS PER 30 DAYS); MNPA
PREVYMIS TAB 240MG	3	
PREVYMIS TAB 480MG	3	
VALCYTE SOL 50MG/ML	3	QL (1000 ML PER 30 DAYS); MNPA
VALCYTE TAB 450MG	3	QL (120 TABLETS FOR 30 DAYS); MNPA
<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)
<b>HEPATITIS AGENTS</b>		
<i>adefovir dipivoxil tab 10 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BARACLUDE SOL	3	QL (630 ML PER 30 DAYS)
BARACLUDE TAB 0.5MG	3	QL (30 TABS PER 30 DAYS); MNPA
BARACLUDE TAB 1MG	3	QL (30 TABS PER 30 DAYS); MNPA
<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	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPIVIR HBV SOL 5MG/ML	3	
EPIVIR HBV TAB 100MG	3	
HARVONI PAK	2	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG	2	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 90-400MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HEPSERA TAB 10MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lamivudine tab 100 mg (hbv)</i>	1	
MAVYRET PAK 50-20MG	3	PA, QL (140 PKTS PER 28 DAYS); MNPA
MAVYRET TAB 100-40MG	3	PA, QL (84 TABLETS PER 28 DAYS); MNPA
PEGASYS INJ	2	PA, QL (9 syringes every 30 days)
PEGASYS INJ 180MCG/M	2	PA, QL (4.5 vials every 30 days)
PEGINTRON KIT 50MCG	3	PA
<i>ribavirin cap 200 mg</i>	1	PA
<i>ribavirin tab 200 mg</i>	1	PA
SOVALDI PAK 150MG	3	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI PAK 200MG	3	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI TAB 200MG	3	PA, QL (28 TABLETS PER 28 DAYS)
SOVALDI TAB 400MG	3	PA, QL (28 TABLETS PER 28 DAYS)
VEMLIDY TAB 25MG	2	QL (30 TABLETS PER 30 DAYS)
VIEKIRA PAK TAB	3	PA, QL (112 TABLETS PER 28 DAYS); MNPA
VOSEVI TAB	2	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)
ZEPATIER TAB 50-100MG	3	PA, QL (28 TABLETS PER 28 DAYS); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>HERPES AGENTS</b>		
<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	
VALTREX TAB 1GM	3	MNPA
VALTREX TAB 500MG	3	MNPA
ZOVIRAX SUS 200/5ML	3	
<b>INFLUENZA AGENTS</b>		
<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)
XOFLUZA TAB 20MG	3	
XOFLUZA TAB 40MG	3	
<b>MISC. ANTIVIRALS</b>		
FAVIPIRAVIR TAB 200MG	3	
LAGEVRIO CAP 200MG	3	QL (40 caps every 30 days)
TEMBEXA SUS 10MG/ML	3	
TEMBEXA TAB 100MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TPOXX CAP 200MG	3	
TPOXX INJ	3	

**BETA BLOCKERS****ALPHA-BETA BLOCKERS**

<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	
<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 CR CAP 10MG	3	MNPA
COREG CR CAP 20MG	3	MNPA
COREG CR CAP 40MG	3	MNPA
COREG CR CAP 80MG	3	MNPA
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	
BYSTOLIC TAB 2.5MG	3	MNPA
BYSTOLIC TAB 5MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BYSTOLIC TAB 10MG	3	MNPA
BYSTOLIC TAB 20MG	3	MNPA
KAPSPARGO CAP 25MG	3	
KAPSPARGO CAP 50MG	3	
KAPSPARGO CAP 100MG	3	
KAPSPARGO CAP 200MG	3	
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	
<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	
TOPROL XL TAB 25MG	3	MNPA
TOPROL XL TAB 50MG	3	MNPA
TOPROL XL TAB 100MG	3	MNPA
TOPROL XL TAB 200MG	3	MNPA
<b>BETA BLOCKERS NON-SELECTIVE</b>		
BETAPACE AF TAB 80MG	3	PA; MNPA
BETAPACE AF TAB 120MG	3	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BETAPACE AF TAB 160MG	3	PA; MNPA
BETAPACE TAB 80MG	3	PA; MNPA
BETAPACE TAB 120MG	3	PA; MNPA
BETAPACE TAB 160MG	3	PA; MNPA
CORGARD TAB 20MG	3	
CORGARD TAB 40MG	3	
CORGARD TAB 80MG	3	
HEMANGEOL SOL 4.28/ML	3	
INDERAL LA CAP 60MG	3	MNPA
INDERAL LA CAP 80MG	3	MNPA
INDERAL LA CAP 120MG	3	MNPA
INDERAL LA CAP 160MG	3	MNPA
INDERAL XL CAP 80MG	3	MNPA
INDERAL XL CAP 120MG	3	MNPA
INNOPRAN XL CAP 80MG	3	MNPA
INNOPRAN XL CAP 120MG	3	MNPA
<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/af) tab 80 mg</i>	1	
<i>sotalol hcl (afib/af) tab 120 mg</i>	1	
<i>sotalol hcl (afib/af) tab 160 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 BLOCKER COMBINATIONS**

CONSENSI TAB 2.5-200	3	PA; MNPA
CONSENSI TAB 5-200MG	3	PA; MNPA
CONSENSI TAB 10-200MG	3	PA; MNPA

**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	
CARDIZEM CD CAP 120MG/24	3	MNPA
CARDIZEM CD CAP 180MG/24	3	MNPA
CARDIZEM CD CAP 240MG/24	3	MNPA
CARDIZEM CD CAP 300MG/24	3	MNPA
CARDIZEM CD CAP 360MG/24	3	MNPA
CARDIZEM LA TAB 120MG	3	MNPA
CARDIZEM LA TAB 180MG	3	MNPA
CARDIZEM LA TAB 240MG	3	MNPA
CARDIZEM LA TAB 300MG/24	3	MNPA
CARDIZEM LA TAB 360MG	3	MNPA
CARDIZEM LA TAB 420MG/24	3	MNPA
CARDIZEM TAB 30MG	3	MNPA
CARDIZEM TAB 60MG	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CARDIZEM TAB 120MG	3	MNPA
CONJUPRI TAB 2.5MG	3	
diltiazem hcl cap er 12hr 60 mg	1	
diltiazem hcl cap er 12hr 90 mg	1	
diltiazem hcl cap er 12hr 120 mg	1	
diltiazem hcl cap er 24hr 120 mg	1	
diltiazem hcl cap er 24hr 180 mg	1	
diltiazem hcl cap er 24hr 240 mg	1	
diltiazem hcl coated beads cap er 24hr 120 mg	1	
diltiazem hcl coated beads cap er 24hr 180 mg	1	
diltiazem hcl coated beads cap er 24hr 240 mg	1	
diltiazem hcl coated beads cap er 24hr 300 mg	1	
diltiazem hcl coated beads cap er 24hr 360 mg	1	
diltiazem hcl extended release beads cap er 24hr 120 mg	1	
diltiazem hcl extended release beads cap er 24hr 180 mg	1	
diltiazem hcl extended release beads cap er 24hr 240 mg	1	
diltiazem hcl extended release beads cap er 24hr 300 mg	1	
diltiazem hcl extended release beads cap er 24hr 360 mg	1	
diltiazem hcl extended release beads cap er 24hr 420 mg	1	
diltiazem hcl tab 30 mg	1	
diltiazem hcl tab 60 mg	1	
diltiazem hcl tab 90 mg	1	
diltiazem hcl tab 120 mg	1	
diltiazem hcl tab er 24hr 180 mg	1	MNPA
diltiazem hcl tab er 24hr 240 mg	1	MNPA
diltiazem hcl tab er 24hr 300 mg	1	MNPA
diltiazem hcl tab er 24hr 360 mg	1	MNPA
diltiazem hcl tab er 24hr 420 mg	1	MNPA
felodipine tab er 24hr 2.5 mg	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
KATERZIA SUS 1MG/ML	3	
<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	
NORLIQVA SOL 1MG/ML	3	
NORVASC TAB 2.5MG	3	MNPA
NORVASC TAB 5MG	3	MNPA
NORVASC TAB 10MG	3	MNPA
NYMALIZE SOL	3	
PROCARDIA CAP 10MG	3	
PROCARDIA XL TAB 30MG CR	3	
PROCARDIA XL TAB 60MG CR	3	
PROCARDIA XL TAB 90MG CR	3	
SULAR TAB 8.5MG	3	
SULAR TAB 17MG	3	
SULAR TAB 34MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CARDIOVASCULAR AGENTS - MISC.</b>		
<b>CARDIAC MYOSIN INHIBITORS</b>		
CAMZYOS CAP 2.5MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 5MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 10MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 15MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
<b>CARDIOVASCULAR AGENTS MISC. - COMBINATIONS</b>		
<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	
BIDIL TAB	2	
CADUET TAB 5-10MG	3	
CADUET TAB 5-20MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
<b>CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS</b>		
LODOCO TAB 0.5MG	3	
<b>CARDIOVASCULAR SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS</b>		
INPEFA TAB 200MG	3	
<b>IMPOTENCE AGENTS</b>		
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
CIALIS TAB 2.5MG	3	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
CIALIS TAB 5MG	3	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
CIALIS TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
CIALIS TAB 20MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
LEVITRA TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
LEVITRA TAB 20MG	3	QL (6 tabs 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
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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STAXYN TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
STENDRA TAB 50MG	3	PA, QL (6 tabs every 30 days); Coverage is subject to your plan/benefits;MNPA
STENDRA TAB 100MG	3	PA, QL (6 tabs every 30 days); Coverage is subject to your plan/benefits;MNPA
STENDRA TAB 200MG	3	PA, QL (6 tabs every 30 days); Coverage is subject to your plan/benefits;MNPA
<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>ardenafil hcl orally disintegrating tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>ardenafil hcl tab 2.5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>ardenafil hcl tab 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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>vardenafil hcl tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>vardenafil hcl tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
VIAGRA TAB 25MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
VIAGRA TAB 50MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
VIAGRA TAB 100MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits

**PROSTAGLANDIN VASODILATORS**

ORENITRAM TAB 0.25MG	2	PA
ORENITRAM TAB 0.125MG	2	PA
ORENITRAM TAB 1MG	2	PA
ORENITRAM TAB 2.5MG	2	PA
ORENITRAM TAB 5MG	2	PA
ORENITRAM TAB MONTH 1	2	PA
ORENITRAM TAB MONTH 2	2	PA
ORENITRAM TAB MONTH 3	2	PA
TYVASO DPI POW 16-32-48	3	PA, QL (252 CARTRIDGES PER 28 DAYS); MNPA
TYVASO DPI POW 16-32MCG	3	PA, QL (196 CARTRIDGES PER 28 DAYS); MNPA
TYVASO DPI POW 16MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS); MNPA
TYVASO DPI POW 32-48MCG	3	PA, QL (224 CARTRIDGES PER 28 DAYS); MNPA
TYVASO DPI POW 32MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS); MNPA
TYVASO DPI POW 48MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TYVASO DPI POW 64MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS); MNPA
TYVASO REFIL SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO START SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
VENTAVIS SOL 10MCG/ML	3	PA, QL (270 AMPULES PER 30 DAYS)
VENTAVIS SOL 20MCG/ML	3	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)
<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)
LETAIRIS TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
LETAIRIS TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
OPSUMIT TAB 10MG	2	PA, QL (30 TABLETS PER 30 DAYS)
TRACLEER TAB 32MG	3	PA, QL (112 TABLETS PER 28 DAYS); MNPA
TRACLEER TAB 62.5MG	3	PA, QL (60 TABLETS PER 30 DAYS); MNPA
TRACLEER TAB 125MG	3	PA, QL (60 TABLETS PER 30 DAYS); MNPA

### **PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS**

ADCIRCA TAB 20MG	3	PA, QL (60 TABLETS PER 30 DAYS)
------------------	---	---------------------------------

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LIQREV SUS 10MG/ML	3	PA, QL (732 mL PER 30 DAYS)
REVATIO SUS 10MG/ML	3	PA, QL (784 ML PER 30 DAYS)
REVATIO TAB 20MG	3	PA, QL (360 TABLETS PER 30 DAYS)
<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	3	PA, QL (300 ML PER 30 DAYS)
<b>PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST</b>		
UPTRAVI PACK TAB 200/800	2	PA, QL (1 PACK EVERY 28 DAYS)
UPTRAVI TAB 200MCG	2	PA, QL (140 TABLETS PER 28 DAYS)
UPTRAVI TAB 400MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 600MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 800MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1000MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1200MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1400MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1600MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
<b>PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS TAB 0.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ADEMPAS TAB 1.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2MG	2	PA, QL (90 TABLETS PER 30 DAYS)
<b>SINUS NODE INHIBITORS</b>		
CORLANOR SOL 5MG/5ML	3	
CORLANOR TAB 5MG	2	
CORLANOR TAB 7.5MG	2	
<b>TRANSTHYRETIN STABILIZERS</b>		
VYNDAMAX CAP 61MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
VYNDAQEL CAP 20MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
<b>VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)</b>		
VERQUVO TAB 2.5MG	2	
VERQUVO TAB 5MG	2	
VERQUVO TAB 10MG	2	
<b>CEPHALOSPORINS</b>		
<b>CEPHALOSPORINS - 1ST GENERATION</b>		
cefadroxil cap 500 mg	1	
cefadroxil for susp 250 mg/5ml	1	
cefadroxil for susp 500 mg/5ml	1	
cefadroxil tab 1 gm	1	
cephalexin cap 250 mg	1	
cephalexin cap 500 mg	1	
cephalexin cap 750 mg	1	
cephalexin for susp 125 mg/5ml	1	
cephalexin for susp 250 mg/5ml	1	
cephalexin tab 250 mg	1	
cephalexin tab 500 mg	1	
KEFLEX CAP 750MG	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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CEPHALOSPORINS - 2ND GENERATION</b>		
cefaclor cap 250 mg	1	
cefaclor cap 500 mg	1	
CEFACLOR ER TAB 500MG	3	
cefaclor for susp 125 mg/5ml	1	
cefaclor for susp 250 mg/5ml	1	
cefaclor for susp 375 mg/5ml	1	
cefprozil for susp 125 mg/5ml	1	
cefprozil for susp 250 mg/5ml	1	
cefprozil tab 250 mg	1	
cefprozil tab 500 mg	1	
cefuroxime axetil tab 250 mg	1	
cefuroxime axetil tab 500 mg	1	
<b>CEPHALOSPORINS - 3RD GENERATION</b>		
cefdinir cap 300 mg	1	
cefdinir for susp 125 mg/5ml	1	
cefdinir for susp 250 mg/5ml	1	
cefixime cap 400 mg	1	
cefixime for susp 100 mg/5ml	1	
cefixime for susp 200 mg/5ml	1	
cefpodoxime proxetil for susp 50 mg/5ml	1	
cefpodoxime proxetil for susp 100 mg/5ml	1	
cefpodoxime proxetil tab 100 mg	1	
cefpodoxime proxetil tab 200 mg	1	
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	
<b>CONTRACEPTIVES</b>		
<b>COMBINATION CONTRACEPTIVES - ORAL</b>		
BALCOLTRA TAB 0.1-20	0	MNPA
BEYAZ TAB	0	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)	0	
desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg	0	
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	0	
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	0	
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	0	
drospirenone-ethinyl estradiol tab 3-0.02 mg	0	
drospirenone-ethinyl estradiol tab 3-0.03 mg	0	
ESTROSTEP FE TAB	0	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	0	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	0	
GENERESS FE CHW	0	
levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg	0	
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	0	
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	0	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	0	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	0	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	0	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	0	
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	0	
LO LOESTRIN TAB 1-10-10	0	
LOSEASONIQUE TAB	0	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MINASTRIN 24 CHW FE	0	MNPA
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	
<i>norethindrone &amp; ethinyl estradiol tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol tab 0.5 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone &amp; 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 &amp; ethinyl estradiol tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace &amp; 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 &amp; ethinyl estradiol tab 0.25 mg-35 mcg</i>	0	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 &amp; ethinyl estradiol tab 0.3 mg-30 mcg</i>	0	
QUARTETTE TAB	0	
SAFYRAL TAB	0	
SEASONIQUE TAB	0	PA; MNPA
TAYTULLA CAP 1MG/20MC	0	MNPA
TYBLUME CHW 0.1-0.02	0	
YASMIN 28 TAB 3-0.03MG	0	MNPA
YAZ TAB 3-0.02MG	0	MNPA
<b>COMBINATION CONTRACEPTIVES - TRANSDERMAL</b>		
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	0	
TWIRLA DIS 120-30	0	
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>		
ANNOVERA MIS	0	QL (1 ring every 300 days)
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	0	QL (13 rings every 300 days)
NUVARING MIS	0	QL (13 rings every 300 days)
<b>EMERGENCY CONTRACEPTIVES</b>		
ELLA TAB 30MG	0	
<i>levonorgestrel tab 1.5 mg</i>	0	
<b>PROGESTIN CONTRACEPTIVES - INJECTABLE</b>		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
DEPO-SQ PROV INJ 104	0	QL (6.154 injections every 300 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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>		
<i>norethindrone tab 0.35 mg</i>	0	
ORTHO MICRON TAB 0.35MG	0	
SLYND TAB 4MG	0	
<b>CORTICOSTEROIDS</b>		
<b>GLUCOCORTICOSTEROIDS</b>		
ALKINDI SPRI CAP 0.5MG	3	
ALKINDI SPRI CAP 1MG	3	
ALKINDI SPRI CAP 2MG	3	
ALKINDI SPRI CAP 5MG	3	
<i>budesonide delayed release particles cap 3 mg</i>	1	
<i>budesonide tab er 24hr 9 mg</i>	1	
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	3	
CORTISONE TAB 25MG	3	
DEXABLISS TAB 1.5MG	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	
<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 (27)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (49)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
DXEVO 11-DAY PAK 1.5MG	3	
EMFLAZA SUS 22.75/ML	3	PA, QL (52 ML PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EMFLAZA TAB 6MG	3	PA, QL (60 TABLETS PER 30 DAYS)
EMFLAZA TAB 18MG	3	PA, QL (30 TABLETS PER 30 DAYS)
EMFLAZA TAB 30MG	3	PA, QL (30 TABLETS PER 30 DAYS)
EMFLAZA TAB 36MG	3	PA, QL (30 TABLETS PER 30 DAYS)
ENTOCORT EC CAP 3MG DR	3	
HEMADY TAB 20MG	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	
MILLIPRED TAB 5MG	3	PA; MNPA
ORAPRED ODT TAB 10MG	3	
ORAPRED ODT TAB 15MG	3	
ORAPRED ODT TAB 30MG	3	
ORTIKOS CAP 6MG ER	3	
ORTIKOS CAP 9MG ER	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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 10 mg/5ml (base equiv)</i>	1	MNPA
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sod phosphate oral soln 20 mg/5ml (base equiv)</i>	1	MNPA
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	
<i>prednisolone soln 15 mg/5ml</i>	1	
PREDNISON 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	
RAYOS TAB 1MG	3	MNPA
RAYOS TAB 2MG	3	MNPA
RAYOS TAB 5MG	3	MNPA
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	3	
ZCORT 7-DAY TAB 1.5MG	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MINERALOCORTICIDS</b>		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	
<b>COUGH/COLD/ALLERGY</b>		
<b>ANTITUSSIVES</b>		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
HYCODAN SYP 5-1.5/5	3	QL (210 mL every 25 days)
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	QL (210 mL every 25 days)
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	QL (42 tabs every 25 days)
TESSALON PER CAP 100MG	2	
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>		
CLARINEX-D TAB 2.5-120	3	
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>	1	QL (315 mL every 25 days)
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	1	QL (420 mL every 25 days)
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	QL (70 mL every 25 days)
MAR-COF CG LIQ 225-7.5	3	QL (315 mL every 25 days)
NEOTUSS PLUS LIQ	3	
<i>promethazine &amp; 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 25 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 25 days)
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
TUSSICAPS CAP 10-8MG	3	QL (14 caps every 25 days)
TUXARIN ER TAB 54.3-8MG	3	QL (14 tabs every 25 days)
TUZISTRA XR SUS	3	QL (140 mL every 25 days)
<b>MISC. RESPIRATORY INHALANTS</b>		
HYPERSAL NEB 3.5%	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
<b>MUCOLYTICS</b>		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
<b>DERMATOLOGICALS</b>		
<b>ACNE PRODUCTS</b>		
ABSORICA CAP 10MG	2	
ABSORICA CAP 20MG	2	
ABSORICA CAP 25MG	2	
ABSORICA CAP 30MG	2	
ABSORICA CAP 35MG	2	
ABSORICA CAP 40MG	2	
ABSORICA LD CAP 8MG	3	
ABSORICA LD CAP 16MG	3	
ABSORICA LD CAP 24MG	3	
ABSORICA LD CAP 32MG	3	
ACANYA GEL 1.2-2.5%	3	QL (50 gm every 25 days); MNPA
ACZONE GEL 5%	3	MNPA
ACZONE GEL 7.5%	3	MNPA
<i>adapalene cream 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.3%</i>	1	PA
<i>adapalene pads 0.1%</i>	1	PA; MNPA
ADAPALENE SOL 0.1%	3	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
ALTRENO LOT 0.05%	3	PA
AMZEEQ AER 4%	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARAZLO LOT 0.045%	2	PA
ATRALIN GEL 0.05%	3	PA
AZELEX CRE 20%	3	MNPA
BENZ PER FOR LOT HC 7.5-1	3	
BENZ PEROXID GEL 6.5%	3	
BENZAACLIN GEL 1-5%	3	QL (50 gm every 25 days); MNPA
BENZAACLIN GEL 1-5%PUMP	3	QL (50 gm every 25 days); MNPA
BENZAMYCIN GEL 5-3%	3	QL (47 gm every 25 days)
BENZEPRO AER 5.2%	3	
BENZEPRO AER 9.7%	3	
BENZEPRO LIQ 6.8%	3	
BENZEPRO MIS 5.8%	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	
BENZOYL PERX LIQ 6.9%	3	
CLEOCIN-T LOT 1%	3	QL (60 mL every 30 days)
CLINDAGEL GEL 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 gel 1%</i>	1	PA, QL (60 mL every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
DIFFERIN LOT 0.1%	3	PA; MNPA
EPIDUO FORTE GEL 0.3-2.5%	2	PA
EPIDUO GEL 0.1-2.5%	2	PA
EPSOLAY CRE 5%	3	
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)
EVOCLIN AER 1%	3	
FABIOR AER 0.1%	3	PA; MNPA
<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)
OXIAZAR CRE 4-0.1%	3	
PR BENZOYL LIQ 7% WASH	1	
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
RETIN-A MICR GEL 0.1%	3	PA
RETIN-A MICR GEL 0.1%PUMP	3	PA
RETIN-A MICR GEL 0.04%	3	PA
RETIN-A MICR GEL 0.04%PMP	3	PA
RETIN-A MICR GEL 0.06%	3	PA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RETIN-A MICR GEL 0.08%	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	
TAZAROTENE AER 0.1%	3	PA
<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
VELTIN GEL	3	PA; MNPA
WINLEVI CRE 1%	2	PA
ZACLIR LOT 8%	3	
ZIANA GEL	3	PA; MNPA
<b>AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS</b>		
VEREGEN OIN 15%	3	PA; MNPA
<b>ANTI-INFLAMMATORY AGENTS - TOPICAL</b>		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	PA, QL (150 mL every 21 days)
<i>diclofenac sodium soln 2%</i>	1	MNPA
DICLONA GEL 1-4.5%	3	
DICLONA+ PAD 1.25-4.5	3	
FENOVAR KIT	3	
FLECTOR DIS 1.3%	3	
LICART DIS 1.3%	3	
PENNSAID SOL 2%	3	PA, QL (112 gm every 21 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIBIOTICS - TOPICAL</b>		
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 calcium cream 2%</i>	1	PA, QL (30 gm every 25 days); MNPA
<i>mupirocin oint 2%</i>	1	QL (30 gm every 25 days)
NEO-SYNALAR CRE	3	PA; MNPA
XEPI CRE 1%	3	PA
<b>ANTIFUNGALS - TOPICAL</b>		
<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	
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	
<i>econazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
ECOZA AER 1%	3	QL (70 gm every 25 days)
ERTACZO CRE 2%	3	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)
HIXDEFRIMA SOL 8-1-1%	3	
<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)
KERYDIN SOL 5%	3	PA, QL (4 mL every 21 days)
<i>ketoconazole cream 2%</i>	1	QL (120 gm every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ketoconazole foam 2%</i>	1	PA, QL (100 gm every 25 days); MNPA
<i>ketoconazole shampoo 2%</i>	1	QL (120 mL every 25 days)
LOPROX CRE 0.77%	3	QL (120 gm every 25 days)
LOPROX SHA 1%	3	QL (120 mL every 25 days)
LOPROX SUS 0.77%	3	QL (120 mL every 25 days)
<i>luliconazole cream 1%</i>	1	PA, QL (60 gm every 25 days); MNPA
LUZU CRE 1%	3	QL (60 gm 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)
NAFTIN GEL 1%	2	QL (120 gm every 25 days)
NAFTIN GEL 2%	2	QL (60 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)
<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	
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	
<i>oxiconazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
<i>oxiconazole nitrate cream 1%</i>	1	PA, QL (60 gm every 25 days); MNPA
OXISTAT CRE 1%	3	QL (60 gm every 25 days)
OXISTAT LOT 1%	3	QL (60 mL every 25 days)
RECURA CRE	3	
<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)
<i>tavaborole soln 5%</i>	1	PA, QL (4 mL every 21 days); MNPA
VUSION OIN	3	QL (100 gm every 25 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XOLEGEL GEL 2%	3	PA, QL (45 gm every 25 days); MNPA
<b>ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL</b>		
AMELUZ GEL 10%	3	
CARAC CRE 0.5%	3	MNPA
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	PA
EFUDEX CRE 5%	3	
FLUOROPLEX CRE 1%	3	
<i>fluorouracil cream 0.5%</i>	1	MNPA
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
KLISYRI OIN 1%	3	PA, QL (5 ea every 25 days)
LEVULAN KERA SOL 20%	3	
PANRETIN GEL 0.1%	3	
PICATO GEL 0.05%	2	
PICATO GEL 0.015%	2	
ROAOXIA GEL 3-4%	3	
TARGRETIN GEL 1%	3	PA; MNPA
TOLAK CRE 4%	3	
VALCHLOR GEL 0.016%	3	PA, QL (2 TUBES PER 30 DAYS)
<b>ANTIPRURITICS - TOPICAL</b>		
<i>doxepin hcl cream 5%</i>	1	ST, PA, QL (90 gm every 25 days); MNPA
PRUDOXIN CRE 5%	3	ST, PA, QL (90 gm every 25 days)
ZONALON CRE 5%	3	ST, PA, QL (90 gm every 25 days)
<b>ANTIPSORIATICS</b>		
<i>acitretin cap 10 mg</i>	1	
<i>acitretin cap 17.5 mg</i>	1	
<i>acitretin cap 25 mg</i>	1	
<i>calcipotriene cream 0.005%</i>	1	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>calcipotriene foam 0.005%</i>	1	PA; MNPA
<i>calcipotriene oint 0.005%</i>	1	PA
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	PA
<i>calcitriol oint 3 mcg/gm</i>	1	PA; MNPA
COSENTYX INJ 75MG/0.5	2	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	2	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COSENTYX INJ 300DOSE	2	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 PEN INJ 150MG/ML	2	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	2	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COSENTYX UNO INJ 300/2ML	2	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	
OXSORALEN-UL CAP 10MG	3	
SILIQ INJ 210/1.5	3	PA, QL (2 SYRINGES PER 28 DAYS); LOADING DOSE: 4 SYRINGES PER 28 DAYS
SKYRIZI INJ 150DOSE	2	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	2	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SKYRIZI PEN INJ 150MG/ML	2	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	
SORILUX AER 0.005%	3	PA; MNPA
SOTYKTU TAB 6MG	2	PA, QL (30 TABLETS PER 30 DAYS)
STELARA INJ 45MG/0.5	2	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
STELARA INJ 45MG/0.5	2	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STELARA INJ 90MG/ML	2	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	2	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	2	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
<i>tazarotene cream 0.1%</i>	1	PA
<i>tazarotene gel 0.1%</i>	1	
<i>tazarotene gel 0.05%</i>	1	
TAZORAC CRE 0.1%	3	MNPA
TAZORAC CRE 0.05%	3	MNPA
TAZORAC GEL 0.1%	3	MNPA
TAZORAC GEL 0.05%	3	MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TREMFYA INJ 100MG/ML	2	PA, QL (1 PENS PER 8 WEEKS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
TREMFYA INJ 100MG/ML	2	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
VECTICAL OIN 3MCG/GM	3	PA; MNPA
VTAMA CRE 1%	2	PA
ZORYVE CRE 0.3%	2	ST, PA, QL (60 gms per 25 days)
<b>ANTISEBORRHEIC PRODUCTS</b>		
ESKATA SOL 40%	3	
<i>selenium sulfide lotion 2.5%</i>	1	
SODIUM SULFA LIQ 10% WASH	3	
<b>ANTIVIRALS - TOPICAL</b>		
<i>acyclovir cream 5%</i>	1	PA; MNPA
<i>acyclovir oint 5%</i>	1	
DENAVIR CRE 1%	3	
<i>penciclovir cream 1%</i>	1	
XERESE CRE 5-1%	3	
ZOVIRAX CRE 5%	3	
ZOVIRAX OIN 5%	3	
<b>BURN PRODUCTS</b>		
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SILVADENE CRE 1%	2	
<i>silver sulfadiazine cream 1%</i>	1	
SULFAMYLON CRE 85MG/GM	3	
SULFAMYLON PAK 5%	3	
<b>CORTICOSTEROIDS - TOPICAL</b>		
ACIOXIA GEL 0.1-0.5%	3	
ALA-SCALP LOT 2%	1	QL (120 mL every 30 days)
ALA-SCALP LOT 2%	3	QL (120 mL every 30 days)
<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)
APEXICON E CRE 0.05%	3	QL (120 gm every 30 days); MNPA
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	QL (120 gm every 30 days)
<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 dipropionate oint 0.05%</i>	1	QL (120 gm every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>calcipotriene-betamethasone dipropionate oint 0.005-0.064%</i>	1	PA; MNPA
<i>calcipotriene-betamethasone dipropionate susp 0.005-0.064%</i>	1	PA; MNPA
CAPEX SHA 0.01%	2	QL (120 mL 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 emulsion foam 0.05%</i>	1	QL (120 gm every 30 days); MNPA
<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)
<i>clobetasol propionate spray 0.05%</i>	1	QL (120 mL every 30 days); MNPA
CLOBEX LOT 0.05%	2	QL (120 mL every 30 days)
CLOBEX SHA 0.05%	2	QL (120 mL every 30 days)
CLOBEX SPR 0.05%	3	QL (120 mL every 30 days); MNPA
<i>clocortolone pivalate cream 0.1%</i>	1	PA, QL (120 gm every 30 days); MNPA
CLODERM CRE 0.1%	3	QL (120 gm every 30 days)
CORDRAN 80X3 TAP 4MCG/CM	3	QL (1.002 ea every 30 days); MNPA
CORDRAN CRE 0.05%	3	QL (120 gm every 30 days); MNPA
CORDRAN CRE 0.025%	3	QL (120 gm every 30 days); MNPA
CORDRAN LOT 0.05%	3	QL (120 mL every 30 days); MNPA
CORDRAN OIN 0.05%	3	PA, QL (120 gm every 30 days); MNPA
CUTIVATE LOT 0.05%	3	QL (120 mL every 30 days)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DERMA-SMOOTH OIL /FS BODY	2	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS SCLP	2	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 gel 0.05%</i>	1	QL (120 gm every 30 days); MNPA
<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)
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 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
<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)
<i>diflorasone diacetate cream 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
<i>diflorasone diacetate oint 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
DIPROLENE AF CRE 0.05%	3	QL (120 gm every 30 days)
DIPROLENE OIN 0.05%	3	QL (120 gm every 30 days)
DUOBRII LOT	2	MNPA
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 0.1%</i>	1	PA, QL (120 gm every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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>flurandrenolide cream 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
<i>flurandrenolide lotion 0.05%</i>	1	PA, QL (120 mL every 30 days); MNPA
<i>flurandrenolide oint 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
<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>halcinonide cream 0.1%</i>	1	PA, QL (120 gm every 30 days); MNPA
HALOBETASOL AER 0.05%	3	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)
HALOG CRE 0.1%	3	QL (120 gm every 30 days); MNPA
HALOG OIN 0.1%	3	QL (120 gm every 30 days); MNPA
HALOG SOL 0.1%	3	QL (120 mL every 30 days); MNPA
HYDROCORT KIT 2%	3	
HYDROCORTISO PAK 2%	3	
<i>hydrocortisone butyrate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate hydrophilic lipo base cream 0.1%</i>	1	PA, QL (120 gm every 30 days); MNPA
<i>hydrocortisone butyrate lotion 0.1%</i>	1	PA, QL (120 mL every 30 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydrocortisone valerate oint 0.2%</i>	1	QL (120 gm every 30 days)
HYDROXYM GEL 2%	3	
IMPEKLO LOT 0.05%	3	QL (120 gm every 30 days)
IMPOYZ CRE 0.025%	3	QL (120 gm every 30 days)
KENALOG AER SPRAY	3	QL (120 gm every 30 days)
LEXETTE AER 0.05%	3	QL (120 gm every 30 days)
LOCOID LIPO CRE 0.1%	3	QL (120 gm every 30 days)
LOCOID LOT 0.1%	3	QL (120 mL every 30 days)
LUXIQ AER 0.12%	3	QL (120 gm 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)
OLUX-E AER 0.05%	3	QL (120 gm every 30 days); MNPA
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)
PSORCON CRE 0.05%	3	PA, QL (120 gm every 30 days); MNPA
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	3	PA
TACLONEX SUS	3	PA
TEMOVATE CRE 0.05%	2	QL (120 gm every 30 days)
TEMOVATE OIN 0.05%	2	QL (120 gm every 30 days)
TEXACORT SOL 2.5%	2	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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 aerosol soln 0.147 mg/gm</i>	1	PA, QL (120 gm every 30 days); MNPA
<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)
<i>triamcinolone acetonide oint 0.05%</i>	1	PA, QL (120 gm every 30 days); MNPA
<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)
ULTRAVATE LOT 0.05%	3	QL (120 mL every 30 days); MNPA
VANOS CRE 0.1%	3	QL (120 gm every 30 days)
VERDESO AER 0.05%	3	QL (120 gm every 30 days)
WYNZORA CRE	3	PA
<b>ECZEMA AGENTS</b>		
ADBRY INJ 150MG/ML	2	PA, QL (4 SYRINGES PER 28 DAYS); LOADING DOSE: 4 SYRINGES PER 14 DAYS
CIBINQO TAB 50MG	2	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 100MG	2	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 200MG	2	PA, QL (30 TABLETS PER 30 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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DUPIXENT INJ 200MG	2	PA, QL (2 PENS (400 MG) PER 28 DAYS); LOADING DOSE:2 PENS (400 MG) PER 14 DAYS
DUPIXENT INJ 300/2ML	2	PA, QL (4 PENS PER 28 DAYS)
DUPIXENT INJ 300/2ML	2	PA, QL (4 PFS PER 28 DAYS)
OPZELURA CRE 1.5%	3	PA
<b>EMOLLIENT/KERATOLYTIC AGENTS</b>		
<i>urea cream 39%</i>	1	
<i>urea lotion 40%</i>	1	
<b>EMOLLIENTS</b>		
LACTIC ACID LOT 10%	3	
<b>ENZYMES - TOPICAL</b>		
NEXOBRID GEL 8.8%	3	
SANTYL OIN 250/GM	3	
<b>HAIR GROWTH AGENTS</b>		
LITFULO CAP 50MG	3	PA, QL (28 caps per 28 days)
<b>IMMUNOMODULATING AGENTS - TOPICAL</b>		
ALDARA CRE 5%	3	QL (21 ea every 25 days)
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	QL (21 ea every 25 days)
ZYCLARA CRE 3.75%	2	
ZYCLARA PUMP CRE 2.5%	2	
ZYCLARA PUMP CRE 3.75%	2	
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>		
ELIDEL CRE 1%	3	ST; MNPA
OXIANUJO CRE 4-0.1%	3	
<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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>		
CANTHARIDIN SOL 0.7%	3	
CONDYLOX GEL 0.5%	2	
GEAMETDRAY GEL 5-2-17%	3	
GORDOFILM SOL	3	
<i>podofilox soln 0.5%</i>	1	
PYROGALL ACD OIN	3	
RAYASAL CRE 5.9%	3	
SALIMEZ CRE 6%	3	
SALIMEZ FORT CRE 10%	3	
UREA/SALICY CRE 39.5-2%	3	
YCANTH SOL 0.7%	3	
<b>LINIMENTS</b>		
TURPENTINE SOL SPIRITS	3	
<b>LOCAL ANESTHETICS - TOPICAL</b>		
ANACAINE OIN	3	
ELEMAR PATCH KIT 5%-6%	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	
LIDO/RAC/TET GEL	3	
LIDOCA/TETRA CRE 7/7%	3	QL (30 gm every 25 days)
LIDOCAINE CRE TETRACAI	3	PA, QL (30 gm every 25 days); MNPA
<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)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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%	2	QL (90 ea every 30 days)
LIDOSOL-50 KIT 5%	3	
NYNUTEY CRE 23-7%	3	MNPA
PLIAGLIS CRE 7-7%	3	QL (30 gm every 25 days)
PRAMOX GEL 1%	3	
SYNERA DIS 70-70MG	3	QL (2 patches every 25 days)
TOPICAL GEL L.E.T	3	
XYLIDERM KIT	3	
ZTLIDO PAD 1.8%	3	QL (90 ea every 30 days)
<b>MISC. TOPICAL</b>		
ARNICA TIN FLOWER	3	
DRYSOL SOL 20%	3	
EPICYN SPR	3	
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL</b>		
EUCRISA OIN 2%	2	
<b>ROSACEA AGENTS</b>		
<i>azelaic acid gel 15%</i>	1	PA
<i>brimonidine tartrate gel 0.33% (base equivalent)</i>	1	PA
<i>doxycycline (rosacea) cap delayed release 40 mg</i>	1	
<i>doxycycline (rosacea) cap delayed release 40 mg</i>	3	
FINACEA AER 15%	2	PA
FINACEA GEL 15%	3	PA; MNPA
IDAOXIA GEL 1-4%	3	
METROCREAM CRE 0.75%	3	
METROGEL GEL 1%	3	
METROLOTION LOT 0.75%	3	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
MIRVASO GEL 0.33%	3	PA; MNPA
NORITATE CRE 1%	3	PA; MNPA
ORACEA CAP 40MG	3	
RHOFADE CRE 1%	2	PA
SOOLANTRA CRE 1%	2	
ZILXI AER 1.5%	3	
<b>SCABICIDES &amp; PEDICULICIDES</b>		
<i>crotamiton lotion 10%</i>	1	
ELIMITE CRE 5%	2	
<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%	2	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
SULF LIME SOL	3	
<b>TAR PRODUCTS</b>		
<i>coal tar soln 20%</i>	1	
<b>WOUND CARE PRODUCTS</b>		
REGRANEX GEL 0.01%	3	
<b>DIAGNOSTIC PRODUCTS</b>		
<b>DIAGNOSTIC TESTS</b>		
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 GUIDE	0	QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ACCU-CHEK TES SMART	0	QL (150 strips every 30 days)
ACCUTREND TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
ADVANCE TES INTUITIO	0	PA, QL (150 strips every 30 days); MNPA
ADVANCE TES MICRO-DW	0	PA, QL (150 strips every 30 days); MNPA
ADVOCATE TES	0	PA, QL (150 strips every 30 days); MNPA
ADVOCATE TES REDI-COD	0	PA, QL (150 strips every 30 days); MNPA
ADVOCATE TES REDICODE	0	PA, QL (150 strips every 30 days); MNPA
AGAMATRIX TES AMP	0	PA, QL (150 strips every 30 days); MNPA
AGAMATRIX TES JAZZ	0	PA, QL (150 strips every 30 days); MNPA
AGAMATRIX TES KEYNOTE	0	PA, QL (150 strips every 30 days); MNPA
AGAMATRIX TES PRESTO	0	PA, QL (150 strips every 30 days); MNPA
ASSURE 3 TES	0	PA, QL (150 strips every 30 days); MNPA
ASSURE 4 TES	0	PA, QL (150 strips every 30 days); MNPA
ASSURE II TES	0	PA, QL (150 strips every 30 days); MNPA
ASSURE II TES CHECK	0	PA, QL (150 strips every 30 days); MNPA
ASSURE PRISM TES MULTI	0	PA, QL (150 strips every 30 days); MNPA
ASSURE PRO TES	0	PA, QL (150 strips every 30 days); MNPA
ASSURE TES PLATINUM	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AUTOCODE TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
BIOSCANNER TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
BLOOD GLUCOS TES	0	PA, QL (150 strips every 30 days); MNPA
BLOOD GLUCOS TES LE1	0	PA, QL (150 strips every 30 days); MNPA
BLOOD GLUCOS TES PREMIUM	0	PA, QL (150 strips every 30 days); MNPA
BLOOD GLUCOS TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
CARESENS N TES	0	PA, QL (150 strips every 30 days); MNPA
CARETOUCH MIS TST STRP	0	PA, QL (150 strips every 30 days); MNPA
CHEMSTRIP K TES	0	
CHEMSTRIP TES UGK	0	
CLEVER CHEK TES	0	PA, QL (150 strips every 30 days); MNPA
CLEVER CHEK TES AUTO CD	0	PA, QL (150 strips every 30 days); MNPA
CLEVER CHEK TES TALK	0	PA, QL (150 strips every 30 days); MNPA
CLEVER CHEK TES VOICE	0	PA, QL (150 strips every 30 days); MNPA
CLEVER CHOIC TES MICRO	0	PA, QL (150 strips every 30 days); MNPA
CLEVR CHOICE TES AUTO-CD	0	PA, QL (150 strips every 30 days); MNPA
CLEVR CHOICE TES NOCODE	0	PA, QL (150 strips every 30 days); MNPA
CONFIRM/MICR TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
CONTOUR TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CONTOUR TES NEXT	0	PA, QL (150 strips every 30 days); MNPA
COOL BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
CVS ADVANCED TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
CVS GLUCOSE TES TEST STR	0	PA, QL (150 strips every 30 days); MNPA
CVS KETONE TES CARE	0	
D-CARE BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
DIASTIX TES STRIPS	0	
DIATHRIVE MIS TEST STR	0	PA, QL (150 strips every 30 days); MNPA
DIATHRIVE+ MIS TEST STR	0	PA, QL (150 strips every 30 days); MNPA
DIATRUE PLUS TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
DUO-CARE TES	0	PA, QL (150 strips every 30 days); MNPA
EASY PLUS II TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EASY STEP TES	0	PA, QL (150 strips every 30 days); MNPA
EASY TALK TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EASY TOUCH TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
EASY TOUCH TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
EASY TRAK II TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EASY TRAK TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EASYGLUCO TES	0	PA, QL (150 ea every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EASYGLUCO TES PLUS	0	PA, QL (150 strips every 30 days); MNPA
EASYMAX 15 TES	0	PA, QL (150 strips every 30 days); MNPA
EASYMAX TES	0	PA, QL (150 strips every 30 days); MNPA
EASYPRO PLUS TES	0	PA, QL (150 strips every 30 days); MNPA
EASYPRO TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
ELEMENT TES	0	PA, QL (150 strips every 30 days); MNPA
ELEMNT COMPA TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
EMBRACE EVO TES	0	PA, QL (150 strips every 30 days); MNPA
EMBRACE PRO TES	0	PA, QL (150 strips every 30 days); MNPA
EMBRACE TALK TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
EMBRACE TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE + TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE G2 TES	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE G3 TES	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE TES MINI	0	PA, QL (150 strips every 30 days); MNPA
EVENCARE TES PROVIEW	0	PA, QL (150 strips every 30 days); MNPA
EVOLUTION TES AUTOCODE	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EXACTECH TES	0	PA, QL (150 strips every 30 days); MNPA
EXACTECH TES R-S-G	0	PA, QL (150 strips every 30 days); MNPA
FIFTY50 GLUC TES 2.0	0	PA, QL (150 strips every 30 days); MNPA
FORA 6 MIS CONNECT	0	QL (150 strips every 30 days); MNPA
FORA BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
FORA D15G TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA D20 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA D40/G31 TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
FORA G20 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA G30/V10 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA GD20 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA GD50 TES	0	PA, QL (150 strips every 30 days); MNPA
FORA GTEL TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA GTEL TES KETONE	0	
FORA TN'G TES TN'G VOI	0	PA, QL (150 strips every 30 days); MNPA
FORA V10 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA V12 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORA V20 TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FORA V30A TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FORACARE TES GD40	0	PA, QL (150 strips every 30 days); MNPA
FORACARE TES PREM V10	0	PA, QL (150 strips every 30 days); MNPA
FORACARE TES TST N GO	0	PA, QL (150 strips every 30 days); MNPA
FORTISCARE TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
FREESTYLE TES	0	PA, QL (150 strips every 30 days); MNPA
FREESTYLE TES INSULINX	0	PA, QL (150 strips every 30 days); MNPA
FREESTYLE TES LITE	0	PA, QL (150 strips every 30 days); MNPA
FREESTYLE TES PREC NEO	0	PA, QL (150 strips every 30 days); MNPA
GE100 BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
GENULTIMATE TES	0	PA, QL (150 strips every 30 days); MNPA
GHT TEST TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
GLUCO PERFEC TES 3	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCARD 01 TES PLUS	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCARD 01 TES SENSOR	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCARD TES EXPRESSI	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCARD TES SHINE	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCARD TES VITAL	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GLUCOCARD TES X-SENSOR	0	PA, QL (150 strips every 30 days); MNPA
GLUCOCOM TES	0	PA, QL (150 strips every 30 days); MNPA
GLUCONAVII TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
GLUCOSE TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
GOJJI BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
GOJJI BLOOD TES KETONE	0	
GOJJI STRIPS MIS W/LANCET	0	PA, QL (150 strips every 30 days); MNPA
HARMONY TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
HW EMBRACE TES PRO	0	PA, QL (150 strips every 30 days); MNPA
HW EMBRACE TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
IGLUCOSE TES	0	PA, QL (150 strips every 30 days); MNPA
IN TOUCH TES BLOOD	0	PA, QL (150 strips every 30 days); MNPA
INFINITY TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
INFINITY TES VOICE	0	PA, QL (150 strips every 30 days); MNPA
KETO-DIASTIX TES	0	
KETONE TES	0	
KETONE TEST TES	0	
KETOSTIX TES STRIP	0	
KROGER BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
KROGER TES	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LIBERTY NEXT TES GEN	0	PA, QL (150 strips every 30 days); MNPA
LIBERTY TES	0	PA, QL (150 strips every 30 days); MNPA
MEIJER BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
MEIJER TES TRUETEST	0	PA, QL (150 strips every 30 days); MNPA
MEIJER TES TRUETRAC	0	PA, QL (150 strips every 30 days); MNPA
MICRODOT TES	0	PA, QL (150 strips every 30 days); MNPA
MICRODOT TES XTRA	0	PA, QL (150 strips every 30 days); MNPA
MYGLUCOHEALT TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
NEUTEK 2TEK TES STRIPS	0	PA, QL (150 strips every 30 days); MNPA
NO CODING TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
NOVA MAX PLS TES KETONE	0	
NOVA MAX TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
ONE DROP TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
ONETOUCH TES ULTRA	0	QL (150 strips every 30 days)
ONETOUCH TES VERIO	0	
ONETOUCH TES VERIO	0	QL (150 strips every 30 days)
OPTIUM TES	0	PA, QL (150 strips every 30 days); MNPA
OPTIUMEZ TES	0	PA, QL (150 strips every 30 days); MNPA
POCKETCHEM TES EZ	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRECISION PT TES OF CARE	0	PA, QL (150 strips every 30 days); MNPA
PRECISION TES PCX	0	PA, QL (150 strips every 30 days); MNPA
PRECISION TES PCX PLUS	0	PA, QL (150 strips every 30 days); MNPA
PRECISION TES QID	0	PA, QL (150 strips every 30 days); MNPA
PRECISION TES SOF-TACT	0	PA, QL (150 strips every 30 days); MNPA
PRECISION TES XTRA	0	PA, QL (150 strips every 30 days); MNPA
PRECISN XTRA TES KETONE	0	
PREMIUM BLOO MIS GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
PRO VOICE TES V8/V9	0	PA, QL (150 strips every 30 days); MNPA
PRODIGY NO TES CODING	0	PA, QL (150 strips every 30 days); MNPA
PTS PANELS TES GLUCOSE	0	PA, QL (150 ea every 30 days); MNPA
PTS PANELS TES KETONE	0	
QUICKTEK TES	0	PA, QL (150 strips every 30 days); MNPA
QUINTET AC TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
QUINTET TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
REFUAH PLUS TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
RELION BLOOD TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
RELION PREMI TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
RELION PRIME TES	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RELION PRIME TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
RELION TES KETONE	0	
RELION TES ULTIMA	0	PA, QL (150 strips every 30 days); MNPA
RELION TRUE TES METRIX	0	QL (150 strips every 30 days); MNPA
RIGHTEST TES GS100	0	PA, QL (150 strips every 30 days); MNPA
RIGHTEST TES GS300	0	PA, QL (150 strips every 30 days); MNPA
RIGHTEST TES GS550	0	PA, QL (150 strips every 30 days); MNPA
SMART SENSE TES TEST	0	PA, QL (150 strips every 30 days); MNPA
SMARTEST TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
SOLUS V2 TES AUDIBLE	0	PA, QL (150 strips every 30 days); MNPA
SUPREME TES	0	PA, QL (150 strips every 30 days); MNPA
SURE-TEST TES EASYPLUS	0	PA, QL (150 strips every 30 days); MNPA
TRUE FOCUS MIS BLOOD	0	PA, QL (150 strips every 30 days); MNPA
TRUE METRIX TES GLUCOSE	0	PA, QL (150 strips every 30 days); MNPA
TRUETEST TES	0	PA, QL (150 strips every 30 days); MNPA
TRUETRACK TES	0	PA, QL (150 strips every 30 days); MNPA
TRUETRACK TES BLD GLUC	0	PA, QL (150 strips every 30 days); MNPA
UNISTRIP1 TES GENERIC	0	PA, QL (150 strips every 30 days); MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VERASENS TES	0	PA, QL (150 strips every 30 days); MNPA
VIVAGUARD TES INO	0	PA, QL (150 strips every 30 days); MNPA

**DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS****DIETARY MANAGEMENT PRODUCTS**

ACERFLEX POW	3	Coverage is subject to your plan/benefits
BCAD 2 POW	3	Coverage is subject to your plan/benefits
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
CYCLINEX-1 POW	3	Coverage is subject to your plan/benefits
CYCLINEX-2 POW	3	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
ELECARE DHA/ POW ARA INFA	3	PA; Coverage is subject to your plan/benefits
ELECARE POW DHA/ARA	3	PA; Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
ENTERAGAM POW 5GM	3	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
FOSTEUM CAP	3	PA; MNPA
FOSTEUM PLUS CAP	3	PA; MNPA
GA POW	3	Coverage is subject to your plan/benefits
GA-1 ANAMIX POW ERLY YRS	3	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
GLUTAREX-1 POW	3	Coverage is subject to your plan/benefits
GLUTAREX-2 POW	3	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
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 ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
HCU EXP20 PAK UNFLAVOR	3	Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HCU EXPRESS PAK	3	Coverage is subject to your plan/benefits
HCY 2 POW	3	Coverage is subject to your plan/benefits
HOM 2 POW	3	Coverage is subject to your plan/benefits
HOMACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
HOMINEX-1 POW	3	Coverage is subject to your plan/benefits
HOMINEX-2 POW	3	Coverage is subject to your plan/benefits
I-VALEX-1 POW	3	Coverage is subject to your plan/benefits
I-VALEX-2 POW	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
IVA ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
IVA MAXAMUM POW	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
KETONEX-1 POW	3	Coverage is subject to your plan/benefits
KETONEX-2 POW	3	Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LANAFLEX PAK	3	Coverage is subject to your plan/benefits
LIPISTART POW	3	PA; Coverage is subject to your plan/benefits
LIQUID HOPE LIQ	3	PA; Coverage is subject to your plan/benefits
LMD POW	3	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
METHIONAID POW	3	Coverage is subject to your plan/benefits
MMA/PA ANAMI POW ERLY YRS	3	Coverage is subject to your plan/benefits
MMA/PA MAXAM POW	3	Coverage is subject to your plan/benefits
MODULEN IBD POW	3	PA; Coverage is subject to your plan/benefits
MSUD AID POW	3	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
NICAPRIN TAB	3	PA; MNPA
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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
OA 2 POW	3	Coverage is subject to your plan/benefits
OMNIVEX TAB	3	PA; MNPA
OPTIMENTAL LIQ	3	PA; Coverage is subject to your plan/benefits
OS 2 POW	3	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

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
PERIFLEX POW ADVANCE	3	Coverage is subject to your plan/benefits
PFD 2 POW	3	Coverage is subject to your plan/benefits
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHENEX-1 POW	3	Coverage is subject to your plan/benefits
PHENEX-2 POW	3	Coverage is subject to your plan/benefits
PHENYL-FREE POW 2	3	Coverage is subject to your plan/benefits
PHENYLADE60 POW	3	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
PORTAGEN POW	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

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
PROPIMEX-1 POW	3	Coverage is subject to your plan/benefits
PROPIMEX-2 POW	3	Coverage is subject to your plan/benefits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
PROVIMIN POW	3	Coverage is subject to your plan/benefits
RENASTART POW	3	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
RHEUMATE CAP	3	PA; MNPA
RIBOZEL CAP	3	PA; MNPA
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
SOL CARB POW	3	PA; Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
TYR ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
TYREX-1 POW	3	Coverage is subject to your plan/benefits
TYREX-2 POW	3	Coverage is subject to your plan/benefits
TYROS 2 POW	3	Coverage is subject to your plan/benefits
UCD ANAMIX POW JUNIOR	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
ULTRAMINO POW SOY PROT	3	PA; Coverage is subject to your plan/benefits
ULTRIENT 1.5 LIQ SAFE-T	3	PA; Coverage is subject to your plan/benefits
VASCULERA TAB	3	PA; MNPA
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
WND 2 POW	3	Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XLYS-XTRP POW MAXAMAID	3	Coverage is subject to your plan/benefits
XMET XCYS POW MAXAMAID	3	Coverage is subject to your plan/benefits
XPHE-XTYR POW MAXAMAID	3	Coverage is subject to your plan/benefits
XYZBAC TAB	3	PA; MNPA
ZYVIT TAB	3	PA

**DIGESTIVE AIDS*****DIGESTIVE ENZYMES***

CREON CAP 3000UNIT	2	
CREON CAP 6000UNIT	2	
CREON CAP 12000UNT	2	
CREON CAP 24000UNT	2	
CREON CAP 36000UNT	2	
PANCREAZE CAP 2600UNIT	3	
PANCREAZE CAP 4200UNIT	3	
PANCREAZE CAP 10500UNT	3	
PANCREAZE CAP 16800UNT	3	
PANCREAZE CAP 21000UNT	3	
PANCREAZE CAP 37000	3	
PERTZYE CAP 4000UNIT	3	
PERTZYE CAP 8000UNIT	3	
PERTZYE CAP 16000U	3	
PERTZYE CAP 24000U	3	
SUCRAID SOL 8500/ML	3	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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DIURETICS</b>		
<b>CARBONIC ANHYDRASE INHIBITORS</b>		
<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	3	PA, QL (120 TABLETS PER 30 DAYS)
<i>methazolamide tab 25 mg</i>	1	
<i>methazolamide tab 50 mg</i>	1	
<b>DIURETIC COMBINATIONS</b>		
ALDACTAZIDE TAB 25/25	3	
ALDACTAZIDE TAB 50/50	3	
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i>	1	
MAXZIDE TAB 75-50	3	
MAXZIDE-25 TAB	3	
<i>spironolactone &amp; hydrochlorothiazide tab 25-25 mg</i>	1	
<i>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</i>	1	
<i>triamterene &amp; hydrochlorothiazide tab 37.5-25 mg</i>	1	
<i>triamterene &amp; hydrochlorothiazide tab 75-50 mg</i>	1	
<b>LOOP DIURETICS</b>		
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>POTASSIUM SPARING DIURETICS</b>		
ALDACTONE TAB 25MG	2	
ALDACTONE TAB 50MG	2	
ALDACTONE TAB 100MG	2	
<i>amiloride hcl tab 5 mg</i>	1	
CAROSPIR SUS 25MG/5ML	3	
DYRENIUM CAP 50MG	3	PA; MNPA
DYRENIUM CAP 100MG	3	PA; MNPA
<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	
<b>THIAZIDES AND THIAZIDE-LIKE DIURETICS</b>		
<i>chlorthalidone tab 25 mg</i>	1	
<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	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ENDOCRINE AND METABOLIC AGENTS - MISC.</b>		
<b>ADRENAL STEROID INHIBITORS</b>		
ISTURISA TAB 1MG	3	PA, QL (240 TABLETS PER 30 DAYS)
ISTURISA TAB 5MG	3	PA, QL (360 TABLETS PER 30 DAYS)
ISTURISA TAB 10MG	3	PA, QL (180 TABLETS PER 30 DAYS)
<b>BONE DENSITY REGULATORS</b>		
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	
ATELVIA 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	2	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	
MIACALCIN INJ 200/ML	3	PA; MNPA
NATPARA INJ 25MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 75MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NATPARA INJ 100MCG	3	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	
TERIPARATIDE INJ	3	PA, QL (1 PENS PER 28 DAYS)
TYMLOS INJ	2	PA, QL (1 PEN PER 30 DAYS)
<b>CORTICOTROPIN</b>		
ACTHAR INJ 80UNIT	3	PA, QL (35ML PER 21 DAYS)
CORTROPHIN GEL 80UNIT	3	PA, QL (35ML PER 21 DAYS); MNPA
<b>FERTILITY REGULATORS</b>		
CHOR GONADOT INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
<i>clomiphene citrate tab 50 mg</i>	1	Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 300UNIT	3	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 600UNIT	3	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 900UNIT	3	PA, QL (7 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GONAL-F INJ 450UNIT	2	PA, QL (10 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F INJ 1050UNIT	2	PA, QL (6 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 75UNIT	2	PA, QL (60 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 300/0.5	2	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 450/0.75	2	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 900/1.5	2	PA, QL (7 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	2	PA; Coverage is subject to your plan/benefits
NOVAREL INJ 5000UNIT	3	PA; Coverage is subject to your plan/benefits
NOVAREL INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	2	PA; Coverage is subject to your plan/benefits
PREGNYL INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
<b>GNRH/LHRH ANTAGONISTS</b>		
CETROTIDE KIT 0.25MG	2	PA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GANIRELIX AC INJ 250/0.5	3	PA
<i>ganirelix acetate soln prefilled syringe 250 mcg/0.5ml</i>	1	PA
ORLISSA TAB 150MG	2	PA
ORLISSA TAB 200MG	2	PA
<b>GROWTH HORMONE RECEPTOR ANTAGONISTS</b>		
SOMAVERT INJ 10MG	2	PA, QL (30 VIALS PER 30 DAYS); MNPA
SOMAVERT INJ 15MG	2	PA, QL (30 VIALS PER 30 DAYS); MNPA
SOMAVERT INJ 20MG	2	PA, QL (30 VIALS PER 30 DAYS); MNPA
SOMAVERT INJ 25MG	2	PA, QL (30 VIALS PER 30 DAYS); MNPA
SOMAVERT INJ 30MG	2	PA, QL (30 VIALS PER 30 DAYS); MNPA
<b>GROWTH HORMONE RELEASING HORMONES (GHRH)</b>		
EGRIFTA SV INJ 2MG	3	PA, QL (30 VIALS PER 30 DAYS)
<b>GROWTH HORMONES</b>		
GENOTROPIN INJ 0.2MG	3	PA
GENOTROPIN INJ 0.4MG	3	PA
GENOTROPIN INJ 0.6MG	3	PA
GENOTROPIN INJ 0.8MG	3	PA
GENOTROPIN INJ 1.2MG	3	PA
GENOTROPIN INJ 1.4MG	3	PA
GENOTROPIN INJ 1.6MG	3	PA
GENOTROPIN INJ 1.8MG	3	PA
GENOTROPIN INJ 1MG	3	PA
GENOTROPIN INJ 2MG	3	PA
GENOTROPIN INJ 5MG	3	PA
GENOTROPIN INJ 12MG	3	PA
HUMATROPE INJ 5MG	2	PA
HUMATROPE INJ 6MG	2	PA; MNPA
HUMATROPE INJ 12MG	2	PA; MNPA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMATROPE INJ 24MG	2	PA; MNPA
NGENLA INJ 24/1.2ML	3	PA
NGENLA INJ 60/1.2ML	3	PA
NORDITROPIN INJ 5/1.5ML	2	PA
NORDITROPIN INJ 10/1.5ML	2	PA
NORDITROPIN INJ 15/1.5ML	2	PA
NORDITROPIN INJ 30/3ML	2	PA
NUTROPIN AQ INJ 10MG/2ML	3	PA; MNPA
NUTROPIN AQ INJ 20MG/2ML	3	PA; MNPA
NUTROPIN AQ INJ NUSPIN 5	3	PA; MNPA
OMNITROPE INJ 5.8MG	3	PA; MNPA
OMNITROPE INJ 5/1.5ML	3	PA; MNPA
OMNITROPE INJ 10/1.5ML	3	PA; MNPA
SAIZEN INJ 5MG	3	PA; MNPA
SAIZEN INJ 8.8MG	3	PA; MNPA
SAIZENPREP INJ 8.8MG	3	PA; MNPA
SEROSTIM INJ 4MG	3	PA
SEROSTIM INJ 5MG	3	PA
SEROSTIM INJ 6MG	3	PA
SOGROYA INJ 5MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 10MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 15MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
ZOMACTON INJ 5MG	3	PA
ZOMACTON INJ 10MG	3	PA
ZORBTIVE INJ 8.8MG	3	PA
<b>HORMONE RECEPTOR MODULATORS</b>		
EVISTA TAB 60MG	0	
OSPHENA TAB 60MG	2	MNPA
<i>raloxifene hcl tab 60 mg</i>	0	
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>		
INCRELEX INJ 40MG/4ML	3	PA

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL SOL 2MG/ML	3	
<b>MENOPAUSAL SYMPTOMS SUPPRESSANTS</b>		
VEOZAH TAB 45MG	3	
<b>METABOLIC MODIFIERS</b>		
BUPHENYL POW	3	PA, QL (798 GRAMS PER 30 DAYS)
BUPHENYL TAB 500MG	3	PA, QL (1200 TABLETS PER 30 DAYS)
<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	
CARBAGLU TAB 200MG	3	PA; MNPA
<i>carglumic acid soluble tab 200 mg</i>	1	PA
CARNITOR SF SOL 1GM/10ML	3	PA; MNPA
CARNITOR SOL 1GM/10ML	3	PA; MNPA
CARNITOR TAB 330MG	3	PA; MNPA
<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)
CITRULLINE TAB EASY 1GM	3	
CYSTADANE POW	3	PA; MNPA
<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	3	PA, QL (14 CAPSULES PER 28 DAYS)
KUVAN POW 100MG	3	PA; MNPA
KUVAN POW 500MG	3	PA; MNPA
KUVAN TAB 100MG	3	PA; MNPA
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	
<i>levocarnitine tab 330 mg</i>	1	

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MYALEPT INJ 11.3MG	3	PA, QL (30 VIALS PER 30 DAYS)
<i>nitisinone cap 2 mg</i>	1	PA
<i>nitisinone cap 5 mg</i>	1	PA
<i>nitisinone cap 10 mg</i>	1	PA
NITYR TAB 2MG	3	PA; MNPA
NITYR TAB 5MG	3	PA; MNPA
NITYR TAB 10MG	3	PA; MNPA
OLPRUVA PAK 2GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
OLPRUVA PAK 3GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
OLPRUVA PAK 4 GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
OLPRUVA PAK 5GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
OLPRUVA PAK 6.67GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
OLPRUVA PAK 6GM	3	PA, QL (90 ENVELOPES (1 kit) PER 30 DAYS)
ORFADIN CAP 2MG	2	PA
ORFADIN CAP 5MG	2	PA
ORFADIN CAP 10MG	2	PA
ORFADIN CAP 20MG	2	PA
ORFADIN SUS 4MG/ML	2	PA
PALYNZIQ INJ 2.5/0.5	3	PA, QL (8 PFS PER 28 DAYS)
PALYNZIQ INJ 10/0.5ML	3	PA, QL (30 PFS PER 30 DAYS)
PALYNZIQ INJ 20MG/ML	3	PA, QL (90 PFS PER 30 DAYS)
<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	3	PA, QL (672 GRAMS (8 BOTTLES) PER 30 DAYS)

**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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RAVICTI LIQ 1.1GM/ML	3	PA
REVCIVI INJ 1.6MG/ML	3	
ROCALTROL CAP 0.5MCG	2	
ROCALTROL CAP 0.25MCG	2	
ROCALTROL SOL 1MCG/ML	2	
<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	3	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 60MG	3	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 90MG	3	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	3	PA
STRENSIQ INJ 28/0.7ML	3	PA
STRENSIQ INJ 40MG/ML	3	PA
STRENSIQ INJ 80/0.8ML	3	PA
XURIDEN POW 2GM	3	QL (4 PACKETS PER DAY)
ZEMPLAR CAP 1MCG	2	
ZEMPLAR CAP 2MCG	2	
<b>MINERALOCORTICOID RECEPTOR ANTAGONISTS</b>		
KERENDIA TAB 10MG	3	PA
KERENDIA TAB 20MG	3	PA
<b>NATRIURETIC PEPTIDES</b>		
VOXZOGO INJ 0.4MG	3	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 0.56MG	3	PA, QL (30 VIALS PER 30 DAYS)

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

233

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VOXZOGO INJ 1.2MG	3	PA, QL (30 VIALS PER 30 DAYS)
<b>POSTERIOR PITUITARY HORMONES</b>		
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	
STIMATE SOL 1.5MG/ML	3	PA
<b>PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX TAB 200MG	3	
<i>mifepristone tab 200 mg</i>	1	\$0 copay based on your plan/benefit
<b>PROLACTIN INHIBITORS</b>		
<i>cabergoline tab 0.5 mg</i>	1	
<b>SOMATOSTATIC AGENTS</b>		
BYNFEZIA PEN INJ 2500MCG	3	PA, QL (7 pens every 30 days)
MYCAPSSA CAP 20MG	3	PA, QL (112 CAPSULES PER 28 DAYS)
<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)
<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)

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

234

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SANDOSTATIN INJ 50MCG/ML	3	PA, QL (90 ampules every 30 days)
SANDOSTATIN INJ 100MCG	3	PA, QL (90 VIALS PER 30 DAYS)
SANDOSTATIN INJ 500MCG	3	PA, QL (90 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.3MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.6MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.9MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)

**VASOPRESSIN RECEPTOR ANTAGONISTS**

JYNARQUE PAK 15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 30-15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 45-15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 60-30MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 90-30MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE TAB 15MG	3	PA, QL (60 TABLETS PER 30 DAYS)
JYNARQUE TAB 30MG	3	PA, QL (30 TABLETS PER 30 DAYS)
SAMSCA TAB 15MG	3	PA, QL (60 TABLETS PER 30 DAYS)
SAMSCA TAB 30MG	3	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	
-----------------------	---	--

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

235

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ANGELIQ TAB 0.5-1MG	3	
ANGELIQ TAB 0.25-0.5	3	
BIJUVA CAP 1-100MG	3	
CLIMARA PRO DIS WEEKLY	2	
COMBIPATCH DIS	2	
DUAVEE TAB 0.45-20	2	
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	
estradiol & norethindrone acetate tab 1-0.5 mg	1	
FEMHRT TAB 0.5-2.5	3	
MYFEMBREE TAB	2	PA
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	1	
ORIAHNN CAP	2	PA
PREFEST TAB	3	
PREMPHASE TAB	2	
PREMPRO TAB	2	
PREMPRO TAB 0.3-1.5	2	
PREMPRO TAB 0.45-1.5	2	
PREMPRO TAB 0.625-5	2	
<b>ESTROGENS</b>		
ALORA DIS 0.1MG	3	
ALORA DIS 0.05MG	3	
ALORA DIS 0.025MG	3	
ALORA DIS 0.075MG	3	
CLIMARA DIS 0.1MG	3	MNPA
CLIMARA DIS 0.05MG	3	MNPA
CLIMARA DIS 0.06MG	3	QL (2 ea every 25 days); MNPA
CLIMARA DIS 0.025MG	3	MNPA
CLIMARA DIS 0.075MG	3	MNPA
CLIMARA DIS 0.0375MG	3	MNPA
DELESTROGEN INJ 10MG/ML	3	PA

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

236

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
ELESTRIN GEL 0.06%	3	
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	
<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
ESTROGEL GEL	3	

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

237

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EVAMIST SPR 1.53MG	2	
MENEST TAB 0.3MG	3	MNPA
MENEST TAB 0.625MG	3	MNPA
MENEST TAB 1.25MG	3	MNPA
MENOSTAR DIS 14MCG	3	
MINIVELLE DIS 0.1MG	3	MNPA
MINIVELLE DIS 0.05MG	3	MNPA
MINIVELLE DIS 0.025MG	3	MNPA
MINIVELLE DIS 0.075MG	3	MNPA
MINIVELLE DIS 0.0375MG	3	MNPA
PREMARIN INJ 25MG	3	PA
PREMARIN TAB 0.3MG	2	MNPA
PREMARIN TAB 0.9MG	2	MNPA
PREMARIN TAB 0.45MG	2	MNPA
PREMARIN TAB 0.625MG	2	MNPA
PREMARIN TAB 1.25MG	2	MNPA
VIVELLE-DOT DIS 0.1MG	3	MNPA
VIVELLE-DOT DIS 0.05MG	3	MNPA
VIVELLE-DOT DIS 0.025MG	3	MNPA
VIVELLE-DOT DIS 0.075MG	3	MNPA
VIVELLE-DOT DIS 0.0375MG	3	MNPA

**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	

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

238

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>GASTROINTESTINAL AGENTS - MISC.</b>		
<b>5-HT4 RECEPTOR AGONISTS</b>		
MOTEGRITY TAB 1MG	3	
MOTEGRITY TAB 2MG	3	
<b>AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)</b>		
TRULANCE TAB 3MG	3	
<b>BILE ACID SYNTHESIS DISORDER AGENTS</b>		
CHOLBAM CAP 50MG	3	PA
CHOLBAM CAP 250MG	3	PA
<b>FARNESOID X RECEPTOR (FXR) AGONISTS</b>		
OCALIVA TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OCALIVA TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
<b>GALLSTONE SOLUBILIZING AGENTS</b>		
CHENODAL TAB 250MG	3	
RELTONE CAP 200MG	3	PA
RELTONE CAP 400MG	3	PA
URSO 250 TAB 250MG	2	
URSO FORTE TAB 500MG	2	
<i>ursodiol cap 300 mg</i>	1	
<i>ursodiol tab 250 mg</i>	1	
<i>ursodiol tab 500 mg</i>	1	
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	
GASTROCROM CON 100/5ML	3	
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>		
AMITIZA CAP 8MCG	3	MNPA
AMITIZA CAP 24MCG	3	MNPA
<i>lubiprostone cap 8 mcg</i>	1	

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

239

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lubiprostone cap 24 mcg</i>	1	
<b>GASTROINTESTINAL STIMULANTS</b>		
GIMOTI SPR 15MG	3	
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	
<b>ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS</b>		
BYLVAY CAP 200MCG	3	PA, QL (360 caps per 30 days)
BYLVAY CAP 400MCG	3	PA, QL (540 caps per 30 days)
BYLVAY CAP 600MCG	3	PA, QL (120 caps per 30 days)
BYLVAY CAP 1200MCG	3	PA, QL (180 caps per 30 days)
LIVMARLI SOL 9.5MG/ML	3	PA, QL (90 ML PER 30 DAYS)
<b>INFLAMMATORY BOWEL AGENTS</b>		
APRISO CAP 0.375GM	3	
ASACOL HD TAB 800MG	3	MNPA
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
<i>balsalazide disodium cap 750 mg</i>	1	
CANASA SUP 1000MG	3	

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

240

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CIMZIA KIT 200MG	3	PA, QL (2 KITS PER 28 DAYS); Preferred agent for Non-radiographic Axial Spondyloarthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:3 KITS (6 VIALS) PER 28 DAYS
CIMZIA PREFL KIT 200MG/ML	3	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. MNPA
CIMZIA START KIT 200MG/ML	3	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. MNPA
COLAZAL CAP 750MG	3	PA; MNPA
DELZICOL CAP 400MG	3	MNPA
DIPENTUM CAP 250MG	3	
LIALDA TAB 1.2GM	3	MNPA
<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	

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

241

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mesalamine rectal enema 4 gm &amp; 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	
PENTASA CAP 250MG CR	2	MNPA
PENTASA CAP 500MG CR	2	MNPA
ROWASA KIT 4GM	3	
SFROWASA ENE 4GM	3	
SKYRIZI INJ 180/1.2	2	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	2	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	
<b>INTESTINAL ACIDIFIERS</b>		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	
<b>IRRITABLE BOWEL SYNDROME (IBS) AGENTS</b>		
<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	

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

242

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LINZESS CAP 290MCG	2	
LOTRONEX TAB 0.5MG	3	
LOTRONEX TAB 1MG	3	
VIBERZI TAB 75MG	2	
VIBERZI TAB 100MG	2	
ZELNORM TAB 6MG	3	
<b>LIVE FECAL MICROBIOTA</b>		
VOWST CAP	3	PA, QL (12 CAPSULES PER 30 DAYS)
<b>PERIPHERAL OPIOID RECEPTOR ANTAGONISTS</b>		
<i>alvimopan cap 12 mg</i>	1	
ENTEREG CAP 12MG	3	
MOVANTIK TAB 12.5MG	2	PA; MNPA
MOVANTIK TAB 25MG	2	PA; MNPA
RELISTOR INJ 8/0.4ML	3	PA
RELISTOR INJ 12/0.6ML	3	PA
RELISTOR TAB 150MG	3	PA
SYMPROIC TAB 0.2MG	2	PA
<b>PHOSPHATE BINDER AGENTS</b>		
AURYXIA TAB 210MG	2	
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	
FOSRENOL CHW 500MG	3	PA; MNPA
FOSRENOL CHW 750MG	3	PA; MNPA
FOSRENOL CHW 1000MG	3	PA; MNPA
FOSRENOL POW 750MG	3	MNPA
FOSRENOL POW 1000MG	3	MNPA
<i>lanthanum carbonate chew tab 500 mg (elemental)</i>	1	PA; MNPA
<i>lanthanum carbonate chew tab 750 mg (elemental)</i>	1	PA; MNPA
<i>lanthanum carbonate chew tab 1000 mg (elemental)</i>	1	PA; MNPA
PHOSLYRA SOL	3	
RENAGEL TAB 800MG	3	

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

243

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RENVELA POW 0.8GM	3	
RENVELA POW 2.4GM	3	
RENVELA 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	
VELPHORO CHW 500MG	2	
<b>SHORT BOWEL SYNDROME (SBS) AGENTS</b>		
GATTEX KIT 5MG	3	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
<b>TRYPTOPHAN HYDROXYLASE INHIBITORS</b>		
XERMELO TAB 250MG	3	PA, QL (90 TABLETS PER 30 DAYS)
<b>GENITOURINARY AGENTS - MISCELLANEOUS</b>		
<b>ACIDIFIERS</b>		
K-PHOS TAB NO 2	3	
<b>ALKALINIZERS</b>		
ORACIT SOL	3	
<i>pot &amp; sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	1	
<i>potassium citrate &amp; citric acid powder pack 3300-1002 mg</i>	1	
<i>potassium citrate &amp; 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	
<i>sodium citrate &amp; citric acid soln 500-334 mg/5ml</i>	1	
UROCIT-K 5 TAB	2	
UROCIT-K 10 TAB	2	
UROCIT-K 15 TAB	2	

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

244

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CYSTINOSIS AGENTS</b>		
CYSTAGON CAP 50MG	3	PA
CYSTAGON CAP 150MG	3	PA
PROCYSBI CAP 25MG	3	PA, QL (240 CAPSULES PER 30 DAYS)
PROCYSBI CAP 75MG	3	PA, QL (750 CAPSULES PER 30 DAYS)
PROCYSBI GRA 75MG	3	PA, QL (180 PACKETS PER 30 DAYS)
PROCYSBI GRA 300MG	3	PA, QL (180 PACKETS PER 30 DAYS)
<b>INTERSTITIAL CYSTITIS AGENTS</b>		
ELMIRON CAP 100MG	3	MNPA
PENTOSAN CAP 150MG	3	
PENTOSAN CAP 200MG	3	
RIMSO-50 SOL 50%	3	PA; MNPA
<b>PROSTATIC HYPERTROPHY AGENTS</b>		
<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	
JALYN CAP	3	MNPA
PROSCAR TAB 5MG	3	
RAPAFLO CAP 4MG	3	MNPA
RAPAFLO CAP 8MG	3	MNPA
<i>silodosin cap 4 mg</i>	1	
<i>silodosin cap 8 mg</i>	1	
<i>tamsulosin hcl cap 0.4 mg</i>	1	
UROXATRAL TAB 10MG	3	PA; MNPA
<b>URINARY ANALGESICS</b>		
<i>phenazopyridine hcl tab 200 mg</i>	1	

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

245

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>URINARY STONE AGENTS</b>		
LITHOSTAT TAB 250MG	3	MNPA
THIOLA EC TAB 100MG	3	MNPA
THIOLA EC TAB 300MG	3	MNPA
<i>tiopronin tab 100 mg</i>	1	PA
<b>GOUT AGENTS</b>		
<b>GOUT AGENT COMBINATIONS</b>		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	
<b>GOUT AGENTS</b>		
<i>allopurinol tab 100 mg</i>	1	
<i>allopurinol tab 300 mg</i>	1	
<i>colchicine cap 0.6 mg</i>	1	QL (60 caps per 30 days)
<i>colchicine tab 0.6 mg</i>	1	QL (120 tabs per 30 days)
COLCRYS TAB 0.6MG	3	QL (120 tabs per 30 days); MNPA
<i>febuxostat tab 40 mg</i>	1	
<i>febuxostat tab 80 mg</i>	1	
GLOPERBA SOL 0.6/5ML	3	QL (300 mL per 30 days)
MITIGARE CAP 0.6MG	3	QL (60 caps per 30 days)
ULORIC TAB 40MG	3	MNPA
ULORIC TAB 80MG	3	MNPA
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
<b>URICOSURICS</b>		
<i>probenecid tab 500 mg</i>	1	
<b>HEMATOLOGICAL AGENTS - MISC.</b>		
<b>ANTIHEMOPHILIC PRODUCTS</b>		
HEMLIBRA INJ 30MG/ML	3	PA
HEMLIBRA INJ 60/0.4	3	PA
HEMLIBRA INJ 105/0.7	3	PA
HEMLIBRA INJ 150/ML	3	PA
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
FIRAZYR INJ 30MG/3ML	3	PA, QL (45 syringes every 90 days); MNPA

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

246

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	1	PA, QL (45 syringes every 90 days)
<b>COMPLEMENT INHIBITORS</b>		
BERINERT INJ 500UNIT	3	PA, QL (60 VIALS PER 90 DAYS); MNPA
CINRYZE SOL 500 UNIT	3	PA, QL (20 VIALS PER 30 DAYS); MNPA
HAEGARDA INJ 2000UNIT	3	PA, QL (20 VIALS PER 30 DAYS)
HAEGARDA INJ 3000UNIT	3	PA, QL (20 VIALS PER 30 DAYS)
RUCONEST INJ 2100UNIT	2	PA, QL (60 VIALS PER 90 DAYS)
<b>HEMATAOLOGIC - TYROSINE KINASE INHIBITORS</b>		
TAVALISSE TAB 100MG	2	PA, QL (60 TABLETS PER 30 DAYS)
TAVALISSE TAB 150MG	2	PA, QL (60 TABLETS PER 30 DAYS)
<b>HEMATORHEOLOGIC AGENTS</b>		
<i>pentoxifylline tab er 400 mg</i>	1	
<b>PLASMA KALLIKREIN INHIBITORS</b>		
KALBITOR INJ 10MG/ML	3	PA, QL (30 CARTONS (900 MG) PER 90 DAYS)
ORLADEYO CAP 110MG	2	PA, QL (28 CAPSULES PER 28 DAYS)
ORLADEYO CAP 150MG	2	PA, QL (28 CAPSULES PER 28 DAYS)
TAKHZYRO INJ 150MG/ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
TAKHZYRO INJ 300/2ML	2	PA, QL (2 VIALS PER 28 DAYS)
<b>PLATELET AGGREGATION INHIBITORS</b>		
AGRYLIN CAP 0.5MG	2	
<i>anagrelide hcl cap 0.5 mg</i>	1	
<i>anagrelide hcl cap 1 mg</i>	1	

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

247

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ASA/OMEPRAZO TAB 81-40MG	3	
ASP/OMEPRAZO TAB 325-40MG	3	
<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	
DURLAZA CAP 162.5MG	3	
EFFIENT TAB 5MG	3	
EFFIENT TAB 10MG	3	
PLAVIX TAB 75MG	3	MNPA
<i>prasugrel hcl tab 5 mg (base equiv)</i>	1	
<i>prasugrel hcl tab 10 mg (base equiv)</i>	1	
YOSPRALA TAB 81-40MG	3	
YOSPRALA TAB 325-40MG	3	
ZONTIVITY TAB 2.08MG	3	MNPA
<b>PYRUVATE KINASE ACTIVATORS</b>		
PYRUKYND TAB 5MG	3	PA, QL (1 PACK PER 28 DAYS)
PYRUKYND TAB 20MG	3	PA, QL (1 PACK PER 28 DAYS)
PYRUKYND TAB 50MG	3	PA, QL (1 PACK PER 28 DAYS)
<b>HEMATOPOIETIC AGENTS</b>		
<b>AGENTS FOR GAUCHER DISEASE</b>		
CERDELGA CAP 84MG	2	PA, QL (56 CAPSULES PER 28 DAYS)
<i>miglustat cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)

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

248

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZAVESCA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS)
<b>AGENTS FOR SICKLE CELL DISEASE</b>		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	
ENDARI POW 5GM	2	PA, QL (180 PACKETS PER 30 DAYS)
OXBRYTA TAB 300MG	3	PA, QL (150 TABLETS PER 30 DAYS)
OXBRYTA TAB 500MG	3	PA, QL (90 TABLETS PER 30 DAYS)
SIKLOS TAB 100MG	2	
SIKLOS TAB 1000MG	2	
<b>COBALAMINS</b>		
CYANOCOBALAM SOL 2000MCG	3	PA
<i>cyanocobalamin inj 1000 mcg/ml</i>	1	PA
NASCOBAL SPR 500MCG	3	
<b>FOLIC ACID/FOLATES</b>		
<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
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
ARANESP INJ 10MCG	2	PA
ARANESP INJ 25MCG	2	PA
ARANESP INJ 40MCG	2	PA
ARANESP INJ 60MCG	2	PA
ARANESP INJ 100MCG	2	PA
ARANESP INJ 150MCG	2	PA
ARANESP INJ 200MCG	2	PA
ARANESP INJ 300MCG	2	PA

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

249

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ARANESP INJ 500MCG	2	PA
DOPTELET TAB 20MG	2	PA, QL (60 tabs every 30 days)
DOPTELET TAB 20MG	2	PA, QL (90 tabs every 30 days)
EPOGEN INJ 2000/ML	3	PA; MNPA
EPOGEN INJ 3000/ML	3	PA; MNPA
EPOGEN INJ 4000/ML	3	PA; MNPA
EPOGEN INJ 10000/ML	3	PA; MNPA
EPOGEN INJ 20000/ML	3	PA; MNPA
FULPHILA INJ 6/0.6ML	3	PA, QL (2 SYRINGES PER 28 DAYS); MNPA
FYLNETRA INJ 6MG/0.6	2	PA, QL (2 PFS PER 28 DAYS)
GRANIX INJ 300/0.5	2	PA; MNPA
GRANIX INJ 480/0.8	2	PA; MNPA
LEUKINE INJ 250MCG	3	PA; MNPA
MIRCERA INJ 30MCG	3	PA
MIRCERA INJ 50MCG	3	PA
MIRCERA INJ 75MCG	3	PA
MIRCERA INJ 100MCG	3	PA
MIRCERA INJ 120MCG	3	PA
MIRCERA INJ 150MCG	3	PA
MIRCERA INJ 200MCG	3	PA
MULPLETA TAB 3MG	3	PA, QL (7 TABLETS PER 14 DAYS)
NEULASTA INJ 6MG/0.6M	2	PA, QL (2 SYRINGES PER 28 DAYS); MNPA
NEULASTA KIT 6MG/0.6M	2	PA, QL (2 SYRINGES PER 28 DAYS); MNPA
NEUPOGEN INJ 300/0.5	2	PA; MNPA
NEUPOGEN INJ 300MCG	2	PA; MNPA
NEUPOGEN INJ 480/0.8	2	PA; MNPA
NEUPOGEN INJ 480MCG	2	PA; MNPA
NIVESTYM INJ 300/0.5	2	PA

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

250

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NIVESTYM INJ 300MCG	2	PA
NIVESTYM INJ 480/0.8	2	PA
NIVESTYM INJ 480MCG	2	PA
NYVEPRIA INJ 6/0.6ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
PROCRIT INJ 2000/ML	2	PA; MNPA
PROCRIT INJ 3000/ML	2	PA; MNPA
PROCRIT INJ 4000/ML	2	PA; MNPA
PROCRIT INJ 10000/ML	2	PA; MNPA
PROCRIT INJ 20000/ML	2	PA; MNPA
PROCRIT INJ 40000/ML	2	PA; MNPA
PROMACTA PAK 25MG	2	PA, QL (180 PACKETS PER 30 DAYS)
PROMACTA POW 12.5MG	2	PA, QL (120 PACKETS PER 30 DAYS)
PROMACTA TAB 12.5MG	2	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 25MG	2	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 50MG	2	PA, QL (60 TABLETS PER 30 DAYS)
PROMACTA TAB 75MG	2	PA, QL (60 TABLETS PER 30 DAYS)
RETACRIT INJ 2000UNIT	2	PA
RETACRIT INJ 3000UNIT	2	PA
RETACRIT INJ 4000UNIT	2	PA
RETACRIT INJ 10000UNT	2	PA
RETACRIT INJ 20000UNI	2	PA
RETACRIT INJ 40000UNT	2	PA
STIMUFEND INJ 6/0.6ML	3	PA, QL (2 SYRINGES PER 28 DAYS)
UDENYCA INJ 6MG/.6ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
ZARXIO INJ 300/0.5	2	PA; MNPA
ZARXIO INJ 480/0.8	2	PA; MNPA

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

251

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZIEXTENZO INJ 6/0.6ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
<b>HEMATOPOIETIC MIXTURES</b>		
FERIVA TAB 21/7	3	PA; MNPA
<i>folic acid-cholecalciferol tab 1 mg-3775 unit</i>	1	PA; MNPA
ORTHO DF CAP 1-3775IU	3	PA; MNPA
TALIVA CAP	3	PA; MNPA
<b>HEMOSTATICS</b>		
<b>HEMOSTATICS - SYSTEMIC</b>		
AMICAR SOL 0.25/ML	3	
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	
<i>aminocaproic acid tab 1000 mg</i>	1	
LYSTEDA TAB 650MG	3	
<i>tranexamic acid tab 650 mg</i>	1	
<b>HEMOSTATICS - TOPICAL</b>		
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	
<b>HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS</b>		
<b>BARBITURATE HYPNOTICS</b>		
<i>phenobarbital elixir 20 mg/5ml</i>	1	
<i>phenobarbital tab 15 mg</i>	1	
<i>phenobarbital tab 16.2 mg</i>	1	

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

252

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>HYPNOTICS - TRICYCLIC AGENTS</b>		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
SILENOR TAB 3MG	3	MNPA
SILENOR TAB 6MG	3	MNPA
<b>NON-BARBITURATE HYPNOTICS</b>		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	
EDLUAR SUB 5MG	3	MNPA
EDLUAR SUB 10MG	3	MNPA
<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	
IGALMI MIS 120MCG	3	
IGALMI MIS 180MCG	3	
LUNESTA TAB 1MG	3	MNPA
LUNESTA TAB 2MG	3	MNPA
LUNESTA TAB 3MG	3	MNPA
<i>quazepam tab 15 mg</i>	1	PA; MNPA
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	

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

253

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
ZOLPIDEM TAR CAP 7.5MG	3	
<i>zolpidem tartrate sl tab 1.75 mg</i>	1	PA; MNPA
<i>zolpidem tartrate sl tab 3.5 mg</i>	1	PA; MNPA
<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	
ZOLPIMIST SPR 5MG	3	PA; MNPA
<b>OREXIN RECEPTOR ANTAGONISTS</b>		
BELSOMRA TAB 5MG	2	
BELSOMRA TAB 10MG	2	
BELSOMRA TAB 15MG	2	
BELSOMRA TAB 20MG	2	
DAYVIGO TAB 5MG	2	
DAYVIGO TAB 10MG	2	
QUVIVIQ TAB 25MG	2	
QUVIVIQ TAB 50MG	2	
<b>SELECTIVE MELATONIN RECEPTOR AGONISTS</b>		
HETLIOZ CAP 20MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	3	PA, QL (5 ML PER DAY)
<i>ramelteon tab 8 mg</i>	1	
ROZEREM TAB 8MG	3	MNPA
<i>tasimelteon capsule 20 mg</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)

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

254

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LAXATIVES</b>		
<b>LAXATIVE COMBINATIONS</b>		
<i>bisacodyl tab &amp; peg 3350-kcl-sod bicarb-nacl for soln kit</i>	0	\$0 copay for members age 45 through 75
CLENPIQ SOL	0	\$0 copay for members age 45 through 75
GOLYTELY SOL	3	MNPA
MOVIPREP SOL	3	MNPA
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-nacl-na sulfate-na ascorbate-c for soln 100 gm</i>	0	\$0 copay for members age 45 through 75;MNPA
<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
PLENVU SOL	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
SUPREP BOWEL SOL PREP KIT	2	MNPA
SUTAB TAB	0	\$0 copay for members age 45 through 75
<b>LAXATIVES - MISCELLANEOUS</b>		
KRISTALOSE PAK 10GM	3	
KRISTALOSE PAK 20GM	3	
LACTULOSE PAK 10GM	3	PA; MNPA
<i>lactulose solution 10 gm/15ml</i>	1	
<b>SALINE LAXATIVES</b>		
OSMOPREP TAB 1.5GM	3	MNPA
<b>STIMULANT LAXATIVES</b>		
CASCARA EXT SAGRADA	3	

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

255

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MACROLIDES</b>		
<b>AZITHROMYCIN</b>		
<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	
<b>CLARITHROMYCIN</b>		
<i>clarithromycin for susp 125 mg/5ml</i>	1	
<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	
<b>ERYTHROMYCINS</b>		
E.E.S. GRAN SUS 200/5ML	3	PA; MNPA
ERYPED SUS 200/5ML	3	PA; MNPA
ERYPED SUS 400/5ML	3	PA; MNPA
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	MNPA
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	MNPA
<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	

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

256

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
erythromycin tab delayed release 500 mg	1	
erythromycin w/ delayed release particles cap 250 mg	1	
<b>FIDAXOMICIN</b>		
DIFICID SUS	2	
DIFICID TAB 200MG	2	
<b>MEDICAL DEVICES AND SUPPLIES</b>		
<b>BANDAGES-DRESSINGS-TAPE</b>		
REALSIL-6 MIS	3	
<b>CONTRACEPTIVES</b>		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 boxes every 25 days)
FC FEMALE MIS CONDOM	0	QL (12 boxes every 25 days)
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)
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)
<b>DIABETIC SUPPLIES</b>		
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	

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

257

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

258

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

259

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

260

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 G5 MIS RECEIVER	0	
DEXCOM G5 MIS TRANSMIT	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	
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	

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

261

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	
EASYSTEP HGH SOL CONTROL	0	
EASYSTEP LOW SOL CONTROL	0	
ELEMENT CONT LIQ NORMAL	0	

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

262

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
ENLITE GLUCO MIS SENSOR	0	QL (5 sensors per month)
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	
EVERSENSE E3 MIS SENSOR	0	QL (1 sensor per 150 days)
EVERSENSE MIS SENSOR	0	QL (1 sensor per 75 days)
EVOLUTION SOL NORMAL	0	
EZ-LETS 21G MIS LANCETS	0	
EZ-LETS 26G MIS LANCETS	0	
EZ-LETS 28G MIS LANCETS	0	
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	

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

263

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
FREESTY LIBR KIT 2 SENSOR	0	QL (2 sensors per month)
FREESTY LIBR KIT 3 SENSOR	0	QL (2 sensors per month)
FREESTY LIBR MIS 2 READER	0	FREESTYLE LIBRE
FREESTYLE KIT SENSOR	0	QL (2 sensors per month)
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS READER	0	FREESTYLE LIBRE
FREESTYLE MIS UNISTICK	0	
G4 PLAT PED MIS RVC/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS PEDIATRC	0	QL (1 each every year)
G4 PLATINUM MIS RCV/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS RECEIVER	0	
G4 PLATINUM MIS TRANSMIT	0	
G4 SENSOR MIS	0	QL (3 boxes every 30 days)
G5/G4 MIS SENSOR	0	QL (3 sensors per month)
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	

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

264

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	
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	

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

265

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GOJJI MIS LANC DEV	0	
GOODSENSE MIS LANC 26G	0	
GOODSENSE MIS LANC 30G	0	
GOODSENSE MIS LANC 33G	0	
GOODSENSE MIS LANC DVC	0	
GUARDIAN 4 MIS SENSOR	0	QL (5 sensors per month)
GUARDIAN MIS SENSOR 3	0	QL (5 sensors per month)
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	

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

266

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

267

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

268

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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 DASH KIT PDM	0	PA, QL (1 kit per 999 days)
OMNIPOD GO KIT 10UNT/DY	0	
OMNIPOD GO KIT 15UNT/DY	0	
OMNIPOD GO KIT 20UNT/DY	0	
OMNIPOD GO KIT 25UNT/DY	0	
OMNIPOD GO KIT 30UNT/DY	0	
OMNIPOD GO KIT 35UNT/DY	0	
OMNIPOD GO KIT 40UNT/DY	0	
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 KIT ULTRA 2	0	
ONETOUCH KIT VERIO FL	0	
ONETOUCH KIT VERIO RE	0	
ONETOUCH LIQ ULT CONT	0	
ONETOUCH LIQ VERIO	0	
ONETOUCH LIQ VERIO 4	0	

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

269

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

270

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
RELION KIT LANCING	0	
RELION LANCE MIS THIN 26G	0	
RELION LANCE MIS THIN 30G	0	
RELION LANCI 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	

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

271

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

272

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

273

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

274

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

275

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	PA, QL (30 pumps per month)
V-GO 40 KIT	0	PA, 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	
VIVAGUARD MIS 30G	0	
VIVAGUARD MIS LANCING	0	
<b>MISC. DEVICES</b>		
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	

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

276

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	QL (2 ea every 25 days)
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	
SM ALCOHOL PAD PREP	0	
ULTICARE PAD ALCOHOL	0	
ULTILET PAD ALCOHOL	0	
WEBCOL PREP PAD LARGE	0	
WEBCOL PREP PAD MEDIUM	0	
<b>PARENTERAL THERAPY SUPPLIES</b>		
BD U-500 MIS 31GX6MM	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	MNPA
BD ULTRAFINE PEN NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
CEQUR SIMPL KIT PATCH 2U	0	
COMFORT EZ MIS 31GX5/16	0	MNPA
HM INSULIN S MIS 0.3/31G	0	MNPA
HM INSULIN S MIS 1ML/30G	0	MNPA
INPEN 100EL MIS BLUE-HUM	0	

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

277

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSULIN SRYG MIS 1ML/32G	0	MNPA
SYRINGE MIS 0.5/30G	0	MNPA
1ML SYRINGE MIS 29G	0	MNPA
1ML SYRINGE MIS 30G	0	MNPA
<b>RESPIRATORY THERAPY SUPPLIES</b>		
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	
BREATHE EASE MIS LG MASK	3	
BREATHE EASE MIS MED MASK	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	
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	

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

278

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSPIRACHAMB MIS MOUTH PCE	3	
INSPIRACHAMB MIS SMALL	3	
INSPIREASE MIS DD SYST	3	
INSPIREASE MIS RES BAG	3	
MICROCHAMBER MIS	3	
OPTICHAMBER MIS DIA MD	3	
OPTICHAMBER MIS DIA SM	3	
OPTICHAMBER MIS DIAMOND	3	
POCKET CHAMB MIS	3	
POCKET SPACE MIS	3	
RITEFLO MIS	3	
TRUZONE PEAK MIS FLOW MTR	3	

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

AIMOVIG INJ 70MG/ML	2	ST, QL (2 pens every 25 days)
AIMOVIG INJ 140MG/ML	2	ST, QL (1 pen every 25 days)
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	PA, QL (16 tabs every 25 days)

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

279

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
UBRELVY TAB 100MG	2	PA, QL (16 ea every 25 days)
ZAVZPRET SPR 10MG	3	
<b>MIGRAINE COMBINATIONS</b>		
CAFERGOT TAB 1-100MG	3	PA; MNPA
<i>ergotamine w/ caffeine suppos 2-100 mg</i>	1	PA; MNPA
<i>ergotamine w/ caffeine tab 1-100 mg</i>	1	PA; MNPA
<i>sumatriptan-naproxen sodium tab 85-500 mg</i>	1	PA, QL (9 tabs every 30 days); MNPA
TREXIMET TAB 85-500MG	3	PA, QL (9 tabs every 30 days); MNPA
<b>MIGRAINE PRODUCTS</b>		
<i>dihydroergotamine mesylate nasal spray 4 mg/ml</i>	1	PA, QL (8.01 mL every 30 days); MNPA
ERGOMAR SUB 2MG	3	
MIGRANAL SPR 4MG/ML	3	QL (8.01 mL every 30 days)
TRUDHESA AER 0.725MG	3	
<b>MIGRAINE PRODUCTS - NSAIDS</b>		
CAMBIA POW 50MG	3	MNPA
<i>diclofenac potassium (migraine) packet 50 mg</i>	1	MNPA
<b>SEROTONIN AGONISTS</b>		
<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)

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

280

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 INJ 6MG/0.5	3	QL (24 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)
MAXALT TAB 10MG	3	QL (30 tabs every 30 days); MNPA
MAXALT-MLT TAB 10MG	3	QL (30 tabs every 30 days); MNPA
<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)
ONZETRA XSAI MIS 11MG	2	QL (16 nosepieces every 25 days)
RELPAX TAB 20MG	3	QL (12 tabs every 30 days)
RELPAX 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)

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

281

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 (24 injections every 30 days)
<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	1	QL (24 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)
TOSYMRA SOL 10MG	3	QL (3 ea every 30 days)
ZEMBRACE SYM INJ 3/0.5ML	2	QL (24 injections every 25 days)
<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)

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

282

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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****POTASSIUM**

K-TAB TAB 8MEQ CR	3	
K-TAB TAB 10MEQ CR	2	
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**

CUPRIMINE CAP 250MG	3	MNPA
CUVRIOR TAB 300MG	3	PA

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

283

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DEPEN TITRA TAB 250MG	3	
<i>penicillamine cap 250 mg</i>	1	
<i>penicillamine tab 250 mg</i>	1	
SYPRINE CAP 250MG	3	MNPA
<i>trientine hcl cap 250 mg</i>	1	
<b>IMMUNOMODULATORS</b>		
JOENJA TAB 70MG	3	PA, QL (60 TABLETS PER 30 DAYS)
<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)
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)
RYSTIGGO INJ 280/2ML	3	PA, QL (18 vials per 45 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)

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

284

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
THALOMID CAP 200MG	0	PA, QL (56 CAPSULES PER 28 DAYS)

**IMMUNOSUPPRESSIVE AGENTS**

ASTAGRAF XL CAP 0.5MG	3	
ASTAGRAF XL CAP 1MG	3	
ASTAGRAF XL CAP 5MG	3	
azathioprine tab 50 mg	1	
azathioprine tab 75 mg	2	
azathioprine tab 100 mg	2	
CELLCEPT CAP 250MG	3	
CELLCEPT SUS 200MG/ML	3	
CELLCEPT TAB 500MG	3	
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	
ENSPRYNG INJ	2	PA, QL (1 PFS PER 28 DAYS); LOADING DOSE: 3 PFS PER 29 DAYS
ENVARUSUS XR TAB 0.75MG	3	
ENVARUSUS XR TAB 1MG	3	
ENVARUSUS XR TAB 4MG	3	
everolimus tab 0.5 mg	1	
everolimus tab 0.25 mg	1	
everolimus tab 0.75 mg	1	
IMURAN TAB 50MG	2	
LUPKYNIS CAP 7.9MG	3	PA, QL (180 CAPS PER 30 DAYS)
mycophenolate mofetil cap 250 mg	1	
mycophenolate mofetil for oral susp 200 mg/ml	1	
mycophenolate mofetil tab 500 mg	1	
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)	1	

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

285

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>mycophenolate sodium tab dr 360 mg</i> ( <i>mycophenolic acid equiv</i> )	1	
MYFORTIC TAB 180MG	3	
MYFORTIC TAB 360MG	3	
NEORAL CAP 25MG	3	
NEORAL CAP 100MG	3	
NEORAL SOL 100MG/ML	3	
PROGRAF CAP 0.5MG	3	
PROGRAF CAP 1MG	3	
PROGRAF CAP 5MG	3	
PROGRAF GRA 0.2MG	3	
PROGRAF GRA 1MG	3	
RAPAMUNE SOL 1MG/ML	3	
RAPAMUNE TAB 0.5MG	3	
RAPAMUNE TAB 1MG	3	
RAPAMUNE TAB 2MG	3	
REZUROCK TAB 200MG	3	PA, QL (30 TABS FOR 30 DAYS)
SANDIMMUNE CAP 25MG	3	
SANDIMMUNE CAP 100MG	3	
SANDIMMUNE SOL 100MG/ML	3	
<i>sirolimus oral soln 1 mg/ml</i>	1	
<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	
ZORTRESS TAB 0.25MG	3	
ZORTRESS TAB 0.75MG	3	
ZORTRESS TAB 1MG	3	
<b>PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS</b>		
VIJOICE TAB 50MG	3	QL (1 CARTON PER 28 DAYS)

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

286

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIJOICE TAB 125MG	3	QL (1 CARTON PER 28 DAYS)
VIJOICE TAB 250MG	3	QL (1 CARTON PER 28 DAYS)
<b>POTASSIUM REMOVING AGENTS</b>		
LOKELMA PAK 5GM	2	
LOKELMA PAK 10GM	2	
<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	
<b>PROGERIA TREATMENT AGENTS</b>		
ZOKINVY CAP 50MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
<b>SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS</b>		
BENLYSTA INJ 200MG/ML	3	PA, QL (4 INJ PER 28 DAYS); LOADING DOSE: 8 SYR PER 28 DAYS
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<b>ANESTHETICS TOPICAL ORAL</b>		
<i>lidocaine hcl laryngotracheal soln 4%</i>	1	
<i>lidocaine hcl viscous soln 2%</i>	1	
<b>ANTI-INFECTIVES - THROAT</b>		
<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	
<b>ANTISEPTICS - MOUTH/THROAT</b>		
<i>chlorhexidine gluconate soln 0.12%</i>	1	
PERIDEX SOL 0.12%	3	
<b>DENTAL PRODUCTS</b>		
NAFRINSE DLY SOL /NEUTRAL	3	
<b>PA</b> - Prior Authorization <b>QL</b> - Quantity Limits <b>ST</b> - Step Therapy		287

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
sodium fluoride gel 1.1% (0.5% f)	1	
VANISH LIQ 5%	3	
<b>STEROIDS - MOUTH/THROAT/DENTAL</b>		
triamcinolone acetonide dental paste 0.1%	1	
<b>THROAT PRODUCTS - MISC.</b>		
cevimeline hcl cap 30 mg	1	
EVOXAC CAP 30MG	2	
ORAFATE PST 10%	3	
pilocarpine hcl tab 5 mg	1	
pilocarpine hcl tab 7.5 mg	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	2	
SALAGEN TAB 7.5MG	2	
<b>MULTIVITAMINS</b>		
<b>B-COMPLEX W/ FOLIC ACID</b>		
b-complex w/ c & folic acid tab	1	PA; MNPA
b-complex w/ c & folic acid tab 1 mg	1	PA; MNPA
b-complex w/ c & folic acid tab 5 mg	1	PA; MNPA
FOLIC-K CAP	3	PA; MNPA
<b>MULTIPLE VITAMINS W/ MINERALS</b>		
multiple vitamins w/ minerals cap	1	PA; MNPA
NICAZEL TAB	3	PA; MNPA
NICAZEL TAB FORTE	3	PA; MNPA
<b>PRENATAL VITAMINS</b>		
ATABEX EC TAB 29-1MG	3	MNPA
ATABEX OB TAB 29-1MG	3	MNPA
AZESCHEW CHW 13-1MG	3	
AZESCO TAB 13-1MG	3	PA; MNPA
C-NATE DHA CAP 28-1-200	3	MNPA
CITRANATAL CAP HARMONY	3	MNPA
CITRANATAL CAP MEDLEY	3	MNPA
CITRANATAL MIS	3	MNPA

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

288

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CITRANATAL MIS 90 DHA	3	MNPA
CITRANATAL MIS B-CALM	3	MNPA
CITRANATAL PAK ASSURE	3	MNPA
CITRANATAL PAK DHA	3	MNPA
CITRANATAL TAB BLOOM	3	MNPA
CITRANATAL TAB RX	3	MNPA
CO-NATAL FA TAB 29-1MG	3	MNPA
CONCEPT DHA CAP	3	MNPA
CONCEPT OB CAP	3	MNPA
DUET DHA 400 MIS 25-1-400	3	MNPA
DUET DHA MIS BALANCED	3	MNPA
ENBRACE HR CAP	3	
JENLIVA CAP	3	
KOSHR PRENAT TAB 30-1MG	3	
M-NATAL PLUS TAB	3	
MYNATAL CAP	3	
MYNATAL PLUS TAB	3	
MYNATAL-Z TAB	3	
NATACHEW CHW	3	MNPA
NATALVIT TAB 75-1MG	3	MNPA
NEEVO DHA CAP 27-1.13	3	MNPA
NEONATAL 19 TAB	3	
NEONATAL FE TAB	3	
NEONATAL PLS TAB 27-1MG	3	MNPA
NEONATAL TAB COMPLETE	3	
NEONATAL TAB COMPLTE	3	MNPA
NEONATAL/DHA MIS	3	
NESTABS DHA PAK	3	MNPA
NESTABS ONE CAP	3	
NESTABS TAB	3	MNPA
NIVA-PLUS TAB	3	MNPA
O-CAL TAB PRENATAL	3	
OB COMPLETE CAP ONE	3	MNPA
OB COMPLETE CAP PETITE	3	MNPA
OB COMPLETE TAB	3	MNPA

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

289

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
OB COMPLETE TAB PREMIER	3	MNPA
OB COMPLETE/ CAP DHA	3	MNPA
OBSTETRIX EC TAB	3	MNPA
OBSTETRIX MIS DHA	3	MNPA
OBSTETRX ONE CAP 38-1-225	3	
ONE VITE TAB 1MG PLUS	3	
PNV TAB 20-1 TAB	3	
PNV TABS TAB 29-1MG	3	MNPA
PNV-DHA CAP DOCUSATE	3	MNPA
PNV-OMEGA CAP	3	MNPA
PREGEN DHA CAP	3	
PREGENNA TAB	3	MNPA
PREMESISRX TAB	3	MNPA
PRENA1 CHW	3	MNPA
PRENA1 PEARL CAP	3	MNPA
PRENA 1 TRUE MIS	3	MNPA
PRENAISSANCE CAP	3	MNPA
PRENAISSANCE CAP PLUS	3	MNPA
PRENARA CAP PRENATAL	3	
<i>prenat w/o a w/fefum-methfol-fa-dha cap 27-0.6-0.4-300 mg</i>	1	
PRENATAL 19 CHW 29-1MG	3	MNPA
PRENATAL 19 TAB 29-1MG	3	MNPA
PRENATAL TAB 27-1MG	3	MNPA
PRENATAL VIT TAB LOW IRON	3	MNPA
<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	
PRENATAL+FE TAB 29-1MG	3	MNPA
PRENATAL-U CAP 106.5-1	3	MNPA
PRENATE AM TAB 1MG	3	MNPA
PRENATE CAP ENHANCE	3	MNPA

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

290

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRENATE CAP ESSENT	3	MNPA
PRENATE CAP PIXIE	3	MNPA
PRENATE CAP RESTORE	3	MNPA
PRENATE CHW 0.6-0.4	3	MNPA
PRENATE DHA CAP	3	MNPA
PRENATE MINI CAP	3	MNPA
PRENATE TAB ELITE	3	MNPA
PRENATRIX TAB	3	
PRENATRYL TAB	3	
PRENATVITE TAB COMPLETE	3	
PRENATVITE TAB PLUS	3	
PRENATVITE TAB RX	3	
PREPLUS TAB 27-1MG	3	MNPA
PRETAB TAB 29-1MG	3	MNPA
PRIMACARE CAP	3	
PROVIDA OB CAP	3	MNPA
REDICHEW RX CHW	3	MNPA
RELNATE DHA CAP	3	MNPA
SE-NATAL 19 CHW	3	MNPA
SE-NATAL 19 TAB	3	MNPA
SELECT-OB CHW	3	MNPA
SELECT-OB+ PAK DHA	3	MNPA
TARON-PREX CAP	3	MNPA
THRIVITE RX TAB 29-1MG	3	MNPA
TRICARE PRE CAP 27-1-500	3	
TRICARE TAB PRENATAL	3	MNPA
TRINAZ TAB 12-1MG	3	PA; MNPA
TRISTART CAP FREE	3	
TRISTART DHA CAP	3	
TRISTART ONE CAP 35-1-215	3	
VINATE DHA CAP 27-1.13	3	MNPA
VINATE II TAB	3	MNPA
VINATE ONE TAB	3	MNPA
VIRT-C DHA CAP	3	MNPA
VIRT-NATE CAP DHA	3	MNPA

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

291

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VIRT-PN DHA CAP	3	MNPA
VIRT-PN PLUS CAP	3	MNPA
VITAFOL CAP ULTRA	3	MNPA
VITAFOL CHW GUMMIES	3	MNPA
VITAFOL FE+ CAP	3	
VITAFOL STRP MIS 1MG	3	
VITAFOL-NANO TAB	3	MNPA
VITAFOL-OB PAK +DHA	3	MNPA
VITAFOL-OB TAB 65-1MG	3	MNPA
VITAFOL-ONE CAP	3	MNPA
VITAMEDMD CAP ONE RX	3	MNPA
VITAPEARL CAP	3	MNPA
VITATHELY TAB	3	
VITATRUE MIS	3	MNPA
VIVA DHA CAP	3	MNPA
VP-PNV-DHA CAP	3	MNPA
WESTAB PLUS TAB 27-1MG	3	
WESTGEL DHA CAP	3	
ZALVIT TAB 13-1MG	3	PA; MNPA
<b>VITAMIN MIXTURES</b>		
NICOMIDE TAB	3	PA; MNPA
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<b>CENTRAL MUSCLE RELAXANTS</b>		
AMRIX CAP 15MG	3	PA; MNPA
AMRIX CAP 30MG	3	PA; MNPA
BACLOFEN SOL 10MG/5ML	3	
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	
<i>carisoprodol tab 250 mg</i>	1	PA, QL (84 tabs every 25 days); MNPA
<i>carisoprodol tab 350 mg</i>	1	QL (84 tabs every 25 days)
<i>chlorzoxazone tab 250 mg</i>	3	PA; MNPA
<i>chlorzoxazone tab 375 mg</i>	1	PA; MNPA
<i>chlorzoxazone tab 500 mg</i>	1	

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

292

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>chlorzoxazone tab 500 mg</i>	1	PA; MNPA
<i>chlorzoxazone tab 750 mg</i>	1	PA; MNPA
<i>cyclobenzaprine hcl cap er 24hr 15 mg</i>	1	PA; MNPA
<i>cyclobenzaprine hcl cap er 24hr 30 mg</i>	1	PA; MNPA
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 7.5 mg</i>	1	PA; MNPA
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
LYVISPAH GRA 5MG	2	
LYVISPAH GRA 10MG	2	
LYVISPAH GRA 20MG	2	
<i>metaxalone tab 400 mg</i>	1	PA; MNPA
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	PA; MNPA
<i>methocarbamol tab 750 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	PA; MNPA
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
OZOBAX DS SOL 10MG/5ML	3	
OZOBAX SOL 5MG/5ML	3	
SKELAXIN TAB 800MG	2	
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	
<b><i>DIRECT MUSCLE RELAXANTS</i></b>		
DANTRIUM CAP 25MG	2	
DANTRIUM CAP 50MG	2	
<i>dantrolene sodium cap 25 mg</i>	1	

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

293

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
<b>FIBRODYSPLASIA OSSIFICANS PROGRESSIVA (FOP) AGENTS</b>		
SOHONOS CAP 1.5MG	3	
SOHONOS CAP 1MG	3	
SOHONOS CAP 2.5MG	3	
SOHONOS CAP 5MG	3	
SOHONOS CAP 10MG	3	
<b>MUSCLE RELAXANT COMBINATIONS</b>		
<i>carisoprodol w/ aspirin &amp; codeine tab 200-325-16 mg</i>	1	QL (168 tabs every 25 days)
NORGESIC TAB FORTE	3	PA; MNPA
<i>orphenadrine w/ aspirin &amp; caffeine tab 50-770-60 mg</i>	1	PA; MNPA
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>		
<b>NASAL AGENT COMBINATIONS</b>		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 package (23gm) per 25 days)
DYMISTA SPR 137-50	3	QL (1 package (23gm) per 25 days); MNPA
<b>NASAL AGENTS - MISC.</b>		
NOZIN NASAL MIS SANITIZE	0	
<b>NASAL ANESTHETICS</b>		
COCAINE HCL SOL 40MG/ML	3	
GOPRELTO SOL 40MG/ML	3	
NUMBRINO SOL 40MG/ML	3	MNPA
<b>NASAL ANTIALLERGY</b>		
<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)

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

294

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NASAL ANTICHOLINERGICS</b>		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	
<b>NASAL STEROIDS</b>		
BECONASE AQ SUS 0.042%	3	QL (2 packages (25gm each) per 25 days); MNPA
<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)
OMNARIS SPR	3	QL (1 package (12.5gm) per 25 days); MNPA
QNASL AER 80MCG	3	MNPA
QNASL CHILD SPR 40MCG	3	MNPA
XHANCE MIS 93MCG	3	PA, QL (2 packages (16mL each) per 25 days)
ZETONNA AER 37MCG	3	QL (1 package (6.1gm) per 25 days); MNPA
<b>SYMPATHOMIMETIC DECONGESTANTS</b>		
ADRENALIN SOL 1:1000	3	
<b>NEUROMUSCULAR AGENTS</b>		
<b>ALS AGENTS</b>		
EXSERVAN MIS 50MG	3	
RADICAVA ORS SUS 105/5ML	3	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RADICAVA ORS SUS STARTER	3	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RELYVRIO PAK 3-1GM	3	PA, QL (56 PACKETS PER 28 DAYS)

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

295

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RILUTEK TAB 50MG	3	
<i>riluzole tab 50 mg</i>	1	
TIGLUTIK SUS 50/10ML	3	
<b>FRIEDRICH'S ATAXIA AGENTS</b>		
SKYCLARYS CAP 50MG	3	PA
<b>RETT SYNDROME AGENTS</b>		
DAYBUE SOL 200MG/ML	3	PA, QL (3600 ML PER 30 DAYS)
<b>SPINAL MUSCULAR ATROPHY AGENTS (SMA)</b>		
EVRYSDI SOL	3	PA, QL (2 BOTTLES (120 MG) PER 24 DAYS)
<b>NUTRIENTS</b>		
<b>LIPIDS</b>		
DOJOLVI LIQ 100%	3	PA
<b>MISC. NUTRITIONAL SUBSTANCES</b>		
ALTEMIA EMU	3	
<b>OPHTHALMIC AGENTS</b>		
<b>ARTIFICIAL TEARS AND LUBRICANTS</b>		
LACRISERT MIS 5MG OP	3	MNPA
<b>BETA-BLOCKERS - OPTHALMIC</b>		
<i>betaxolol hcl ophth soln 0.5%</i>	1	
BETIMOL SOL 0.5%	2	
BETIMOL SOL 0.5%	2	MNPA
BETIMOL SOL 0.25%	2	MNPA
BETOPTIC-S SUS 0.25% OP	2	
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	
<i>carteolol hcl ophth soln 1%</i>	1	
COMBIGAN SOL 0.2/0.5%	3	MNPA
COSOPT PF SOL 2%-0.5%	3	
COSOPT SOL 2-0.5%OP	3	
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	

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

296

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	
ISTALOL SOL 0.5% OP	3	
<i>levobunolol hcl ophth soln 0.5%</i>	1	
TIM/BRIM/DOR SOL	3	
TIM/DORZ/LAT SOL	3	
TIMOL/BRIM SOL DORZ/LAT	3	
TIMOL/LATAN SOL	3	
<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	
<i>timolol maleate preservative free ophth soln 0.25%</i>	1	
TIMOPTIC OCU SOL 0.5% OP	3	MNPA
TIMOPTIC OCU SOL 0.25% OP	3	MNPA
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	
<b>CHOLINERGIC AGONISTS</b>		
TYRVAYA SOL 0.03MG	3	PA
<b>CYCLOPLEGIC MYDRIATICS</b>		
ATROPINE SUL DRO 0.05%	3	
ATROPINE SUL DRO 0.025%	3	
ATROPINE SUL SOL 0.01%	3	
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	

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

297

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
TROP-CYC-PE DRO 1-1-2.5	3	
TROP-PHENYL SOL 1-2.5%	3	
TROP/CYC/PE/ SOL KETO/PRO	3	
TROP/CYC/PE/ SOL KETOROLA	3	
TROP/CYCL/PE SOL KETOROLA	3	
<b>MIOTICS</b>		
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	
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
BRIMO/DORZO SOL 0.15-2%	3	
<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	
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
AZASITE SOL 1%	3	MNPA
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
BESIVANCE SUS 0.6%	2	
BETADINE SOL 5% OP	3	
BLEPH-10 SOL 10% OP	3	

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

298

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CILOXAN OIN 0.3% OP	2	MNPA
CILOXAN SOL 0.3% OP	3	MNPA
<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)
KLARITY-A DRO 1%	3	
<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	
MOXIFLOXACIN SOL 0.5%	3	
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	
VANCOMYCIN SOL 10MG/ML	3	
VIGAMOX DRO 0.5%	3	

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

299

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XDEMVY DRO 0.25%	3	
ZIRGAN GEL 0.15%	3	MNPA
ZYMAXID SOL 0.5%	3	
<b>OPHTHALMIC COMPLEMENT INHIBITORS</b>		
IZERVAY SOL 2/0.1ML	3	
<b>OPHTHALMIC IMMUNOMODULATORS</b>		
CEQUA SOL 0.09%	3	PA
<i>cyclosporine (ophth) emulsion 0.05%</i>	1	
RESTASIS EMU 0.05% OP	2	PA
RESTASIS MUL EMU 0.05% OP	2	PA
<b>OPHTHALMIC INTEGRIN ANTAGONISTS</b>		
XIIDRA DRO 5%	2	PA
<b>OPHTHALMIC KINASE INHIBITORS</b>		
RHOPRESSA SOL 0.02%	2	
ROCKLATAN DRO	2	
<b>OPHTHALMIC LOCAL ANESTHETICS</b>		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
IHEEZO GEL 3%	3	
<i>proparacaine hcl ophth soln 0.5%</i>	1	
<i>tetracaine hcl ophth soln 0.5%</i>	1	
<b>OPHTHALMIC NERVE GROWTH FACTORS</b>		
OXERVATE SOL 20MCG/ML	3	PA, QL (16 CARTONS PER 56 DAYS - ONE TIME TREATMENT)
<b>OPHTHALMIC PHOTOENHANCERS</b>		
PHOTREXA VIS SOL 0.146-20	3	
PHOTREXA/PHO SOL VISC KIT	3	
<b>OPHTHALMIC STEROIDS</b>		
ALREX SUS 0.2%	3	MNPA
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	

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

300

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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
FLAREX SUS 0.1% OP	3	MNPA
<i>fluorometholone ophth susp 0.1%</i>	1	
FML FORTE SUS 0.25% OP	2	MNPA
FML LIQUIFLM SUS 0.1% OP	3	PA; MNPA
FML OIN 0.1% OP	2	MNPA
INVELTYS SUS 1%	3	MNPA
KLARITY-L DRO 0.2%	3	
KLARITY-L DRO 0.5%	3	
LOTEMAX GEL 0.5%	3	MNPA
LOTEMAX OIN 0.5%	3	MNPA
LOTEMAX SM GEL 0.38%	3	MNPA
LOTEMAX SUS 0.5%	3	MNPA
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
MAXIDEX SUS 0.1% OP	2	MNPA
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 FORTE SUS 1% OP	3	PA; MNPA
PRED MILD SUS 0.12% OP	2	PA; MNPA
PRED MOXIFLO SOL 1-0.5%	3	
PRED MOXIFLO SUS BROMFEN	3	
PRED SOD PHO SOL 1% OP	3	
PRED-G S.O.P OIN OP	3	
PRED-G SUS OP	3	
PRED-GATI SUS 1-0.5%	3	

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

301

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PRED-GATIFL- SUS BROMFENA	3	
PRED/NEPAFEN DRO 1-0.1%	3	
PREDNI/MOXI/ DRO NEPAFENA	3	
PREDNI/MOXIF DRO 1-0.5%	3	
<i>prednisolone acetate ophth susp 1%</i>	1	
PREDNISOLONE SOL MOX-BROM	3	
PREDNISOLONE SUS 1%	3	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1%	2	
TOBRADEX ST SUS 0.3-0.05	2	MNPA
TOBRADEX SUS 0.3-0.1%	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
ZYLET SUS 0.5-0.3%	3	MNPA
<b>OPHTHALMIC SURGICAL AIDS</b>		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
<b>OPHTHALMICS - MISC.</b>		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ACUVAIL SOL 0.45%	2	MNPA
ALOCRIAL SOL 2%	3	
ALOMIDE SOL 0.1% OP	3	
<i>azelastine hcl ophth soln 0.05%</i>	1	
AZOPT SUS 1% OP	3	
BEPREVE DRO 1.5%	3	MNPA
<i>brinzolamide ophth susp 1%</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
BROMSITE DRO 0.075%	3	MNPA
CHONDROITIN SOL	3	
<i>cromolyn sodium ophth soln 4%</i>	1	

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

302

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CYSTADROPS SOL 0.37%	3	PA, QL (4 BOTTLES PER 28 DAYS)
CYSTARAN SOL 0.44%	3	PA, QL (4 BOTTLES PER 28 DAYS)
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	
DORZOLAMIDE SOL 2%	3	
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
ILEVRO DRO 0.3% OP	2	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
LASTACAFT SOL 0.25%	2	MNPA
MIEBO DRO 1.3GM/ML	3	
NEVANAC SUS 0.1%	2	MNPA
NEVANAC SUS 0.1% OP	2	
PROLENSA SOL 0.07%	3	
TRUSOPT SOL 2% OP	3	
UPNEEQ SOL 0.1%	3	
ZERVIAE DRO 0.24%	2	

**PROSTAGLANDINS - OPHTHALMIC**

<i>bimatoprost ophth soln 0.03%</i>	1	
IYUZEH DRO 0.005%	3	
<i>latanoprost ophth soln 0.005%</i>	1	
LUMIGAN SOL 0.01%	2	
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	
TRAVATAN Z DRO 0.004%	3	MNPA
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	
VYZULTA SOL 0.024%	3	
XALATAN SOL 0.005%	3	
XELPROS EMU 0.005%	3	
ZIOPTAN DRO 0.0015%	2	

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

303

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS - MISCELLANEOUS</b>		
<i>acetic acid otic soln 2%</i>	1	
<b>OTIC ANTI-INFECTIVES</b>		
CETRAXAL SOL 0.2%	3	
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
<b>OTIC COMBINATIONS</b>		
CIPRO HC SUS OTIC	3	MNPA
CIPRODEX SUS 0.3-0.1%	3	MNPA
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
<i>ciprofloxacin-fluocinolone acetone (pf) otic soln 0.3-0.025%</i>	1	MNPA
CORTISPORIN SUS -TC OTIC	3	
<i>neomycin-polymyxin-hc otic soln 1%</i>	1	
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	1	
OTOVEL DRO	3	
<b>OTIC STEROIDS</b>		
DERMOTIC OIL 0.01%	3	
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
<b>OXYTOCICS</b>		
<b>ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING</b>		
CERVIDIL VAG MIS 10MG INS	3	
PREPIDIL GEL 0.5MG/3G	3	
PROSTIN E2 SUP 20MG	3	
<b>OXYTOCICS</b>		
<i>methylergonovine maleate tab 0.2 mg</i>	1	PA, QL (120 tabs every 30 days)

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

304

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PENICILLINS</b>		
<b>AMINOPENICILLINS</b>		
<i>amoxicillin (trihydrate) cap 250 mg</i>	1	
<i>amoxicillin (trihydrate) cap 500 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	1	
<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	
<b>NATURAL PENICILLINS</b>		
<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	
<b>PENICILLIN COMBINATIONS</b>		
<i>amoxicillin &amp; k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin &amp; k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i>	1	

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

305

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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AUGMENTIN SUS 125/5ML	3	
AUGMENTIN SUS 250/5ML	3	
AUGMENTIN SUS ES-600	3	
AUGMENTIN TAB 500MG	3	
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
<b>PHARMACEUTICAL ADJUVANTS</b>		
<b>LIQUID VEHICLES</b>		
TRICHOSOL SOL	3	
<b>PROGESTINS</b>		
<b>PROGESTINS</b>		
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	
PROMETRIUM CAP 100MG	3	PA; MNPA
PROMETRIUM CAP 200MG	3	PA; MNPA
PROVERA TAB 2.5MG	3	
PROVERA TAB 5MG	3	
PROVERA TAB 10MG	3	
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	
<i>disulfiram tab 250 mg</i>	1	
<i>disulfiram tab 500 mg</i>	1	
LUCEMYRA TAB 0.18MG	3	

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

306

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTI-CATAPLECTIC AGENTS</b>		
LUMRYZ PAK 6GM	3	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PAK 7.5GM	3	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PAK 9GM	3	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PKG 4.5GM	3	PA, QL (30 PACKETS PER 30 DAYS)
SOD OXYBATE SOL 500MG/ML	3	PA, QL (540 ML PER 30 DAYS)
XYREM SOL 500MG/ML	3	PA, QL (540 ML PER 30 DAYS)
XYWAV SOL 0.5GM/ML	2	PA, QL (540 ML (270 GRAMS) PER 30 DAYS)
<b>ANTIDEMENTIA AGENTS</b>		
ADLARITY DIS 5MG/DAY	3	
ADLARITY DIS 10MG/DAY	3	
ARICEPT TAB 5MG	3	
ARICEPT TAB 10MG	3	
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	QL (3 patches every 25 days)
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	

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

307

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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 &amp; 21 x 10 mg titration pack</i>	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
NAMENDA XR CAP 7MG	3	
NAMENDA XR CAP 14MG	3	
NAMENDA XR CAP 21MG	3	
NAMENDA XR CAP 28MG	3	
NAMENDA XR CAP TITRATIO	3	
NAMZARIC CAP	2	
NAMZARIC CAP 7-10MG	2	
NAMZARIC CAP 14-10MG	2	
NAMZARIC CAP 21-10MG	2	
NAMZARIC CAP 28-10MG	2	
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	

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

308

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
<b>COMBINATION PSYCHOTHERAPEUTICS</b>		
<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	
<b>FIBROMYALGIA AGENTS</b>		
SAVELLA MIS TITR PAK	2	
SAVELLA TAB 12.5MG	2	
SAVELLA TAB 25MG	2	
SAVELLA TAB 50MG	2	
SAVELLA TAB 100MG	2	
<b>HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS</b>		
VYLEESI INJ 1.75/0.3	3	PA
<b>MOVEMENT DISORDER DRUG THERAPY</b>		
AUSTEDO TAB 6MG	2	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO TAB 9MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO TAB 12MG	2	PA, QL (120 TABLETS PER 30 DAYS)

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

309

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AUSTEDO XR TAB 6MG	2	PA, QL (90 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 12MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 24MG	2	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO XR TAB TITR KIT	2	PA, QL (42 TABLETS PER 28 DAYS)
INGREZZA CAP 40-80MG	2	PA
INGREZZA CAP 40MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 60MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 80MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
<i>tetrabenazine tab 12.5 mg</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
<i>tetrabenazine tab 25 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
XENAZINE TAB 12.5MG	3	PA, QL (120 TABLETS PER 30 DAYS); MNPA
XENAZINE TAB 25MG	3	PA, QL (60 TABLETS PER 30 DAYS); MNPA

**MULTIPLE SCLEROSIS AGENTS**

AMPYRA TAB 10MG	3	PA, QL (60 TABLETS PER 30 DAYS)
AUBAGIO TAB 7MG	3	PA, QL (30 TABLETS PER 30 DAYS)
AUBAGIO TAB 14MG	3	PA, QL (30 TABLETS PER 30 DAYS)
AVONEX PEN KIT 30MCG	2	PA, QL (4 PENS PER 28 DAYS)
AVONEX PREFL KIT 30MCG	2	PA, QL (4 SYRINGES PER 28 DAYS)
BAFIERTAM CAP 95MG	3	PA, QL (120 CAPSULES PER 30 DAYS)

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

310

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BETASERON INJ 0.3MG	2	PA, QL (14 KITS PER 28 DAYS)
COPAXONE INJ 20MG/ML	2	PA, QL (30 SYRINGES PER 30 DAYS)
COPAXONE INJ 40MG/ML	2	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 &amp; 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
EXTAVIA INJ 0.3MG	3	PA, QL (14 KITS PER 28 DAYS); MNPA
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
GILENYA CAP 0.5MG	3	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
<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	2	PA, QL (1 PENS PER 28 DAYS); LOADING DOSE: 3 PENS PER 15 DAYS
MAVENCLAD PAK 10MG(4)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(5)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(6)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(7)	3	PA, QL (20 TABLETS PER 9 MONTHS)

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

311

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MAVENCLAD PAK 10MG(8)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(9)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(10)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAYZENT PAK STARTER	2	PA, QL (7 TABLETS PER 4 DAYS)
MAYZENT TAB 0.25MG	2	PA, QL (12 TABLETS PER 5 DAYS)
MAYZENT TAB 1MG	2	PA, QL (30 TABLETS PER 30 DAYS)
MAYZENT TAB 2MG	2	PA, QL (30 TABLETS PER 30 DAYS)
PLEGRIDY INJ	3	PA, QL (1 CARTON PER 28 DAYS)
PLEGRIDY INJ	3	PA, QL (1 KIT PER 28 DAYS)
PLEGRIDY INJ PEN	3	PA, QL (2 PENS PER 28 DAYS)
PLEGRIDY INJ STARTER	3	PA, QL (1 PACK PER 28 DAYS)
PLEGRIDY PEN INJ STARTER	3	PA, QL (1 PACK PER 28 DAYS)
PONVORY TAB 20MG	3	PA, QL (30 TABLETS FOR 30 DAYS)
PONVORY TAB STARTER	3	PA, QL (1 PACK (14 TABS) FOR 14 DAYS)
REBIF INJ 22/0.5	2	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF INJ 44/0.5	2	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF REBIDO INJ 22/0.5	2	PA, QL (12 SYR PER 28 DAYS)
REBIF REBIDO INJ 44/0.5	2	PA, QL (12 SYR PER 28 DAYS)

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

312

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
REBIF REBIDO INJ TITRATN	2	PA, QL (12 INJ PER 28 DAYS)
REBIF TITRTN INJ PACK	2	PA, QL (12 SYRINGES PER 28 DAYS)
TASCENSO ODT TAB 0.5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
TASCENSO ODT TAB 0.25MG	3	PA, QL (30 TABLETS PER 30 DAYS)
TECFIDERA CAP 120MG	3	PA, QL (14 CAPSULES PER 28 DAYS); MNPA
TECFIDERA CAP 240MG	3	PA, QL (60 CAPSULES PER 30 DAYS); MNPA
TECFIDERA CAP STARTER	3	PA, QL (60 CAPSULES PER 30 DAYS); MNPA
<i>teriflunomide tab 7 mg</i>	3	PA, QL (30 tabs every 30 days)
<i>teriflunomide tab 14 mg</i>	3	PA, QL (30 tabs every 30 days)
VUMERITY CAP 231MG	2	PA, QL (120 CAPSULES PER 30 DAYS)
ZEPOSIA 7DAY CAP STR PACK	2	PA, QL (7 TABLETS PER 7 DAYS)
ZEPOSIA CAP .92MG	2	PA, QL (30 TABLETS PER 30 DAYS)
ZEPOSIA CAP STR KIT	2	PA, QL (1 Starter Kit per 28 days)
ZEPOSIA CAP STR KIT	2	PA, QL (37 TABLETS PER 37 DAYS)
<b>POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS</b>		
GRALISE TAB 300MG	2	QL (150 tabs every 25 days)
GRALISE TAB 450MG	2	PA, QL (90 tablets per 25 days)
GRALISE TAB 600MG	2	QL (90 tabs every 25 days)
GRALISE TAB 750MG	2	PA, QL (60 tablets per 25 days)

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

313

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GRALISE TAB 900MG	2	PA, QL (60 tablets per 25 days)
LYRICA CR TAB 82.5MG	3	QL (60 tabs every 30 days)
LYRICA CR TAB 165MG	3	QL (60 tabs every 30 days)
LYRICA CR TAB 330MG	3	QL (60 tabs every 30 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)
<b>PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS</b>		
<i>fluoxetine hcl (pmdd) tab 10 mg</i>	1	PA; MNPA
<i>fluoxetine hcl (pmdd) tab 20 mg</i>	1	PA; MNPA
<b>PSEUDOBULBAR AFFECT (PBA) AGENTS</b>		
NUEDEXTA CAP 20-10MG	2	MNPA
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<i>ergoloid mesylates tab 1 mg</i>	1	
<i>pimozide tab 1 mg</i>	1	
<i>pimozide tab 2 mg</i>	1	
<b>RESTLESS LEG SYNDROME (RLS) AGENTS</b>		
HORIZANT TAB 300MG ER	3	QL (60 tabs every 25 days); MNPA
HORIZANT TAB 600MG ER	3	QL (60 tabs every 25 days); MNPA
<b>SMOKING DETERRENTS</b>		
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	0	
CHANTIX PAK 1MG	0	
CHANTIX TAB 0.5& 1MG	0	
CHANTIX TAB 0.5MG	0	
CHANTIX TAB 1MG	0	
NICODERM CQ DIS 7MG/24HR	0	
NICODERM CQ DIS 14MG/24H	0	
NICODERM CQ DIS 21MG/24H	0	
NICORETTE GUM 2MG	0	
NICORETTE GUM 2MG CINN	0	
NICORETTE GUM 2MG MINT	0	

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

314

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NICORETTE GUM 2MG ORIG	0	
NICORETTE GUM 2MGFRUIT	0	
NICORETTE GUM 4MG	0	
NICORETTE GUM 4MG CINN	0	
NICORETTE GUM 4MG MINT	0	
NICORETTE GUM 4MG ORIG	0	
NICORETTE GUM 4MGFRUIT	0	
NICORETTE LOZ 2MG MINT	0	
NICORETTE LOZ 4MG MINT	0	
NICORETTE ST GUM 2MG MINT	0	
NICORETTE ST GUM 2MG ORIG	0	
NICORETTE ST GUM 4MG ORIG	0	
<i>nicotine polacrilex gum 2 mg</i>	0	
<i>nicotine polacrilex gum 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	0	
<i>nicotine polacrilex gum 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	0	
<i>nicotine polacrilex lozenge 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	0	
<i>nicotine polacrilex lozenge 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<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	
<b>TRANSTHYRETIN AMYLOIDOSIS AGENTS</b>		
TEGSEDI INJ 284/1.5	2	PA, QL (4 PFS PER 28 DAYS)

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

315

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VASOMOTOR SYMPTOM AGENTS</b>		
BRISDELLE CAP 7.5MG	3	
<i>paroxetine mesylate cap 7.5 mg (base equiv)</i>	1	PA; MNPA
<b>RESPIRATORY AGENTS - MISC.</b>		
<b>CYSTIC FIBROSIS AGENTS</b>		
BRONCHITOL CAP 40MG	3	PA, QL (600 caps every 30 days)
BRONCHITOL CAP TOL TEST	3	PA, QL (90 caps every 30 days)
KALYDECO GRA 5.8MG	3	QL (56 packets per 28 days)
KALYDECO GRA 13.4MG	3	PA, QL (56 packets per 28 days)
KALYDECO PAK 25MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 50MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 75MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO TAB 150MG	3	QL (1 CARTON (56 TABS) PER 28 DAYS)
ORKAMBI GRA 75-94MG	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 100-125	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 150-188	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI TAB 100-125	3	PA, QL (112 TABLETS PER 28 DAYS)
ORKAMBI TAB 200-125	3	PA, QL (112 TABLETS PER 28 DAYS)
PULMOZYME SOL 1MG/ML	2	PA, QL (60 AMPULES PER 30 DAYS)
SYMDEKO TAB 50-75MG	3	PA, QL (56 TABLETS PER 28 DAYS)

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

316

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SYMDEKO TAB 100-150	3	PA, QL (56 TABLETS PER 28 DAYS)
TRIKAFTA PAK 59.5MG	3	PA, QL (56 packets per 28 days)
TRIKAFTA PAK 75MG	3	PA, QL (56 packets per 28 days)
TRIKAFTA TAB	3	PA, QL (84 TABLETS PER 28 DAYS)
<b>PULMONARY FIBROSIS AGENTS</b>		
ESBRIET CAP 267MG	3	PA, QL (270 CAPSULES PER 30 DAYS); MNPA
ESBRIET TAB 267MG	3	PA, QL (270 TABLETS PER 30 DAYS); MNPA
ESBRIET TAB 801MG	3	PA, QL (90 TABLETS PER 30 DAYS); MNPA
OFEV CAP 100MG	2	PA, QL (60 CAPSULES PER 30 DAYS)
OFEV CAP 150MG	2	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)
<b>SULFONAMIDES</b>		
<b>SULFONAMIDES</b>		
<i>sulfadiazine tab 500 mg</i>	3	
<b>TETRACYCLINES</b>		
<b>AMINOMETHYLCYCLINES</b>		
NUZYRA TAB 150MG	3	
<b>TETRACYCLINES</b>		
ACTICLATE TAB 75MG	3	MNPA
ACTICLATE TAB 150MG	3	MNPA
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline hcl tab 300 mg</i>	1	
DORYX MPC TAB 120MG	3	MNPA

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

317

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DORYX TAB 50MG	3	MNPA
DORYX TAB 80MG	3	MNPA
DORYX TAB 200MG	3	MNPA
<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 50 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab 50 mg</i>	3	MNPA
<i>doxycycline hyclate tab 75 mg</i>	1	MNPA
<i>doxycycline hyclate tab 75 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab 100 mg</i>	1	
<i>doxycycline hyclate tab 150 mg</i>	1	MNPA
<i>doxycycline hyclate tab 150 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 50 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 75 mg</i>	1	MNPA
<i>doxycycline hyclate tab delayed release 80 mg</i>	1	MNPA
<i>doxycycline hyclate tab delayed release 100 mg</i>	1	MNPA
<i>doxycycline hyclate tab delayed release 150 mg</i>	1	MNPA
<i>doxycycline hyclate tab delayed release 200 mg</i>	1	PA; MNPA
<i>doxycycline monohydrate cap 50 mg</i>	1	
<i>doxycycline monohydrate cap 75 mg</i>	1	PA; MNPA
<i>doxycycline monohydrate cap 75 mg</i>	1	PA, QL (3 caps every 25 days); MNPA
<i>doxycycline monohydrate cap 100 mg</i>	1	
<i>doxycycline monohydrate cap 150 mg</i>	1	PA; MNPA
<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	

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

318

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>minocycline hcl cap er 24hr 45 mg (base equivalent)</i>	1	PA; MNPA
<i>minocycline hcl cap er 24hr 90 mg (base equivalent)</i>	1	PA; MNPA
<i>minocycline hcl cap er 24hr 135 mg (base equivalent)</i>	1	PA; MNPA
<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>minocycline hcl tab er 24hr 45 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 55 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 65 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 80 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 90 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 105 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 115 mg</i>	1	PA; MNPA
<i>minocycline hcl tab er 24hr 135 mg</i>	1	PA; MNPA
MINOLIRA TAB 105MG	3	
MINOLIRA TAB 135MG	3	
SEYSARA TAB 60MG	3	
SEYSARA TAB 100MG	3	
SEYSARA TAB 150MG	3	
SOLODYN TAB 55MG	3	
SOLODYN TAB 65MG	3	MNPA
SOLODYN TAB 80MG	3	
SOLODYN TAB 105MG	3	
SOLODYN TAB 115MG	3	MNPA
<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	2	
VIBRAMYCIN SYP 50MG/5ML	2	
XIMINO CAP 45MG ER	3	MNPA

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

319

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XIMINO CAP 90MG ER	3	MNPA
XIMINO CAP 135MG ER	3	MNPA

**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	2	
TAPAZOLE TAB 10MG	2	

**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	
CYTOMEL TAB 5MCG	3	MNPA
CYTOMEL TAB 25MCG	3	MNPA
CYTOMEL TAB 50MCG	3	MNPA
<i>levothyroxine sodium cap 13 mcg</i>	1	
<i>levothyroxine sodium cap 25 mcg</i>	1	
<i>levothyroxine sodium cap 50 mcg</i>	1	
<i>levothyroxine sodium cap 75 mcg</i>	1	
<i>levothyroxine sodium cap 88 mcg</i>	1	
<i>levothyroxine sodium cap 100 mcg</i>	1	
<i>levothyroxine sodium cap 112 mcg</i>	1	
<i>levothyroxine sodium cap 125 mcg</i>	1	
<i>levothyroxine sodium cap 137 mcg</i>	1	
<i>levothyroxine sodium cap 150 mcg</i>	1	
<i>levothyroxine sodium cap 175 mcg</i>	1	
<i>levothyroxine sodium cap 200 mcg</i>	1	
<i>levothyroxine sodium tab 25 mcg</i>	1	
<i>levothyroxine sodium tab 50 mcg</i>	1	

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

320

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
NATURE THROI TAB 162.5MG	3	
NATURE-THROI TAB 16.25MG	3	
NATURE-THROI TAB 32.5MG	3	
NATURE-THROI TAB 48.75MG	3	
NATURE-THROI TAB 65MG	3	
NATURE-THROI TAB 81.25MG	3	
NATURE-THROI TAB 97.5MG	3	
NATURE-THROI TAB 113.75MG	3	
NATURE-THROI TAB 130MG	3	
NATURE-THROI TAB 146.25MG	3	
NATURE-THROI TAB 195MG	3	
NATURE-THROI TAB 260MG	3	
NATURE-THROI TAB 325MG	3	
NIVA THYROID TAB 15MG	3	
NIVA THYROID TAB 30MG	3	
NIVA THYROID TAB 60MG	3	
NIVA THYROID TAB 90MG	3	
NIVA THYROID TAB 120MG	3	
NP THYROID TAB 15MG	3	
NP THYROID TAB 30MG	3	
NP THYROID TAB 60MG	3	
NP THYROID TAB 90MG	3	

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

321

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NP THYROID TAB 120MG	3	
SYNTHROID TAB 25MCG	2	
SYNTHROID TAB 50MCG	2	
SYNTHROID TAB 75MCG	2	
SYNTHROID TAB 88MCG	2	
SYNTHROID TAB 100MCG	2	
SYNTHROID TAB 112MCG	2	
SYNTHROID TAB 125MCG	2	
SYNTHROID TAB 137MCG	2	
SYNTHROID TAB 150MCG	2	
SYNTHROID TAB 175MCG	2	
SYNTHROID TAB 200MCG	2	
SYNTHROID TAB 300MCG	2	
THYQUIDITY SOL 100MCG	3	
TIROSINT CAP 13MCG	3	MNPA
TIROSINT CAP 25MCG	3	MNPA
TIROSINT CAP 50MCG	3	MNPA
TIROSINT CAP 75MCG	3	MNPA
TIROSINT CAP 88MCG	3	MNPA
TIROSINT CAP 100MCG	3	MNPA
TIROSINT CAP 112MCG	3	MNPA
TIROSINT CAP 125MCG	3	MNPA
TIROSINT CAP 137MCG	3	MNPA
TIROSINT CAP 150MCG	3	MNPA
TIROSINT CAP 175MCG	3	MNPA
TIROSINT CAP 200	3	MNPA
TIROSINT-SOL SOL 13MCG/ML	3	MNPA
TIROSINT-SOL SOL 25MCG/ML	3	MNPA
TIROSINT-SOL SOL 50MCG/ML	3	MNPA
TIROSINT-SOL SOL 75MCG/ML	3	MNPA
TIROSINT-SOL SOL 88MCG/ML	3	MNPA
TIROSINT-SOL SOL 100MCG	3	MNPA
TIROSINT-SOL SOL 112MCG	3	MNPA
TIROSINT-SOL SOL 125MCG	3	MNPA
TIROSINT-SOL SOL 137MCG	3	MNPA

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

322

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TIROSINT-SOL SOL 150MCG	3	MNPA
TIROSINT-SOL SOL 175MCG	3	MNPA
TIROSINT-SOL SOL 200MCG	3	MNPA
WESTHROID TAB 32.5MG	3	
WESTHROID TAB 65MG	3	
WESTHROID TAB 97.5MG	3	
WESTHROID TAB 130MG	3	
WESTHROID TAB 195MG	3	
WP THYROID TAB 16.25MG	3	
WP THYROID TAB 32.5MG	3	
WP THYROID TAB 48.75MG	3	
WP THYROID TAB 65MG	3	
WP THYROID TAB 81.25MG	3	
WP THYROID TAB 97.5MG	3	
WP THYROID TAB 113.75MG	3	
WP THYROID TAB 130MG	3	

**ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS****ANTISPASMODICS**

ANASPAZ TAB 0.125MG	2	
ATROPINE SUL INJ 0.4MG/ML	3	
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	MNPA
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	PA; MNPA
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	
GLYCATE TAB 1.5MG	3	
GLYCOPYRROLA TAB 1.5MG	3	PA; MNPA
<i>glycopyrrolate inj pf soln pref syr 0.4 mg/2ml (0.2 mg/ml)</i>	3	

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

323

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>glycopyrrolate inj pf soln prefilled syringe 0.2 mg/ml</i>	3	
<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	
<i>hyoscyamine sulfate tab er 12hr 0.375 mg</i>	1	PA; MNPA
LEVBIID TAB 0.375 ER	3	
LEVSIN TAB 0.125MG	2	
LEVSIN/SL SUB 0.125MG	2	
LIBRAX CAP 5-2.5MG	3	MNPA
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
SYMAX DUOTAB TAB	3	
<b>H-2 ANTAGONISTS</b>		
<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	
<b>MISC. ANTI-ULCER</b>		
CARAFATE SUS 1GM/10ML	3	MNPA
CARAFATE TAB 1GM	3	MNPA
<i>sucralfate susp 1 gm/10ml</i>	1	PA; MNPA
<i>sucralfate tab 1 gm</i>	1	

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

324

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PROTON PUMP INHIBITORS</b>		
ACIPHEX SPR CAP 5MG	3	QL (90 caps every year); MNPA
ACIPHEX SPR CAP 10MG	3	QL (90 caps every year); MNPA
ACIPHEX TAB 20MG	3	QL (90 tabs every year); MNPA
DEXILANT CAP 30MG DR	3	QL (90 caps every year); MNPA
DEXILANT CAP 60MG DR	3	QL (90 caps every year); MNPA
<i>dexlansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year); MNPA
<i>dexlansoprazole cap delayed release 60 mg</i>	1	QL (90 caps every year); MNPA
ESOMEPRAZOLE CAP 49.3MG	3	QL (90 caps every year)
<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>lansoprazole tab delayed release orally disintegrating 15 mg</i>	1	QL (90 ea every year); MNPA
<i>lansoprazole tab delayed release orally disintegrating 30 mg</i>	1	QL (90 ea every year); MNPA
NEXIUM CAP 20MG	3	QL (90 caps every year); MNPA
NEXIUM CAP 40MG	3	QL (90 caps every year); MNPA

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

325

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NEXIUM GRA 2.5MG DR	3	QL (90 packets every year); MNPA
NEXIUM GRA 5MG DR	3	QL (90 packets every year); MNPA
NEXIUM GRA 10MG DR	3	QL (90 packets every year); MNPA
NEXIUM GRA 20MG DR	3	QL (90 packets every year); MNPA
NEXIUM GRA 40MG DR	3	QL (90 packets every year); MNPA
<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 delayed release susp packet 40 mg</i>	1	PA, QL (90 packets every year); MNPA
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	1	QL (90 vials every year)
PREVACID CAP 15MG DR	3	QL (90 caps every year); MNPA
PREVACID CAP 30MG DR	3	QL (90 caps every year); MNPA
PREVACID TAB 15MG STB	3	QL (90 ea every year); MNPA
PREVACID TAB 30MG STB	3	QL (90 ea every year); MNPA
PRILOSEC POW 2.5MG	3	PA, QL (90 packets every year); MNPA
PRILOSEC POW 10MG	3	PA, QL (90 packets every year); MNPA
PROTONIX INJ 40MG	3	QL (90 vials every year)
PROTONIX PAK 40MG	3	QL (90 packets every year); MNPA

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

326

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PROTONIX TAB 20MG	3	QL (90 tabs every year); MNPA
PROTONIX TAB 40MG	3	QL (90 tabs every year); MNPA
RABEPRAZOLE CAP 10MG DR	3	QL (90 caps every year)
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year)
<b>ULCER DRUGS - PROSTAGLANDINS</b>		
CYTOTEC TAB 100MCG	2	
CYTOTEC TAB 200MCG	2	
<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
<b>ULCER THERAPY COMBINATIONS</b>		
<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr 500 &amp; 500 &amp; 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
HELIDAC MIS THERAPY	3	
KONVOMEPEP SUS 2-84/ML	3	
OMECLAMOX- MIS PAK	3	
<i>omeprazole-sodium bicarbonate cap 20-1100 mg</i>	1	PA, QL (90 caps every year); MNPA
<i>omeprazole-sodium bicarbonate cap 40-1100 mg</i>	1	PA, QL (90 caps every year); MNPA
<i>omeprazole-sodium bicarbonate powd pack for susp 20-1680 mg</i>	1	PA, QL (90 packets every year); MNPA
<i>omeprazole-sodium bicarbonate powd pack for susp 40-1680 mg</i>	1	PA, QL (90 packets every year); MNPA
PYLERA CAP	2	
TALICIA CAP	2	
VOQUEZNA PAK DUAL PAK	3	
VOQUEZNA PAK TRIP PK	3	
ZEGERID CAP 20-1100	3	PA, QL (90 caps every year); MNPA

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

327

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZEGERID CAP 40-1100	3	PA, QL (90 caps every year); MNPA
ZEGERID POW 20-1680	3	PA, QL (90 packets every year); MNPA
ZEGERID POW 40-1680	3	PA, QL (90 packets every year); MNPA

**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 LA CAP 2MG	3	MNPA
DETROL LA CAP 4MG	3	MNPA
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
ENABLEX TAB 7.5MG	3	MNPA
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	
GELNIQUE GEL 10%	3	
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride solution 5 mg/5ml</i>	3	
<i>oxybutynin chloride tab 2.5 mg</i>	3	
<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	
OXYTROL DIS 3.9MG/24	3	MNPA
<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	

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

328

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tolterodine tartrate tab 2 mg</i>	1	
TOVIAZ TAB 4MG	3	MNPA
TOVIAZ TAB 8MG	3	MNPA
<i>tropium chloride cap er 24hr 60 mg</i>	1	
<i>tropium chloride tab 20 mg</i>	1	
VESICARE LS SUS 5MG/5ML	3	
VESICARE TAB 5MG	3	
VESICARE TAB 10MG	3	
<b>URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS</b>		
GEMTESA TAB 75MG	3	
MYRBETRIQ SUS 8MG/ML	2	MNPA
MYRBETRIQ TAB 25MG	2	MNPA
MYRBETRIQ TAB 50MG	2	MNPA
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
<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	
<b>URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS</b>		
<i>flavoxate hcl tab 100 mg</i>	1	
<b>VAGINAL AND RELATED PRODUCTS</b>		
<b>MISCELLANEOUS VAGINAL PRODUCTS</b>		
INTRAROSA SUP 6.5MG	3	MNPA
<b>SPERMICIDES</b>		
ENCARE SUP 100MG	0	OTC
GYNOL II GEL 3%	0	
SHUR-SEAL GEL 2%	0	
TODAY SPONGE MIS	0	
VCF VAGINAL AER CONTRACP	0	
VCF VAGINAL GEL CONTRACE	0	
VCF VAGINAL MIS CONTRACP	0	
<b>VAGINAL ANTI-INFECTIVES</b>		
CLEOCIN CRE 2% VAG	2	
CLEOCIN SUP 100MG	3	

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

329

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<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	
NUVESSA GEL 1.3%	3	
<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	
<b>VAGINAL ESTROGENS</b>		
ESTRACE VAG CRE 0.01%	3	
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
<i>estradiol vaginal tab 10 mcg</i>	1	
ESTRING MIS 2MG	2	
FEMRING MIS 0.1MG/24	3	MNPA
FEMRING MIS 0.05/24H	3	MNPA
IMVEXXY MAIN SUP 4MCG	3	
IMVEXXY MAIN SUP 10MCG	3	
IMVEXXY STRT SUP 4MCG	3	
IMVEXXY STRT SUP 10MCG	3	
PREMARIN VAG CRE 0.625MG	2	MNPA
VAGIFEM TAB 10MCG	3	
<b>VAGINAL PROGESTINS</b>		
CRINONE GEL 4% VAG	2	
CRINONE GEL 8% VAG	2	
ENDOMETRIN SUP 100MG	2	
<b>VASOPRESSORS</b>		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
ADRENALIN INJ 1MG/ML	3	MNPA
ADRENALIN INJ 30/30ML	3	MNPA
AUVI-Q INJ 0.1MG	2	QL (3 pens every 300 days)

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

330

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
AUVI-Q INJ 0.3MG	2	QL (6 pens every 300 days)
AUVI-Q INJ 0.15MG	2	QL (3 pens every 300 days)
EPINEPHR PRO KIT 1MG/ML	3	QL (6 kits every 300 days)
<i>epinephrine inj 30 mg/30ml (1 mg/ml) (1:1000)</i>	1	
EPINEPHRINE KIT SNAP-EMS	3	QL (6 kits every 300 days)
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	QL (3 pens every 300 days)
EPINPHEPHRIN KIT SNAP-V	3	QL (6 kits every 300 days)
EPIPEN 2-PAK INJ 0.3MG	2	QL (6 pens every 300 days)
EPIPEN-JR INJ 0.15MG	2	QL (6 pens every 300 days)
SYMJEPI INJ 0.3MG	3	QL (3 syringes every 300 days); MNPA
SYMJEPI INJ 0.15MG	3	QL (3 syringes every 300 days); MNPA

**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)
NORTHERA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS); MNPA
NORTHERA CAP 200MG	3	PA, QL (180 CAPSULES PER 30 DAYS); MNPA
NORTHERA CAP 300MG	3	PA, QL (180 CAPSULES PER 30 DAYS); MNPA

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

331

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VASOPRESSORS</b>		
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	
<b>VITAMINS</b>		
<b>OIL SOLUBLE VITAMINS</b>		
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

332

*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](http://www.carefirst.com/myaccount)) and click on Drug & Pharmacy Resources under the Coverage tab.*

## Index

<b>1</b>	
1ML SYRINGE MIS 29G.....	278
1ML SYRINGE MIS 30G .....	278
<b>A</b>	
<i>abacavir sulfate-lamivudine tab 600-300 mg</i> .....	147
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i> .....	147
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i> .....	147
<i>abacavir sulfate tab 300 mg (base equiv)</i> .....	147
ABILIFY ASIM INJ 720MG .....	145
ABILIFY ASIM INJ 960MG.....	145
ABILIFY MAIN INJ 300MG .....	145
ABILIFY MAIN INJ 400MG .....	145
ABILIFY MYCI TAB 10MG .....	146
ABILIFY MYCI TAB 10MG MNT.....	146
ABILIFY MYCI TAB 10MG STR .....	146
ABILIFY MYCI TAB 15MG .....	146
ABILIFY MYCI TAB 15MG MNT.....	146
ABILIFY MYCI TAB 15MG STR .....	146
ABILIFY MYCI TAB 20MG.....	146
ABILIFY MYCI TAB 20MG MNT .....	146
ABILIFY MYCI TAB 20MG STR .....	146
ABILIFY MYCI TAB 2MG .....	145
ABILIFY MYCI TAB 2MG MANT.....	145
ABILIFY MYCI TAB 2MG STRT.....	146
ABILIFY MYCI TAB 30MG .....	146
ABILIFY MYCI TAB 30MG MNT.....	146
ABILIFY MYCI TAB 30MG STR .....	146
ABILIFY MYCI TAB 5MG.....	146
ABILIFY MYCI TAB 5MG MANT.....	146
ABILIFY MYCI TAB 5MG STRT .....	146
ABILIFY TAB 10MG.....	146
ABILIFY TAB 15MG .....	146
ABILIFY TAB 20MG .....	146
ABILIFY TAB 2MG.....	146
ABILIFY TAB 30MG .....	146
ABILIFY TAB 5MG.....	146
<i>abiraterone acetate tab 250 mg</i> .....	120
<i>abiraterone acetate tab 500 mg</i> .....	120
ABSORICA CAP 10MG .....	182
ABSORICA CAP 20MG.....	182
ABSORICA CAP 25MG.....	182
ABSORICA CAP 30MG.....	182
ABSORICA CAP 35MG.....	182
ABSORICA CAP 40MG .....	182
ABSORICA LD CAP 16MG.....	182
ABSORICA LD CAP 24MG.....	182
ABSORICA LD CAP 32MG .....	182
ABSORICA LD CAP 8MG .....	182
<i>acamprosate calcium tab delayed release 333 mg</i> .....	306
ACANYA GEL 1.2-2.5% .....	182
<i>acarbose tab 100 mg</i> .....	85
<i>acarbose tab 25 mg</i> .....	85
<i>acarbose tab 50 mg</i> .....	85
ACCOLATE TAB 10MG .....	59
ACCOLATE TAB 20MG .....	59
ACCU-CHEK GUIDE .....	204
ACCU-CHEK KIT FASTCLIX .....	257
ACCU-CHEK KIT SOFTCLIX .....	257
ACCU-CHEK LIQ GUIDE.....	257
ACCU-CHEK LIQ SMART .....	257
ACCU-CHEK MIS MLTICLIX.....	257
ACCU-CHEK SOL.....	257
ACCU-CHEK SOL COMPACT.....	257
ACCU-CHEK TES AVIVA PL .....	204
ACCU-CHEK TES COMPACT .....	204
ACCU-CHEK TES GUIDE.....	204
ACCU-CHEK TES SMART .....	205
ACCUPRIL TAB 10MG.....	104
ACCUPRIL TAB 20MG .....	105
ACCUPRIL TAB 40MG .....	105
ACCUPRIL TAB 5MG .....	104
ACCURETIC TAB 10-12.5 .....	109
ACCURETIC TAB 20-12.5 .....	109
ACCURETIC TAB 20-25MG .....	109
ACCUTREND SOL GLUCOSE .....	258
ACCUTREND TES GLUCOSE.....	205
<i>acebutolol hcl cap 200 mg</i> .....	159
<i>acebutolol hcl cap 400 mg</i> .....	159
ACERFLEX POW .....	215

<i>acetaminophen-caffeine-dihydrocodeine</i>	ACTONEL TAB 35MG.....	226
<i>cap 320.5-30-16 mg</i> .....	ACTOPLUS MET TAB 15-500MG.....	85
<i>acetaminophen-caffeine-dihydrocodeine</i>	ACTOPLUS MET TAB 15-850MG.....	85
<i>tab 325-30-16 mg</i> .....	ACTOS TAB 15MG.....	92
<i>acetaminophen w/ codeine soln 120-12</i>	ACTOS TAB 30MG.....	92
<i>mg/5ml</i> .....	ACTOS TAB 45MG.....	92
<i>acetaminophen w/ codeine tab 300-15 mg</i>	ACULAR LS SOL 0.4% .....	302
.....	ACULAR SOL 0.5% OP .....	302
.....	ACUVAIL SOL 0.45% .....	302
<i>acetaminophen w/ codeine tab 300-30 mg</i>	<i>acyclovir cap 200 mg</i> .....	158
.....	<i>acyclovir cream 5%</i> .....	194
<i>acetaminophen w/ codeine tab 300-60 mg</i>	<i>acyclovir oint 5%</i> .....	194
.....	<i>acyclovir susp 200 mg/5ml</i> .....	158
<i>acetazolamide cap er 12hr 500 mg</i> .....	<i>acyclovir tab 400 mg</i> .....	158
<i>acetazolamide tab 125 mg</i> .....	<i>acyclovir tab 800 mg</i> .....	158
<i>acetazolamide tab 250 mg</i> .....	ACZONE GEL 5%.....	182
<i>acetic acid otic soln 2%</i> .....	ACZONE GEL 7.5%.....	182
<i>acetylcysteine inhal soln 10%</i> .....	ADALIMU-ADAZ INJ 40/0.4ML.....	15, 16
<i>acetylcysteine inhal soln 20%</i> .....	ADALIMU-FKJP KIT 20/0.4ML.....	16
ACIOXIA GEL 0.1-0.5%.....	ADALIMU-FKJP KIT 40/0.8ML.....	16
ACIPHEX SPR CAP 10MG .....	<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	
ACIPHEX SPR CAP 5MG.....	.....	182
ACIPHEX TAB 20MG .....	<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	
<i>acitretin cap 10 mg</i> .....	.....	182
<i>acitretin cap 17.5 mg</i> .....	<i>adapalene cream 0.1%</i> .....	182
<i>acitretin cap 25 mg</i> .....	<i>adapalene gel 0.1%</i> .....	182
ACTEMRA INJ 162/0.9 .....	<i>adapalene gel 0.3%</i> .....	182
ACTEMRA INJ ACTPEN .....	<i>adapalene pads 0.1%</i> .....	182
ACTHAR INJ 80UNIT.....	ADAPALENE SOL 0.1%.....	182
ACTICLATE TAB 150MG.....	ADASUVE INH 10MG.....	142
ACTICLATE TAB 75MG.....	ADBRY INJ 150MG/ML.....	200
ACTI-LANCE MIS 28G.....	ADCIRCA TAB 20MG .....	171
ACTI-LANCE MIS LITE 28G .....	ADDERALL TAB 10MG.....	1
ACTI-LANCE MIS SPEC 17G.....	ADDERALL TAB 12.5MG.....	1
ACTI-LANCE MIS UNIV 23G.....	ADDERALL TAB 15MG.....	1
ACTIMMUNE INJ 2MU/0.5 .....	ADDERALL TAB 20MG.....	1
ACTIQ LOZ 1200MCG.....	ADDERALL TAB 30MG.....	1
ACTIQ LOZ 1600MCG.....	ADDERALL TAB 5MG .....	1
ACTIQ LOZ 200MCG .....	ADDERALL TAB 7.5MG .....	1
ACTIQ LOZ 400MCG .....	ADDERALL XR CAP 10MG .....	1
ACTIQ LOZ 600MCG .....	ADDERALL XR CAP 15MG .....	1
ACTIQ LOZ 800MCG .....	ADDERALL XR CAP 20MG.....	1
ACTIVEVILLA TAB 1-0.5MG .....	ADDERALL XR CAP 25MG.....	1
ACTONEL TAB 150MG .....		

ADDERALL XR CAP 30MG.....1	ADVOCATE MIS LANC DEV .....258
ADDERALL XR CAP 5MG.....1	ADVOCATE MIS LANCETS .....258
<i>adefovir dipivoxil tab 10 mg</i> .....155	ADVOCATE TES .....205
ADEMPAS TAB 0.5MG.....172	ADVOCATE TES REDI-COD.....205
ADEMPAS TAB 1.5MG.....173	ADVOCATE TES REDICODE.....205
ADEMPAS TAB 1MG.....173	ADV TRAVEL MIS LANC 28G .....258
ADEMPAS TAB 2.5MG .....173	ADZENYS ER SUS 1.25MG .....1
ADEMPAS TAB 2MG .....173	ADZENYS XR TAB 12.5MG .....2
ADHANSIA XR CAP 25MG .....8	ADZENYS XR TAB 15.7 MG .....2
ADHANSIA XR CAP 35MG .....8	ADZENYS XR TAB 18.8MG .....2
ADHANSIA XR CAP 45MG.....8	ADZENYS XR TAB 3.1MG .....1
ADHANSIA XR CAP 55MG.....8	ADZENYS XR TAB 6.3MG .....1
ADHANSIA XR CAP 70MG.....8	ADZENYS XR TAB 9.4MG .....1
ADHANSIA XR CAP 85MG.....8	AEMCOLO TAB 194MG.....51
ADIPEX-P CAP 37.5MG.....5	AERCHMBR PLS MIS FLOW-VU .....278
ADIPEX-P TAB 37.5MG .....5	AERCHMBR PLS MIS LRG MASK .....278
ADJ LANCING MIS DEVICE.....258	AERCHMBR PLS MIS MED MASK .....278
ADLARITY DIS 10MG/DAY .....307	AERCHMBR PLS MIS SM MASK .....278
ADLARITY DIS 5MG/DAY .....307	AERCHMBR Z- MIS STAT PLS .....278
ADLYXIN INJ 10/20MCG .....89	AEROCHAMBER KIT ACTION .....278
ADLYXIN INJ 20MCG.....89	AEROCHAMBER MIS CHAMBER.....278
ADMELOG INJ 100U/ML .....90	AEROCHAMBER MIS FLOSIGNA.....278
ADMELOG SOLO INJ 100U/ML .....90	AEROCHAMBER MIS MV .....278
ADRENALIN INJ 1MG/ML.....330	AEROCHAMBER MIS PLUS .....278
ADRENALIN INJ 30/30ML .....330	AEROVENT MIS PLUS .....278
ADRENALIN SOL 1:1000 .....295	AFINITOR DIS TAB 2MG .....124
ADVAIR DISKU AER 100/50 .....61	AFINITOR DIS TAB 3MG .....124
ADVAIR DISKU AER 250/50.....61	AFINITOR DIS TAB 5MG .....124
ADVAIR DISKU AER 500/50 .....61	AFINITOR TAB 10MG .....124
ADVAIR HFA AER 115/21 .....61	AFINITOR TAB 2.5MG .....124
ADVAIR HFA AER 230/21.....62	AFINITOR TAB 5MG .....124
ADVAIR HFA AER 45/21.....61	AFINITOR TAB 7.5MG .....124
ADVANCE LIQ CONTROL .....258	AFREZZA POW 12 UNIT.....90
ADVANCE LIQ INTUITIO .....258	AFREZZA POW 4-8-12.....90
ADVANCE NORM LIQ CONTROL .....258	AFREZZA POW 4-8 UNIT .....90
ADVANCE TES INTUITIO .....205	AFREZZA POW 4UNIT .....90
ADVANCE TES MICRO-DW.....205	AFREZZA POW 8-12UNIT.....90
ADVOCATE SAFE MIS LANC 26G .....258	AFREZZA POW 8 UNIT .....90
ADV LANCING MIS DEVICE .....258	AGAMATRIX MIS 33G .....258
ADVOCATE+ SOL REDI-COD.....258	AGAMATRIX SOL HIGH .....258
ADVOCATE LIQ HIGH .....258	AGAMATRIX SOL LEVEL 2 .....258
ADVOCATE LIQ LOW .....258	AGAMATRIX SOL LEVEL 4 .....258
ADVOCATE MIS LANC 30G .....258	AGAMATRIX SOL NORM/HGH.....258

AGAMATRIX SOL NORMAL .....	258	<i>alclometasone dipropionate oint 0.05%</i> .....	195
AGAMATRIX TES AMP.....	205	ALCOH-GLOVE PAD CONTOURE .....	276
AGAMATRIX TES JAZZ.....	205	ALCOHOL PAD.....	276
AGAMATRIX TES KEYNOTE.....	205	ALCOHOL PAD 70%.....	276
AGAMATRIX TES PRESTO .....	205	ALCOHOL PAD PREP .....	276
AGRYLIN CAP 0.5MG.....	247	ALCOHOL PAD SWABSTIC .....	276
AIMOVIG INJ 140MG/ML .....	279	ALCOHOL PREP PAD .....	276
AIMOVIG INJ 70MG/ML .....	279	ALCOHOL PREP PAD 70%.....	276
AIMSCO TWIST MIS 32G.....	258	ALCOHOL PREP PAD MED 70% .....	276
AIMSCO TWIST MIS 33G.....	258	ALCOHOL PREP PAD PADS 70%.....	276
AIRDUO DGHLR INH 113-14 .....	62	ALCOHOL SWAB PAD .....	276
AIRDUO DGHLR INH 232-14.....	62	ALCOHOL SWAB PAD 70% .....	276
AIRDUO DGHLR INH 55-14.....	62	ALCOHOL SWAB PAD EX-THICK.....	276
AIRDUO RESPI INH 113-14.....	62	ALCOHOL WIPE PAD .....	276
AIRDUO RESPI INH 232-14 .....	62	ALDACTAZIDE TAB 25/25.....	224
AIRDUO RESPI INH 55-14 .....	62	ALDACTAZIDE TAB 50/50 .....	224
AIRSUPRA AER 90-80MCG.....	62	ALDACTONE TAB 100MG.....	225
AJOVY INJ 225/1.5 .....	279	ALDACTONE TAB 25MG.....	225
AKLIEF CRE 0.005% .....	182	ALDACTONE TAB 50MG .....	225
AKTEN GEL 3.5%.....	300	ALDARA CRE 5%.....	201
AKYNZEO CAP 300-0.5.....	96	ALECENSA CAP 150MG .....	124
ALA-SCALP LOT 2% .....	195	<i>alendronate sodium oral soln 70 mg/75ml</i>	
<i>albendazole tab 200 mg</i> .....	51	.....	226
ALBENZA TAB 200MG.....	51	<i>alendronate sodium tab 10 mg</i> .....	226
ALBUTEROL NEB 0.5% .....	62	<i>alendronate sodium tab 35 mg</i> .....	226
<i>albuterol sulfate inhal aero 108 mcg/act</i>		<i>alendronate sodium tab 5 mg</i> .....	226
<i>(90mcg base equiv)</i> .....	62	<i>alendronate sodium tab 70 mg</i> .....	226
<i>albuterol sulfate soln nebu 0.083% (2.5</i>		<i>alfuzosin hcl tab er 24hr 10 mg</i> .....	245
<i>mg/3ml)</i> .....	62	ALINIA SUS 100/5ML .....	52
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>		ALINIA TAB 500MG.....	52
.....	62	<i>aliskiren fumarate tab 150 mg (base</i>	
<i>albuterol sulfate soln nebu 0.63 mg/3ml</i>		<i>equivalent)</i> .....	114
<i>(base equiv)</i> .....	62	<i>aliskiren fumarate tab 300 mg (base</i>	
<i>albuterol sulfate soln nebu 1.25 mg/3ml</i>		<i>equivalent)</i> .....	114
<i>(base equiv)</i> .....	62	ALKERAN TAB 2MG.....	117
<i>albuterol sulfate syrup 2 mg/5ml</i> .....	62	ALKINDI SPRI CAP 0.5MG .....	178
<i>albuterol sulfate tab 2 mg</i> .....	62	ALKINDI SPRI CAP 1MG.....	178
<i>albuterol sulfate tab 4 mg</i> .....	62	ALKINDI SPRI CAP 2MG.....	178
<i>albuterol sulfate tab er 12hr 4 mg</i> .....	62	ALKINDI SPRI CAP 5MG.....	178
<i>albuterol sulfate tab er 12hr 8 mg</i> .....	62	<i>allopurinol tab 100 mg</i> .....	246
ALCAINE SOL 0.5% OP .....	300	<i>allopurinol tab 300 mg</i> .....	246
<i>alclometasone dipropionate cream 0.05%</i>		ALLZITAL TAB 25-325MG .....	34
.....	195	<i>almotriptan malate tab 12.5 mg</i> .....	280

<i>almotriptan malate tab 6.25 mg</i> .....	280	ALTACE CAP 1.25MG.....	105
ALOCRI SOL 2% .....	302	ALTACE CAP 10MG.....	105
<i>alogliptin benzoate tab 12.5 mg (base equiv)</i> .....	88	ALTACE CAP 2.5MG .....	105
<i>alogliptin benzoate tab 25 mg (base equiv)</i> .....	88	ALTACE CAP 5MG .....	105
<i>alogliptin benzoate tab 6.25 mg (base equiv)</i> .....	88	ALTEMIA EMU.....	296
<i>alogliptin-metformin hcl tab 12.5-1000 mg</i> .....	85	ALTERNARIA SOL ALTERNAT .....	14
<i>alogliptin-metformin hcl tab 12.5-500 mg</i>	85	ALTOPREV TAB 20MG ER .....	101
<i>alogliptin-pioglitazone tab 12.5-15 mg</i> .....	85	ALTOPREV TAB 40MG ER.....	102
<i>alogliptin-pioglitazone tab 12.5-30 mg</i> .....	85	ALTOPREV TAB 60MG ER.....	102
<i>alogliptin-pioglitazone tab 12.5-45 mg</i> .....	85	ALTRENO LOT 0.05%.....	182
<i>alogliptin-pioglitazone tab 25-15 mg</i> .....	85	ALUNBRIG PAK.....	124
<i>alogliptin-pioglitazone tab 25-30 mg</i> .....	85	ALUNBRIG TAB 180MG .....	124
<i>alogliptin-pioglitazone tab 25-45 mg</i> .....	85	ALUNBRIG TAB 30MG .....	124
ALOMIDE SOL 0.1% OP .....	302	ALUNBRIG TAB 90MG .....	124
ALORA DIS 0.025MG .....	236	ALVESCO AER 160MCG.....	59
ALORA DIS 0.05MG.....	236	ALVESCO AER 80MCG .....	59
ALORA DIS 0.075MG .....	236	<i>alvimopan cap 12 mg</i> .....	243
ALORA DIS 0.1MG.....	236	<i>amantadine hcl cap 100 mg</i> .....	135
<i>alose tron hcl tab 0.5 mg (base equiv)</i> .....	242	<i>amantadine hcl soln 50 mg/5ml</i> .....	135
<i>alose tron hcl tab 1 mg (base equiv)</i> .....	242	<i>amantadine hcl tab 100 mg</i> .....	135
ALPHAGAN P SOL 0.1% .....	298	AMARYL TAB 1MG .....	93
ALPHAGAN P SOL 0.15% .....	298	AMARYL TAB 2MG .....	93
ALPRAZOLAM CON 1 MG/ML.....	55	AMARYL TAB 4MG .....	93
<i>alprazolam orally disintegrating tab 0.25 mg</i> .....	55	AMBIEN CR TAB 12.5MG .....	253
<i>alprazolam orally disintegrating tab 0.5 mg</i> .....	55	AMBIEN CR TAB 6.25MG.....	253
<i>alprazolam orally disintegrating tab 1 mg</i>	55	AMBIEN TAB 10MG.....	253
<i>alprazolam orally disintegrating tab 2 mg</i>	55	AMBIEN TAB 5MG .....	253
<i>alprazolam tab 0.25 mg</i> .....	55	<i>ambrisentan tab 10 mg</i> .....	171
<i>alprazolam tab 0.5 mg</i> .....	55	<i>ambrisentan tab 5 mg</i> .....	171
<i>alprazolam tab 1 mg</i> .....	55	<i>amcinonide cream 0.1%</i> .....	195
<i>alprazolam tab 2 mg</i> .....	55	<i>amcinonide lotion 0.1%</i> .....	195
<i>alprazolam tab er 24hr 0.5 mg</i> .....	55	<i>amcinonide oint 0.1%</i> .....	195
<i>alprazolam tab er 24hr 1 mg</i> .....	55	AMELUZ GEL 10% .....	188
<i>alprazolam tab er 24hr 2 mg</i> .....	55	AMERGE TAB 1MG.....	280
<i>alprazolam tab er 24hr 3 mg</i> .....	55	AMERGE TAB 2.5MG.....	280
ALREX SUS 0.2% .....	300	AMICAR SOL 0.25/ML .....	252
ALTABAX OIN 1% .....	186	AMICAR TAB 1000MG .....	252
		AMICAR TAB 500MG .....	252
		<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i> .....	224
		<i>amiloride hcl tab 5 mg</i> .....	225
		<i>aminocaproic acid oral soln 0.25 gm/ml</i>	252
		<i>aminocaproic acid tab 1000 mg</i> .....	252

<i>aminocaproic acid tab 500 mg</i> .....	252	<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i> .....	109
<i>amiodarone hcl tab 100 mg</i> .....	57	<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i> .....	109
<i>amiodarone hcl tab 200 mg</i> .....	57	<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i> .....	109
<i>amiodarone hcl tab 400 mg</i> .....	57	<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i> .....	109
AMITIZA CAP 24MCG .....	239	<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i> .....	109
AMITIZA CAP 8MCG .....	239	<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i> .....	109
<i>amitriptyline hcl tab 100 mg</i> .....	83	<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i> .....	109
<i>amitriptyline hcl tab 10 mg</i> .....	83	<i>amlodipine besylate tab 10 mg (base equivalent)</i> .....	162
<i>amitriptyline hcl tab 150 mg</i> .....	83	<i>amlodipine besylate tab 2.5 mg (base equivalent)</i> .....	162
<i>amitriptyline hcl tab 25 mg</i> .....	83	<i>amlodipine besylate tab 5 mg (base equivalent)</i> .....	162
<i>amitriptyline hcl tab 50 mg</i> .....	83	<i>amlodipine besylate-valsartan tab 10-160 mg</i> .....	109
<i>amitriptyline hcl tab 75 mg</i> .....	83	<i>amlodipine besylate-valsartan tab 10-320 mg</i> .....	109
AMJEVITA INJ 10/0.2ML .....	16	<i>amlodipine besylate-valsartan tab 5-160 mg</i> .....	109
AMJEVITA INJ 20/0.4ML .....	16	<i>amlodipine besylate-valsartan tab 5-320 mg</i> .....	109
AMJEVITA INJ 40/0.8ML .....	16	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i> .....	109
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i> .....	166	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i> .....	109
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i> .....	166	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i> .....	110
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i> .....	166	<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i> .....	109
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i> .....	166	<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i> .....	109
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i> .....	166	<i>amoxapine tab 100 mg</i> .....	83
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i> .....	166	<i>amoxapine tab 150 mg</i> .....	83
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i> .....	166	<i>amoxapine tab 25 mg</i> .....	83
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i> .....	166	<i>amoxapine tab 50 mg</i> .....	83
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i> .....	166		
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i> .....	166		
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i> .....	166		
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i> .....	109		
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i> .....	109		
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i> .....	109		

<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap</i>	
<i>dr 500 &amp; 500 &amp; 30mg</i> .....	327
<i>amoxicillin (trihydrate) cap 250 mg</i> .....	305
<i>amoxicillin (trihydrate) cap 500 mg</i> .....	305
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	305
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	
.....	305
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	
.....	305
<i>amoxicillin (trihydrate) for susp 200</i>	
<i>mg/5ml</i> .....	305
<i>amoxicillin (trihydrate) for susp 250</i>	
<i>mg/5ml</i> .....	305
<i>amoxicillin (trihydrate) for susp 400</i>	
<i>mg/5ml</i> .....	305
<i>amoxicillin (trihydrate) tab 500 mg</i> .....	305
<i>amoxicillin (trihydrate) tab 875 mg</i> .....	305
<i>amoxicillin &amp; k clavulanate chew tab 200-</i>	
<i>28.5 mg</i> .....	305
<i>amoxicillin &amp; k clavulanate chew tab 400-</i>	
<i>57 mg</i> .....	305
<i>amoxicillin &amp; k clavulanate for susp 200-</i>	
<i>28.5 mg/5ml</i> .....	305
<i>amoxicillin &amp; k clavulanate for susp 250-</i>	
<i>62.5 mg/5ml</i> .....	305
<i>amoxicillin &amp; k clavulanate for susp 400-57</i>	
<i>mg/5ml</i> .....	305
<i>amoxicillin &amp; k clavulanate for susp 600-</i>	
<i>42.9 mg/5ml</i> .....	305
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i>	
.....	305
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i>	
.....	305
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i>	
.....	305
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-</i>	
<i>62.5 mg</i> .....	305
<i>AMPHETAMI ER SUS 1.25/ML</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 10 mg</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 15 mg</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 20 mg</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 25 mg</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 30 mg</i> .....	2
<i>amphetamine-dextroamphetamine cap er</i>	
<i>24hr 5 mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 10</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 12.5</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 15</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 20</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 30</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 5</i>	
<i>mg</i> .....	2
<i>amphetamine-dextroamphetamine tab 7.5</i>	
<i>mg</i> .....	2
<i>amphetamine sulfate tab 10 mg</i> .....	2
<i>amphetamine sulfate tab 5 mg</i> .....	2
<i>ampicillin cap 500 mg</i> .....	305
<i>AMPYRA TAB 10MG</i> .....	310
<i>AMRIX CAP 15MG</i> .....	292
<i>AMRIX CAP 30MG</i> .....	292
<i>AMZEEQ AER 4%</i> .....	182
<i>ANACAINE OIN</i> .....	202
<i>ANAFRANIL CAP 25MG</i> .....	83
<i>ANAFRANIL CAP 50MG</i> .....	83
<i>ANAFRANIL CAP 75MG</i> .....	83
<i>anagrelide hcl cap 0.5 mg</i> .....	247
<i>anagrelide hcl cap 1 mg</i> .....	247
<i>ANALPRAM-HC CRE 1-1%</i> .....	50
<i>ANALPRAM-HC LOT 2.5%</i> .....	50
<i>ANASPAZ TAB 0.125MG</i> .....	323
<i>anastrozole tab 1 mg</i> .....	120
<i>ANCOBON CAP 250MG</i> .....	97
<i>ANCOBON CAP 500MG</i> .....	97
<i>ANDRODERM DIS 2MG/24HR</i> .....	49
<i>ANDRODERM DIS 4MG/24HR</i> .....	49



ANDROGEL GEL 1.62% .....	49	APTIVUS SOL .....	147
ANDROGEL GEL 1%(25MG) .....	49	AQUALANCE MIS 30G .....	258
ANDROGEL GEL 1%(50MG) .....	49	ARAKODA TAB 100MG.....	115
ANGELIQ TAB 0.25-0.5.....	236	ARANESP INJ 100MCG.....	249
ANGELIQ TAB 0.5-1MG.....	236	ARANESP INJ 10MCG .....	249
ANNOVERA MIS.....	177	ARANESP INJ 150MCG.....	249
ANORO ELLIPT AER 62.5-25.....	62	ARANESP INJ 200MCG.....	249
ANTARA CAP 30MG.....	100	ARANESP INJ 25MCG.....	249
ANTARA CAP 90MG.....	100	ARANESP INJ 300MCG.....	249
ANUSOL-HC CRE 2.5%.....	50	ARANESP INJ 40MCG .....	249
ANZEMET TAB 100MG .....	96	ARANESP INJ 500MCG.....	250
ANZEMET TAB 50MG .....	95, 96	ARANESP INJ 60MCG .....	249
APADAZ TAB 4.08-325 .....	45	ARAVA TAB 10MG .....	31
APADAZ TAB 6.12-325 .....	45	ARAVA TAB 20MG.....	31
APADAZ TAB 8.16-325 .....	45	ARAZLO LOT 0.045% .....	183
APEXICON E CRE 0.05%.....	195	ARCALYST INJ 220MG .....	27
APIDRA INJ SOLOSTAR.....	90	<i>arformoterol tartrate soln nebu 15 mcg/2ml</i> <i>(base equiv).....</i>	62
APIDRA INJ U-100 .....	90	ARICEPT TAB 10MG .....	307
ALENZIN TAB 174MG.....	78	ARICEPT TAB 23MG.....	307
ALENZIN TAB 348MG .....	78	ARICEPT TAB 5MG.....	307
ALENZIN TAB 522MG .....	78	ARIKAYCE SUS.....	15
APLICARE ALC PAD SWABSTIC.....	277	ARIMIDEX TAB 1MG .....	120
APOKYN INJ 10MG/ML .....	135	<i>aripiprazole orally disintegrating tab 10 mg</i> .....	146
<i>apraclonidine hcl ophth soln 0.5% (base</i> <i>equivalent) .....</i>	298	<i>aripiprazole orally disintegrating tab 15 mg</i> .....	146
<i>aprepitant capsule 125 mg.....</i>	97	<i>aripiprazole oral solution 1 mg/ml .....</i>	146
<i>aprepitant capsule 40 mg .....</i>	97	<i>aripiprazole tab 10 mg.....</i>	146
<i>aprepitant capsule 80 mg .....</i>	97	<i>aripiprazole tab 15 mg.....</i>	146
<i>aprepitant capsule therapy pack 80 &amp; 125</i> <i>mg .....</i>	97	<i>aripiprazole tab 20 mg .....</i>	146
APRISO CAP 0.375GM.....	240	<i>aripiprazole tab 2 mg .....</i>	146
APTENSIO XR CAP 10MG.....	8	<i>aripiprazole tab 30 mg .....</i>	146
APTENSIO XR CAP 15MG.....	8	<i>aripiprazole tab 5 mg .....</i>	146
APTENSIO XR CAP 20MG.....	8	ARISTADA INJ 1064MG.....	147
APTENSIO XR CAP 30MG.....	8	ARISTADA INJ 441MG/1.....	146
APTENSIO XR CAP 40MG.....	8	ARISTADA INJ 662MG/2.....	146
APTENSIO XR CAP 50MG.....	8	ARISTADA INJ 882MG/3.....	146
APTENSIO XR CAP 60MG.....	9	ARISTADA INJ INITIO .....	147
APTIOM TAB 200MG .....	69	ARIXTRA INJ 10/0.8ML.....	66
APTIOM TAB 400MG .....	69	ARIXTRA INJ 2.5/0.5.....	66
APTIOM TAB 600MG .....	69	ARIXTRA INJ 5/0.4ML .....	66
APTIOM TAB 800MG .....	69	ARIXTRA INJ 7.5/0.6.....	66
APTIVUS CAP 250MG.....	147		

<i>armodafinil tab 150 mg</i> .....	9	<i>aspirin chew tab 81 mg</i> .....	35
<i>armodafinil tab 200 mg</i> .....	9	<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i> .....	248
<i>armodafinil tab 250 mg</i> .....	9	<i>aspirin tab delayed release 81 mg</i> .....	35
<i>armodafinil tab 50 mg</i> .....	9	ASSURE 3 LIQ CONTROL.....	258
ARMONAIR DIG AER 113MCG.....	59	ASSURE 3 TES.....	205
ARMONAIR DIG AER 232MCG.....	60	ASSURE 4 LIQ LEVEL1/2.....	258
ARMONAIR DIG AER 55MCG.....	59	ASSURE 4 TES.....	205
ARMOUR THYRO TAB 120MG.....	320	ASSURE CMFRT MIS 28G.....	258
ARMOUR THYRO TAB 15MG.....	320	ASSURE DOSE SOL NORM/HGH.....	258
ARMOUR THYRO TAB 180MG.....	320	ASSURE DOSE SOL NORMAL.....	258
ARMOUR THYRO TAB 240MG.....	320	ASSURE II LIQ LEVEL 1.....	258
ARMOUR THYRO TAB 300MG.....	320	ASSURE II LIQ LEVEL1/2.....	258
ARMOUR THYRO TAB 30MG.....	320	ASSURE II TES.....	205
ARMOUR THYRO TAB 60MG.....	320	ASSURE II TES CHECK.....	205
ARMOUR THYRO TAB 90MG.....	320	ASSURE LANCE MIS 21G.....	258
ARNICA TIN FLOWER.....	203	ASSURE LANCE MIS 28G.....	259
ARNUITY ELPT INH 100MCG.....	60	ASSURE LANCE MIS LOW FLOW.....	259
ARNUITY ELPT INH 200MCG.....	60	ASSURE LANCE MIS MICRO.....	259
ARNUITY ELPT INH 50MCG.....	60	ASSURE LANCE MIS SAFE 25G.....	259
AROMASIN TAB 25MG.....	121	ASSURE LANCE MIS SAFE 30G.....	259
ARTHROTEC 50 TAB.....	27	ASSURE PLUS MIS HIGH 18G.....	259
ARTHROTEC 75 TAB.....	27	ASSURE PLUS MIS LOW 25G.....	259
ARTISS SOL 10ML.....	252	ASSURE PLUS MIS MCRO 28G.....	259
ARTISS SOL 2ML.....	252	ASSURE PLUS MIS NORM 21G.....	259
ARTISS SOL 4ML.....	252	ASSURE PLUS MIS PEDIATRI.....	259
ASA/OMEPRAZO TAB 81-40MG.....	248	ASSURE PRISM SOL LEVEL1/2.....	259
ASACOL HD TAB 800MG.....	240	ASSURE PRISM TES MULTI.....	205
<i>asenapine maleate sl tab 10 mg (base</i> <i>equiv)</i> .....	142	ASSURE PRO LIQ LEVEL1/2.....	259
<i>asenapine maleate sl tab 2.5 mg (base</i> <i>equiv)</i> .....	142	ASSURE PRO TES.....	205
<i>asenapine maleate sl tab 5 mg (base equiv)</i> .....	142	ASSURE TES PLATINUM.....	205
ASMANEX 120 AER 220MCG.....	60	ASTAGRAF XL CAP 0.5MG.....	285
ASMANEX 14 AER 220MCG.....	60	ASTAGRAF XL CAP 1MG.....	285
ASMANEX 30 AER 110MCG.....	60	ASTAGRAF XL CAP 5MG.....	285
ASMANEX 30 AER 220MCG.....	60	ATABEX EC TAB 29-1MG.....	288
ASMANEX 60 AER 220MCG.....	60	ATABEX OB TAB 29-1MG.....	288
ASMANEX 7 AER 110MCG.....	60	ATACAND HCT TAB 16-12.5.....	110
ASMANEX HFA AER 100 MCG.....	60	ATACAND HCT TAB 32-12.5.....	110
ASMANEX HFA AER 200 MCG.....	60	ATACAND HCT TAB 32-25MG.....	110
ASMANEX HFA AER 50MCG.....	60	ATACAND TAB 16MG.....	106
ASP/OMEPRAZO TAB 325-40MG.....	248	ATACAND TAB 32MG.....	106
		ATACAND TAB 4MG.....	106
		ATACAND TAB 8MG.....	106

<i>atazanavir sulfate cap 150 mg (base equiv)</i> .....148	ATROVENT HFA AER 17MCG .....58
<i>atazanavir sulfate cap 200 mg (base equiv)</i> .....148	AUBAGIO TAB 14MG.....310
<i>atazanavir sulfate cap 300 mg (base equiv)</i> .....148	AUBAGIO TAB 7MG .....310
ATELVIA TAB.....226	AUGMENTIN SUS 125/5ML.....306
<i>atenolol &amp; chlorthalidone tab 100-25 mg</i> ..110	AUGMENTIN SUS 250/5ML.....306
<i>atenolol &amp; chlorthalidone tab 50-25 mg</i> ..110	AUGMENTIN SUS ES-600 .....306
<i>atenolol tab 100 mg</i> .....159	AUGMENTIN TAB 500MG.....306
<i>atenolol tab 25 mg</i> .....159	AURORA LANCE MIS 30G .....259
<i>atenolol tab 50 mg</i> .....159	AURORA LANCE MIS THIN 23G .....259
ATIVAN TAB 0.5MG.....55	AURYXIA TAB 210MG.....243
ATIVAN TAB 1MG.....55	AUSTEDO TAB 12MG .....309
ATIVAN TAB 2MG .....56	AUSTEDO TAB 6MG.....309
<i>atomoxetine hcl cap 100 mg (base equiv)</i> ..7	AUSTEDO TAB 9MG.....309
<i>atomoxetine hcl cap 10 mg (base equiv)</i> ....6	AUSTEDO XR TAB 12MG .....310
<i>atomoxetine hcl cap 18 mg (base equiv)</i> .....6	AUSTEDO XR TAB 24MG .....310
<i>atomoxetine hcl cap 25 mg (base equiv)</i> ....7	AUSTEDO XR TAB 6MG.....310
<i>atomoxetine hcl cap 40 mg (base equiv)</i> ....7	AUSTEDO XR TAB TITR KIT .....310
<i>atomoxetine hcl cap 60 mg (base equiv)</i> ....7	AUTOCODE TES BLD GLUC .....206
<i>atomoxetine hcl cap 80 mg (base equiv)</i> ....7	AUTO LANCET MIS.....259
ATORVALIQ SUS 20MG/5ML .....102	AUTO-LANCET MIS .....259
<i>atorvastatin calcium tab 10 mg (base equivalent)</i> .....102	AUTO-LANCET MIS MINI.....259
<i>atorvastatin calcium tab 20 mg (base equivalent)</i> .....102	AUTOLET II KIT CLINISAF .....259
<i>atorvastatin calcium tab 40 mg (base equivalent)</i> .....102	AUTOLET IMPR MIS LANC DEV.....259
<i>atorvastatin calcium tab 80 mg (base equivalent)</i> .....102	AUTOLET LANC MIS DEVICE .....259
<i>atovaquone-proguanil hcl tab 250-100 mg</i> .....115	AUTOLET LITE KIT .....259
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i> .....115	AUTOLET LITE KIT CLINISAF .....259
<i>atovaquone susp 750 mg/5ml</i> .....52	AUTOLET LITE KIT STARTER .....259
ATRALIN GEL 0.05% .....183	AUTOLET MINI MIS .....259
ATRIPLA TAB .....148	AUTOLET PLAT MIS 1.8MM.....259
ATROPINE SUL DRO 0.025%.....297	AUTOLET PLAT MIS 2.4MM.....259
ATROPINE SUL DRO 0.05%.....297	AUTOLET PLAT MIS 3.0MM.....259
ATROPINE SUL INJ 0.4MG/ML .....323	AUTOLET PLUS MIS .....259
ATROPINE SUL SOL 0.01%.....297	AUTOLET PLUS MIS LANC DEV .....259
ATROPINE SUL SOL 1% OP .....297	AUVELITY TAB 45-105MG .....78
	AUVI-Q INJ 0.15MG.....331
	AUVI-Q INJ 0.1MG .....330
	AUVI-Q INJ 0.3MG .....331
	AVALIDE TAB 150-12.5.....110
	AVALIDE TAB 300-12.5 .....110
	AVANDIA TAB 2MG .....92
	AVANDIA TAB 4MG.....92
	AVAPRO TAB 150MG.....107
	AVAPRO TAB 300MG.....107

AVAPRO TAB 75MG.....	107	AZULFIDINE TAB 500MG EN .....	240
AVODART CAP 0.5MG.....	245	<b>B</b>	
AVONEX PEN KIT 30MCG.....	310	<i>bacitracin ophth oint 500 unit/gm.....</i>	298
AVONEX PREFL KIT 30MCG.....	310	<i>bacitracin-polymyxin b ophth oint.....</i>	298
AYGESTIN TAB 5MG.....	306	<i>bacitracin-polymyxin-neomycin-hc ophth</i>	
AYVAKIT TAB 100MG .....	123	<i>oint 1%.....</i>	300
AYVAKIT TAB 200MG.....	123	BACLOFEN SOL 10MG/5ML .....	292
AYVAKIT TAB 25MG .....	122	<i>baclofen tab 10 mg .....</i>	292
AYVAKIT TAB 300MG.....	123	<i>baclofen tab 20 mg.....</i>	292
AYVAKIT TAB 50MG .....	123	<i>baclofen tab 5 mg .....</i>	292
<i>azacitidine for inj 100 mg.....</i>	117	BACTRIM DS TAB 800-160 .....	51
AZASITE SOL 1%.....	298	BACTRIM TAB 400-80MG .....	51
<i>azathioprine tab 100 mg.....</i>	285	BAFIERTAM CAP 95MG .....	310
<i>azathioprine tab 50 mg .....</i>	285	BALCOLTRA TAB 0.1-20 .....	174
<i>azathioprine tab 75 mg .....</i>	285	<i>balsalazide disodium cap 750 mg.....</i>	240
<i>azelaic acid gel 15% .....</i>	203	BALVERSA TAB 3MG .....	124
<i>azelastine hcl-fluticasone prop nasal spray</i>		BALVERSA TAB 4MG .....	125
<i>137-50 mcg/act.....</i>	294	BALVERSA TAB 5MG .....	125
<i>azelastine hcl nasal spray 0.1% (137</i>		BANZEL SUS 40MG/ML.....	69
<i>mcg/spray) .....</i>	294	BANZEL TAB 200MG.....	69
<i>azelastine hcl nasal spray 0.15% (205.5</i>		BANZEL TAB 400MG .....	69
<i>mcg/spray) .....</i>	294	BAQSIMI ONE POW 3MG/DOSE .....	88
<i>azelastine hcl ophth soln 0.05%.....</i>	302	BAQSIMI TWO POW 3MG/DOSE .....	88
AZELEX CRE 20%.....	183	BARACLUDE SOL .....	156
AZESCHEW CHW 13-1MG .....	288	BARACLUDE TAB 0.5MG .....	156
AZESCO TAB 13-1MG .....	288	BARACLUDE TAB 1MG.....	156
AZILECT TAB 0.5MG.....	138	BASAGLAR INJ 100UNIT .....	90
AZILECT TAB 1MG .....	138	BAXDELA TAB 450MG.....	238
<i>azithromycin for susp 100 mg/5ml.....</i>	256	BCAD 2 POW .....	215
<i>azithromycin for susp 200 mg/5ml.....</i>	256	<i>b-complex w/ c &amp; folic acid tab .....</i>	288
<i>azithromycin powd pack for susp 1 gm...256</i>		<i>b-complex w/ c &amp; folic acid tab 1 mg .....</i>	288
<i>azithromycin tab 250 mg .....</i>	256	<i>b-complex w/ c &amp; folic acid tab 5 mg .....</i>	288
<i>azithromycin tab 500 mg.....</i>	256	BD LANCET UF MIS 30G.....	259
<i>azithromycin tab 600 mg.....</i>	256	BD LANCET UF MIS 33G .....	259
AZOPT SUS 1% OP.....	302	BD MICROTAIN MIS LANCETS.....	259
AZOR TAB 10-20MG .....	110	BD SWAB BFLY PAD SNGL USE .....	277
AZOR TAB 10-40MG.....	110	BD U-500 MIS 31GX6MM .....	277
AZOR TAB 5-20MG.....	110	BD ULTRAFINE INSULIN	
AZOR TAB 5-40MG.....	110	SYRINGES/NEEDLES.....	277
AZSTARYS CAP 26.1-5.2 .....	9	BD ULTRAFINE PEN NEEDLES.....	277
AZSTARYS CAP 39.2-7.8 .....	9	BECONASE AQ SUS 0.042%.....	295
AZSTARYS CAP 52.3-10.....	9	BELBUCA MIS 150MCG.....	47
AZULFIDINE TAB 500MG .....	240	BELBUCA MIS 300MCG.....	47

BELBUCA MIS 450MCG.....	47	<i>benzonatate cap 100 mg</i> .....	181
BELBUCA MIS 600MCG.....	47	<i>benzonatate cap 150 mg</i> .....	181
BELBUCA MIS 750MCG.....	47	<i>benzonatate cap 200 mg</i> .....	181
BELBUCA MIS 75MCG .....	47	<i>benzoyl peroxide-erythromycin gel 5-3%</i>	
BELBUCA MIS 900MCG.....	47	.....	183
BELLA/OPIUM SUP 16.2-30 .....	323	<i>benzoyl peroxide foam 9.8%</i> .....	183
BELLA/OPIUM SUP 16.2-60 .....	323	<i>benzoyl peroxide-hydrocortisone lotion 5-</i>	
BELSOMRA TAB 10MG .....	254	<i>0.5%</i> .....	183
BELSOMRA TAB 15MG.....	254	<i>benzoyl peroxide liq 7%</i> .....	183
BELSOMRA TAB 20MG.....	254	BENZOYL PERX LIQ 6.9% .....	183
BELSOMRA TAB 5MG .....	254	BENZ PER FOR LOT HC 7.5-1.....	183
<i>benazepril &amp; hydrochlorothiazide tab 10-</i>		BENZ PEROXID GEL 6.5% .....	183
<i>12.5 mg</i> .....	110	<i>benzphetamine hcl tab 25 mg</i> .....	5
<i>benazepril &amp; hydrochlorothiazide tab 20-</i>		<i>benzphetamine hcl tab 50 mg</i> .....	5
<i>12.5 mg</i> .....	110	<i>benztropine mesylate tab 0.5 mg</i> .....	135
<i>benazepril &amp; hydrochlorothiazide tab 20-25</i>		<i>benztropine mesylate tab 1 mg</i> .....	135
<i>mg</i> .....	110	<i>benztropine mesylate tab 2 mg</i> .....	135
<i>benazepril &amp; hydrochlorothiazide tab 5-</i>		BEPREVE DRO 1.5% .....	302
<i>6.25 mg</i> .....	110	BERINERT INJ 500UNIT.....	247
<i>benazepril hcl tab 10 mg</i> .....	105	BESIVANCE SUS 0.6% .....	298
<i>benazepril hcl tab 20 mg</i> .....	105	BESREMI SOL 500MCG.....	134
<i>benazepril hcl tab 40 mg</i> .....	105	BETADINE SOL 5% OP.....	298
<i>benazepril hcl tab 5 mg</i> .....	105	<i>betamethasone dipropionate augmented</i>	
BENICAR HCT TAB 20-12.5 .....	110	<i>cream 0.05%</i> .....	195
BENICAR HCT TAB 40-12.5 .....	110	<i>betamethasone dipropionate augmented</i>	
BENICAR HCT TAB 40-25MG .....	110	<i>gel 0.05%</i> .....	195
BENICAR TAB 20MG.....	107	<i>betamethasone dipropionate augmented</i>	
BENICAR TAB 40MG .....	107	<i>lotion 0.05%</i> .....	195
BENICAR TAB 5MG.....	107	<i>betamethasone dipropionate augmented</i>	
BENLYSTA INJ 200MG/ML.....	287	<i>oint 0.05%</i> .....	195
BENZAFLIN GEL 1-5% .....	183	<i>betamethasone dipropionate cream 0.05%</i>	
BENZAFLIN GEL 1-5%PUMP .....	183	.....	195
BENZALKONIUM SOL NF .....	147	<i>betamethasone dipropionate lotion 0.05%</i>	
BENZAMYCIN GEL 5-3%.....	183	.....	195
BENZEPRO AER 5.2% .....	183	<i>betamethasone dipropionate oint 0.05%</i>	
BENZEPRO AER 9.7% .....	183	.....	195
BENZEPRO LIQ 6.8% .....	183	<i>betamethasone valerate aerosol foam</i>	
BENZEPRO MIS 5.8%.....	183	<i>0.12%</i> .....	195
BENZHY/ACETA TAB 4.08-325.....	45	<i>betamethasone valerate cream 0.1% (base</i>	
BENZHY/ACETA TAB 6.12-325.....	45	<i>equivalent)</i> .....	195
BENZHY/ACETA TAB 8.16-325.....	45	<i>betamethasone valerate lotion 0.1% (base</i>	
BENZNIDAZOLE TAB 100MG .....	51	<i>equivalent)</i> .....	195
BENZNIDAZOLE TAB 12.5MG .....	51		

<i>betamethasone valerate oint 0.1% (base equivalent)</i> .....	195	<i>bisoprolol fumarate tab 10 mg</i> .....	159
BETAPACE AF TAB 120MG .....	160	<i>bisoprolol fumarate tab 5 mg</i> .....	159
BETAPACE AF TAB 160MG .....	161	BLEPH-10 SOL 10% OP .....	298
BETAPACE AF TAB 80MG .....	160	BLEPHAMIDE OIN S.O.P.....	300
BETAPACE TAB 120MG.....	161	BLEPHAMIDE SUS OP .....	300
BETAPACE TAB 160MG.....	161	BLOOD GLUCOS TES .....	206
BETAPACE TAB 80MG .....	161	BLOOD GLUCOS TES LE1 .....	206
BETASERON INJ 0.3MG.....	311	BLOOD GLUCOS TES PREMIUM .....	206
<i>betaxolol hcl ophth soln 0.5%</i> .....	296	BLOOD GLUCOS TES STRIPS .....	206
<i>betaxolol hcl tab 10 mg</i> .....	159	BONIVA TAB 150MG.....	226
<i>betaxolol hcl tab 20 mg</i> .....	159	BONJESTA TAB 20-20MG.....	96
<i>bethanechol chloride tab 10 mg</i> .....	329	<i>bosentan tab 125 mg</i> .....	171
<i>bethanechol chloride tab 25 mg</i> .....	329	<i>bosentan tab 62.5 mg</i> .....	171
<i>bethanechol chloride tab 50 mg</i> .....	329	BOSULIF TAB 100MG .....	125
<i>bethanechol chloride tab 5 mg</i> .....	329	BOSULIF TAB 400MG .....	125
BETHKIS NEB 300/4ML.....	15	BOSULIF TAB 500MG .....	125
BETIMOL SOL 0.25% .....	296	BRAFTOVI CAP 75MG.....	125
BETIMOL SOL 0.5% .....	296	BREATHE EASE MIS LG MASK.....	278
BETOPTIC-S SUS 0.25% OP .....	296	BREATHE EASE MIS MED MASK .....	278
BEVESPI AER 9-4.8MCG.....	63	BREATHE EASE MIS SM MASK.....	278
<i>bexarotene cap 75 mg</i> .....	134	BRENZAVVY TAB 20MG .....	93
BEYAZ TAB .....	174	BREO ELLIPTA INH 100-25 .....	63
<i>bicalutamide tab 50 mg</i> .....	121	BREO ELLIPTA INH 200-25 .....	63
BIDIL TAB.....	166	BREO ELLIPTA INH 50-25MCG .....	63
BIJUVA CAP 1-100MG .....	236	BREXAFEMME TAB 150MG .....	97
BIKTARVY TAB .....	148	BREZTRI AERO AER SPHERE .....	63
BILTRICIDE TAB 600MG.....	51	BRILINTA TAB 60MG .....	248
<i>bimatoprost ophth soln 0.03%</i> .....	303	BRILINTA TAB 90MG .....	248
BINOSTO TAB 70MG.....	226	BRIMO/DORZO SOL 0.15-2% .....	298
BIO-STATIN CAP 1000000.....	97	<i>brimonidine tartrate gel 0.33% (base equivalent)</i> .....	203
BIO-STATIN CAP 500000 .....	97	<i>brimonidine tartrate ophth soln 0.15%</i> ..	298
<i>bisacodyl tab &amp; peg 3350-kcl-sod bicarb-nacl for soln kit</i> .....	255	<i>brimonidine tartrate ophth soln 0.2%</i> .....	298
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i> .....	327	<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i> .....	296
<i>bisoprolol &amp; hydrochlorothiazide tab 10-6.25 mg</i> .....	110	<i>brinzolamide ophth susp 1%</i> .....	302
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5-6.25 mg</i> .....	110	BRISDELLE CAP 7.5MG .....	316
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</i> .....	110	BRIVIACT SOL 10MG/ML.....	69
		BRIVIACT TAB 100MG.....	70
		BRIVIACT TAB 10MG .....	69
		BRIVIACT TAB 25MG.....	69
		BRIVIACT TAB 50MG .....	69
		BRIVIACT TAB 75MG.....	70

<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i> .....	302	<i>buprenorphine hcl sl tab 2 mg (base equiv)</i> .....	48
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i> .....	135	<i>buprenorphine hcl sl tab 8 mg (base equiv)</i> .....	48
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i> .....	135	<i>buprenorphine td patch weekly 10 mcg/hr</i> .....	48
BROMSITE DRO 0.075% .....	302	<i>buprenorphine td patch weekly 15 mcg/hr</i> .....	48
BRONCHITOL CAP 40MG .....	316	<i>buprenorphine td patch weekly 20 mcg/hr</i> .....	48
BRONCHITOL CAP TOL TEST .....	316	<i>buprenorphine td patch weekly 5 mcg/hr</i> .....	48
BROVANA NEB 15MCG .....	63	<i>buprenorphine td patch weekly 7.5 mcg/hr</i> .....	48
BRUKINSA CAP 80MG.....	125	<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i> .....	314
BRYHALI LOT 0.01% .....	195	<i>bupropion hcl tab 100 mg</i> .....	78
<i>budesonide delayed release particles cap 3 mg</i> .....	178	<i>bupropion hcl tab 75 mg</i> .....	78
<i>budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act</i> .....	63	<i>bupropion hcl tab er 12hr 100 mg</i> .....	78
<i>budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act</i> .....	63	<i>bupropion hcl tab er 12hr 150 mg</i> .....	78
<i>budesonide inhalation susp 0.25 mg/2ml</i> .....	60	<i>bupropion hcl tab er 12hr 200 mg</i> .....	78
<i>budesonide inhalation susp 0.5 mg/2ml</i> ..	60	<i>bupropion hcl tab er 24hr 150 mg</i> .....	78
<i>budesonide inhalation susp 1 mg/2ml</i> .....	60	<i>bupropion hcl tab er 24hr 300 mg</i> .....	78
<i>budesonide tab er 24hr 9 mg</i> .....	178	<i>bupropion hcl tab er 24hr 450 mg</i> .....	78
<i>bumetanide tab 0.5 mg</i> .....	224	<i>bupropion hcl tab 10 mg</i> .....	55
<i>bumetanide tab 1 mg</i> .....	224	<i>bupropion hcl tab 15 mg</i> .....	55
<i>bumetanide tab 2 mg</i> .....	224	<i>bupropion hcl tab 30 mg</i> .....	55
BUMEX TAB 0.5MG .....	224	<i>bupropion hcl tab 5 mg</i> .....	55
BUNAVAIL MIS 4.2-0.7.....	47	<i>bupropion hcl tab 7.5 mg</i> .....	55
BUNAVAIL MIS 6.3-1MG .....	48	BUT/ASA/CAF TAB .....	34
BUPHENYL POW .....	231	<i>butalbital-acetaminophen-caffeine cap 50-300-40 mg</i> .....	34
BUPHENYL TAB 500MG.....	231	<i>butalbital-acetaminophen-caffeine cap 50-325-40 mg</i> .....	34
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i> .....	48	<i>butalbital-acetaminophen-caffeine soln 50-325-40 mg/15ml</i> .....	34
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i> .....	48	<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i> .....	35
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i> .....	48	<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i> .....	45
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i> .....	48	<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i> .....	45
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i> .....	48	<i>butalbital-acetaminophen cap 50-300 mg</i> .....	34
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i> .....	48		

<i>butalbital-acetaminophen tab 25-325 mg</i>	34	<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	5
<i>butalbital-acetaminophen tab 50-300 mg</i>	34	CALAN SR TAB 120MG	162
.....	34	CALAN SR TAB 180MG	162
<i>butalbital-acetaminophen tab 50-325 mg</i>	34	CALAN SR TAB 240MG	162
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	35	<i>calcipotriene-betamethasone dipropionate oint 0.005-0.064%</i>	196
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	45	<i>calcipotriene-betamethasone dipropionate susp 0.005-0.064%</i>	196
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	48	<i>calcipotriene cream 0.005%</i>	188
BUTRANS DIS 10MCG/HR	48	<i>calcipotriene foam 0.005%</i>	189
BUTRANS DIS 15MCG/HR	48	<i>calcipotriene oint 0.005%</i>	189
BUTRANS DIS 20MCG/HR	48	<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	189
BUTRANS DIS 5MCG/HR	48	<i>calcitonin (salmon) nasal soln 200 unit/act</i>	226
BUTRANS DIS 7.5/HR	48	<i>calcitriol cap 0.25 mcg</i>	231
BYDUREON BC INJ 2/0.85ML	89	<i>calcitriol cap 0.5 mcg</i>	231
BYDUREON PEN INJ 2MG	89	<i>calcitriol oint 3 mcg/gm</i>	189
BYETTA INJ 10MCG	89	<i>calcitriol oral soln 1 mcg/ml</i>	231
BYETTA INJ 5MCG	89	<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	243
BYLVAY CAP 1200MCG	240	CALQUENCE CAP 100MG	125
BYLVAY CAP 200MCG	240	CALQUENCE TAB 100MG	125
BYLVAY CAP 400MCG	240	CAMBIA POW 50MG	280
BYLVAY CAP 600MCG	240	CAMINO PRO LIQ 15PE	215
BYNFEZIA PEN INJ 2500MCG	234	CAMZYOS CAP 10MG	166
BYSTOLIC TAB 10MG	160	CAMZYOS CAP 15MG	166
BYSTOLIC TAB 2.5MG	159	CAMZYOS CAP 2.5MG	166
BYSTOLIC TAB 20MG	160	CAMZYOS CAP 5MG	166
BYSTOLIC TAB 5MG	159	CANASA SUP 1000MG	240
<b>C</b>		<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	110
CABENUVA SUS 400-600	148	<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	110
CABENUVA SUS 600-900	148	<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	110
<i>cabergoline tab 0.5 mg</i>	234	<i>candesartan cilexetil tab 16 mg</i>	107
CABOMETYX TAB 20MG	125	<i>candesartan cilexetil tab 32 mg</i>	107
CABOMETYX TAB 40MG	125	<i>candesartan cilexetil tab 4 mg</i>	107
CABOMETYX TAB 60MG	125	<i>candesartan cilexetil tab 8 mg</i>	107
CADUET TAB 10-10MG	167	CANTHARIDIN SOL 0.7%	202
CADUET TAB 10-20MG	167	<i>capecitabine tab 150 mg</i>	117
CADUET TAB 10-40MG	167	<i>capecitabine tab 500 mg</i>	117
CADUET TAB 10-80MG	167		
CADUET TAB 5-10MG	166		
CADUET TAB 5-20MG	166		
CADUET TAB 5-40MG	167		
CADUET TAB 5-80MG	167		
CAFERGOT TAB 1-100MG	280		



CAPEX SHA 0.01% .....	196	<i>carbidopa &amp; levodopa tab er 25-100 mg</i> .....	135
CAPLYTA CAP 10.5MG .....	139	<i>carbidopa &amp; levodopa tab er 50-200 mg</i> .....	135
CAPLYTA CAP 21MG .....	139	<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i> .....	136
CAPLYTA CAP 42MG.....	139	<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i> .....	136
CAPRELSA TAB 100MG .....	125	<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i> .....	136
CAPRELSA TAB 300MG .....	125	<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i> .....	136
<i>captopril &amp; hydrochlorothiazide tab 25-15 mg</i> .....	110	<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i> .....	136
<i>captopril &amp; hydrochlorothiazide tab 25-25 mg</i> .....	110	<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i> .....	136
<i>captopril &amp; hydrochlorothiazide tab 50-15 mg</i> .....	111	<i>carbidopa tab 25 mg</i> .....	134
<i>captopril &amp; hydrochlorothiazide tab 50-25 mg</i> .....	111	<i>carbinoxamine maleate soln 4 mg/5ml</i> ....	98
<i>captopril tab 100 mg</i> .....	105	<i>carbinoxamine maleate tab 4 mg</i> .....	98
<i>captopril tab 12.5 mg</i> .....	105	CARBINOXAMIN TAB 6MG .....	98
<i>captopril tab 25 mg</i> .....	105	CARDIOCOM MIS LANCING .....	259
<i>captopril tab 50 mg</i> .....	105	CARDIZEM CD CAP 120MG/24 .....	162
CARAC CRE 0.5% .....	188	CARDIZEM CD CAP 180MG/24 .....	162
CARAFATE SUS 1GM/10ML.....	324	CARDIZEM CD CAP 240MG/24 .....	162
CARAFATE TAB 1GM.....	324	CARDIZEM CD CAP 300MG/24 .....	162
CARBAGLU TAB 200MG .....	231	CARDIZEM CD CAP 360MG/24 .....	162
<i>carbamazepine cap er 12hr 100 mg</i> .....	70	CARDIZEM LA TAB 120MG .....	162
<i>carbamazepine cap er 12hr 200 mg</i> .....	70	CARDIZEM LA TAB 180MG .....	162
<i>carbamazepine cap er 12hr 300 mg</i> .....	70	CARDIZEM LA TAB 240MG.....	162
<i>carbamazepine chew tab 100 mg</i> .....	70	CARDIZEM LA TAB 300MG/24 .....	162
<i>carbamazepine susp 100 mg/5ml</i> .....	70	CARDIZEM LA TAB 360MG.....	162
<i>carbamazepine tab 200 mg</i> .....	70	CARDIZEM LA TAB 420MG/24 .....	162
<i>carbamazepine tab er 12hr 100 mg</i> .....	70	CARDIZEM TAB 120MG .....	163
<i>carbamazepine tab er 12hr 200 mg</i> .....	70	CARDIZEM TAB 30MG.....	162
<i>carbamazepine tab er 12hr 400 mg</i> .....	70	CARDIZEM TAB 60MG.....	162
CARBATROL CAP 100MG.....	70	CARDURA TAB 1MG.....	108
CARBATROL CAP 200MG.....	70	CARDURA TAB 2MG .....	108
CARBATROL CAP 300MG.....	70	CARDURA TAB 4MG .....	108
<i>carbidopa &amp; levodopa orally disintegrating tab 10-100 mg</i> .....	135	CARDURA TAB 8MG.....	108
<i>carbidopa &amp; levodopa orally disintegrating tab 25-100 mg</i> .....	135	CARDURA XL TAB 4MG.....	245
<i>carbidopa &amp; levodopa orally disintegrating tab 25-250 mg</i> .....	135	CARDURA XL TAB 8MG.....	245
<i>carbidopa &amp; levodopa tab 10-100 mg</i> .....	135	CAREONE ADV MIS LANCING.....	259
<i>carbidopa &amp; levodopa tab 25-100 mg</i> .....	135	CAREONE LANC MIS 30G .....	259
<i>carbidopa &amp; levodopa tab 25-250 mg</i> .....	135	CAREONE LANC MIS THIN 23G .....	260
		CARESENS 30G MIS LANCETS .....	260

CARESENS N TES .....	206	<i>cefaclor for susp 250 mg/5ml</i> .....	174
CARESENS SOL CONTROL .....	260	<i>cefaclor for susp 375 mg/5ml</i> .....	174
CARETOUCH MIS EJECTOR .....	260	<i>cefadroxil cap 500 mg</i> .....	173
CARETOUCH MIS LANC 26G.....	260	<i>cefadroxil for susp 250 mg/5ml</i> .....	173
CARETOUCH MIS LANC 28G.....	260	<i>cefadroxil for susp 500 mg/5ml</i> .....	173
CARETOUCH MIS LANC 30G .....	260	<i>cefadroxil tab 1 gm</i> .....	173
CARETOUCH MIS TST STRP.....	206	<i>cefdinir cap 300 mg</i> .....	174
CARETOUCH MIS TWIST 28 .....	260	<i>cefdinir for susp 125 mg/5ml</i> .....	174
CARETOUCH MIS TWIST 30 .....	260	<i>cefdinir for susp 250 mg/5ml</i> .....	174
CARETOUCH MIS TWIST 33 .....	260	<i>cefixime cap 400 mg</i> .....	174
CARETOUCH PAD ALCOHOL .....	277	<i>cefixime for susp 100 mg/5ml</i> .....	174
<i>carglumic acid soluble tab 200 mg</i> .....	231	<i>cefixime for susp 200 mg/5ml</i> .....	174
<i>carisoprodol tab 250 mg</i> .....	292	<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	
<i>carisoprodol tab 350 mg</i> .....	292	.....	174
<i>carisoprodol w/ aspirin &amp; codeine tab 200-</i>		<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	
<i>325-16 mg</i> .....	294	.....	174
CARNITOR SF SOL 1GM/10ML .....	231	<i>cefpodoxime proxetil tab 100 mg</i> .....	174
CARNITOR SOL 1GM/10ML.....	231	<i>cefpodoxime proxetil tab 200 mg</i> .....	174
CARNITOR TAB 330MG.....	231	<i>cefprozil for susp 125 mg/5ml</i> .....	174
CAROSPIR SUS 25MG/5ML .....	225	<i>cefprozil for susp 250 mg/5ml</i> .....	174
<i>carteolol hcl ophth soln 1%</i> .....	296	<i>cefprozil tab 250 mg</i> .....	174
<i>carvedilol phosphate cap er 24hr 10 mg</i> .159		<i>cefprozil tab 500 mg</i> .....	174
<i>carvedilol phosphate cap er 24hr 20 mg</i> .159		<i>cefuroxime axetil tab 250 mg</i> .....	174
<i>carvedilol phosphate cap er 24hr 40 mg</i> 159		<i>cefuroxime axetil tab 500 mg</i> .....	174
<i>carvedilol phosphate cap er 24hr 80 mg</i> 159		CELEBREX CAP 100MG.....	27
<i>carvedilol tab 12.5 mg</i> .....	159	CELEBREX CAP 200MG.....	27
<i>carvedilol tab 25 mg</i> .....	159	CELEBREX CAP 400MG.....	27
<i>carvedilol tab 3.125 mg</i> .....	159	CELEBREX CAP 50MG .....	27
<i>carvedilol tab 6.25 mg</i> .....	159	<i>celecoxib cap 100 mg</i> .....	28
CASCARA EXT SAGRADA .....	255	<i>celecoxib cap 200 mg</i> .....	28
CASODEX TAB 50MG.....	121	<i>celecoxib cap 400 mg</i> .....	28
CATAPRES-TTS DIS 0.1/24HR .....	108	<i>celecoxib cap 50 mg</i> .....	28
CATAPRES-TTS DIS 0.2/24HR.....	108	CELEXA TAB 10MG.....	79
CATAPRES-TTS DIS 0.3/24HR.....	108	CELEXA TAB 20MG .....	79
CAVERJECT IM KIT 10MCG .....	167	CELEXA TAB 40MG .....	79
CAVERJECT INJ 40MCG.....	167	CELLCEPT CAP 250MG.....	285
CAVERJECT KIT 20MCG .....	167	CELLCEPT SUS 200MG/ML.....	285
CAYA DPR.....	257	CELLCEPT TAB 500MG.....	285
CAYSTON INH 75MG .....	53	CELONTIN CAP 300MG.....	77
<i>cefaclor cap 250 mg</i> .....	174	CENTANY OIN 2%.....	186
<i>cefaclor cap 500 mg</i> .....	174	<i>cephalexin cap 250 mg</i> .....	173
CEFACLOR ER TAB 500MG.....	174	<i>cephalexin cap 500 mg</i> .....	173
<i>cefaclor for susp 125 mg/5ml</i> .....	174	<i>cephalexin cap 750 mg</i> .....	173

<i>cephalexin for susp 125 mg/5ml</i> .....	173	<i>chlorzoxazone tab 500 mg</i> .....	292, 293
<i>cephalexin for susp 250 mg/5ml</i> .....	173	<i>chlorzoxazone tab 750 mg</i> .....	293
<i>cephalexin tab 250 mg</i> .....	173	CHOLBAM CAP 250MG.....	239
<i>cephalexin tab 500 mg</i> .....	173	CHOLBAM CAP 50MG.....	239
CEQUA SOL 0.09% .....	300	<i>cholestyramine light powder 4 gm/dose</i> 100	
CEQUR SIMPL KIT PATCH 2U .....	277	<i>cholestyramine light powder packets 4 gm</i>	
CERDELGA CAP 84MG .....	248	.....	100
CERVIDIL VAG MIS 10MG INS .....	304	<i>cholestyramine powder 4 gm/dose</i> .....	100
CETRAXAL SOL 0.2% .....	304	<i>cholestyramine powder packets 4 gm</i> ....	100
CETROTIDE KIT 0.25MG.....	228	<i>choline fenofibrate cap dr 135 mg</i>	
<i>cevimeline hcl cap 30 mg</i> .....	288	( <i>fenofibric acid equiv</i> ) .....	101
CHANTIX PAK 1MG .....	314	<i>choline fenofibrate cap dr 45 mg (fenofibric</i>	
CHANTIX TAB 0.5& 1MG .....	314	<i>acid equiv)</i> .....	101
CHANTIX TAB 0.5MG .....	314	CHONDROITIN SOL .....	302
CHANTIX TAB 1MG .....	314	CHOR GONADOT INJ 10000UNT .....	227
CHEMET CAP 100MG.....	94	CIALIS TAB 10MG .....	167
CHEMSTRIP K TES .....	206	CIALIS TAB 2.5MG.....	167
CHEMSTRIP TES UGK.....	206	CIALIS TAB 20MG .....	167
CHENODAL TAB 250MG .....	239	CIALIS TAB 5MG.....	167
<i>chlordiazepoxide-amitriptyline tab 10-25</i>		CIBINQO TAB 100MG .....	200
<i>mg</i> .....	309	CIBINQO TAB 200MG.....	200
<i>chlordiazepoxide-amitriptyline tab 5-12.5</i>		CIBINQO TAB 50MG .....	200
<i>mg</i> .....	309	<i>ciclopirox gel 0.77%</i> .....	186
<i>chlordiazepoxide hcl cap 10 mg</i> .....	56	<i>ciclopirox olamine cream 0.77% (base</i>	
<i>chlordiazepoxide hcl cap 25 mg</i> .....	56	<i>equiv)</i> .....	186
<i>chlordiazepoxide hcl cap 5 mg</i> .....	56	<i>ciclopirox olamine susp 0.77% (base equiv)</i>	
<i>chlordiazepoxide hcl-clidinium bromide</i>		.....	186
<i>cap 5-2.5 mg</i> .....	323	<i>ciclopirox shampoo 1%</i> .....	186
CHLORHEX GLU SOL 20%.....	147	<i>ciclopirox solution 8%</i> .....	186
<i>chlorhexidine gluconate soln 0.12%</i> .....	287	<i>cilostazol tab 100 mg</i> .....	248
<i>chloroquine phosphate tab 250 mg</i> .....	115	<i>cilostazol tab 50 mg</i> .....	248
<i>chloroquine phosphate tab 500 mg</i> .....	115	CILOXAN OIN 0.3% OP.....	299
<i>chlorpromazine hcl inj 25 mg/ml</i> .....	144	CILOXAN SOL 0.3% OP.....	299
<i>chlorpromazine hcl inj 50 mg/2ml</i> .....	144	CIMDUO TAB 300-300 .....	148
<i>chlorpromazine hcl tab 100 mg</i> .....	144	<i>cimetidine hcl soln 300 mg/5ml</i> .....	324
<i>chlorpromazine hcl tab 10 mg</i> .....	144	<i>cimetidine tab 300 mg</i> .....	324
<i>chlorpromazine hcl tab 200 mg</i> .....	145	<i>cimetidine tab 400 mg</i> .....	324
<i>chlorpromazine hcl tab 25 mg</i> .....	144	<i>cimetidine tab 800 mg</i> .....	324
<i>chlorpromazine hcl tab 50 mg</i> .....	144	CIMZIA KIT 200MG .....	241
<i>chlorthalidone tab 25 mg</i> .....	225	CIMZIA PREFL KIT 200MG/ML .....	241
<i>chlorthalidone tab 50 mg</i> .....	225	CIMZIA START KIT 200MG/ML.....	241
<i>chlorzoxazone tab 250 mg</i> .....	292	<i>cinacalcet hcl tab 30 mg (base equiv)</i> ....	231
<i>chlorzoxazone tab 375 mg</i> .....	292	<i>cinacalcet hcl tab 60 mg (base equiv)</i> ....	231

<i>cinacalcet hcl tab 90 mg (base equiv)</i> .....	231	<i>clarithromycin for susp 125 mg/5ml</i> .....	256
CINRYZE SOL 500 UNIT.....	247	<i>clarithromycin for susp 250 mg/5ml</i> .....	256
CIPRO (10%) SUS 500MG/5 .....	238	<i>clarithromycin tab 250 mg</i> .....	256
CIPRO (5%) SUS 250MG/5 .....	238	<i>clarithromycin tab 500 mg</i> .....	256
CIPRODEX SUS 0.3-0.1% .....	304	<i>clarithromycin tab er 24hr 500 mg</i> .....	256
<i>ciprofloxacin-dexamethasone otic susp</i> <i>0.3-0.1%</i> .....	304	CLEANLET 28G MIS LANCETS .....	260
<i>ciprofloxacin-fluocinolone acetone (pf) otic</i> <i>soln 0.3-0.025%</i> .....	304	<i>clemastine fumarate syrup 0.67 mg/5ml</i> <i>(0.5 mg/5ml base eq)</i> .....	99
<i>ciprofloxacin hcl ophth soln 0.3% (base</i> <i>equivalent)</i> .....	299	<i>clemastine fumarate tab 2.68 mg</i> .....	99
<i>ciprofloxacin hcl otic soln 0.2% (base</i> <i>equivalent)</i> .....	304	CLENPIQ SOL .....	255
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i> .....	238	CLEOCIN CAP 150MG .....	52
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i> .....	238	CLEOCIN CAP 300MG .....	52
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i> .....	238	CLEOCIN CAP 75MG .....	52
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i> .....	238	CLEOCIN CRE 2% VAG .....	329
CIPRO HC SUS OTIC .....	304	CLEOCIN PED SOL 75MG/5ML .....	52
CIPRO TAB 250MG.....	238	CLEOCIN SUP 100MG .....	329
CIPRO TAB 500MG .....	238	CLEOCIN-T LOT 1%.....	183
<i>citalopram hydrobromide oral soln 10</i> <i>mg/5ml</i> .....	79	CLEVER CHECK MIS .....	260
<i>citalopram hydrobromide tab 10 mg (base</i> <i>equiv)</i> .....	79	CLEVER CHECK MIS 30G.....	260
<i>citalopram hydrobromide tab 20 mg (base</i> <i>equiv)</i> .....	79	CLEVER CHEK TES .....	206
<i>citalopram hydrobromide tab 40 mg (base</i> <i>equiv)</i> .....	79	CLEVER CHEK TES AUTO CD .....	206
CITRANATAL CAP HARMONY .....	288	CLEVER CHEK TES TALK .....	206
CITRANATAL CAP MEDLEY .....	288	CLEVER CHEK TES VOICE.....	206
CITRANATAL MIS .....	288	CLEVER CHOIC TES MICRO .....	206
CITRANATAL MIS 90 DHA .....	289	CLEVR CHOICE LIQ HIGH .....	260
CITRANATAL MIS B-CALM .....	289	CLEVR CHOICE LIQ LOW .....	260
CITRANATAL PAK ASSURE.....	289	CLEVR CHOICE TES AUTO-CD.....	206
CITRANATAL PAK DHA .....	289	CLEVR CHOICE TES NOCODE.....	206
CITRANATAL TAB BLOOM.....	289	CLIMARA DIS 0.025MG.....	236
CITRANATAL TAB RX.....	289	CLIMARA DIS 0.0375MG.....	236
CITRULLINE TAB EASY 1GM .....	231	CLIMARA DIS 0.05MG .....	236
CLARINEX-D TAB 2.5-120.....	181	CLIMARA DIS 0.06MG .....	236
		CLIMARA DIS 0.075MG.....	236
		CLIMARA DIS 0.1MG .....	236
		CLIMARA PRO DIS WEEKLY .....	236
		CLINDAGEL GEL 1% .....	183
		<i>clindamycin hcl cap 150 mg</i> .....	52
		<i>clindamycin hcl cap 300 mg</i> .....	52
		<i>clindamycin hcl cap 75 mg</i> .....	52
		<i>clindamycin palmitate hcl for soln 75</i> <i>mg/5ml (base equiv)</i> .....	52
		<i>clindamycin phosphate-benzoyl peroxide</i> <i>gel 1.2-2.5%</i> .....	183

<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i> .....	183	<i>clonazepam orally disintegrating tab 0.5 mg</i> .....	68
<i>clindamycin phosphate foam 1%</i> .....	183	<i>clonazepam orally disintegrating tab 1 mg</i> .....	68
<i>clindamycin phosphate gel 1%</i> .....	183	<i>clonazepam orally disintegrating tab 2 mg</i> .....	68
<i>clindamycin phosphate lotion 1%</i> .....	183	<i>clonazepam tab 0.5 mg</i> .....	68
<i>clindamycin phosphate soln 1%</i> .....	183	<i>clonazepam tab 1 mg</i> .....	68
<i>clindamycin phosphate swab 1%</i> .....	183	<i>clonazepam tab 2 mg</i> .....	68
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i> .....	184	<i>clonidine hcl tab 0.1 mg</i> .....	108
<i>clindamycin phosphate vaginal cream 2%</i> .....	330	<i>clonidine hcl tab 0.2 mg</i> .....	108
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i> .....	183	<i>clonidine hcl tab 0.3 mg</i> .....	108
<b>CLINDESSE CRE 2%</b> .....	330	<i>clonidine hcl tab er 12hr 0.1 mg</i> .....	7
<i>clobazam suspension 2.5 mg/ml</i> .....	68	<i>clonidine td patch weekly 0.1 mg/24hr</i> ...	108
<i>clobazam tab 10 mg</i> .....	68	<i>clonidine td patch weekly 0.2 mg/24hr</i> ...108	
<i>clobazam tab 20 mg</i> .....	68	<i>clonidine td patch weekly 0.3 mg/24hr</i> ..108	
<i>clobetasol propionate cream 0.05%</i> .....	196	<i>clopidogrel bisulfate tab 300 mg (base equiv)</i> .....	248
<i>clobetasol propionate emollient base cream 0.05%</i> .....	196	<i>clopidogrel bisulfate tab 75 mg (base equiv)</i> .....	248
<i>clobetasol propionate emulsion foam 0.05%</i> .....	196	<i>clorazepate dipotassium tab 15 mg</i> .....	56
<i>clobetasol propionate foam 0.05%</i> .....	196	<i>clorazepate dipotassium tab 3.75 mg</i> .....	56
<i>clobetasol propionate gel 0.05%</i> .....	196	<i>clorazepate dipotassium tab 7.5 mg</i> .....	56
<i>clobetasol propionate lotion 0.05%</i> .....	196	<i>clotrimazole troche 10 mg</i> .....	287
<i>clobetasol propionate oint 0.05%</i> .....	196	<i>clotrimazole w/ betamethasone cream 1-0.05%</i> .....	186
<i>clobetasol propionate shampoo 0.05%</i> ..196		<i>clotrimazole w/ betamethasone lotion 1-0.05%</i> .....	186
<i>clobetasol propionate soln 0.05%</i> .....	196	<i>clozapine orally disintegrating tab 100 mg</i> .....	142
<i>clobetasol propionate spray 0.05%</i> .....	196	<i>clozapine orally disintegrating tab 12.5 mg</i> .....	142
<b>CLOBEX LOT 0.05%</b> .....	196	<i>clozapine orally disintegrating tab 150 mg</i> .....	142
<b>CLOBEX SHA 0.05%</b> .....	196	<i>clozapine orally disintegrating tab 200 mg</i> .....	142
<b>CLOBEX SPR 0.05%</b> .....	196	<i>clozapine orally disintegrating tab 25 mg</i> .....	142
<i>clocortolone pivalate cream 0.1%</i> .....	196	<i>clozapine tab 100 mg</i> .....	142
<b>CLODERM CRE 0.1%</b> .....	196	<i>clozapine tab 200 mg</i> .....	142
<i>clomiphene citrate tab 50 mg</i> .....	227	<i>clozapine tab 25 mg</i> .....	142
<i>clomipramine hcl cap 25 mg</i> .....	83	<i>clozapine tab 50 mg</i> .....	142
<i>clomipramine hcl cap 50 mg</i> .....	83	<b>CLOZARIL TAB 100MG</b> .....	142
<i>clomipramine hcl cap 75 mg</i> .....	83		
<i>clonazepam orally disintegrating tab 0.125 mg</i> .....	68		
<i>clonazepam orally disintegrating tab 0.25 mg</i> .....	68		

CLOZARIL TAB 200MG .....	143	COMFORT TCH MIS LANC 28G .....	260
CLOZARIL TAB 25MG .....	142	COMFORT TCH MIS LANC 31G .....	260
CLOZARIL TAB 50MG.....	142	COMPACT SPAC MIS CHAMBER.....	278
C-NATE DHA CAP 28-1-200 .....	288	COMPACT SPAC MIS LG MASK.....	278
COAGUCHEK MIS LANCETS .....	260	COMPACT SPAC MIS MD MASK.....	278
<i>coal tar soln 20%</i> .....	204	COMPACT SPAC MIS SM MASK .....	278
COARTEM TAB 20-120MG .....	115	COMPLEAT LIQ CLS SYS .....	215
COCAINE HCL SOL 40MG/ML .....	294	COMPLEAT PED LIQ ORG BLND.....	215
<i>codeine sulfate tab 30 mg</i> .....	35	COMPLERA TAB.....	148
CODEINE SULF TAB 15MG.....	35	COMTAN TAB 200MG.....	135
CODEINE SULF TAB 60MG.....	35	CO-NATAL FA TAB 29-1MG .....	289
COLAZAL CAP 750MG .....	241	CONCEPT DHA CAP .....	289
<i>colchicine cap 0.6 mg</i> .....	246	CONCEPT OB CAP .....	289
<i>colchicine tab 0.6 mg</i> .....	246	CONCERTA TAB 18MG.....	9
<i>colchicine w/ probenecid tab 0.5-500 mg</i> .....	246	CONCERTA TAB 27MG .....	9
COLCRYS TAB 0.6MG .....	246	CONCERTA TAB 36MG .....	9
<i>colesevelam hcl packet for susp 3.75 gm</i> .....	100	CONCERTA TAB 54MG .....	9
<i>colesevelam hcl tab 625 mg</i> .....	100	CONDYLOX GEL 0.5% .....	202
COLESTID FLA GRA 5/7.5GM .....	100	CONFIRM/MICR TES GLUCOSE.....	206
COLESTID FLA GRA 5GM .....	100	CONJUPRI TAB 2.5MG .....	163
COLESTID GRA 5GM .....	100	CONJUPRI TAB 5MG .....	148
COLESTID POW 5GM .....	100	CONSENSI TAB 10-200MG.....	162
COLESTID TAB 1GM.....	100	CONSENSI TAB 2.5-200.....	162
<i>colestipol hcl granule packets 5 gm</i> .....	100	CONSENSI TAB 5-200MG.....	162
<i>colestipol hcl granules 5 gm</i> .....	100	CONTOUR HIGH LIQ CONTROL.....	260
<i>colestipol hcl tab 1 gm</i> .....	100	CONTOUR LOW LIQ CONTROL .....	260
COMBIGAN SOL 0.2/0.5%.....	296	CONTOUR NEXT SOL LEVEL 1.....	260
COMBIPATCH DIS .....	236	CONTOUR NEXT SOL LEVEL 2 .....	260
COMBIVENT AER 20-100 .....	63	CONTOUR NORM LIQ CONTROL .....	260
COMBIVIR TAB 150-300 .....	148	CONTOUR TES BLD GLUC .....	206
COMETRIQ KIT 100MG.....	125	CONTOUR TES NEXT .....	207
COMETRIQ KIT 140MG .....	125	CONTRAVE TAB 8-90MG .....	5
COMETRIQ KIT 60MG.....	125	CONTROL HIGH SOL UNISTRIP .....	260
COMFORT ASSU MIS LANC 28G .....	260	CONTROL LOW SOL UNISTRIP .....	260
COMFORT ASSU MIS LANC 33G .....	260	CONTROL NORM SOL EASY STP .....	260
COMFORT EZ MIS 21G .....	260	CONTROL SOL LIQ HI/MID/L.....	260
COMFORT EZ MIS 23G .....	260	CONTROL SOL LIQ HIGH/LOW.....	260
COMFORT EZ MIS 28G .....	260	CONTROL SOL LIQ LEVEL 2 .....	261
COMFORT EZ MIS 31GX5/16.....	277	CONTROL SOL LIQ MID.....	261
COMFORT MIS LANCETS.....	260	CONTROL SOL NORMAL .....	261
COMFORTOUCH MIS LANCET.....	260	CONZIP CAP 100MG .....	35
		CONZIP CAP 200MG.....	35
		CONZIP CAP 300MG.....	35

COOL BLOOD TES GLUCOSE .....	207	COTEMPLA XR TAB 17.3MG .....	9
COOL CONTROL SOL A.....	261	COTEMPLA XR TAB 25.9MG .....	9
COOL CONTROL SOL B.....	261	COTEMPLA XR TAB 8.6MG .....	9
COPAXONE INJ 20MG/ML.....	311	COZAAR TAB 100MG.....	107
COPAXONE INJ 40MG/ML.....	311	COZAAR TAB 25MG.....	107
COPIKTRA CAP 15MG.....	125	COZAAR TAB 50MG .....	107
COPIKTRA CAP 25MG.....	126	CREON CAP 12000UNT .....	223
CORDRAN 80X3 TAP 4MCG/CM .....	196	CREON CAP 24000UNT .....	223
CORDRAN CRE 0.025% .....	196	CREON CAP 3000UNIT.....	223
CORDRAN CRE 0.05% .....	196	CREON CAP 36000UNT .....	223
CORDRAN LOT 0.05% .....	196	CREON CAP 6000UNIT .....	223
CORDRAN OIN 0.05%.....	196	CRESEMBA CAP 186 MG .....	97
COREG CR CAP 10MG .....	159	CRESTOR TAB 10MG .....	102
COREG CR CAP 20MG .....	159	CRESTOR TAB 20MG.....	102
COREG CR CAP 40MG .....	159	CRESTOR TAB 40MG .....	102
COREG CR CAP 80MG .....	159	CRESTOR TAB 5MG.....	102
COREG TAB 12.5MG.....	159	CRINONE GEL 4% VAG .....	330
COREG TAB 25MG .....	159	CRINONE GEL 8% VAG.....	330
COREG TAB 3.125MG .....	159	CRIXIVAN CAP 400MG .....	148
COREG TAB 6.25MG.....	159	<i>cromolyn sodium ophth soln 4%.....</i>	302
CORGARD TAB 20MG .....	161	<i>cromolyn sodium oral conc 100 mg/5ml</i>	239
CORGARD TAB 40MG.....	161	<i>cromolyn sodium soln nebu 20 mg/2ml...</i>	58
CORGARD TAB 80MG.....	161	<i>crotamiton lotion 10% .....</i>	204
CORLANOR SOL 5MG/5ML.....	173	CRUCIAL LIQ UNFLAVOR.....	215
CORLANOR TAB 5MG .....	173	CUPRIMINE CAP 250MG.....	283
CORLANOR TAB 7.5MG .....	173	CURITY PREP PAD ALCOHOL.....	277
CORTEF TAB 10MG .....	178	CURITY SWABS PAD ALCOHOL.....	277
CORTEF TAB 20MG .....	178	CUTIVATE LOT 0.05% .....	196
CORTEF TAB 5MG.....	178	CUVPOSA SOL 1MG/5ML.....	323
CORTENEMA ENE 100MG.....	50	CUVRIOR TAB 300MG .....	283
CORTIFOAM AER 90MG.....	50	CVS ADVANCED TES GLUCOSE .....	207
CORTISONE TAB 25MG.....	178	CVS GLUCOSE TES TEST STR .....	207
CORTISPORIN SUS -TC OTIC .....	304	CVS KETONE TES CARE .....	207
CORTROPHIN GEL 80UNIT .....	227	CVS LANCETS MIS 21G.....	261
COSENTYX INJ 150MG/ML .....	189	CVS LANCETS MIS 30G.....	261
COSENTYX INJ 300DOSE.....	190	CVS LANCETS MIS 33G.....	261
COSENTYX INJ 75MG/0.5 .....	189	CVS LANCETS MIS ORIGINAL.....	261
COSENTYX PEN INJ 150MG/ML .....	190	CVS LANCETS MIS THIN 26G.....	261
COSENTYX PEN INJ 300DOSE .....	190	CVS LANCETS MIS THIN 30G.....	261
COSENTYX UNO INJ 300/2ML.....	191	CVS LANCETS MIS THIN 33G.....	261
COSOPT PF SOL 2%-0.5%.....	296	CVS LANCING MIS DEVICE.....	261
COSOPT SOL 2-0.5%OP .....	296	<i>cyanocobalamin inj 1000 mcg/ml .....</i>	249
COTELLIC TAB 20MG.....	126	CYANOCOBALAM SOL 2000MCG .....	249

CYCLINEX-1 POW.....	215	CYTOMEL TAB 25MCG.....	320
CYCLINEX-2 POW.....	215	CYTOMEL TAB 50MCG.....	320
<i>cyclobenzaprine hcl cap er 24hr 15 mg</i> ..	293	CYTOMEL TAB 5MCG.....	320
<i>cyclobenzaprine hcl cap er 24hr 30 mg</i> ..	293	CYTOTEC TAB 100MCG.....	327
<i>cyclobenzaprine hcl tab 10 mg</i> ..	293	CYTOTEC TAB 200MCG.....	327
<i>cyclobenzaprine hcl tab 5 mg</i> ..	293	<b>D</b>	
<i>cyclobenzaprine hcl tab 7.5 mg</i> ..	293	<i>dalfampridine tab er 12hr 10 mg</i> ..	311
CYCLOGYL SOL 0.5% OP.....	297	DALIRESP TAB 250MCG.....	59
CYCLOGYL SOL 1% OP.....	297	DALIRESP TAB 500MCG.....	59
CYCLOGYL SOL 2% OP.....	297	<i>danazol cap 100 mg</i> .....	49
CYCLOMYDRIL SOL OP.....	297	<i>danazol cap 200 mg</i> .....	49
<i>cyclopentolate hcl ophth soln 0.5%</i> ..	297	<i>danazol cap 50 mg</i> ..	49
<i>cyclopentolate hcl ophth soln 1%</i> ..	298	DANTRIUM CAP 25MG.....	293
<i>cyclopentolate hcl ophth soln 2%</i> ..	298	DANTRIUM CAP 50MG.....	293
<i>cyclophosphamide cap 25 mg</i> ..	117	<i>dantrolene sodium cap 100 mg</i> ..	294
<i>cyclophosphamide cap 50 mg</i> ..	117	<i>dantrolene sodium cap 25 mg</i> ..	293
CYCLOPHOSPH TAB 25MG.....	117	<i>dantrolene sodium cap 50 mg</i> .....	294
CYCLOPHOSPH TAB 50MG.....	117	<i>dapsone gel 5%</i> .....	184
<i>cycloserine cap 250 mg</i> ..	116	<i>dapsone gel 7.5%</i> .....	184
CYCLOSET TAB 0.8MG.....	89	<i>dapsone tab 100 mg</i> ..	52
<i>cyclosporine (ophth) emulsion 0.05%</i> ...	300	<i>dapsone tab 25 mg</i> ..	52
<i>cyclosporine cap 100 mg</i> ..	285	DARAPRIM TAB 25MG.....	115
<i>cyclosporine cap 25 mg</i> ..	285	<i>darifenacin hydrobromide tab er 24hr 15</i> <i>mg (base equiv)</i> .....	328
<i>cyclosporine modified cap 100 mg</i> ..	285	<i>darifenacin hydrobromide tab er 24hr 7.5</i> <i>mg (base equiv)</i> .....	328
<i>cyclosporine modified cap 25 mg</i> ..	285	DAURISMO TAB 100MG.....	120
<i>cyclosporine modified cap 50 mg</i> ..	285	DAURISMO TAB 25MG.....	120
<i>cyclosporine modified oral soln 100 mg/ml</i> .....	285	DAYBUE SOL 200MG/ML.....	296
CYLTEZO INJ 10/0.2ML.....	16	DAYPRO TAB 600MG.....	28
CYLTEZO INJ 20/0.4ML.....	16	DAYTRANA DIS 10MG/9HR.....	9
CYLTEZO INJ 40/0.8ML.....	16	DAYTRANA DIS 15MG/9HR.....	9
CYLTEZO INJ CROHNS ..	16	DAYTRANA DIS 20MG/9HR.....	9
CYLTEZO INJ PSORIASI ..	16	DAYTRANA DIS 30MG/9HR.....	9
CYMBALTA CAP 20MG.....	81	DAYVIGO TAB 10MG.....	254
CYMBALTA CAP 30MG.....	81	DAYVIGO TAB 5MG.....	254
CYMBALTA CAP 60MG.....	82	D-CARE BLOOD TES GLUCOSE ..	207
<i>cyproheptadine hcl syrup 2 mg/5ml</i> ..	99	DDAVP SOL 0.01% ..	234
<i>cyproheptadine hcl tab 4 mg</i> ..	99	DDAVP TAB 0.1MG ..	234
CYSTADANE POW.....	231	DDAVP TAB 0.2MG ..	234
CYSTADROPS SOL 0.37% ..	303	<i>deferasirox granules packet 180 mg</i> ..	94
CYSTAGON CAP 150MG ..	245	<i>deferasirox granules packet 360 mg</i> ..	94
CYSTAGON CAP 50MG.....	245	<i>deferasirox granules packet 90 mg</i> ..	94
CYSTARAN SOL 0.44% ..	303		



<i>deferasirox tab 180 mg</i> .....	94	<i>desmopressin acetate tab 0.2 mg</i> .....	234
<i>deferasirox tab 360 mg</i> .....	94	<i>desogest-eth estrad &amp; eth estrad tab 0.15-</i>	
<i>deferasirox tab 90 mg</i> .....	94	<i>0.02/0.01 mg(21/5)</i> .....	175
<i>deferasirox tab for oral susp 125 mg</i> .....	94	<i>desogest-ethin est tab 0.1-0.025/0.125-</i>	
<i>deferasirox tab for oral susp 250 mg</i> .....	94	<i>0.025/0.15-0.025mg-mg</i> .....	175
<i>deferasirox tab for oral susp 500 mg</i> .....	95	<i>desogestrel &amp; ethinyl estradiol tab 0.15 mg-</i>	
<i>deferiprone tab 500 mg</i> .....	95	<i>30 mcg</i> .....	175
<i>deferoxamine mesylate for inj 2 gm</i> .....	95	DESONATE GEL 0.05% .....	197
DELESTROGEN INJ 10MG/ML.....	236	<i>desonide cream 0.05%</i> .....	197
DELESTROGEN INJ 20MG/ML .....	237	<i>desonide gel 0.05%</i> .....	197
DELESTROGEN INJ 40MG/ML .....	237	<i>desonide lotion 0.05%</i> .....	197
DELSTRIGO TAB.....	148	<i>desonide oint 0.05%</i> .....	197
DELZICOL CAP 400MG .....	241	DESOWEN CRE 0.05% .....	197
<i>demeclocycline hcl tab 150 mg</i> .....	317	<i>desoximetasone cream 0.05%</i> .....	197
<i>demeclocycline hcl tab 300 mg</i> .....	317	<i>desoximetasone cream 0.25%</i> .....	197
DEMSEER CAP 250MG.....	106	<i>desoximetasone gel 0.05%</i> .....	197
DENAVIR CRE 1% .....	194	<i>desoximetasone oint 0.05%</i> .....	197
DEPAKOTE ER TAB 250MG.....	77	<i>desoximetasone oint 0.25%</i> .....	197
DEPAKOTE ER TAB 500MG.....	77	<i>desoximetasone spray 0.25%</i> .....	197
DEPAKOTE SPR CAP 125MG.....	77	DESOXYN TAB 5MG .....	2
DEPAKOTE TAB 125MG DR .....	77	<i>desvenlafaxine succinate tab er 24hr 100</i>	
DEPAKOTE TAB 250MG DR .....	77	<i>mg (base equiv)</i> .....	82
DEPAKOTE TAB 500MG DR.....	77	<i>desvenlafaxine succinate tab er 24hr 25 mg</i>	
DEPEN TITRA TAB 250MG.....	284	<i>(base equiv)</i> .....	82
DEPO-ESTRADI INJ 5MG/ML .....	237	<i>desvenlafaxine succinate tab er 24hr 50 mg</i>	
DEPO-PROVERA INJ 150MG/ML.....	177	<i>(base equiv)</i> .....	82
DEPO-SQ PROV INJ 104 .....	177	DESVENLAFAX TAB 100MG ER .....	82
DERMA-SMOOTH OIL /FS BODY.....	197	DESVENLAFAX TAB 50MG ER.....	82
DERMA-SMOOTH OIL /FS SCLP.....	197	DETROL LA CAP 2MG .....	328
DERMOTIC OIL 0.01%.....	304	DETROL LA CAP 4MG.....	328
DESCOVY TAB 120-15MG .....	148	DETROL TAB 1MG.....	328
DESCOVY TAB 200/25MG.....	149	DETROL TAB 2MG .....	328
<i>desipramine hcl tab 100 mg</i> .....	84	DEXABLISS TAB 1.5MG.....	178
<i>desipramine hcl tab 10 mg</i> .....	83	DEXAMETHASON CON 1MG/ML .....	178
<i>desipramine hcl tab 150 mg</i> .....	84	<i>dexamethasone elixir 0.5 mg/5ml</i> .....	178
<i>desipramine hcl tab 25 mg</i> .....	83	<i>dexamethasone sodium phosphate ophth</i>	
<i>desipramine hcl tab 50 mg</i> .....	83	<i>soln 0.1%</i> .....	301
<i>desipramine hcl tab 75 mg</i> .....	84	<i>dexamethasone soln 0.5 mg/5ml</i> .....	178
<i>desmopressin acetate nasal spray soln</i>		<i>dexamethasone tab 0.5 mg</i> .....	178
<i>0.01%</i> .....	234	<i>dexamethasone tab 0.75 mg</i> .....	178
<i>desmopressin acetate nasal spray soln</i>		<i>dexamethasone tab 1.5 mg</i> .....	178
<i>0.01% (refrigerated)</i> .....	234	<i>dexamethasone tab 1 mg</i> .....	178
<i>desmopressin acetate tab 0.1 mg</i> .....	234	<i>dexamethasone tab 2 mg</i> .....	178

<i>dexamethasone tab 4 mg</i> .....	178	<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i> .....	10
<i>dexamethasone tab 6 mg</i> .....	178	<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i> 9	
<i>dexamethasone tab therapy pack 1.5 mg</i> <i>(21)</i> .....	178	<i>dexmethylphenidate hcl tab 10 mg</i> .....	10
<i>dexamethasone tab therapy pack 1.5 mg</i> <i>(27)</i> .....	178	<i>dexmethylphenidate hcl tab 2.5 mg</i> .....	10
<i>dexamethasone tab therapy pack 1.5 mg</i> <i>(35)</i> .....	178	<i>dexmethylphenidate hcl tab 5 mg</i> .....	10
<i>dexamethasone tab therapy pack 1.5 mg</i> <i>(49)</i> .....	178	<i>dextroamphetamine sulfate cap er 24hr 10</i> <i>mg</i> .....	3
<i>dexamethasone tab therapy pack 1.5 mg</i> <i>(51)</i> .....	178	<i>dextroamphetamine sulfate cap er 24hr 15</i> <i>mg</i> .....	3
<i>dexchlorpheniramine maleate oral soln 2</i> <i>mg/5ml</i> .....	98	<i>dextroamphetamine sulfate cap er 24hr 5</i> <i>mg</i> .....	3
DEXCOM G5 MIS RECEIVER .....	261	<i>dextroamphetamine sulfate oral solution 5</i> <i>mg/5ml</i> .....	3
DEXCOM G5 MIS TRANSMIT.....	261	<i>dextroamphetamine sulfate tab 10 mg</i> .....	3
DEXCOM G6 MIS RECEIVER .....	261	<i>dextroamphetamine sulfate tab 15 mg</i> .....	3
DEXCOM G6 MIS SENSOR.....	261	<i>dextroamphetamine sulfate tab 2.5 mg</i> .....	3
DEXCOM G6 MIS TRANSMIT.....	261	<i>dextroamphetamine sulfate tab 20 mg</i> .....	3
DEXCOM G7 MIS RECEIVER .....	261	<i>dextroamphetamine sulfate tab 30 mg</i> .....	3
DEXCOM G7 MIS SENSOR.....	261	<i>dextroamphetamine sulfate tab 5 mg</i> .....	3
DEXEDRINE CAP 10MG CR .....	3	<i>dextroamphetamine sulfate tab 7.5 mg</i> .....	3
DEXEDRINE CAP 15MG CR .....	3	DIABETIC TF LIQ .....	215
DEXEDRINE CAP 5MG CR.....	3	DIABETISOURC LIQ .....	215
DEXILANT CAP 30MG DR .....	325	DIACOMIT CAP 250MG .....	70
DEXILANT CAP 60MG DR .....	325	DIACOMIT CAP 500MG.....	70
<i>dexlansoprazole cap delayed release 30</i> <i>mg</i> .....	325	DIACOMIT PAK 250MG .....	70
<i>dexlansoprazole cap delayed release 60</i> <i>mg</i> .....	325	DIACOMIT PAK 500MG .....	70
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i> .....	9	DIASTAT ACDL GEL 12.5-20 .....	69
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i> .....	10	DIASTAT ACDL GEL 5-10MG.....	69
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i> .....	10	DIASTAT PED GEL 2.5M GEL .....	69
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i> .....	10	DIATHRIX TES STRIPS .....	207
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i> .....	10	DIATHRIVE+ MIS TEST STR .....	207
<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i> .....	10	DIATHRIVE LIQ CONTROL .....	261
		DIATHRIVE MIS LANCETS.....	261
		DIATHRIVE MIS LANCING.....	261
		DIATHRIVE MIS TEST STR.....	207
		DIATHRIVE MIS UT 30G.....	261
		DIATRUE CONT SOL LEVEL 1.....	261
		DIATRUE CONT SOL LEVEL 2.....	261
		DIATRUE CONT SOL LEVEL 3.....	261
		DIATRUE PLUS TES STRIPS .....	207
		<i>diazepam conc 5 mg/ml</i> .....	56
		<i>diazepam oral soln 1 mg/ml</i> .....	56

<i>diazepam rectal gel delivery system 10 mg</i> .....69	DIFFERIN CRE 0.1%.....184
<i>diazepam rectal gel delivery system 2.5 mg</i> .....69	DIFFERIN GEL 0.1%.....184
<i>diazepam rectal gel delivery system 20 mg</i> .....69	DIFFERIN GEL 0.3%.....184
<i>diazepam tab 10 mg</i> .....56	DIFFERIN LOT 0.1%.....184
<i>diazepam tab 2 mg</i> .....56	DIFICID SUS.....257
<i>diazepam tab 5 mg</i> .....56	DIFICID TAB 200MG.....257
<i>diazoxide susp 50 mg/ml</i> .....88	<i>diflorasone diacetate cream 0.05%</i> .....197
DIBENZYLINE CAP 10MG.....106	<i>diflorasone diacetate oint 0.05%</i> .....197
<i>dichlorphenamide tab 50 mg</i> .....224	DIFLUCAN SUS 10MG/ML.....97
DICLEGIS TAB 10-10MG.....96	DIFLUCAN SUS 40MG/ML.....97
DICLOFENAC CAP 35MG.....28	DIFLUCAN TAB 100MG.....98
<i>diclofenac epolamine patch 1.3%</i> .....185	DIFLUCAN TAB 150MG.....98
<i>diclofenac potassium (migraine) packet 50 mg</i> .....280	DIFLUCAN TAB 200MG.....98
<i>diclofenac potassium tab 50 mg</i> .....28	DIFLUCAN TAB 50MG.....97
<i>diclofenac sodium (actinic keratoses) gel 3%</i> .....188	<i>diflunisal tab 500 mg</i> .....35
<i>diclofenac sodium ophth soln 0.1%</i> .....303	<i>difluprednate ophth emulsion 0.05%</i> .....301
<i>diclofenac sodium soln 1.5%</i> .....185	<i>digoxin oral soln 0.05 mg/ml</i> .....165
<i>diclofenac sodium soln 2%</i> .....185	<i>digoxin tab 125 mcg (0.125 mg)</i> .....165
<i>diclofenac sodium tab delayed release 25 mg</i> .....28	<i>digoxin tab 250 mcg (0.25 mg)</i> .....165
<i>diclofenac sodium tab delayed release 50 mg</i> .....28	<i>dihydroergotamine mesylate nasal spray 4 mg/ml</i> .....280
<i>diclofenac sodium tab delayed release 75 mg</i> .....28	DILANTIN-125 SUS 125/5ML.....77
<i>diclofenac sodium tab er 24hr 100 mg</i> .....28	DILANTIN CAP 100MG.....77
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i> .....28	DILANTIN CAP 30MG.....77
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i> .....28	DILANTIN CHW 50MG.....77
DICLONA+ PAD 1.25-4.5.....185	DILATRATE SR CAP 40MG.....54
DICLONA GEL 1-4.5%.....185	DILAUDID LIQ 1MG/ML.....36
<i>dicloxacillin sodium cap 250 mg</i> .....306	DILAUDID TAB 2MG.....36
<i>dicloxacillin sodium cap 500 mg</i> .....306	DILAUDID TAB 4MG.....36
<i>dicyclomine hcl cap 10 mg</i> .....323	DILAUDID TAB 8MG.....36
<i>dicyclomine hcl oral soln 10 mg/5ml</i> .....323	<i>diltiazem hcl cap er 12hr 120 mg</i> .....163
<i>dicyclomine hcl tab 20 mg</i> .....323	<i>diltiazem hcl cap er 12hr 60 mg</i> .....163
<i>diethylpropion hcl tab 25 mg</i> .....5	<i>diltiazem hcl cap er 12hr 90 mg</i> .....163
<i>diethylpropion hcl tab er 24hr 75 mg</i> .....6	<i>diltiazem hcl cap er 24hr 120 mg</i> .....163
	<i>diltiazem hcl cap er 24hr 180 mg</i> .....163
	<i>diltiazem hcl cap er 24hr 240 mg</i> .....163
	<i>diltiazem hcl coated beads cap er 24hr 120 mg</i> .....163
	<i>diltiazem hcl coated beads cap er 24hr 180 mg</i> .....163
	<i>diltiazem hcl coated beads cap er 24hr 240 mg</i> .....163

<i>diltiazem hcl coated beads cap er 24hr 300 mg</i> .....	163	<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i> .....	94
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i> .....	163	<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i> .....	94
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i> .....	163	DIPROLENE AF CRE 0.05% .....	197
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i> .....	163	DIPROLENE OIN 0.05%.....	197
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i> .....	163	<i>dipyridamole tab 25 mg</i> .....	248
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i> .....	163	<i>dipyridamole tab 50 mg</i> .....	248
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i> .....	163	<i>dipyridamole tab 75 mg</i> .....	248
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i> .....	163	<i>disopyramide phosphate cap 100 mg</i> .....	56
<i>diltiazem hcl tab 120 mg</i> .....	163	<i>disopyramide phosphate cap 150 mg</i> .....	56
<i>diltiazem hcl tab 30 mg</i> .....	163	<i>disulfiram tab 250 mg</i> .....	306
<i>diltiazem hcl tab 60 mg</i> .....	163	<i>disulfiram tab 500 mg</i> .....	306
<i>diltiazem hcl tab 90 mg</i> .....	163	DITROPAN XL TAB 10MG .....	328
<i>diltiazem hcl tab er 24hr 180 mg</i> .....	163	DITROPAN XL TAB 5MG.....	328
<i>diltiazem hcl tab er 24hr 240 mg</i> .....	163	DIURIL SUS 250/5ML .....	225
<i>diltiazem hcl tab er 24hr 300 mg</i> .....	163	<i>divalproex sodium cap delayed release sprinkle 125 mg</i> .....	77
<i>diltiazem hcl tab er 24hr 360 mg</i> .....	163	<i>divalproex sodium tab delayed release 125 mg</i> .....	77
<i>diltiazem hcl tab er 24hr 420 mg</i> .....	163	<i>divalproex sodium tab delayed release 250 mg</i> .....	77
<i>dimethyl fumarate capsule delayed release 120 mg</i> .....	311	<i>divalproex sodium tab delayed release 500 mg</i> .....	77
<i>dimethyl fumarate capsule delayed release 240 mg</i> .....	311	<i>divalproex sodium tab er 24 hr 250 mg</i> ....	77
<i>dimethyl fumarate capsule dr starter pack 120 mg &amp; 240 mg</i> .....	311	<i>divalproex sodium tab er 24 hr 500 mg</i> ....	77
DIOVAN HCT TAB 160-12.5 .....	111	DIVIGEL GEL 0.25MG .....	237
DIOVAN HCT TAB 160-25MG.....	111	DIVIGEL GEL 0.5MG .....	237
DIOVAN HCT TAB 320-12.5.....	111	DIVIGEL GEL 0.75MG .....	237
DIOVAN HCT TAB 320-25MG.....	111	DIVIGEL GEL 1.25MG .....	237
DIOVAN HCT TAB 80/12.5.....	111	DIVIGEL GEL 1MG/GM .....	237
DIOVAN TAB 160MG.....	107	<i>dofetilide cap 125 mcg (0.125 mg)</i> .....	57
DIOVAN TAB 320MG .....	107	<i>dofetilide cap 250 mcg (0.25 mg)</i> .....	57
DIOVAN TAB 40MG .....	107	<i>dofetilide cap 500 mcg (0.5 mg)</i> .....	57
DIOVAN TAB 80MG .....	107	DOJOLVI LIQ 100% .....	296
DIPENTUM CAP 250MG.....	241	<i>donepezil hydrochloride orally disintegrating tab 10 mg</i> .....	307
<i>diphenhydramine hcl elixir 12.5 mg/5ml</i> ...99		<i>donepezil hydrochloride orally disintegrating tab 5 mg</i> .....	307
		<i>donepezil hydrochloride tab 10 mg</i> .....	307
		<i>donepezil hydrochloride tab 23 mg</i> .....	307
		<i>donepezil hydrochloride tab 5 mg</i> .....	307
		DOPTELET TAB 20MG .....	250

DORAL TAB 15MG.....	253	<i>doxycycline hyclate tab delayed release</i>	
DORYX MPC TAB 120MG .....	317	150 mg .....	318
DORYX TAB 200MG.....	318	<i>doxycycline hyclate tab delayed release</i>	
DORYX TAB 50MG .....	318	200 mg .....	318
DORYX TAB 80MG .....	318	<i>doxycycline hyclate tab delayed release 50</i>	
<i>dorzolamide hcl ophth soln 2% .....</i>	<i>303</i>	mg .....	<i>318</i>
<i>dorzolamide hcl-timolol maleate ophth soln</i>		<i>doxycycline hyclate tab delayed release 75</i>	
2-0.5%.....	296	mg .....	318
<i>dorzolamide hcl-timolol maleate pf ophth</i>		<i>doxycycline hyclate tab delayed release 80</i>	
soln 2-0.5%.....	297	mg .....	318
DORZOLAMIDE SOL 2% .....	303	<i>doxycycline monohydrate cap 100 mg ...</i>	<i>318</i>
DOVATO TAB 50-300MG .....	149	<i>doxycycline monohydrate cap 150 mg....</i>	<i>318</i>
DOVONEX CRE 0.005%.....	191	<i>doxycycline monohydrate cap 50 mg .....</i>	<i>318</i>
<i>doxazosin mesylate tab 1 mg .....</i>	<i>108</i>	<i>doxycycline monohydrate cap 75 mg .....</i>	<i>318</i>
<i>doxazosin mesylate tab 2 mg .....</i>	<i>108</i>	<i>doxycycline monohydrate for susp 25</i>	
<i>doxazosin mesylate tab 4 mg .....</i>	<i>108</i>	mg/5ml.....	318
<i>doxazosin mesylate tab 8 mg .....</i>	<i>108</i>	<i>doxycycline monohydrate tab 100 mg ...</i>	<i>318</i>
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>		<i>doxycycline monohydrate tab 150 mg ...</i>	<i>318</i>
.....	253	<i>doxycycline monohydrate tab 50 mg .....</i>	<i>318</i>
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>		<i>doxycycline monohydrate tab 75 mg .....</i>	<i>318</i>
.....	253	<i>doxylamine-pyridoxine tab delayed release</i>	
<i>doxepin hcl cap 100 mg .....</i>	<i>84</i>	10-10 mg .....	96
<i>doxepin hcl cap 10 mg.....</i>	<i>84</i>	DRISDOL CAP 50000UNT .....	332
<i>doxepin hcl cap 150 mg .....</i>	<i>84</i>	DRIZALMA CAP 20MG DR.....	82
<i>doxepin hcl cap 25 mg .....</i>	<i>84</i>	DRIZALMA CAP 30MG DR.....	82
<i>doxepin hcl cap 50 mg .....</i>	<i>84</i>	DRIZALMA CAP 40MG DR.....	82
<i>doxepin hcl cap 75 mg .....</i>	<i>84</i>	DRIZALMA CAP 60MG DR.....	82
<i>doxepin hcl conc 10 mg/ml .....</i>	<i>84</i>	<i>dronabinol cap 10 mg .....</i>	<i>96</i>
<i>doxepin hcl cream 5%.....</i>	<i>188</i>	<i>dronabinol cap 2.5 mg.....</i>	<i>96</i>
<i>doxercalciferol cap 0.5 mcg .....</i>	<i>231</i>	<i>dronabinol cap 5 mg.....</i>	<i>96</i>
<i>doxercalciferol cap 1 mcg.....</i>	<i>231</i>	DROPLET LANC MIS 30G.....	261
<i>doxercalciferol cap 2.5 mcg.....</i>	<i>231</i>	DROPLET LANC MIS DEVICE .....	261
<i>doxycycline (rosacea) cap delayed release</i>		DROPLET PERS MIS LANC 30G .....	261
40 mg .....	203	<i>drospirenone-ethinyl estradiol tab 3-0.02</i>	
<i>doxycycline hyclate cap 100 mg .....</i>	<i>318</i>	mg .....	175
<i>doxycycline hyclate cap 50 mg .....</i>	<i>318</i>	<i>drospirenone-ethinyl estradiol tab 3-0.03</i>	
<i>doxycycline hyclate tab 100 mg .....</i>	<i>318</i>	mg .....	175
<i>doxycycline hyclate tab 150 mg .....</i>	<i>318</i>	<i>drospirenone-ethinyl estrad-levomefolate</i>	
<i>doxycycline hyclate tab 20 mg.....</i>	<i>318</i>	tab 3-0.02-0.451 mg.....	175
<i>doxycycline hyclate tab 50 mg.....</i>	<i>318</i>	<i>drospirenone-ethinyl estrad-levomefolate</i>	
<i>doxycycline hyclate tab 75 mg .....</i>	<i>318</i>	tab 3-0.03-0.451 mg.....	175
<i>doxycycline hyclate tab delayed release</i>		DROXIA CAP 200MG .....	249
100 mg.....	318	DROXIA CAP 300MG .....	249

DROXIA CAP 400MG .....	249	DXEVO 11-DAY PAK 1.5MG.....	178
<i>droxidopa cap 100 mg</i> .....	331	DYANAVEL XR CHW 10MG.....	3
<i>droxidopa cap 200 mg</i> .....	331	DYANAVEL XR CHW 15MG.....	3
<i>droxidopa cap 300 mg</i> .....	331	DYANAVEL XR CHW 20MG.....	3
DRYSOL SOL 20%.....	203	DYANAVEL XR CHW 5MG .....	3
DUAKLIR AER 400/12.....	63	DYANAVEL XR SUS 2.5MG/ML.....	4
DUAVEE TAB 0.45-20 .....	236	DYMISTA SPR 137-50 .....	294
DUETACT TAB 30-2MG .....	85	DYRENIUM CAP 100MG .....	225
DUETACT TAB 30-4MG .....	85	DYRENIUM CAP 50MG .....	225
DUET DHA 400 MIS 25-1-400.....	289	<b>E</b>	
DUET DHA MIS BALANCED .....	289	E.E.S. GRAN SUS 200/5ML .....	256
DUEXIS TAB 800-26.6.....	28	EAA SUPPLEME POW TROPICAL .....	215
DULERA AER 100-5MCG.....	63	EASIVENT MIS.....	278
DULERA AER 200-5MCG.....	63	EASIVENT MIS MASK LG .....	278
DULERA AER 50-5MCG .....	63	EASIVENT MIS MASK MED .....	278
<i>duloxetine hcl enteric coated pellets cap 20</i> <i>mg (base eq)</i> .....	82	EASIVENT MIS MASK SM .....	278
<i>duloxetine hcl enteric coated pellets cap 30</i> <i>mg (base eq)</i> .....	82	EASY COMFORT MIS 30G .....	262
<i>duloxetine hcl enteric coated pellets cap 40</i> <i>mg (base eq)</i> .....	82	EASY COMFORT MIS LANC/30G.....	262
<i>duloxetine hcl enteric coated pellets cap 60</i> <i>mg (base eq)</i> .....	82	EASY COMFORT MIS TWIST.....	262
DUOBRII LOT .....	197	EASY COMFORT PAD ALCOHOL .....	277
DUO-CARE LIQ LEVEL1/2.....	261	EASYGLUCO SOL PLUS .....	262
DUO-CARE TES.....	207	EASYGLUCO TES .....	207
DUPIXENT INJ 100/0.67 .....	58	EASYGLUCO TES PLUS .....	208
DUPIXENT INJ 200/1.14 .....	58	EASYMAX 15 LIQ LEVEL2-3.....	262
DUPIXENT INJ 200MG .....	201	EASYMAX 15 SOL LEVEL 2 .....	262
DUPIXENT INJ 300/2ML.....	201	EASYMAX 15 TES.....	208
DURAGESIC DIS 100MCG/H .....	36	EASYMAX LIQ NORM/HIG .....	262
DURAGESIC DIS 12MCG/HR .....	36	EASYMAX SOL NORMAL.....	262
DURAGESIC DIS 25MCG/HR.....	36	EASYMAX TES.....	208
DURAGESIC DIS 50MCG/HR .....	36	EASY MINI MIS .....	262
DURAGESIC DIS 75MCG/HR.....	36	EASY MINI MIS EJECT .....	262
DUREZOL EMU 0.05%.....	301	EASY PLUS II SOL HIGH.....	262
DURLAZA CAP 162.5MG.....	248	EASY PLUS II SOL LOW.....	262
<i>dutasteride cap 0.5 mg</i> .....	245	EASY PLUS II TES BLD GLUC .....	207
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i> .....	245	EASYPRO PLUS TES.....	208
DUTOPROL TAB 100-12.5 .....	111	EASYPRO TES BLD GLUC.....	208
DUTOPROL TAB 25-12.5 .....	111	EASYSTEP HGH SOL CONTROL.....	262
DUTOPROL TAB 50-12.5.....	111	EASYSTEP LOW SOL CONTROL .....	262
		EASY STEP TES .....	207
		EASY TALK SOL HIGH.....	262
		EASY TALK SOL LOW .....	262
		EASY TALK SOL NORMAL.....	262
		EASY TALK TES BLD GLUC .....	207

EASY TOUCH MIS .....	262	EFFEXOR XR CAP 37.5MG.....	82
EASY TOUCH MIS LANC/21G .....	262	EFFEXOR XR CAP 75MG .....	82
EASY TOUCH MIS LANC/23G.....	262	EFFIENT TAB 10MG .....	248
EASY TOUCH MIS LANC/26G.....	262	EFFIENT TAB 5MG.....	248
EASY TOUCH MIS LANC/28G.....	262	EFUDEX CRE 5%.....	188
EASY TOUCH MIS LANC/30G .....	262	EGRIFTA SV INJ 2MG.....	229
EASY TOUCH MIS LANC/32G.....	262	ELECARE DHA/ POW ARA INFA .....	215
EASY TOUCH MIS LANC/33G.....	262	ELECARE POW DHA/ARA.....	215
EASY TOUCH SOL CONTROL .....	262	ELEMAR PATCH KIT 5%-6% .....	202
EASY TOUCH SOL HIGH/LOW .....	262	ELEMENT CONT LIQ NORMAL.....	262
EASY TOUCH TES GLUCOSE .....	207	ELEMENT LIQ HIGH.....	263
EASY TOUCH TES STRIPS.....	207	ELEMENT LIQ LOW .....	263
EASY TRAK II LIQ NORMAL.....	262	ELEMENT TES .....	208
EASY TRAK II TES BLD GLUC.....	207	ELEMNT COMPA SOL LEVEL 2.....	263
EASY TRAK SOL HIGH .....	262	ELEMNT COMPA SOL LEVEL 3.....	263
EASY TRAK SOL LOW .....	262	ELEMNT COMPA TES STRIPS .....	208
EASY TRAK SOL NORMAL .....	262	ELEPSIA XR TAB 1000MG .....	70
EASY TRAK TES BLD GLUC.....	207	ELEPSIA XR TAB 1500MG.....	70
EC-NAPROSYN TAB 375MG .....	28	ELESTRIN GEL 0.06% .....	237
EC-NAPROSYN TAB 500MG.....	28	<i>eletriptan hydrobromide tab 20 mg (base</i>	
<i>econazole nitrate cream 1%</i> .....	186	<i>equivalent)</i> .....	281
ECOZA AER 1% .....	186	<i>eletriptan hydrobromide tab 40 mg (base</i>	
EDARBI TAB 40MG .....	107	<i>equivalent)</i> .....	281
EDARBI TAB 80MG .....	107	ELIDEL CRE 1% .....	201
EDARBYCLOR TAB 40-12.5.....	111	ELIMITE CRE 5%.....	204
EDARBYCLOR TAB 40-25MG.....	111	ELIQUIS ST P TAB 5MG.....	66
EDECIN TAB 25MG .....	224	ELIQUIS TAB 2.5MG.....	66
EDEX KIT 10MCG .....	168	ELIQUIS TAB 5MG.....	66
EDEX KIT 20MCG .....	168	ELLA TAB 30MG .....	177
EDEX KIT 40MCG .....	168	ELMIRON CAP 100MG .....	245
EDLUAR SUB 10MG .....	253	EMBRACE CNTR LIQ HIGH .....	263
EDLUAR SUB 5MG.....	253	EMBRACE EVO LIQ LEVEL 1 .....	263
EDURANT TAB 25MG .....	149	EMBRACE EVO TES.....	208
<i>efavirenz cap 200 mg</i> .....	149	EMBRACE LANC MIS /EJECTOR .....	263
<i>efavirenz cap 50 mg</i> .....	149	EMBRACE LANC MIS THIN 30G.....	263
<i>efavirenz-emtricitabine-tenofovir df tab</i>		EMBRACE PRO LIQ GLUCOSE.....	263
<i>600-200-300 mg</i> .....	149	EMBRACE PRO TES.....	208
<i>efavirenz-lamivudine-tenofovir df tab 400-</i>		EMBRACE SOL LOW .....	263
<i>300-300 mg</i> .....	149	EMBRACE TALK SOL HIGH/L2.....	263
<i>efavirenz-lamivudine-tenofovir df tab 600-</i>		EMBRACE TALK SOL LOW/L1 .....	263
<i>300-300 mg</i> .....	149	EMBRACE TALK TES STRIPS.....	208
<i>efavirenz tab 600 mg</i> .....	149	EMBRACE TES BLD GLUC.....	208
EFFEXOR XR CAP 150MG .....	82	EMCYT CAP 140MG.....	121

EMEND CAP 80MG.....	97	ENDOMETRIN SUP 100MG .....	330
EMEND SUS 125MG .....	97	ENLITE GLUCO MIS SENSOR.....	263
EMEND TRIPAC PAK 80 & 125 .....	97	<i>enoxaparin sodium inj 300 mg/3ml .....</i>	67
EMFLAZA SUS 22.75/ML.....	178	<i>enoxaparin sodium inj soln pref syr 100</i>	
EMFLAZA TAB 18MG.....	179	<i>mg/ml .....</i>	67
EMFLAZA TAB 30MG.....	179	<i>enoxaparin sodium inj soln pref syr 120</i>	
EMFLAZA TAB 36MG.....	179	<i>mg/0.8ml.....</i>	67
EMFLAZA TAB 6MG .....	179	<i>enoxaparin sodium inj soln pref syr 150</i>	
EMGALITY INJ 100MG/ML.....	279	<i>mg/ml .....</i>	67
EMGALITY INJ 120MG/ML.....	279	<i>enoxaparin sodium inj soln pref syr 30</i>	
EMSAM DIS 12MG/24H.....	79	<i>mg/0.3ml.....</i>	67
EMSAM DIS 6MG/24HR.....	79	<i>enoxaparin sodium inj soln pref syr 40</i>	
EMSAM DIS 9MG/24HR.....	79	<i>mg/0.4ml.....</i>	67
<i>emtricitabine caps 200 mg .....</i>	149	<i>enoxaparin sodium inj soln pref syr 60</i>	
<i>emtricitabine-tenofovir disoproxil fumarate</i>		<i>mg/0.6ml.....</i>	67
<i>tab 100-150 mg .....</i>	149	<i>enoxaparin sodium inj soln pref syr 80</i>	
<i>emtricitabine-tenofovir disoproxil fumarate</i>		<i>mg/0.8ml.....</i>	67
<i>tab 133-200 mg .....</i>	149	ENOXILUV KIT INJ 40/0.4ML .....	67
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSPRYNG INJ .....	285
<i>tab 167-250 mg .....</i>	149	ENSTILAR AER.....	197
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSURE PLANT LIQ CHOCOLAT .....	215
<i>tab 200-300 mg.....</i>	149	<i>entacapone tab 200 mg .....</i>	135
EMTRIVA CAP 200MG.....	149	<i>entecavir tab 0.5 mg .....</i>	156
EMTRIVA SOL 10MG/ML.....	149	<i>entecavir tab 1 mg .....</i>	156
EMVERM CHW 100MG .....	51	ENTERAGAM POW 5GM .....	215
ENABLEX TAB 7.5MG.....	328	ENTEREG CAP 12MG.....	243
<i>enalapril maleate &amp; hydrochlorothiazide tab</i>		ENTOCORT EC CAP 3MG DR .....	179
<i>10-25 mg.....</i>	111	ENTRESTO TAB 24-26MG.....	167
<i>enalapril maleate &amp; hydrochlorothiazide tab</i>		ENTRESTO TAB 49-51MG .....	167
<i>5-12.5 mg.....</i>	111	ENTRESTO TAB 97-103MG.....	167
<i>enalapril maleate oral soln 1 mg/ml .....</i>	105	ENVARBUS XR TAB 0.75MG .....	285
<i>enalapril maleate tab 10 mg .....</i>	105	ENVARBUS XR TAB 1MG.....	285
<i>enalapril maleate tab 2.5 mg .....</i>	105	ENVARBUS XR TAB 4MG.....	285
<i>enalapril maleate tab 20 mg .....</i>	105	EO28 SPLASH LIQ ORANGE .....	216
<i>enalapril maleate tab 5 mg.....</i>	105	EPANED SOL 1MG/ML.....	105
ENBRACE HR CAP .....	289	EPCLUSA PAK 150-37.5 .....	156
ENBREL INJ 25/0.5ML .....	33	EPCLUSA PAK 200-50MG .....	156
ENBREL INJ 25MG.....	33	EPCLUSA TAB 200-50MG .....	156
ENBREL INJ 50MG/ML .....	33	EPCLUSA TAB 400-100.....	156
ENBREL MINI INJ 50MG/ML.....	34	EPICYN SPR.....	203
ENBREL SRCLK INJ 50MG/ML.....	34	EPIDIOLEX SOL 100MG/ML .....	70
ENCARE SUP 100MG.....	329	EPIDUO FORTE GEL 0.3-2.5% .....	184
ENDARI POW 5GM .....	249	EPIDUO GEL 0.1-2.5%.....	184



EPIFOAM AER 1% .....	197	<i>ergotamine w/ caffeine tab 1-100 mg</i> .....	280
<i>epinastine hcl ophth soln 0.05%</i> .....	303	ERIVEDGE CAP 150MG.....	120
EPINEPHRINE INJ 0.2MG .....	332	ERLEADA TAB 240MG.....	121
<i>epinephrine inj 30 mg/30ml (1 mg/ml)</i>		ERLEADA TAB 60MG.....	121
<i>(1:1000)</i> .....	331	<i>erlotinib hcl tab 100 mg (base equivalent)</i>	
EPINEPHRINE KIT SNAP-EMS.....	331	.....	119
<i>epinephrine solution auto-injector 0.15</i>		<i>erlotinib hcl tab 150 mg (base equivalent)</i>	
<i>mg/0.15ml (1:1000)</i> .....	331	.....	119
<i>epinephrine solution auto-injector 0.15</i>		<i>erlotinib hcl tab 25 mg (base equivalent)</i> .....	119
<i>mg/0.3ml (1:2000)</i> .....	331	ERTACZO CRE 2%.....	186
<i>epinephrine solution auto-injector 0.3</i>		ERYGEL GEL 2% .....	184
<i>mg/0.3ml (1:1000)</i> .....	331	ERYPED SUS 200/5ML .....	256
EPINEPHR PRO KIT 1MG/ML .....	331	ERYPED SUS 400/5ML .....	256
EPINPHEPHRIN KIT SNAP-V .....	331	<i>erythromycin ethylsuccinate for susp 200</i>	
EPIPEN 2-PAK INJ 0.3MG .....	331	<i>mg/5ml</i> .....	256
EPIPEN-JR INJ 0.15MG.....	331	<i>erythromycin ethylsuccinate for susp 400</i>	
EPIVIR HBV SOL 5MG/ML .....	156	<i>mg/5ml</i> .....	256
EPIVIR HBV TAB 100MG.....	156	<i>erythromycin ethylsuccinate tab 400 mg</i>	
EPIVIR SOL 10MG/ML.....	150	.....	256
EPIVIR TAB 150MG.....	150	<i>erythromycin gel 2%</i> .....	184
EPIVIR TAB 300MG.....	150	<i>erythromycin ophth oint 5 mg/gm</i> .....	299
<i>eplerenone tab 25 mg</i> .....	114	<i>erythromycin pads 2%</i> .....	184
<i>eplerenone tab 50 mg</i> .....	114	<i>erythromycin soln 2%</i> .....	184
EPOGEN INJ 10000/ML .....	250	<i>erythromycin stearate tab 250 mg</i> .....	256
EPOGEN INJ 2000/ML .....	250	<i>erythromycin tab 250 mg</i> .....	256
EPOGEN INJ 20000/ML.....	250	<i>erythromycin tab 500 mg</i> .....	256
EPOGEN INJ 3000/ML .....	250	<i>erythromycin tab delayed release 250 mg</i>	
EPOGEN INJ 4000/ML .....	250	.....	256
EPRONTIA SOL 25MG/ML .....	70	<i>erythromycin tab delayed release 333 mg</i>	
EPSOLAY CRE 5%.....	184	.....	256
EPZICOM TAB 600-300 .....	150	<i>erythromycin tab delayed release 500 mg</i>	
EQL LANCETS MIS 21G COLR.....	263	.....	257
EQL LANCETS MIS 33G COLR .....	263	<i>erythromycin w/ delayed release particles</i>	
EQL LANCETS MIS THIN 26G .....	263	<i>cap 250 mg</i> .....	257
EQL LANCETS MIS THIN 30G .....	263	ESBRIET CAP 267MG.....	317
EQUETRO CAP 100MG .....	139	ESBRIET TAB 267MG .....	317
EQUETRO CAP 200MG.....	139	ESBRIET TAB 801MG.....	317
EQUETRO CAP 300MG.....	139	<i>escitalopram oxalate soln 5 mg/5ml (base</i>	
<i>ergocalciferol cap 1.25 mg (50000 unit)</i> .....	332	<i>equiv)</i> .....	79
<i>ergoloid mesylates tab 1 mg</i> .....	314	<i>escitalopram oxalate tab 10 mg (base</i>	
ERGOMAR SUB 2MG.....	280	<i>equiv)</i> .....	79
<i>ergotamine w/ caffeine suppos 2-100 mg</i>		<i>escitalopram oxalate tab 20 mg (base</i>	
.....	280	<i>equiv)</i> .....	79

<i>escitalopram oxalate tab 5 mg (base equiv)</i>	<i>estradiol td patch weekly 0.025 mg/24hr</i>
.....79	.....237
ESGIC TAB .....35	<i>estradiol td patch weekly 0.0375 mg/24hr</i>
ESKATA SOL 40% .....194	<i>(37.5 mcg/24hr) .....237</i>
ESOMEPRAZOLE CAP 49.3MG.....325	<i>estradiol td patch weekly 0.05 mg/24hr 237</i>
<i>esomeprazole magnesium cap delayed</i>	<i>estradiol td patch weekly 0.06 mg/24hr 237</i>
<i>release 20 mg (base eq).....325</i>	<i>estradiol td patch weekly 0.075 mg/24hr</i>
<i>esomeprazole magnesium cap delayed</i>	.....237
<i>release 40 mg (base eq) .....325</i>	<i>estradiol td patch weekly 0.1 mg/24hr....237</i>
<i>esomeprazole magnesium for delayed</i>	<i>estradiol vaginal cream 0.1 mg/gm.....330</i>
<i>release susp packet 10 mg .....325</i>	<i>estradiol vaginal tab 10 mcg.....330</i>
<i>esomeprazole magnesium for delayed</i>	<i>estradiol valerate im in oil 20 mg/ml .....237</i>
<i>release susp packet 20 mg.....325</i>	<i>estradiol valerate im in oil 40 mg/ml .....237</i>
<i>esomeprazole magnesium for delayed</i>	ESTRING MIS 2MG .....330
<i>release susp packet 40 mg.....325</i>	ESTROGEL GEL .....237
<i>estazolam tab 1 mg .....253</i>	ESTROSTEP FE TAB .....175
<i>estazolam tab 2 mg .....253</i>	<i>eszopiclone tab 1 mg .....253</i>
ESTRACE TAB 0.5MG.....237	<i>eszopiclone tab 2 mg .....253</i>
ESTRACE TAB 1MG.....237	<i>eszopiclone tab 3 mg .....253</i>
ESTRACE TAB 2MG .....237	<i>ethacrynic acid tab 25 mg .....224</i>
ESTRACE VAG CRE 0.01% .....330	<i>ethambutol hcl tab 100 mg .....116</i>
<i>estradiol &amp; norethindrone acetate tab 0.5-</i>	<i>ethambutol hcl tab 400 mg .....116</i>
<i>0.1 mg .....236</i>	<i>ethosuximide cap 250 mg .....77</i>
<i>estradiol &amp; norethindrone acetate tab 1-0.5</i>	<i>ethosuximide soln 250 mg/5ml .....77</i>
<i>mg .....236</i>	ETHYL CHLOR AER FINE PIN.....202
<i>estradiol tab 0.5 mg.....237</i>	ETHYL CHLOR AER FN STRM.....202
<i>estradiol tab 1 mg .....237</i>	ETHYL CHLOR AER MED JET .....202
<i>estradiol tab 2 mg .....237</i>	ETHYL CHLOR AER MED STRM .....202
<i>estradiol td gel 0.25 mg/0.25gm (0.1%) 237</i>	ETHYL CHLOR AER MIST .....202
<i>estradiol td gel 0.5 mg/0.5gm (0.1%) .....237</i>	<i>ethyl chloride aerosol spray .....202</i>
<i>estradiol td gel 0.75 mg/0.75gm (0.1%) 237</i>	<i>ethynodiol diacetate &amp; ethinyl estradiol tab</i>
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)...237</i>	<i>1 mg-35 mcg.....175</i>
<i>estradiol td gel 1 mg/gm (0.1%).....237</i>	<i>ethynodiol diacetate &amp; ethinyl estradiol tab</i>
<i>estradiol td patch twice weekly 0.025</i>	<i>1 mg-50 mcg.....175</i>
<i>mg/24hr.....237</i>	<i>etodolac cap 200 mg.....28</i>
<i>estradiol td patch twice weekly 0.0375</i>	<i>etodolac cap 300 mg.....28</i>
<i>mg/24hr.....237</i>	<i>etodolac tab 400 mg .....28</i>
<i>estradiol td patch twice weekly 0.05</i>	<i>etodolac tab 500 mg .....28</i>
<i>mg/24hr.....237</i>	<i>etodolac tab er 24hr 400 mg .....28</i>
<i>estradiol td patch twice weekly 0.075</i>	<i>etodolac tab er 24hr 500 mg .....28</i>
<i>mg/24hr.....237</i>	<i>etodolac tab er 24hr 600 mg .....28</i>
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	<i>etonogestrel-ethinyl estradiol va ring 0.120-</i>
.....237	<i>0.015 mg/24hr .....177</i>

<i>etoposide cap 50 mg</i> .....	134	<i>exemestane tab 25 mg</i> .....	121
<i>etravirine tab 100 mg</i> .....	150	EXFORGE HCT TAB 10-160-12.5 .....	111
<i>etravirine tab 200 mg</i> .....	150	EXFORGE HCT TAB 10-160-25 .....	111
EUCRISA OIN 2% .....	203	EXFORGE HCT TAB 10-320-25 .....	111
EVAMIST SPR 1.53MG.....	238	EXFORGE HCT TAB 5-160-12.5.....	111
EVEKEO ODT TAB 10MG .....	4	EXFORGE HCT TAB 5-160-25 .....	111
EVEKEO ODT TAB 15MG .....	4	EXFORGE TAB 10-160MG .....	111
EVEKEO ODT TAB 20MG .....	4	EXFORGE TAB 10-320MG.....	111
EVEKEO ODT TAB 5MG.....	4	EXFORGE TAB 5-160MG .....	111
EVEKEO TAB 10MG.....	4	EXFORGE TAB 5-320MG .....	111
EVEKEO TAB 5MG.....	4	EXJADE TAB 125MG.....	95
EVENCARE + TES BLD GLUC .....	208	EXJADE TAB 250MG.....	95
EVENCARE G2 SOL LOW/HIGH .....	263	EXJADE TAB 500MG.....	95
EVENCARE G2 TES.....	208	EXODERM LOT 25-1% .....	186
EVENCARE G3 SOL LOW/HIGH .....	263	EXSERVAN MIS 50MG .....	295
EVENCARE G3 TES.....	208	EXTAVIA INJ 0.3MG.....	311
EVENCARE SOL LIQ LOW/HIGH .....	263	EXTINA AER 2%.....	186
EVENCARE TES BLD GLUC .....	208	EYSUVIS DRO 0.25% .....	301
EVENCARE TES MINI .....	208	EZALLOR SPR CAP 10MG .....	102
EVENCARE TES PROVIEW .....	208	EZALLOR SPR CAP 20MG.....	102
EVENCAR MINI SOL NORMAL.....	263	EZALLOR SPR CAP 40MG.....	102
<i>everolimus tab 0.25 mg</i> .....	285	EZALLOR SPR CAP 5MG .....	102
<i>everolimus tab 0.5 mg</i> .....	285	EZETIM/ATORV TAB 10-10MG.....	99
<i>everolimus tab 0.75 mg</i> .....	285	EZETIM/ATORV TAB 10-20MG.....	99
<i>everolimus tab 2.5 mg</i> .....	126	EZETIM/ATORV TAB 10-40MG.....	99
<i>everolimus tab 5 mg</i> .....	126	EZETIM/ATORV TAB 10-80MG.....	99
<i>everolimus tab 7.5 mg</i> .....	126	<i>ezetimibe-simvastatin tab 10-10 mg</i> .....	99
EVERSENSE E3 MIS SENSOR.....	263	<i>ezetimibe-simvastatin tab 10-20 mg</i> .....	99
EVERSENSE MIS SENSOR .....	263	<i>ezetimibe-simvastatin tab 10-40 mg</i> .....	99
EVISTA TAB 60MG .....	230	<i>ezetimibe-simvastatin tab 10-80 mg</i> .....	99
EVOCLIN AER 1%.....	184	<i>ezetimibe tab 10 mg</i> .....	104
EVOLUTION SOL NORMAL .....	263	E-ZJECT LANC MIS 33G .....	262
EVOLUTION TES AUTOCODE .....	208	E-Z JECT MIS 21G .....	261
EVOTAZ TAB 300-150 .....	150	E-Z JECT MIS 21G COLR.....	261
EVOXAC CAP 30MG.....	288	E-Z JECT MIS 30G .....	261
EVRYSDI SOL.....	296	E-Z JECT MIS 32G COLR .....	261
EXACTECH TES.....	209	E-Z JECT MIS LANC 21G .....	262
EXACTECH TES R-S-G.....	209	E-Z JECT MIS THIN 26G .....	262
EXELDERM CRE 1%.....	186	EZ-LETS 21G MIS LANCETS .....	263
EXELDERM SOL 1%.....	186	EZ-LETS 26G MIS LANCETS .....	263
EXELON DIS 13.3/24.....	307	EZ-LETS 28G MIS LANCETS.....	263
EXELON DIS 4.6MG/24.....	307	EZ-LETS 30G MIS LANCETS .....	263
EXELON DIS 9.5MG/24.....	307		

<b>F</b>	
F.A.A. LIQ .....	216
FABIOR AER 0.1% .....	184
<i>famciclovir tab 125 mg</i> .....	158
<i>famciclovir tab 250 mg</i> .....	158
<i>famciclovir tab 500 mg</i> .....	158
<i>famotidine for susp 40 mg/5ml</i> .....	324
<i>famotidine tab 40 mg</i> .....	324
FANAPT PAK.....	140
FANAPT TAB 10MG.....	140
FANAPT TAB 12MG.....	140
FANAPT TAB 1MG .....	140
FANAPT TAB 2MG .....	140
FANAPT TAB 4MG .....	140
FANAPT TAB 6MG .....	140
FANAPT TAB 8MG .....	140
FARESTON TAB 60MG.....	121
FARXIGA TAB 10MG .....	93
FARXIGA TAB 5MG.....	93
FARYDAK CAP 10MG.....	126
FARYDAK CAP 15MG.....	126
FARYDAK CAP 20MG .....	126
FASENRA PEN INJ 30MG/ML.....	58
FASTCLIX MIS LANCETS.....	263
FAVIPIRAVIR TAB 200MG.....	158
FC2 FEMALE MIS CONDOM.....	257
FC FEMALE MIS CONDOM.....	257
<i>febuxostat tab 40 mg</i> .....	246
<i>febuxostat tab 80 mg</i> .....	246
<i>felbamate susp 600 mg/5ml</i> .....	76
<i>felbamate tab 400 mg</i> .....	76
<i>felbamate tab 600 mg</i> .....	76
FELBATOL SUS 600/5ML .....	76
FELBATOL TAB 400MG .....	76
FELBATOL TAB 600MG .....	76
FELDENE CAP 10MG .....	28
FELDENE CAP 20MG.....	28
<i>felodipine tab er 24hr 10 mg</i> .....	164
<i>felodipine tab er 24hr 2.5 mg</i> .....	163
<i>felodipine tab er 24hr 5 mg</i> .....	164
FEMARA TAB 2.5MG.....	121
FEMCAP MIS 22MM .....	257
FEMCAP MIS 26MM .....	257
FEMCAP MIS 30MM.....	257
FEMHRT TAB 0.5-2.5 .....	236
FEMRING MIS 0.05/24H.....	330
FEMRING MIS 0.1MG/24 .....	330
<i>fenofibrate cap 150 mg</i> .....	101
<i>fenofibrate cap 50 mg</i> .....	101
<i>fenofibrate micronized cap 130 mg</i> .....	101
<i>fenofibrate micronized cap 134 mg</i> .....	101
<i>fenofibrate micronized cap 200 mg</i> .....	101
<i>fenofibrate micronized cap 30 mg</i> .....	101
<i>fenofibrate micronized cap 43 mg</i> .....	101
<i>fenofibrate micronized cap 67 mg</i> .....	101
<i>fenofibrate micronized cap 90 mg</i> .....	101
<i>fenofibrate tab 120 mg</i> .....	101
<i>fenofibrate tab 145 mg</i> .....	101
<i>fenofibrate tab 160 mg</i> .....	101
<i>fenofibrate tab 40 mg</i> .....	101
<i>fenofibrate tab 48 mg</i> .....	101
<i>fenofibrate tab 54 mg</i> .....	101
<i>fenofibric acid tab 105 mg</i> .....	101
<i>fenofibric acid tab 35 mg</i> .....	101
FENOGLIDE TAB 120MG .....	101
FENOGLIDE TAB 40MG .....	101
<i>fenoprofen calcium cap 400 mg</i> .....	28
<i>fenoprofen calcium tab 600 mg</i> .....	28
FENOPROFEN CAP 200MG.....	28
FENORTHO CAP 200MG .....	28
FENOVAR KIT .....	185
<i>fantanyl citrate buccal tab 100 mcg (base equiv)</i> .....	36
<i>fantanyl citrate buccal tab 200 mcg (base equiv)</i> .....	36
<i>fantanyl citrate buccal tab 400 mcg (base equiv)</i> .....	36
<i>fantanyl citrate buccal tab 600 mcg (base equiv)</i> .....	36
<i>fantanyl citrate buccal tab 800 mcg (base equiv)</i> .....	36
<i>fantanyl citrate lozenge on a handle 1200 mcg</i> .....	36
<i>fantanyl citrate lozenge on a handle 1600 mcg</i> .....	36

<i>fentanyl citrate lozenge on a handle 200 mcg</i> .....	36	FINACEA AER 15% .....	203
<i>fentanyl citrate lozenge on a handle 400 mcg</i> .....	36	FINACEA GEL 15% .....	203
<i>fentanyl citrate lozenge on a handle 600 mcg</i> .....	36	<i>finasteride tab 5 mg</i> .....	245
<i>fentanyl citrate lozenge on a handle 800 mcg</i> .....	36	FINE 30 MIS .....	263
<i>fentanyl td patch 72hr 100 mcg/hr</i> .....	37	FINGERSTIX MIS LANCETS .....	263
<i>fentanyl td patch 72hr 12 mcg/hr</i> .....	36	<i> fingolimod hcl cap 0.5 mg (base equiv)</i> ...	311
<i>fentanyl td patch 72hr 25 mcg/hr</i> .....	36	FINTEPLA SOL 2.2MG/ML .....	70
<i>fentanyl td patch 72hr 37.5 mcg/hr</i> .....	36	FIORICET CAP .....	35
<i>fentanyl td patch 72hr 50 mcg/hr</i> .....	36	FIORICET CAP CODEINE .....	45
<i>fentanyl td patch 72hr 62.5 mcg/hr</i> .....	37	FIRAZYR INJ 30MG/3ML .....	246
<i>fentanyl td patch 72hr 75 mcg/hr</i> .....	37	FIRDAPSE TAB 10MG .....	116
<i>fentanyl td patch 72hr 87.5 mcg/hr</i> .....	37	FIRVANQ SOL 25MG/ML .....	52
FENTORA TAB 100MCG .....	37	FIRVANQ SOL 50MG/ML .....	52
FENTORA TAB 200MCG .....	37	FLAGYL CAP 375MG .....	51
FENTORA TAB 400MCG .....	37	FLAGYL TAB 500MG .....	51
FENTORA TAB 600MCG .....	37	FLAREX SUS 0.1% OP .....	301
FENTORA TAB 800MCG .....	37	<i>flavoxate hcl tab 100 mg</i> .....	329
FERIVA TAB 21/7 .....	252	<i>flecainide acetate tab 100 mg</i> .....	57
FERPRX 2-DAY TAB 1000MG .....	95	<i>flecainide acetate tab 150 mg</i> .....	57
FERRIPROX SOL 100MG/ML .....	95	<i>flecainide acetate tab 50 mg</i> .....	57
FERRIPROX TAB 1000MG .....	95	FLECTOR DIS 1.3% .....	185
FERRIPROX TAB 500MG .....	95	FLEXICHAMBER MIS .....	278
<i>fesoterodine fumarate tab er 24hr 4 mg</i> .....	328	FLEXICHAMBER MIS MASK LRG .....	278
<i>fesoterodine fumarate tab er 24hr 8 mg</i> .....	328	FLEXICHAMBER MIS MASK SM .....	278
FETZIMA CAP 120MG .....	82	FLOLIPID SUS 20MG/5ML .....	102
FETZIMA CAP 20MG .....	82	FLOLIPID SUS 40MG/5ML .....	102
FETZIMA CAP 40MG .....	82	FLOMAX CAP 0.4MG .....	245
FETZIMA CAP 80MG .....	82	FLOVENT DISK AER 100MCG .....	60
FETZIMA CAP TITRATIO .....	82	FLOVENT DISK AER 250MCG .....	60
FIASP FLEX INJ TOUCH .....	90	FLOVENT DISK AER 50MCG .....	60
FIASP INJ 100/ML .....	91	FLOVENT HFA AER 110MCG .....	61
FIASP PENFIL INJ U-100 .....	91	FLOVENT HFA AER 220MCG .....	61
FIBERSOURCE LIQ CLS SYS .....	216	FLOVENT HFA AER 44MCG .....	60
FIBERSOUR HN LIQ CLS SYS .....	216	<i>fluconazole for susp 10 mg/ml</i> .....	98
FIBRICOR TAB 105MG .....	101	<i>fluconazole for susp 40 mg/ml</i> .....	98
FIBRICOR TAB 35MG .....	101	<i>fluconazole tab 100 mg</i> .....	98
FIFTY50 GLUC TES 2.0 .....	209	<i>fluconazole tab 150 mg</i> .....	98
FIFTY50 PREP PAD PADS .....	277	<i>fluconazole tab 200 mg</i> .....	98
FIFTY50 SAFE MIS LANCETS .....	263	<i>fluconazole tab 50 mg</i> .....	98
		<i>flucytosine cap 250 mg</i> .....	97
		<i>flucytosine cap 500 mg</i> .....	97
		<i>fludrocortisone acetate tab 0.1 mg</i> .....	181

<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	<i>flurandrenolide lotion 0.05%</i> .....	198
.....295	<i>flurandrenolide oint 0.05%</i> .....	198
<i>fluocinolone acetonide (otic) oil 0.01%</i> ..	<i>flurazepam hcl cap 15 mg</i> .....	253
304	<i>flurazepam hcl cap 30 mg</i> .....	253
<i>fluocinolone acetonide cream 0.01%</i> .....	<i>flurbiprofen sodium ophth soln 0.03%</i> ...	303
197	<i>flurbiprofen tab 100 mg</i> .....	28
<i>fluocinolone acetonide cream 0.025%</i> ...	<i>flurbiprofen tab 50 mg</i> .....	28
197	<i>flutamide cap 125 mg</i> .....	121
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	<i>fluticasone furoate-vilanterol aero powd ba</i>	
.....197	<i>100-25 mcg/act</i> .....	63
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	<i>fluticasone furoate-vilanterol aero powd ba</i>	
.....197	<i>200-25 mcg/act</i> .....	63
<i>fluocinolone acetonide oint 0.025%</i> .....	<i>fluticasone propionate cream 0.05%</i> .....	198
197	<i>fluticasone propionate hfa inhal aer 110</i>	
<i>fluocinolone acetonide soln 0.01%</i> .....	<i>mcg/act (125/valve)</i> .....	61
197	<i>fluticasone propionate hfa inhal aer 220</i>	
<i>fluocinonide cream 0.05%</i> .....	<i>mcg/act (250/valve)</i> .....	61
197	<i>fluticasone propionate hfa inhal aero 44</i>	
<i>fluocinonide cream 0.1%</i> .....	<i>mcg/act (50/valve)</i> .....	61
197	<i>fluticasone propionate lotion 0.05%</i> .....	198
<i>fluocinonide emulsified base cream 0.05%</i>	<i>fluticasone propionate nasal susp 50</i>	
.....197	<i>mcg/act</i> .....	295
<i>fluocinonide gel 0.05%</i> .....	<i>fluticasone propionate oint 0.005%</i> .....	198
198	<i>fluticasone-salmeterol aer powder ba 100-</i>	
<i>fluocinonide oint 0.05%</i> .....	<i>50 mcg/act</i> .....	64
198	<i>fluticasone-salmeterol aer powder ba 113-</i>	
<i>fluocinonide soln 0.05%</i> .....	<i>14 mcg/act</i> .....	64
198	<i>fluticasone-salmeterol aer powder ba 232-</i>	
<i>fluorometholone ophth susp 0.1%</i> .....	<i>14 mcg/act</i> .....	64
301	<i>fluticasone-salmeterol aer powder ba 250-</i>	
<b>FLUOROPLEX CRE 1%</b> .....	<i>50 mcg/act</i> .....	64
188	<i>fluticasone-salmeterol aer powder ba 500-</i>	
<i>fluorouracil cream 0.5%</i> .....	<i>50 mcg/act</i> .....	64
188	<i>fluticasone-salmeterol aer powder ba 55-14</i>	
<i>fluorouracil cream 5%</i> .....	<i>mcg/act</i> .....	63
188	<i>fluticasone-salmeterol inhal aerosol 115-21</i>	
<i>fluorouracil soln 2%</i> .....	<i>mcg/act</i> .....	64
188	<i>fluticasone-salmeterol inhal aerosol 230-21</i>	
<i>fluoxetine hcl (pmdd) tab 10 mg</i> .....	<i>mcg/act</i> .....	64
314	<i>fluticasone-salmeterol inhal aerosol 45-21</i>	
<i>fluoxetine hcl (pmdd) tab 20 mg</i> .....	<i>mcg/act</i> .....	64
314	<i>fluvastatin sodium cap 20 mg (base</i>	
<i>fluoxetine hcl cap 10 mg</i> .....	<i>equivalent)</i> .....	102
79		
<i>fluoxetine hcl cap 20 mg</i> .....		
80		
<i>fluoxetine hcl cap 40 mg</i> .....		
80		
<i>fluoxetine hcl cap delayed release 90 mg</i>		
80		
<i>fluoxetine hcl solution 20 mg/5ml</i> .....		
80		
<i>fluoxetine hcl tab 10 mg</i> .....		
80		
<i>fluoxetine hcl tab 20 mg</i> .....		
80		
<i>fluoxetine hcl tab 60 mg</i> .....		
80		
<i>fluphenazine decanoate inj 25 mg/ml</i> .....		
145		
<i>fluphenazine hcl elixir 2.5 mg/5ml</i> .....		
145		
<i>fluphenazine hcl inj 2.5 mg/ml</i> .....		
145		
<i>fluphenazine hcl oral conc 5 mg/ml</i> .....		
145		
<i>fluphenazine hcl tab 10 mg</i> .....		
145		
<i>fluphenazine hcl tab 1 mg</i> .....		
145		
<i>fluphenazine hcl tab 2.5 mg</i> .....		
145		
<i>fluphenazine hcl tab 5 mg</i> .....		
145		
<i>flurandrenolide cream 0.05%</i> .....		
198		

<i>fluvastatin sodium cap 40 mg (base equivalent)</i> .....	102	FORACARE GDH SOL HIGH .....	264
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</i> .....	102	FORACARE GDH SOL LOW .....	264
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	80	FORACARE GDH SOL NORMAL .....	264
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	80	FORACARE TES GD40 .....	210
<i>fluvoxamine maleate tab 100 mg</i> .....	80	FORACARE TES PREM V10 .....	210
<i>fluvoxamine maleate tab 25 mg</i> .....	80	FORACARE TES TST N GO .....	210
<i>fluvoxamine maleate tab 50 mg</i> .....	80	FORA CONTROL SOL HIGH .....	263
FML FORTE SUS 0.25% OP .....	301	FORA CONTROL SOL LOW .....	263
FML LIQUIFLM SUS 0.1% OP .....	301	FORA CONTROL SOL NORMAL .....	263
FML OIN 0.1% OP .....	301	FORA D15G TES BLD GLUC .....	209
FOCALIN TAB 10MG .....	10	FORA D20 TES BLD GLUC .....	209
FOCALIN TAB 2.5MG .....	10	FORA D40/G31 TES GLUCOSE .....	209
FOCALIN TAB 5MG .....	10	FORA G20 TES BLD GLUC .....	209
FOCALIN XR CAP 10MG .....	10	FORA G30/V10 TES BLD GLUC .....	209
FOCALIN XR CAP 15MG .....	10	FORA GD20 TES BLD GLUC .....	209
FOCALIN XR CAP 20MG .....	10	FORA GD50 TES .....	209
FOCALIN XR CAP 25MG .....	10	FORA GTEL TES BLD GLUC .....	209
FOCALIN XR CAP 30MG .....	10	FORA GTEL TES KETONE .....	209
FOCALIN XR CAP 35MG .....	10	FORA LANCETS MIS 30G .....	264
FOCALIN XR CAP 40MG .....	11	FORA MIS LANCETS .....	264
FOCALIN XR CAP 5MG .....	10	FORA MIS LANCING .....	264
<i>folic acid cap 0.8 mg</i> .....	249	FORA TN'G TES TN'G VOI .....	209
<i>folic acid-cholecalciferol tab 1 mg-3775 unit</i> .....	252	FORA V10 TES BLD GLUC .....	209
<i>folic acid tab 1 mg</i> .....	249	FORA V12 TES BLD GLUC .....	209
<i>folic acid tab 400 mcg</i> .....	249	FORA V20 TES BLD GLUC .....	209
<i>folic acid tab 800 mcg</i> .....	249	FORA V30A TES BLD GLUC .....	210
FOLIC-K CAP .....	288	FORFIVO XL TAB 450MG .....	78
FOLLISTIM AQ INJ 300UNIT .....	227	<i>formaldehyde solution 10%</i> .....	147
FOLLISTIM AQ INJ 600UNIT .....	227	<i>formoterol fumarate soln nebu 20 mcg/2ml</i> .....	64
FOLLISTIM AQ INJ 900UNIT .....	227	FORTAMET TAB 1000MG .....	87
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i> .....	67	FORTAMET TAB 500MG .....	87
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml</i> .....	67	FORTEO INJ 600/2.4 .....	226
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml</i> .....	67	FORTESTA GEL 10MG/ACT .....	49
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml</i> .....	67	FORTISCARE SOL CNTL HI .....	264
FORA 6 MIS CONNECT .....	209	FORTISCARE SOL CNTL LOW .....	264
FORA BLOOD TES GLUCOSE .....	209	FORTISCARE SOL CNTL NML .....	264
		FORTISCARE TES BLD GLUC .....	210
		FOSAMAX + D TAB 70-2800 .....	226
		FOSAMAX + D TAB 70-5600 .....	226
		FOSAMAX TAB 70MG .....	226
		<i>fosamprenavir calcium tab 700 mg (base equiv)</i> .....	150

<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i> .....	53	<i>furosemide oral soln 10 mg/ml</i> .....	224
<i>fosinopril sodium &amp; hydrochlorothiazide tab 10-12.5 mg</i> .....	111	<i>furosemide oral soln 8 mg/ml</i> .....	224
<i>fosinopril sodium &amp; hydrochlorothiazide tab 20-12.5 mg</i> .....	111	<i>furosemide tab 20 mg</i> .....	224
<i>fosinopril sodium tab 10 mg</i> .....	105	<i>furosemide tab 40 mg</i> .....	225
<i>fosinopril sodium tab 20 mg</i> .....	105	<i>furosemide tab 80 mg</i> .....	225
<i>fosinopril sodium tab 40 mg</i> .....	105	FUZEON INJ 90MG .....	150
FOSRENOL CHW 1000MG .....	243	FYCOMPA SUS 0.5MG/ML.....	68
FOSRENOL CHW 500MG .....	243	FYCOMPA TAB 10MG.....	68
FOSRENOL CHW 750MG .....	243	FYCOMPA TAB 12MG.....	68
FOSRENOL POW 1000MG.....	243	FYCOMPA TAB 2MG .....	68
FOSRENOL POW 750MG .....	243	FYCOMPA TAB 4MG .....	68
FOSTEUM CAP .....	216	FYCOMPA TAB 6MG .....	68
FOSTEUM PLUS CAP .....	216	FYCOMPA TAB 8MG .....	68
FOTIVDA CAP 0.89MG .....	126	FYLNETRA INJ 6MG/0.6 .....	250
FOTIVDA CAP 1.34MG .....	126	<b>G</b>	
FRAGMIN INJ 10000/ML.....	67	G4 PLATINUM MIS PEDIATRC.....	264
FRAGMIN INJ 12500UNT .....	67	G4 PLATINUM MIS RCV/SHAR .....	264
FRAGMIN INJ 15000UNT.....	67	G4 PLATINUM MIS RECEIVER .....	264
FRAGMIN INJ 18000UNT.....	67	G4 PLATINUM MIS TRANSMIT.....	264
FRAGMIN INJ 2500/0.2.....	67	G4 PLAT PED MIS RVC/SHAR .....	264
FRAGMIN INJ 2500/ML.....	67	G4 SENSOR MIS.....	264
FRAGMIN INJ 5000/0.2.....	67	G5/G4 MIS SENSOR.....	264
FRAGMIN INJ 7500/0.3.....	67	GA-1 ANAMIX POW ERLY YRS .....	216
FRAGMIN INJ 95000UNT .....	67	<i>gabapentin cap 100 mg</i> .....	70
FREESTYLE KIT SENSOR .....	264	<i>gabapentin cap 300 mg</i> .....	70
FREESTYLE LIQ CONTROL.....	264	<i>gabapentin cap 400 mg</i> .....	70
FREESTYLE MIS LANCETS .....	264	<i>gabapentin oral soln 250 mg/5ml</i> .....	70
FREESTYLE MIS READER .....	264	<i>gabapentin tab 600 mg</i> .....	71
FREESTYLE MIS UNISTICK.....	264	<i>gabapentin tab 800 mg</i> .....	71
FREESTYLE TES.....	210	GABITRIL TAB 12MG.....	76
FREESTYLE TES INSULINX .....	210	GABITRIL TAB 16MG.....	76
FREESTYLE TES LITE .....	210	GABITRIL TAB 2MG .....	76
FREESTYLE TES PREC NEO .....	210	GABITRIL TAB 4MG .....	76
FREESTY LIBR KIT 2 SENSOR .....	264	GALAFOLD CAP 123MG.....	231
FREESTY LIBR KIT 3 SENSOR .....	264	<i>galantamine hydrobromide cap er 24hr 16 mg</i> .....	307
FREESTY LIBR MIS 2 READER.....	264	<i>galantamine hydrobromide cap er 24hr 24 mg</i> .....	307
FROVA TAB 2.5MG.....	281	<i>galantamine hydrobromide cap er 24hr 8 mg</i> .....	307
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i> .....	281	<i>galantamine hydrobromide oral soln 4 mg/ml</i> .....	308
FULPHILA INJ 6/0.6ML .....	250	<i>galantamine hydrobromide tab 12 mg</i> ....	308



<i>galantamine hydrobromide tab 4 mg</i> .....	308	GENTEEL TIPS MIS CLEAR.....	264
<i>galantamine hydrobromide tab 8 mg</i> .....	308	GENTEEL TIPS MIS GREEN .....	265
<i>ganirelix acetate soln prefilled syringe 250</i>		GENTEEL TIPS MIS ORANGE .....	265
<i>mcg/0.5ml</i> .....	229	GENTEEL TIPS MIS RAINBOW.....	265
GANIRELIX AC INJ 250/0.5 .....	229	GENTEEL TIPS MIS VIOLET .....	265
GA POW .....	216	GENTEEL TIPS MIS YELLOW .....	265
GASTROCROM CON 100/5ML .....	239	GENTLE-LET MIS 26G.....	265
<i>gatifloxacin ophth soln 0.5%</i> .....	299	GENTLE-LET MIS 28G.....	265
GATTEX KIT 5MG.....	244	GENTLE-LET MIS LANCETS.....	265
GAVRETO CAP 100MG .....	126	GENTLE-LET MIS PLATFORM .....	265
GE100 BLOOD TES GLUCOSE .....	210	GENULTIMATE TES.....	210
GE100 CONTRL SOL NORMAL .....	264	GENVOYA TAB .....	150
GEAMETDRAY GEL 5-2-17%.....	202	GEODON CAP 20MG .....	139
GELFILM MIS OP.....	302	GEODON CAP 40MG .....	139
GELNIQUE GEL 10% .....	328	GEODON CAP 60MG .....	139
<i>gemfibrozil tab 600 mg</i> .....	101	GEODON CAP 80MG .....	139
GEMTESA TAB 75MG.....	329	GEODON INJ 20MG .....	139
GENERESS FE CHW .....	175	GHT TEST TES STRIPS.....	210
GENOTROPIN INJ 0.2MG .....	229	GILENYA CAP 0.5MG .....	311
GENOTROPIN INJ 0.4MG.....	229	GILOTRIF TAB 20MG .....	119
GENOTROPIN INJ 0.6MG.....	229	GILOTRIF TAB 30MG .....	119
GENOTROPIN INJ 0.8MG.....	229	GILOTRIF TAB 40MG .....	120
GENOTROPIN INJ 1.2MG.....	229	GIMOTI SPR 15MG.....	240
GENOTROPIN INJ 1.4MG.....	229	<i>glatiramer acetate soln prefilled syringe 20</i>	
GENOTROPIN INJ 1.6MG.....	229	<i>mg/ml</i> .....	311
GENOTROPIN INJ 1.8MG.....	229	<i>glatiramer acetate soln prefilled syringe 40</i>	
GENOTROPIN INJ 12MG .....	229	<i>mg/ml</i> .....	311
GENOTROPIN INJ 1MG .....	229	GLEEVEC TAB 100MG.....	126
GENOTROPIN INJ 2MG .....	229	GLEEVEC TAB 400MG.....	126
GENOTROPIN INJ 5MG .....	229	GLEOSTINE CAP 100MG .....	117
<i>gentamicin sulfate cream 0.1%</i> .....	186	GLEOSTINE CAP 10MG .....	117
<i>gentamicin sulfate oint 0.1%</i> .....	186	GLEOSTINE CAP 40MG.....	117
<i>gentamicin sulfate ophth oint 0.3%</i> .....	299	<i>glimepiride tab 1 mg</i> .....	93
<i>gentamicin sulfate ophth soln 0.3%</i> .....	299	<i>glimepiride tab 2 mg</i> .....	93
GENTEEL LANC KIT BLUE .....	264	<i>glimepiride tab 4 mg</i> .....	93
GENTEEL MIS LANCETS.....	264	<i>glipizide-metformin hcl tab 2.5-250 mg</i> ...	85
GENTEEL MIS NOZZLES .....	264	<i>glipizide-metformin hcl tab 2.5-500 mg</i> ...	85
GENTEEL PLUS MIS BLACK.....	264	<i>glipizide-metformin hcl tab 5-500 mg</i> .....	85
GENTEEL PLUS MIS BLUE .....	264	<i>glipizide tab 10 mg</i> .....	93
GENTEEL PLUS MIS PINK.....	264	<i>glipizide tab 5 mg</i> .....	93
GENTEEL PLUS MIS PURPLE .....	264	<i>glipizide tab er 24hr 10 mg</i> .....	93
GENTEEL PLUS MIS WHITE .....	264	<i>glipizide tab er 24hr 2.5 mg</i> .....	93
GENTEEL TIPS MIS BLUE .....	264	<i>glipizide tab er 24hr 5 mg</i> .....	93

GLOBAL 28G MIS LANCETS .....	265	GLUCOTROL XL TAB 5MG .....	93
GLOBAL 30G MIS LANCETS .....	265	GLUMETZA TAB 1000MG .....	87
GLOBAL LANC MIS DEVICE .....	265	GLUMETZA TAB 500MG .....	87
GLOBAL PREP PAD PADS .....	277	GLUTARALDEHY SOL 25% .....	147
GLOPERBA SOL 0.6/5ML .....	246	GLUTAREX-1 POW .....	216
GLUCAGEN INJ HYPOKIT .....	88	GLUTAREX-2 POW .....	216
<i>glucagon (rdna) for inj kit 1 mg</i> .....	88	<i>glyburide-metformin tab 1.25-250 mg</i> .....	85
GLUCAGON EMR SOL 1MG .....	88	<i>glyburide-metformin tab 2.5-500 mg</i> .....	85
GLUCAGON KIT 1MG .....	88	<i>glyburide-metformin tab 5-500 mg</i> .....	85
GLUC CONTROL LIQ NORMAL .....	265	<i>glyburide micronized tab 1.5 mg</i> .....	93
GLUC CONTROL SOL .....	265	<i>glyburide micronized tab 3 mg</i> .....	94
GLUC CONTROL SOL MID .....	265	<i>glyburide micronized tab 6 mg</i> .....	94
GLUC CONTROL SOL NORMAL .....	265	<i>glyburide tab 1.25 mg</i> .....	94
GLUCERNA 1.0 LIQ CARB VAN .....	216	<i>glyburide tab 2.5 mg</i> .....	94
GLUCERNA LIQ 1.2 CAL .....	216	<i>glyburide tab 5 mg</i> .....	94
GLUCERNA SEL LIQ VANILLA .....	216	GLYCATE TAB 1.5MG .....	323
GLUCOCARD 01 LIQ NORM/HGH .....	265	GLYCOPYRROLA TAB 1.5MG .....	323
GLUCOCARD 01 SOL NORMAL .....	265	<i>glycopyrrolate inj pf soln prefilled syringe</i>	
GLUCOCARD 01 TES PLUS .....	210	<i>0.2 mg/ml</i> .....	324
GLUCOCARD 01 TES SENSOR .....	210	<i>glycopyrrolate inj pf soln pref syr 0.4</i>	
GLUCOCARD LIQ LEVEL 1 .....	265	<i>mg/2ml (0.2 mg/ml)</i> .....	323
GLUCOCARD SOL NORMAL .....	265	<i>glycopyrrolate oral soln 1 mg/5ml</i> .....	324
GLUCOCARD SOL SHINE .....	265	<i>glycopyrrolate tab 1 mg</i> .....	324
GLUCOCARD TES EXPRESSI .....	210	<i>glycopyrrolate tab 2 mg</i> .....	324
GLUCOCARD TES SHINE .....	210	GLYNASE TAB 1.5MG .....	94
GLUCOCARD TES VITAL .....	210	GLYNASE TAB 3MG .....	94
GLUCOCARD TES X-SENSOR .....	211	GLYNASE TAB 6MG .....	94
GLUCOCOM MIS 28G .....	265	GLYTACTIN PAK BTMK/DLT .....	216
GLUCOCOM MIS 30G .....	265	GLYTACTIN POW BETMLK15 .....	216
GLUCOCOM MIS 33G .....	265	GLYTACTIN POW RST LT10 .....	216
GLUCOCOM TES .....	211	GLYTROL LIQ PREBIO1 .....	216
GLUCOCOM TES HIGH CON .....	265	GLYXAMBI TAB 10-5 MG .....	85
GLUCOCOM TES NORM CON .....	265	GLYXAMBI TAB 25-5 MG .....	85
GLUCONAVII TES STRIPS .....	211	GNP ALCOHOL PAD SWABS .....	277
GLUCO PERFEC TES 3 .....	210	GNP LANCETS MIS 21G .....	265
GLUCOSE CONT LIQ HIGH/LOW .....	265	GNP LANCETS MIS THIN .....	265
GLUCOSE CONT SOL HIGH .....	265	GNP LANCETS MIS THIN 26G .....	265
GLUCOSE CONT SOL NORMAL .....	265	GOCOVRI CAP 137MG .....	136
GLUCOSE CONT SOL PRECISIO .....	265	GOCOVRI CAP 68.5MG .....	136
GLUCOSE TES STRIPS .....	211	GOJJI BLOOD TES GLUCOSE .....	211
GLUCOTROL TAB 10MG .....	93	GOJJI BLOOD TES KETONE .....	211
GLUCOTROL XL TAB 10MG .....	93	GOJJI CNTRL SOL NORMAL .....	265
GLUCOTROL XL TAB 2.5MG .....	93	GOJJI LANCET MIS 30G .....	265

GOJJI MIS LANC DEV .....	266	GUARDIAN 4 MIS SENSOR.....	266
GOJJI STRIPS MIS W/LANCET .....	211	GUARDIAN MIS SENSOR 3.....	266
GOLYTELY SOL .....	255	GVOKE HYPO 1 INJ .5/.1ML.....	88
GONAL-F INJ 1050UNIT .....	228	GVOKE HYPO 1 INJ 1MG/.2ML.....	88
GONAL-F INJ 450UNIT .....	228	GVOKE HYPO 2 INJ .5/.1ML .....	88
GONAL-F RFF INJ 300/0.5.....	228	GVOKE HYPO 2 INJ 1MG/.2ML.....	88
GONAL-F RFF INJ 450/0.75 .....	228	GVOKE KIT SOL 1MG/0.2M .....	88
GONAL-F RFF INJ 75UNIT .....	228	GVOKE PFS INJ .....	88
GONAL-F RFF INJ 900/1.5 .....	228	GYNAZOLE-1 CRE 2% .....	330
GONITRO POW 400MCG .....	54	GYNOL II GEL 3%.....	329
GOODSENSE MIS LANC 26G .....	266	<b>H</b>	
GOODSENSE MIS LANC 30G.....	266	HADLIMA INJ 40/0.4ML .....	17
GOODSENSE MIS LANC 33G .....	266	HADLIMA INJ 40/0.8ML .....	17
GOODSENSE MIS LANC DVC .....	266	HADLIMA PUSH INJ 40/0.4ML .....	17
GOPRELTO SOL 40MG/ML.....	294	HADLIMA PUSH INJ 40/0.8ML .....	17
GORDOFILM SOL.....	202	HAEGARDA INJ 2000UNIT .....	247
GRALISE TAB 300MG .....	313	HAEGARDA INJ 3000UNIT .....	247
GRALISE TAB 450MG .....	313	HAEMOLANCE MIS HIGH FLO.....	266
GRALISE TAB 600MG .....	313	HAEMOLANCE MIS LOW FLOW .....	266
GRALISE TAB 750MG .....	313	HAEMOLANCE MIS PLUS.....	266
GRALISE TAB 900MG .....	314	HAEMOLANCE MIS PLUS LOW .....	266
<i>granisetron hcl tab 1 mg</i> .....	96	HAEMOLANCE MIS PLUS MAX .....	266
GRANIX INJ 300/0.5.....	250	HAEMOLANCE MIS PLUS PED .....	266
GRANIX INJ 480/0.8.....	250	HAEMOLANCE MIS RETRACT .....	266
GRASTEK SUB 2800BAU .....	14	<i>halcinonide cream 0.1%</i> .....	198
<i>griseofulvin microsize susp 125 mg/5ml</i> ...97		HALCION TAB 0.25MG .....	253
<i>griseofulvin microsize tab 500 mg</i> .....	97	HALDOL DECAN INJ 100MG/ML.....	142
<i>griseofulvin ultramicrosize tab 125 mg</i> .....97		HALDOL DECAN INJ 50MG/ML .....	142
<i>griseofulvin ultramicrosize tab 250 mg</i> .....97		HALDOL INJ 5MG/ML .....	142
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>		HALOBETASOL AER 0.05%.....	198
.....	181	<i>halobetasol propionate cream 0.05%</i> ....	198
<i>guaifenesin-codeine soln 100-10 mg/5ml</i> 181		<i>halobetasol propionate oint 0.05%</i> .....	198
<i>guanfacine hcl tab 1 mg</i> .....	108	HALOG CRE 0.1% .....	198
<i>guanfacine hcl tab 2 mg</i> .....	108	HALOG OIN 0.1%.....	198
<i>guanfacine hcl tab er 24hr 1 mg (base</i>		HALOG SOL 0.1% .....	198
<i>equiv)</i> .....	7	<i>haloperidol decanoate im soln 100 mg/ml</i>	
<i>guanfacine hcl tab er 24hr 2 mg (base</i>		.....	142
<i>equiv)</i> .....	7	<i>haloperidol decanoate im soln 50 mg/ml</i>	
<i>guanfacine hcl tab er 24hr 3 mg (base</i>		.....	142
<i>equiv)</i> .....	7	<i>haloperidol lactate inj 5 mg/ml</i> .....	142
<i>guanfacine hcl tab er 24hr 4 mg (base</i>		<i>haloperidol lactate oral conc 2 mg/ml</i> ....	142
<i>equiv)</i> .....	7	<i>haloperidol tab 0.5 mg</i> .....	142
GUANIDINE TAB 125MG.....	116	<i>haloperidol tab 10 mg</i> .....	142

<i>haloperidol tab 1 mg</i> .....	142	HOLD CHAMBER MIS SMALL .....	278
<i>haloperidol tab 20 mg</i> .....	142	HOM 2 POW .....	217
<i>haloperidol tab 2 mg</i> .....	142	HOMACTIN AA LIQ PLUS .....	217
<i>haloperidol tab 5 mg</i> .....	142	HOMINEX-1 POW .....	217
HARMONY TES BLD GLUC .....	211	HOMINEX-2 POW .....	217
HARVONI PAK .....	156	HORIZANT TAB 300MG ER .....	314
HARVONI PAK 45-200MG .....	156	HORIZANT TAB 600MG ER .....	314
HARVONI TAB 45-200MG .....	156	HULIO INJ 40/0.8ML .....	17
HARVONI TAB 90-400MG .....	156	HULIO KIT 20/0.4ML .....	17
HC LANCING MIS DEVICE .....	266	HUMALOG INJ 100/ML .....	91
HCU ANAMIX POW ERLY YRS .....	216	HUMALOG JR INJ 100/ML .....	91
HCU EXP20 PAK UNFLAVOR .....	216	HUMALOG KWIK INJ 100/ML .....	91
HCU EXPRESS PAK .....	217	HUMALOG KWIK INJ 200/ML .....	91
HCY 2 POW .....	217	HUMALOG MIX INJ 50/50 .....	91
HELIDAC MIS THERAPY .....	327	HUMALOG MIX INJ 50/50KWP .....	91
HEMADY TAB 20MG .....	179	HUMALOG MIX INJ 75/25KWP .....	91
HEMANGEOL SOL 4.28/ML .....	161	HUMALOG MIX SUS 75/25 .....	91
HEMLIBRA INJ 105/0.7 .....	246	HUMATROPE INJ 12MG .....	229
HEMLIBRA INJ 150/ML .....	246	HUMATROPE INJ 24MG .....	230
HEMLIBRA INJ 30MG/ML .....	246	HUMATROPE INJ 5MG .....	229
HEMLIBRA INJ 60/0.4 .....	246	HUMATROPE INJ 6MG .....	229
HEPARIN SOD INJ 5000/0.5 .....	67	HUMIRA INJ 10/0.1ML .....	17
HEPARIN SOD INJ 5000/ML .....	67	HUMIRA INJ 20/0.2ML .....	18
<i>heparin sodium (porcine) inj 10000 unit/ml</i> .....	67	HUMIRA INJ 40/0.4ML .....	18
<i>heparin sodium (porcine) inj 1000 unit/ml</i> 67		HUMIRA KIT 40MG/0.8 .....	18
<i>heparin sodium (porcine) inj 20000 unit/ml</i> .....	68	HUMIRA PEDIA INJ CROHNS .....	18, 19
<i>heparin sodium (porcine) inj 5000 unit/ml</i> .....	67	HUMIRA PEN INJ 40/0.4ML .....	19
<i>heparin sodium (porcine) pf inj 5000</i> <i>unit/0.5ml</i> .....	68	HUMIRA PEN INJ 40MG/0.8 .....	19
HEPSERA TAB 10MG .....	156	HUMIRA PEN INJ 80/0.8ML .....	19
HETLIOZ CAP 20MG .....	254	HUMIRA PEN INJ CD/UC/HS .....	20
HETLIOZ LQ SUS 4MG/ML .....	254	HUMIRA PEN INJ PS/UV .....	20
HIPREX TAB 1GM .....	53	HUMIRA PEN KIT CD/UC/HS .....	20
HIXDEFRIMA SOL 8-1-1% .....	186	HUMIRA PEN KIT PED UC .....	20
HLTHY ACCNTS MIS LANC 30G .....	266	HUMIRA PEN KIT PS/UV .....	21
HM INSULIN S MIS 0.3/31G .....	277	HUMULIN INJ 70/30 .....	91
HM INSULIN S MIS 1ML/30G .....	277	HUMULIN INJ 70/30KWP .....	91
HM STERILE PAD ALCHOL .....	277	HUMULIN N INJ U-100 .....	91
HOLD CHAMBER MIS ADLT LG .....	278	HUMULIN N INJ U-100KWP .....	91
HOLD CHAMBER MIS MEDIUM .....	278	HUMULIN R INJ U-100 .....	91
		HUMULIN R INJ U-500 .....	91
		HW EMBRACE TES PRO .....	211
		HW EMBRACE TES STRIPS .....	211
		HYCAMTIN CAP 0.25MG .....	134

HYCAMTIN CAP 1MG.....	134	<i>hydrocodone bitartrate tab er 24hr deter</i>	
HYCODAN SYP 5-1.5/5 .....	181	120 mg .....	38
<i>hydralazine hcl tab 100 mg .....</i>	115	<i>hydrocodone bitartrate tab er 24hr deter 20</i>	
<i>hydralazine hcl tab 10 mg .....</i>	115	mg.....	37
<i>hydralazine hcl tab 25 mg .....</i>	115	<i>hydrocodone bitartrate tab er 24hr deter 30</i>	
<i>hydralazine hcl tab 50 mg .....</i>	115	mg.....	37
HYDREA CAP 500MG.....	134	<i>hydrocodone bitartrate tab er 24hr deter 40</i>	
<i>hydrochlorothiazide cap 12.5 mg .....</i>	225	mg.....	37
<i>hydrochlorothiazide tab 12.5 mg.....</i>	225	<i>hydrocodone bitartrate tab er 24hr deter 60</i>	
<i>hydrochlorothiazide tab 25 mg .....</i>	225	mg.....	37
<i>hydrochlorothiazide tab 50 mg .....</i>	225	<i>hydrocodone bitartrate tab er 24hr deter 80</i>	
<i>hydrocodone-acetaminophen soln 10-325</i>		mg.....	37
<i>mg/15ml .....</i>	45	<i>hydrocodone-ibuprofen tab 10-200 mg ...</i>	46
<i>hydrocodone-acetaminophen soln 7.5-325</i>		<i>hydrocodone-ibuprofen tab 5-200 mg.....</i>	46
<i>mg/15ml .....</i>	45	<i>hydrocodone-ibuprofen tab 7.5-200 mg..</i>	46
<i>hydrocodone-acetaminophen tab 10-300</i>		<i>hydrocod polst-chlorphen polst er susp 10-</i>	
<i>mg .....</i>	46	8 mg/5ml .....	181
<i>hydrocodone-acetaminophen tab 10-325</i>		<i>hydrocortisone acetate suppos 25 mg .....</i>	50
<i>mg .....</i>	46	<i>hydrocortisone acetate w/ pramoxine</i>	
<i>hydrocodone-acetaminophen tab 5-300</i>		<i>perianal cream 1-1% .....</i>	50
<i>mg .....</i>	45	<i>hydrocortisone butyrate cream 0.1% .....</i>	198
<i>hydrocodone-acetaminophen tab 5-325</i>		<i>hydrocortisone butyrate hydrophilic lipo</i>	
<i>mg .....</i>	45	<i>base cream 0.1% .....</i>	198
<i>hydrocodone-acetaminophen tab 7.5-300</i>		<i>hydrocortisone butyrate lotion 0.1%.....</i>	198
<i>mg .....</i>	46	<i>hydrocortisone butyrate oint 0.1%.....</i>	198
<i>hydrocodone-acetaminophen tab 7.5-325</i>		<i>hydrocortisone butyrate soln 0.1% .....</i>	198
<i>mg .....</i>	46	<i>hydrocortisone cream 2.5% .....</i>	198
<i>hydrocodone bitart-homatropine</i>		<i>hydrocortisone enema 100 mg/60ml .....</i>	50
<i>methylbromide tab 5-1.5 mg.....</i>	181	<i>hydrocortisone lotion 2.5% .....</i>	198
<i>hydrocodone bitart-homatropine</i>		<i>hydrocortisone oint 2.5% .....</i>	198
<i>methylbrom soln 5-1.5 mg/5ml .....</i>	181	<i>hydrocortisone perianal cream 1%.....</i>	50
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	37	<i>hydrocortisone perianal cream 2.5%.....</i>	50
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	37	<i>hydrocortisone tab 10 mg.....</i>	179
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>		<i>hydrocortisone tab 20 mg .....</i>	179
.....	37	<i>hydrocortisone tab 5 mg .....</i>	179
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>		<i>hydrocortisone valerate cream 0.2% .....</i>	198
.....	37	<i>hydrocortisone valerate oint 0.2%.....</i>	199
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>		<i>hydrocortisone w/ acetic acid otic soln 1-</i>	
.....	37	2%.....	304
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>		HYDROCORTISO PAK 2%.....	198
.....	37	HYDROCORT KIT 2%.....	198
<i>hydrocodone bitartrate tab er 24hr deter</i>		<i>hydrogen peroxide soln 30%.....</i>	147
100 mg .....	38	<i>hydromorphone hcl liqd 1 mg/ml.....</i>	38

<i>hydromorphone hcl tab 2 mg</i> .....	38	HYSINGLA ER TAB 80 MG.....	38
<i>hydromorphone hcl tab 4 mg</i> .....	38	HYZAAR TAB 100-12.5.....	111
<i>hydromorphone hcl tab 8 mg</i> .....	38	HYZAAR TAB 100-25.....	111
<i>hydromorphone hcl tab er 24hr 12 mg</i> .....	38	HYZAAR TAB 50-12.5.....	111
<i>hydromorphone hcl tab er 24hr 16 mg</i> .....	38	<b>I</b>	
<i>hydromorphone hcl tab er 24hr 32 mg</i> .....	38	<i>ibandronate sodium tab 150 mg (base</i>	
<i>hydromorphone hcl tab er 24hr 8 mg</i> .....	38	<i>equivalent)</i> .....	226
HYDROMORPHON SUP 3MG.....	38	IBRANCE CAP 100MG.....	126
<i>hydroxychloroquine sulfate tab 200 mg</i> ..	115	IBRANCE CAP 125MG.....	126
HYDROXYM GEL 2%.....	199	IBRANCE CAP 75MG.....	126
<i>hydroxyurea cap 500 mg</i> .....	134	IBRANCE TAB 100MG.....	126
<i>hydroxyzine hcl syrup 10 mg/5ml</i> .....	55	IBRANCE TAB 125MG.....	126
<i>hydroxyzine hcl tab 10 mg</i> .....	55	IBRANCE TAB 75MG.....	126
<i>hydroxyzine hcl tab 25 mg</i> .....	55	<i>ibuprofen tab 400 mg</i> .....	28
<i>hydroxyzine hcl tab 50 mg</i> .....	55	<i>ibuprofen tab 600 mg</i> .....	29
<i>hydroxyzine pamoate cap 100 mg</i> .....	55	<i>ibuprofen tab 800 mg</i> .....	29
<i>hydroxyzine pamoate cap 25 mg</i> .....	55	<i>icatibant acetate subcutaneous soln pref</i>	
<i>hydroxyzine pamoate cap 50 mg</i> .....	55	<i>syr 30 mg/3ml</i> .....	247
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>		ICLUSIG TAB 10MG.....	127
.....	324	ICLUSIG TAB 15MG.....	127
<i>hyoscyamine sulfate sl tab 0.125 mg</i> .....	324	ICLUSIG TAB 30MG.....	127
<i>hyoscyamine sulfate soln 0.125 mg/ml</i> ..	324	ICLUSIG TAB 45MG.....	127
<i>hyoscyamine sulfate tab 0.125 mg</i> .....	324	<i>icosapent ethyl cap 0.5 gm</i> .....	100
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	324	<i>icosapent ethyl cap 1 gm</i> .....	100
<i>hyoscyamine sulfate tab er 12hr 0.375 mg</i>		IDACIO CROHN INJ DISEASE.....	22
.....	324	IDACIO INJ 40/0.8ML.....	22
HYPERSAL NEB 3.5%.....	181	IDACIO PLAQU INJ PSORIASI.....	22
HYPERSAL NEB 7%.....	182	IDAOXIA GEL 1-4%.....	203
HYPOLANCE KIT LANCING.....	266	IDHIFA TAB 100MG.....	127
HYRIMOZ.....	21	IDHIFA TAB 50MG.....	127
HYRIMOZ INJ 10/0.1ML.....	21	IGALMI MIS 120MCG.....	253
HYRIMOZ INJ 20/0.2ML.....	21	IGALMI MIS 180MCG.....	253
HYRIMOZ INJ 40/0.4ML.....	21	IGLUCOSE TES.....	211
HYRIMOZ INJ 40/0.8ML.....	21	IHEEZO GEL 3%.....	300
HYRIMOZ INJ 80/0.8ML.....	21	ILEVRO DRO 0.3% OP.....	303
HYRIMOZ-PED INJ CROHNS.....	21	<i>imatinib mesylate tab 100 mg (base</i>	
HYRIMOZ-PLAQ INJ PSORIASI.....	22	<i>equivalent)</i> .....	127
HYSINGLA ER TAB 100 MG.....	38	<i>imatinib mesylate tab 400 mg (base</i>	
HYSINGLA ER TAB 120 MG.....	38	<i>equivalent)</i> .....	127
HYSINGLA ER TAB 20 MG.....	38	IMBRUVICA CAP 140MG.....	127
HYSINGLA ER TAB 30 MG.....	38	IMBRUVICA CAP 70MG.....	127
HYSINGLA ER TAB 40 MG.....	38	IMBRUVICA SUS 70MG/ML.....	127
HYSINGLA ER TAB 60 MG.....	38	IMBRUVICA TAB 140MG.....	127

IMBRUVICA TAB 280MG .....127  
 IMBRUVICA TAB 420MG .....127  
 IMBRUVICA TAB 560MG .....127  
 imipramine hcl tab 10 mg .....84  
 imipramine hcl tab 25 mg .....84  
 imipramine hcl tab 50 mg .....84  
 imipramine pamoate cap 100 mg .....84  
 imipramine pamoate cap 125 mg .....84  
 imipramine pamoate cap 150 mg .....84  
 imipramine pamoate cap 75 mg .....84  
 imiquimod cream 3.75% .....201  
 imiquimod cream 5% .....201  
 IMITREX INJ 4MG/0.5 .....281  
 IMITREX INJ 6MG/0.5 .....281  
 IMITREX SPR 20MG/ACT .....281  
 IMITREX SPR 5MG/ACT .....281  
 IMITREX TAB 100MG .....281  
 IMITREX TAB 25MG .....281  
 IMITREX TAB 50MG .....281  
 IMPAVIDO CAP 50MG .....51  
 IMPEKLO LOT 0.05%.....199  
 IMPOYZ CRE 0.025%.....199  
 IMURAN TAB 50MG .....285  
 IMVEXXY MAIN SUP 10MCG.....330  
 IMVEXXY MAIN SUP 4MCG .....330  
 IMVEXXY STRT SUP 10MCG .....330  
 IMVEXXY STRT SUP 4MCG.....330  
 INBRIJA CAP 42MG .....136  
 INCONTROL MIS LANC 28G .....266  
 INCONTROL MIS LANC 30G .....266  
 INCONTROL MIS LANC 33G .....266  
 INCONTROL MIS LANC DEV .....266  
 INCONTROL PAD ALCOHOL .....277  
 INCRELEX INJ 40MG/4ML.....230  
 INCRUSE ELPT INH 62.5MCG .....58  
 indapamide tab 1.25 mg .....225  
 indapamide tab 2.5 mg .....225  
 INDERAL LA CAP 120MG .....161  
 INDERAL LA CAP 160MG .....161  
 INDERAL LA CAP 60MG.....161  
 INDERAL LA CAP 80MG.....161  
 INDERAL XL CAP 120MG .....161  
 INDERAL XL CAP 80MG.....161

INDOCIN SUS 25MG/5ML .....29  
 indomethacin cap 20 mg .....29  
 indomethacin cap 25 mg .....29  
 indomethacin cap 50 mg .....29  
 indomethacin cap er 75 mg .....29  
 indomethacin suppos 50 mg .....29  
 INFINITY SOL NORM CON .....266  
 INFINITY TES BLD GLUC .....211  
 INFINITY TES VOICE .....211  
 INFNTY VOICE LIQ LEVEL 2 .....266  
 INGREGZA CAP 40-80MG.....310  
 INGREGZA CAP 40MG .....310  
 INGREGZA CAP 60MG .....310  
 INGREGZA CAP 80MG .....310  
 INLYTA TAB 1MG.....118  
 INLYTA TAB 5MG .....118  
 INNOPRAN XL CAP 120MG .....161  
 INNOPRAN XL CAP 80MG.....161  
 INPEFA TAB 200MG .....167  
 INPEN 100EL MIS BLUE-HUM .....277  
 INQOVI TAB 35-100MG .....123  
 INREBIC CAP 100MG .....127  
 INS ASP PROT INJ FLEXPEN .....91  
 INSPIRACHAMB MIS LARGE.....278  
 INSPIRACHAMB MIS MEDIUM .....278  
 INSPIRACHAMB MIS MOUTHPE .....279  
 INSPIRACHAMB MIS SMALL .....279  
 INSPIREASE MIS DD SYST .....279  
 INSPIREASE MIS RES BAG .....279  
 INSPRA TAB 25MG .....114  
 INSPRA TAB 50MG .....115  
 INSULIN ASPA INJ 100/ML .....91  
 INSULIN ASPA INJ 70/30 .....91  
 INSULIN ASPA INJ FLEXPEN .....91  
 INSULIN ASPA INJ PENFILL.....91  
 INSULIN LISP INJ 100/ML .....91  
 INSULIN LISP INJ JUNIOR.....91  
 INSULIN LISP INJ PROTAMIN.....91  
 INSULIN SRYG MIS 1ML/32G .....278  
 INTELENCE TAB 100MG.....150  
 INTELENCE TAB 200MG .....150  
 INTELENCE TAB 25MG .....150  
 IN TOUCH LAN MIS 30G.....266

IN TOUCH LAN MIS DEVICE.....	266	<i>ipratropium bromide inhal soln 0.02%</i> .....	58
IN TOUCH SOL GLUCOSE .....	266	<i>ipratropium bromide nasal soln 0.03% (21</i>	
IN TOUCH TES BLOOD .....	211	<i>mcg/spray)</i> .....	295
INTRAROSA SUP 6.5MG.....	329	<i>ipratropium bromide nasal soln 0.06% (42</i>	
INTRON A INJ 10MU .....	134	<i>mcg/spray)</i> .....	295
INTRON A INJ 18MU.....	134	<i>irbesartan-hydrochlorothiazide tab 150-12.5</i>	
INTRON A INJ 25MU.....	134	<i>mg</i> .....	111
INTRON A INJ 50MU.....	134	<i>irbesartan-hydrochlorothiazide tab 300-</i>	
INTUNIV TAB 1MG.....	7	<i>12.5 mg</i> .....	111
INTUNIV TAB 2MG .....	7	<i>irbesartan tab 150 mg</i> .....	107
INTUNIV TAB 3MG .....	7	<i>irbesartan tab 300 mg</i> .....	107
INTUNIV TAB 4MG .....	7	<i>irbesartan tab 75 mg</i> .....	107
INVEGA SUST INJ 117/0.75.....	140	IRESSA TAB 250MG.....	120
INVEGA SUST INJ 156MG/ML.....	140	ISENTRESS CHW 100MG .....	150
INVEGA SUST INJ 234/1.5 .....	140	ISENTRESS CHW 25MG .....	150
INVEGA SUST INJ 39/0.25 .....	140	ISENTRESS HD TAB 600MG.....	150
INVEGA SUST INJ 78/0.5ML .....	140	ISENTRESS POW 100MG .....	150
INVEGA TAB 1.5MG.....	140	ISENTRESS TAB 400MG .....	150
INVEGA TAB 3MG .....	140	<i>isoniazid syrup 50 mg/5ml</i> .....	116
INVEGA TAB 6MG .....	140	<i>isoniazid tab 100 mg</i> .....	116
INVEGA TAB 9MG .....	140	<i>isoniazid tab 300 mg</i> .....	116
INVEGA TRINZ INJ 273MG .....	140	ISOPTO ATROP SOL 1% OP .....	298
INVEGA TRINZ INJ 410MG.....	140	ISOPTO CARP SOL 1% OP.....	298
INVEGA TRINZ INJ 546MG .....	140	ISOPTO CARP SOL 2% OP .....	298
INVEGA TRINZ INJ 819MG.....	140	ISOPTO CARP SOL 4% OP .....	298
INVELTYS SUS 1% .....	301	ISORDIL TAB 40MG.....	54
INVIRASE TAB 500MG .....	150	ISORDIL TAB 5MG .....	54
INVOKAMET TAB 150-1000 .....	86	<i>isosorbide dinitrate tab 10 mg</i> .....	54
INVOKAMET TAB 150-500 .....	86	<i>isosorbide dinitrate tab 20 mg</i> .....	54
INVOKAMET TAB 50-1000 .....	86	<i>isosorbide dinitrate tab 30 mg</i> .....	54
INVOKAMET TAB 50-500MG .....	86	<i>isosorbide dinitrate tab 40 mg</i> .....	54
INVOKAMET XR TAB 150-1000 .....	86	<i>isosorbide dinitrate tab 5 mg</i> .....	54
INVOKAMET XR TAB 150-500 .....	86	<i>isosorbide mononitrate tab 10 mg</i> .....	54
INVOKAMET XR TAB 50-1000 .....	86	<i>isosorbide mononitrate tab 20 mg</i> .....	54
INVOKAMET XR TAB 50-500MG .....	86	<i>isosorbide mononitrate tab er 24hr 120 mg</i>	
INVOKANA TAB 100MG.....	93	.....	54
INVOKANA TAB 300MG .....	93	<i>isosorbide mononitrate tab er 24hr 30 mg</i>	
<i>iodoquinol-hc cream 1-1%</i> .....	186	.....	54
<i>iodoquinol-hydrocortisone in aloe vehicle</i>		<i>isosorbide mononitrate tab er 24hr 60 mg</i>	
<i>cream 1-1.9%</i> .....	186	.....	54
IOPIDINE SOL 1% OP.....	298	ISOSOURCE HN LIQ .....	217
<i>ipratropium-albuterol nebu soln 0.5-2.5(3)</i>		ISOSOURCE LIQ .....	217
<i>mg/3ml</i> .....	64	<i>isotretinoin cap 10 mg</i> .....	184



<i>isotretinoin cap 20 mg</i> .....	184	JATENZO CAP 158MG .....	49
<i>isotretinoin cap 30 mg</i> .....	184	JATENZO CAP 198MG .....	49
<i>isotretinoin cap 40 mg</i> .....	184	JATENZO CAP 237MG .....	49
ISOVACTIN AA LIQ PLUS .....	217	JAYPIRCA TAB 100MG .....	128
<i>isradipine cap 2.5 mg</i> .....	164	JAYPIRCA TAB 50MG .....	128
<i>isradipine cap 5 mg</i> .....	164	JENLIVA CAP .....	289
ISTALOL SOL 0.5% OP .....	297	JENTADUETO TAB 2.5-1000 .....	86
ISTURISA TAB 10MG .....	226	JENTADUETO TAB 2.5-500 .....	86
ISTURISA TAB 1MG .....	226	JENTADUETO TAB 2.5-850 .....	86
ISTURISA TAB 5MG .....	226	JENTADUETO TAB XR .....	86
<i>itraconazole cap 100 mg</i> .....	98	JEVITY 1.2 LIQ CAL .....	217
<i>itraconazole oral soln 10 mg/ml</i> .....	98	JEVITY 1.5 LIQ CAL .....	217
IVA ANAMIX POW ERLY YRS .....	217	JEVITY 1 CAL LIQ .....	217
I-VALEX-1 POW .....	217	JOENJA TAB 70MG .....	284
I-VALEX-2 POW .....	217	JORNAY PM CAP 100MG ER .....	11
IVA MAXAMUM POW .....	217	JORNAY PM CAP 20MG ER .....	11
<i>ivermectin lotion 0.5%</i> .....	204	JORNAY PM CAP 40MG ER .....	11
<i>ivermectin tab 3 mg</i> .....	51	JORNAY PM CAP 60MG ER .....	11
IYUZEH DRO 0.005% .....	303	JORNAY PM CAP 80MG ER .....	11
IZERVAY SOL 2/0.1ML .....	300	JUBLIA SOL 10% .....	186
<b>J</b>		JULUCA TAB 50-25MG .....	151
JADENU SPRKL GRA 180MG .....	95	JUXTAPID CAP 10MG .....	104
JADENU SPRKL GRA 360MG .....	95	JUXTAPID CAP 20MG .....	104
JADENU SPRKL GRA 90MG .....	95	JUXTAPID CAP 30MG .....	104
JADENU TAB 180MG .....	95	JUXTAPID CAP 5MG .....	104
JADENU TAB 360MG .....	95	JYNARQUE PAK 15MG .....	235
JADENU TAB 90MG .....	95	JYNARQUE PAK 30-15MG .....	235
JAKAFI TAB 10MG .....	127	JYNARQUE PAK 45-15MG .....	235
JAKAFI TAB 15MG .....	128	JYNARQUE PAK 60-30MG .....	235
JAKAFI TAB 20MG .....	128	JYNARQUE PAK 90-30MG .....	235
JAKAFI TAB 25MG .....	128	JYNARQUE TAB 15MG .....	235
JAKAFI TAB 5MG .....	127	JYNARQUE TAB 30MG .....	235
JALYN CAP .....	245	<b>K</b>	
JANUMET TAB 50-1000 .....	86	KALBITOR INJ 10MG/ML .....	247
JANUMET TAB 50-500MG .....	86	KALETRA SOL .....	151
JANUMET XR TAB 100-1000 .....	86	KALETRA TAB 100-25MG .....	151
JANUMET XR TAB 50-1000 .....	86	KALETRA TAB 200-50MG .....	151
JANUMET XR TAB 50-500MG .....	86	KALYDECO GRA 13.4MG .....	316
JANUVIA TAB 100MG .....	88	KALYDECO GRA 5.8MG .....	316
JANUVIA TAB 25MG .....	88	KALYDECO PAK 25MG .....	316
JANUVIA TAB 50MG .....	88	KALYDECO PAK 50MG .....	316
JARDIANCE TAB 10MG .....	93	KALYDECO PAK 75MG .....	316
JARDIANCE TAB 25MG .....	93	KALYDECO TAB 150MG .....	316

KAPSPARGO CAP 100MG.....	160	KEVZARA INJ 150/1.14.....	27
KAPSPARGO CAP 200MG.....	160	KEVZARA INJ 200/1.14.....	27
KAPSPARGO CAP 25MG .....	160	KINERET INJ .....	27
KAPSPARGO CAP 50MG .....	160	KINNEY MIS LANCETS.....	266
KAPVAY TAB 0.1 MG.....	7	KINNEY THIN MIS LANCETS.....	266
KARBINAL ER SUS 4MG/5ML.....	99	KISQALI 200 PAK FEMARA.....	123
KATERZIA SUS 1MG/ML.....	164	KISQALI 400 PAK FEMARA .....	124
KAZANO 12.5- TAB 1000MG .....	86	KISQALI 600 PAK FEMARA.....	124
KAZANO 12.5- TAB 500MG.....	86	KISQALI TAB 200DOSE .....	128
KEFLEX CAP 750MG.....	173	KISQALI TAB 400DOSE .....	128
KENALOG AER SPRAY.....	199	KISQALI TAB 600DOSE .....	128
KEPPRA SOL 100MG/ML.....	71	KITABIS PAK NEB 300/5ML .....	15
KEPPRA TAB 1000MG.....	71	KLARITY-A DRO 1%.....	299
KEPPRA TAB 250MG .....	71	KLARITY-L DRO 0.2%.....	301
KEPPRA TAB 500MG .....	71	KLARITY-L DRO 0.5%.....	301
KEPPRA TAB 750MG .....	71	KLARON LOT 10%.....	184
KEPPRA XR TAB 500MG .....	71	KLISYRI OIN 1%.....	188
KEPPRA XR TAB 750MG .....	71	KLONOPIN TAB 0.5MG.....	69
KERENDIA TAB 10MG .....	233	KLONOPIN TAB 1MG.....	69
KERENDIA TAB 20MG.....	233	KLONOPIN TAB 2MG .....	69
KERYDIN SOL 5%.....	186	KLOXXADO SPR 8MG .....	95
KESIMPTA INJ 20/.4ML.....	311	KOMBIGLYZ XR TAB 2.5-1000.....	86
<i>ketoconazole cream 2%</i> .....	186	KOMBIGLYZ XR TAB 5-1000MG .....	86
<i>ketoconazole foam 2%</i> .....	187	KOMBIGLYZ XR TAB 5-500MG .....	86
<i>ketoconazole shampoo 2%</i> .....	187	KONVOMEPEP SUS 2-84/ML .....	327
<i>ketoconazole tab 200 mg</i> .....	98	KORLYM TAB 300MG .....	88
KETO-DIASTIX TES .....	211	KOSELUGO CAP 10MG .....	128
KETONE TES .....	211	KOSELUGO CAP 25MG.....	128
KETONE TEST TES .....	211	KOSHR PRENAT TAB 30-1MG .....	289
KETONEX-1 POW.....	217	K-PHOS TAB NO 2.....	244
KETONEX-2 POW .....	217	KRAZATI TAB 200MG.....	128
<i>ketoprofen cap 25 mg</i> .....	29	KRINTAFEL TAB 150MG.....	115
<i>ketoprofen cap 50 mg</i> .....	29	KRISTALOSE PAK 10GM.....	255
<i>ketoprofen cap 75 mg</i> .....	29	KRISTALOSE PAK 20GM .....	255
<i>ketoprofen cap er 24hr 200 mg</i> .....	29	KROGER BLOOD TES GLUCOSE .....	211
<i>ketorolac tromethamine ophth soln 0.4%</i> .....	303	KROGER LANCE MIS.....	266
<i>ketorolac tromethamine ophth soln 0.5%</i> .....	303	KROGER LANCE MIS 26G.....	266
<i>ketorolac tromethamine tab 10 mg</i> .....	29	KROGER LANCE MIS THIN.....	266
KETOR TROMET SPR 15.75MG.....	29	KROGER LANCE MIS THIN 30G .....	266
KETOSTIX TES STRIP.....	211	KROGER TES.....	211
KEVEYIS TAB 50MG .....	224	K-TAB TAB 10MEQ CR .....	283
		K-TAB TAB 20MEQ.....	283
		K-TAB TAB 8MEQ CR.....	283

KUVAN POW 100MG.....	231	LAMICTAL XR TAB 300MG .....	72
KUVAN POW 500MG.....	231	LAMICTAL XR TAB 50MG .....	71
KUVAN TAB 100MG .....	231	<i>lamivudine oral soln 10 mg/ml</i> .....	151
KYNMOBI MIS 10MG.....	136	<i>lamivudine tab 100 mg (hbv)</i> .....	157
KYNMOBI MIS 15MG.....	136	<i>lamivudine tab 150 mg</i> .....	151
KYNMOBI MIS 20MG .....	136	<i>lamivudine tab 300 mg</i> .....	151
KYNMOBI MIS 25MG .....	136	<i>lamivudine-zidovudine tab 150-300 mg</i> ..	151
KYNMOBI MIS 30MG.....	136	<i>lamotrigine orally disintegrating tab 100 mg</i> .....	72
<b>L</b>		<i>lamotrigine orally disintegrating tab 200 mg</i> .....	72
<i>labetalol hcl tab 100 mg</i> .....	159	<i>lamotrigine orally disintegrating tab 25 mg</i> .....	72
<i>labetalol hcl tab 200 mg</i> .....	159	<i>lamotrigine orally disintegrating tab 50 mg</i> .....	72
<i>labetalol hcl tab 300 mg</i> .....	159	<i>lamotrigine tab 100 mg</i> .....	72
<i>lacosamide oral solution 10 mg/ml</i> .....	71	<i>lamotrigine tab 150 mg</i> .....	72
<i>lacosamide tab 100 mg</i> .....	71	<i>lamotrigine tab 200 mg</i> .....	72
<i>lacosamide tab 150 mg</i> .....	71	<i>lamotrigine tab 25 mg</i> .....	72
<i>lacosamide tab 200 mg</i> .....	71	<i>lamotrigine tab 25 mg (42) &amp; 100 mg (7)</i> <i>starter kit</i> .....	72
<i>lacosamide tab 50 mg</i> .....	71	<i>lamotrigine tab 35 x 25 mg starter kit</i> .....	72
LACRISERT MIS 5MG OP.....	296	<i>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg</i> <i>starter kit</i> .....	72
LACTIC ACID LOT 10%.....	201	<i>lamotrigine tab chewable dispersible 25 mg</i> .....	72
<i>lactulose (encephalopathy) solution 10</i> <i>gm/15ml</i> .....	242	<i>lamotrigine tab chewable dispersible 5 mg</i> .....	72
LACTULOSE PAK 10GM.....	255	<i>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp;</i> <i>100 mg (7) kit</i> .....	72
<i>lactulose solution 10 gm/15ml</i> .....	255	<i>lamotrigine tab er 24hr 100 mg</i> .....	72
LAGEVRIO CAP 200MG.....	158	<i>lamotrigine tab er 24hr 200 mg</i> .....	72
LAMICTAL CHW 25MG.....	71	<i>lamotrigine tab er 24hr 250 mg</i> .....	72
LAMICTAL CHW 5MG.....	71	<i>lamotrigine tab er 24hr 25 mg</i> .....	72
LAMICTAL KIT START 35 .....	71	<i>lamotrigine tab er 24hr 300 mg</i> .....	72
LAMICTAL KIT START 49 .....	71	<i>lamotrigine tab er 24hr 50 mg</i> .....	72
LAMICTAL KIT START 98 .....	71	LAMPIT TAB 120MG .....	52
LAMICTAL ODT KIT.....	71	LAMPIT TAB 30MG.....	52
LAMICTAL ODT TAB 100MG.....	71	LANAFLEX PAK.....	218
LAMICTAL ODT TAB 200MG .....	71	LANCET AUTO MIS INJECTOR.....	266
LAMICTAL ODT TAB 25MG.....	71	LANCET CARRY MIS CASE .....	266
LAMICTAL ODT TAB 50MG .....	71	LANCET DEVIC MIS 30G .....	266
LAMICTAL TAB 100MG.....	71	LANCET DEVIC MIS ADJUST .....	267
LAMICTAL TAB 150MG.....	71		
LAMICTAL TAB 200MG .....	71		
LAMICTAL TAB 25MG.....	71		
LAMICTAL XR KIT.....	71		
LAMICTAL XR TAB 100MG.....	71		
LAMICTAL XR TAB 200MG .....	71		
LAMICTAL XR TAB 250MG.....	72		
LAMICTAL XR TAB 25MG.....	71		

LANCET MICRO MIS THIN 33G .....	267	LANTUS SOLOS INJ 100/ML .....	91
LANCETS MICR MIS THIN 33G.....	267	LANZO MIS LANCING .....	267
LANCETS MIS.....	267	<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	
LANCETS MIS 21G .....	267	.....	128
LANCETS MIS 21G COLR .....	267	LASIX TAB 20MG .....	225
LANCETS MIS 28G.....	267	LASIX TAB 40MG.....	225
LANCETS MIS 30G .....	267	LASIX TAB 80MG.....	225
LANCETS MIS 33G.....	267	LASTACRAFT SOL 0.25% .....	303
LANCETS MIS ORANGE.....	267	<i>latanoprost ophth soln 0.005%</i> .....	303
LANCETS MIS ORIGINAL.....	267	LATUDA TAB 120MG.....	139
LANCETS MIS THIN .....	267	LATUDA TAB 20MG .....	139
LANCETS MIS THIN 26G.....	267	LATUDA TAB 40MG .....	139
LANCETS MIS THIN 30G .....	267	LATUDA TAB 60MG .....	139
LANCETS SUPR MIS THIN 28G.....	267	LATUDA TAB 80MG .....	139
LANCET STAND MIS 21G.....	267	LAZANDA SPR 100MCG .....	38
LANCETS THIN MIS.....	267	LAZANDA SPR 400MCG.....	38
LANCETS THIN MIS 26G.....	267	LB LANCET MIS 28G .....	267
LANCETS ULTR MIS THIN .....	267	LB LANCING MIS DEVICE.....	267
LANCET SUPER MIS THIN 30G.....	267	LEFLUNICLO PAK 20MG-1%.....	15
LANCET ULTRA MIS 28G.....	267	<i>leflunomide tab 10 mg</i> .....	31
LANCET ULTRA MIS THIN 30G.....	267	<i>leflunomide tab 20 mg</i> .....	31
LANCET WITH MIS EJECTOR .....	267	<i>lenalidomide cap 10 mg</i> .....	284
LANCING DEVI MIS .....	267	<i>lenalidomide cap 15 mg</i> .....	284
LANCING DEVI MIS 25G .....	267	<i>lenalidomide cap 25 mg</i> .....	284
LANCING DEVI MIS 30G .....	267	<i>lenalidomide cap 5 mg</i> .....	284
LANCING MIS DEVICE .....	267	LENVIMA CAP 10 MG .....	118
LANOXIN TAB 0.0625MG .....	165	LENVIMA CAP 12MG.....	119
LANOXIN TAB 0.125MG .....	165	LENVIMA CAP 14 MG.....	119
LANOXIN TAB 0.25MG.....	165	LENVIMA CAP 18 MG.....	119
<i>lansoprazole cap delayed release 15 mg</i>	325	LENVIMA CAP 20 MG.....	119
<i>lansoprazole cap delayed release 30 mg</i>	325	LENVIMA CAP 24 MG.....	119
.....	325	LENVIMA CAP 4MG .....	118
<i>lansoprazole tab delayed release orally</i>		LENVIMA CAP 8 MG .....	118
<i>disintegrating 15 mg</i> .....	325	LESCOL XL TAB 80MG .....	102
<i>lansoprazole tab delayed release orally</i>		LETAIRIS TAB 10MG.....	171
<i>disintegrating 30 mg</i> .....	325	LETAIRIS TAB 5MG .....	171
<i>lanthanum carbonate chew tab 1000 mg</i>		<i>letrozole tab 2.5 mg</i> .....	121
<i>(elemental)</i> .....	243	<i>leucovorin calcium tab 10 mg</i> .....	134
<i>lanthanum carbonate chew tab 500 mg</i>		<i>leucovorin calcium tab 15 mg</i> .....	134
<i>(elemental)</i> .....	243	<i>leucovorin calcium tab 25 mg</i> .....	134
<i>lanthanum carbonate chew tab 750 mg</i>		<i>leucovorin calcium tab 5 mg</i> .....	134
<i>(elemental)</i> .....	243	LEUKERAN TAB 2MG.....	117
LANTUS INJ 100/ML .....	91	LEUKINE INJ 250MCG .....	250

<i>leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)</i> .....	121	<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i> .....	175
LEUPROLIDE INJ 22.5MG .....	121	<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i> .....	175
<i>levabuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i> .....	64	<i>levonorgestrel tab 1.5 mg</i> .....	177
<i>levabuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i> .....	64	<i>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth est tab 0.01mg(7)</i> .....	175
<i>levabuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i> .....	64	<i>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth est tab 0.01mg(7)</i> .....	175
<i>levabuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i> .....	64	<i>levorphanol tartrate tab 2 mg</i> .....	38
<i>levabuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i> .....	64	<i>levorphanol tartrate tab 3 mg</i> .....	39
LEVBID TAB 0.375 ER .....	324	<i>levothyroxine sodium cap 100 mcg</i> .....	320
LEVEMIR INJ .....	91	<i>levothyroxine sodium cap 112 mcg</i> .....	320
LEVEMIR INJ FLEXPEN .....	91	<i>levothyroxine sodium cap 125 mcg</i> .....	320
LEVEMIR INJ FLEXTouc .....	91	<i>levothyroxine sodium cap 137 mcg</i> .....	320
<i>levetiracetam oral soln 100 mg/ml</i> .....	72	<i>levothyroxine sodium cap 13 mcg</i> .....	320
<i>levetiracetam tab 1000 mg</i> .....	72	<i>levothyroxine sodium cap 150 mcg</i> .....	320
<i>levetiracetam tab 250 mg</i> .....	72	<i>levothyroxine sodium cap 175 mcg</i> .....	320
<i>levetiracetam tab 500 mg</i> .....	72	<i>levothyroxine sodium cap 200 mcg</i> .....	320
<i>levetiracetam tab 750 mg</i> .....	72	<i>levothyroxine sodium cap 25 mcg</i> .....	320
<i>levetiracetam tab er 24hr 500 mg</i> .....	72	<i>levothyroxine sodium cap 50 mcg</i> .....	320
<i>levetiracetam tab er 24hr 750 mg</i> .....	72	<i>levothyroxine sodium cap 75 mcg</i> .....	320
LEVITRA TAB 10MG .....	168	<i>levothyroxine sodium cap 88 mcg</i> .....	320
LEVITRA TAB 20MG.....	168	<i>levothyroxine sodium tab 100 mcg</i> .....	321
<i>levobunolol hcl ophth soln 0.5%</i> .....	297	<i>levothyroxine sodium tab 112 mcg</i> .....	321
<i>levocarnitine oral soln 1 gm/10ml (10%)</i> ..	231	<i>levothyroxine sodium tab 125 mcg</i> .....	321
<i>levocarnitine tab 330 mg</i> .....	231	<i>levothyroxine sodium tab 137 mcg</i> .....	321
<i>levofloxacin ophth soln 0.5%</i> .....	299	<i>levothyroxine sodium tab 150 mcg</i> .....	321
<i>levofloxacin oral soln 25 mg/ml</i> .....	238	<i>levothyroxine sodium tab 175 mcg</i> .....	321
<i>levofloxacin tab 250 mg</i> .....	238	<i>levothyroxine sodium tab 200 mcg</i> .....	321
<i>levofloxacin tab 500 mg</i> .....	238	<i>levothyroxine sodium tab 25 mcg</i> .....	320
<i>levofloxacin tab 750 mg</i> .....	239	<i>levothyroxine sodium tab 300 mcg</i> .....	321
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &amp; eth est 0.01 mg</i> .....	175	<i>levothyroxine sodium tab 50 mcg</i> .....	320
<i>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</i> .....	175	<i>levothyroxine sodium tab 75 mcg</i> .....	321
<i>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-30 mcg</i> .....	175	<i>levothyroxine sodium tab 88 mcg</i> .....	321
<i>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</i> .....	175	LEVSIN/SL SUB 0.125MG .....	324
		LEVSIN TAB 0.125MG.....	324
		LEVULAN KERA SOL 20%.....	188
		LEXAPRO TAB 10MG.....	80
		LEXAPRO TAB 20MG .....	80
		LEXAPRO TAB 5MG .....	80
		LEXETTE AER 0.05% .....	199
		LEXIVA SUS 50MG/ML.....	151

LEXIVA TAB 700MG .....	151	<i>lisinopril &amp; hydrochlorothiazide tab 20-25</i>	
LIALDA TAB 1.2GM .....	241	<i>mg</i> .....	112
LIBERTY NEXT TES GEN .....	212	<i>lisinopril tab 10 mg</i> .....	105
LIBERTY TES .....	212	<i>lisinopril tab 2.5 mg</i> .....	105
LIBRAX CAP 5-2.5MG .....	324	<i>lisinopril tab 20 mg</i> .....	105
LICART DIS 1.3% .....	185	<i>lisinopril tab 30 mg</i> .....	105
LIDO/RAC/TET GEL .....	202	<i>lisinopril tab 40 mg</i> .....	105
LIDOCA/TETRA CRE 7/7% .....	202	<i>lisinopril tab 5 mg</i> .....	105
LIDOCAINE CRE TETRACAI .....	202	LITETOUCH MIS LANCETS .....	267
<i>lidocaine hcl laryngotracheal soln 4%</i> ....	287	LITE TOUCH MIS LANCETS .....	267
<i>lidocaine hcl soln 4%</i> .....	202	LITE TOUCH MIS LANC PEN .....	267
<i>lidocaine hcl urethral/mucosal gel 2%</i> ...	202	LITFULO CAP 50MG .....	201
<i>lidocaine hcl urethral/mucosal gel prefilled</i>		<i>lithium carbonate cap 150 mg</i> .....	139
<i>syringe 2%</i> .....	202	<i>lithium carbonate cap 300 mg</i> .....	139
<i>lidocaine hcl viscous soln 2%</i> .....	287	<i>lithium carbonate cap 600 mg</i> .....	139
<i>lidocaine oint 5%</i> .....	203	<i>lithium carbonate tab 300 mg</i> .....	139
<i>lidocaine patch 5%</i> .....	203	<i>lithium carbonate tab er 300 mg</i> .....	139
<i>lidocaine-prilocaine cream 2.5-2.5%</i> .....	203	<i>lithium carbonate tab er 450 mg</i> .....	139
LIDODERM DIS 5% .....	203	LITHIUM SOL 8MEQ/5ML .....	139
LIDOSOL-50 KIT 5% .....	203	LITHOBID TAB 300MG CR .....	139
LIFESCAN MIS UNISTIK2 .....	267	LITHOSTAT TAB 250MG .....	246
<i>lindane shampoo 1%</i> .....	204	LIVALO TAB 1MG .....	102
<i>linezolid for susp 100 mg/5ml</i> .....	53	LIVALO TAB 2MG .....	102
<i>linezolid tab 600 mg</i> .....	53	LIVALO TAB 4MG .....	102
LINZESS CAP 145MCG .....	242	LIVMARLI SOL 9.5MG/ML .....	240
LINZESS CAP 290MCG .....	243	LIVTENCITY TAB 200MG .....	155
LINZESS CAP 72MCG .....	242	LMD POW .....	218
<i>liothyronine sodium tab 25 mcg</i> .....	321	LOCOID LIPO CRE 0.1% .....	199
<i>liothyronine sodium tab 50 mcg</i> .....	321	LOCOID LOT 0.1% .....	199
<i>liothyronine sodium tab 5 mcg</i> .....	321	LODINE TAB 400MG .....	29
LIPISTART POW .....	218	LODOCO TAB 0.5MG .....	167
LIPITOR TAB 10MG .....	102	LODOSYN TAB 25MG .....	134
LIPITOR TAB 20MG .....	102	LOKELMA PAK 10GM .....	287
LIPITOR TAB 40MG .....	102	LOKELMA PAK 5GM .....	287
LIPITOR TAB 80MG .....	102	LO LOESTRIN TAB 1-10-10 .....	175
LIPOFEN CAP 150MG .....	101	LOMAIRA TAB 8MG .....	6
LIPOFEN CAP 50MG .....	101	LOMOTIL TAB 2.5MG .....	94
LIQREV SUS 10MG/ML .....	172	LONGS LANCET MIS STANDARD .....	267
LIQUID HOPE LIQ .....	218	LONGS LANCET MIS THIN .....	268
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5</i>		LONGS LANCET MIS ULTRA TH .....	268
<i>mg</i> .....	111	LONHALA MAGN SOL 25MCG .....	58
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5</i>		LONSURF TAB 15-6.14 .....	124
<i>mg</i> .....	112	LONSURF TAB 20-8.19 .....	124

LOPHLEX POW .....	218	LOTREL CAP 5-20MG.....	112
LOPID TAB 600MG .....	101	LOTRONEX TAB 0.5MG .....	243
<i>lopinavir-ritonavir soln 400-100 mg/5ml</i>		LOTRONEX TAB 1MG .....	243
<i>(80-20 mg/ml)</i> .....	151	<i>lovastatin tab 10 mg</i> .....	103
<i>lopinavir-ritonavir tab 100-25 mg</i> .....	151	<i>lovastatin tab 20 mg</i> .....	103
<i>lopinavir-ritonavir tab 200-50 mg</i> .....	151	<i>lovastatin tab 40 mg</i> .....	103
LOPRESSOR TAB 100MG.....	160	LOVAZA CAP 1GM.....	100
LOPRESSOR TAB 50MG.....	160	LOVENOX INJ 100MG/ML.....	68
LOPROX CRE 0.77% .....	187	LOVENOX INJ 120/0.8 .....	68
LOPROX SHA 1% .....	187	LOVENOX INJ 150MG/ML.....	68
LOPROX SUS 0.77%.....	187	LOVENOX INJ 30/0.3ML .....	68
<i>lorazepam conc 2 mg/ml</i> .....	56	LOVENOX INJ 300/3ML .....	68
<i>lorazepam tab 0.5 mg</i> .....	56	LOVENOX INJ 40/0.4ML.....	68
<i>lorazepam tab 1 mg</i> .....	56	LOVENOX INJ 60/0.6ML.....	68
<i>lorazepam tab 2 mg</i> .....	56	LOVENOX INJ 80/0.8ML .....	68
LORBRENA TAB 100MG .....	128	<i>loxapine succinate cap 10 mg</i> .....	143
LORBRENA TAB 25MG .....	128	<i>loxapine succinate cap 25 mg</i> .....	143
LORTAB ELX 10-300MG .....	46	<i>loxapine succinate cap 50 mg</i> .....	143
<i>losartan potassium &amp; hydrochlorothiazide</i>		<i>loxapine succinate cap 5 mg</i> .....	143
<i>tab 100-12.5 mg</i> .....	112	<i>lubiprostone cap 24 mcg</i> .....	240
<i>losartan potassium &amp; hydrochlorothiazide</i>		<i>lubiprostone cap 8 mcg</i> .....	239
<i>tab 100-25 mg</i> .....	112	LUCEMYRA TAB 0.18MG.....	306
<i>losartan potassium &amp; hydrochlorothiazide</i>		<i>luliconazole cream 1%</i> .....	187
<i>tab 50-12.5 mg</i> .....	112	LUMAKRAS TAB 120MG.....	128
<i>losartan potassium tab 100 mg</i> .....	107	LUMAKRAS TAB 320MG .....	128
<i>losartan potassium tab 25 mg</i> .....	107	LUMIGAN SOL 0.01%.....	303
<i>losartan potassium tab 50 mg</i> .....	107	LUMRYZ PAK 6GM .....	307
LOSEASONIQUE TAB.....	175	LUMRYZ PAK 7.5GM .....	307
LOTEMAX GEL 0.5%.....	301	LUMRYZ PAK 9GM .....	307
LOTEMAX OIN 0.5% .....	301	LUMRYZ PKG 4.5GM.....	307
LOTEMAX SM GEL 0.38%.....	301	LUNESTA TAB 1MG.....	253
LOTEMAX SUS 0.5%.....	301	LUNESTA TAB 2MG .....	253
LOTENSIN HCT TAB 10-12.5 .....	112	LUNESTA TAB 3MG.....	253
LOTENSIN HCT TAB 20-12.5 .....	112	LUPKYNIS CAP 7.9MG.....	285
LOTENSIN HCT TAB 20-25MG .....	112	LUPRON DEPOT INJ 11.25MG .....	121
LOTENSIN TAB 10MG.....	105	LUPRON DEPOT INJ 3.75MG .....	121
LOTENSIN TAB 20MG .....	105	<i>lurasidone hcl tab 120 mg</i> .....	139
LOTENSIN TAB 40MG .....	105	<i>lurasidone hcl tab 20 mg</i> .....	139
<i>loteprednol etabonate ophth gel 0.5%</i> ...	301	<i>lurasidone hcl tab 40 mg</i> .....	139
<i>loteprednol etabonate ophth susp 0.5%</i>	301	<i>lurasidone hcl tab 60 mg</i> .....	139
LOTREL CAP 10-20MG.....	112	<i>lurasidone hcl tab 80 mg</i> .....	139
LOTREL CAP 10-40MG.....	112	LUXIQ AER 0.12% .....	199
LOTREL CAP 5-10MG .....	112	LUZU CRE 1%.....	187

LYNPARZA TAB 100MG.....	128	MAVENCLAD PAK 10MG(4).....	311
LYNPARZA TAB 150MG.....	128	MAVENCLAD PAK 10MG(5).....	311
LYRICA CAP 100MG .....	73	MAVENCLAD PAK 10MG(6).....	311
LYRICA CAP 150MG .....	73	MAVENCLAD PAK 10MG(7).....	311
LYRICA CAP 200MG.....	73	MAVENCLAD PAK 10MG(8).....	312
LYRICA CAP 225MG .....	73	MAVENCLAD PAK 10MG(9).....	312
LYRICA CAP 25MG .....	72	MAVYRET PAK 50-20MG.....	157
LYRICA CAP 300MG .....	73	MAVYRET TAB 100-40MG .....	157
LYRICA CAP 50MG.....	73	MAXALT-MLT TAB 10MG.....	281
LYRICA CAP 75MG .....	73	MAXALT TAB 10MG .....	281
LYRICA CR TAB 165MG .....	314	MAXIDEX SUS 0.1% OP .....	301
LYRICA CR TAB 330MG .....	314	MAXITROL OIN 0.1% OP .....	301
LYRICA CR TAB 82.5MG .....	314	MAXITROL SUS 0.1% OP.....	301
LYRICA SOL 20MG/ML .....	73	MAXZIDE-25 TAB.....	224
LYSODREN TAB 500MG .....	121	MAXZIDE TAB 75-50 .....	224
LYSTEDA TAB 650MG .....	252	MAYZENT PAK STARTER.....	312
LYTGOBI TAB 4MG .....	129	MAYZENT TAB 0.25MG.....	312
LYUMJEV INJ 100UT/ML .....	91	MAYZENT TAB 1MG .....	312
LYUMJEV KWPN INJ 100UT/ML.....	91	MAYZENT TAB 2MG.....	312
LYUMJEV KWPN INJ 200UT/ML.....	91	MCT PRO-CAL PAK .....	218
LYVISPAH GRA 10MG .....	293	MECLIZINE TAB 50MG.....	96
LYVISPAH GRA 20MG.....	293	<i>meclofenamate sodium cap 100 mg</i> .....	29
LYVISPAH GRA 5MG .....	293	<i>meclofenamate sodium cap 50 mg</i> .....	29
<b>M</b>		MEDICHOICE MIS LANCET .....	268
MACROBID CAP 100MG .....	53	MEDISENSE LIQ GLUC/KET .....	268
MACRODANTIN CAP 100MG.....	53	MEDISENSE LIQ GLUC-KET .....	268
MACRODANTIN CAP 25MG.....	53	MEDLANCE MIS 30G PLUS.....	268
MACRODANTIN CAP 50MG .....	53	MEDLANCE MIS EXTR 21G.....	268
<i>mafenide acetate packet for topical soln</i>		MEDLANCE MIS LITE 25G.....	268
5% (50 gm).....	194	MEDLANCE MIS PLUS .....	268
MALARONE TAB 250-100.....	115	MEDLANCE MIS PLUS 30G.....	268
MALARONE TAB 62.5-25.....	115	MEDLANCE MIS UNV 21G .....	268
<i>malathion lotion 0.5%</i> .....	204	MEDLANCE PLS MIS 0.8MM .....	268
<i>maprotiline hcl tab 25 mg</i> .....	78	MEDLANCE PLS MIS EXTR 21G .....	268
<i>maprotiline hcl tab 50 mg</i> .....	78	MEDLANCE PLS MIS LITE 25G .....	268
<i>maprotiline hcl tab 75 mg</i> .....	79	MEDLANCE PLS MIS UNIV 21G.....	268
MAR-COF CG LIQ 225-7.5 .....	181	MEDROL TAB 16MG .....	179
MARINOL CAP 10MG .....	97	MEDROL TAB 2MG.....	179
MARINOL CAP 2.5MG.....	96	MEDROL TAB 32MG .....	179
MARINOL CAP 5MG .....	97	MEDROL TAB 4MG.....	179
MARPLAN TAB 10MG.....	79	MEDROL TAB 8MG.....	179
MATULANE CAP 50MG.....	134	<i>medroxyprogesterone acetate im susp 150</i>	
MAVENCLAD PAK 10MG(10) .....	312	<i>mg/ml</i> .....	177



<i>medroxyprogesterone acetate im susp</i>	
<i>prefilled syr 150 mg/ml</i> .....	177
<i>medroxyprogesterone acetate tab 10 mg</i>	
.....	306
<i>medroxyprogesterone acetate tab 2.5 mg</i>	
.....	306
<i>medroxyprogesterone acetate tab 5 mg</i>	306
<i>mefenamic acid cap 250 mg</i> .....	29
<i>mefloquine hcl tab 250 mg</i> .....	115
<i>megestrol acetate susp 40 mg/ml</i> .....	121
<i>megestrol acetate susp 625 mg/5ml</i> .....	306
<i>megestrol acetate tab 20 mg</i> .....	121
<i>megestrol acetate tab 40 mg</i> .....	121
MEIJER BLOOD TES GLUCOSE .....	212
MEIJER LANCE MIS COLOR .....	268
MEIJER LANCE MIS UNIV 21G .....	268
MEIJER LANCE MIS UNIV 30G .....	268
MEIJER LANCE MIS UNIVERSA .....	268
MEIJER MIS LANCETS .....	268
MEIJER TES TRUETEST .....	212
MEIJER TES TRUETRAC .....	212
MEKINIST SOL 0.05/ML.....	129
MEKINIST TAB 0.5MG .....	129
MEKINIST TAB 2MG.....	129
MEKTOVI TAB 15MG.....	129
<i>meloxicam cap 10 mg</i> .....	29
<i>meloxicam cap 5 mg</i> .....	29
<i>meloxicam tab 15 mg</i> .....	29
<i>meloxicam tab 7.5 mg</i> .....	29
<i>melphalan tab 2 mg</i> .....	117
<i>memantine hcl cap er 24hr 14 mg</i> .....	308
<i>memantine hcl cap er 24hr 21 mg</i> .....	308
<i>memantine hcl cap er 24hr 28 mg</i> .....	308
<i>memantine hcl cap er 24hr 7 mg</i> .....	308
<i>memantine hcl oral solution 2 mg/ml</i> ....	308
<i>memantine hcl tab 10 mg</i> .....	308
<i>memantine hcl tab 28 x 5 mg &amp; 21 x 10 mg</i>	
<i>titration pack</i> .....	308
<i>memantine hcl tab 5 mg</i> .....	308
MEMBRANEBLUE INJ 0.15% .....	302
MENEST TAB 0.3MG .....	238
MENEST TAB 0.625MG.....	238
MENEST TAB 1.25MG.....	238
MENOPUR INJ 75UNIT.....	228
MENOSTAR DIS 14MCG.....	238
<i>meperidine hcl oral soln 50 mg/5ml</i> .....	39
<i>meperidine hcl tab 50 mg</i> .....	39
MEPHYTON TAB 5MG .....	332
<i>meprobamate tab 200 mg</i> .....	55
<i>meprobamate tab 400 mg</i> .....	55
MEPRON SUS .....	52
<i>mercaptapurine tab 50 mg</i> .....	117
<i>mesalamine cap dr 400 mg</i> .....	241
<i>mesalamine cap er 24hr 0.375 gm</i> .....	241
<i>mesalamine cap er 500 mg</i> .....	241
<i>mesalamine enema 4 gm</i> .....	241
<i>mesalamine rectal enema 4 gm &amp; cleanser</i>	
<i>wipe kit</i> .....	242
<i>mesalamine suppos 1000 mg</i> .....	242
<i>mesalamine tab delayed release 1.2 gm</i> .....	242
<i>mesalamine tab delayed release 800 mg</i>	
.....	242
MESNEX TAB 400MG .....	134
MESTINON SOL 60MG/5ML .....	116
MESTINON TAB 60MG.....	116
MESTINON TAB TIMESPAN .....	116
<i>metaxalone tab 400 mg</i> .....	293
<i>metaxalone tab 800 mg</i> .....	293
<i>metformin hcl oral soln 500 mg/5ml</i> .....	87
<i>metformin hcl tab 1000 mg</i> .....	87
<i>metformin hcl tab 500 mg</i> .....	87
<i>metformin hcl tab 850 mg</i> .....	87
<i>metformin hcl tab er 24hr 500 mg</i> .....	87
<i>metformin hcl tab er 24hr 750 mg</i> .....	87
<i>metformin hcl tab er 24hr modified release</i>	
<i>1000 mg</i> .....	88
<i>metformin hcl tab er 24hr modified release</i>	
<i>500 mg</i> .....	88
<i>metformin hcl tab er 24hr osmotic 1000 mg</i>	
.....	88
<i>metformin hcl tab er 24hr osmotic 500 mg</i>	
.....	88
METFORMIN TAB 625MG.....	88
<i>methadone hcl conc 10 mg/ml</i> .....	39
<i>methadone hcl soln 10 mg/5ml</i> .....	39
<i>methadone hcl soln 5 mg/5ml</i> .....	39

<i>methadone hcl tab 10 mg</i> .....	39	METHYLIN SOL 5MG/5ML.....	11
<i>methadone hcl tab 5 mg</i> .....	39	<i>methylphenidate hcl cap er 10 mg (cd)</i> .....	11
<i>methadone hcl tab for oral susp 40 mg</i> ....	39	<i>methylphenidate hcl cap er 20 mg (cd)</i> .....	11
METHADOSE CON 10MG/ML .....	39	<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	
METHADOSE SF CON 10MG/ML.....	39	.....	11
<i>methamphetamine hcl tab 5 mg</i> .....	4	<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	
<i>methazolamide tab 25 mg</i> .....	224	.....	11
<i>methazolamide tab 50 mg</i> .....	224	<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	
<i>methenamine hippurate tab 1 gm</i> .....	53	.....	11
<i>methenamine-hyos-meth blue-sod phos-</i>		<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	
<i>phen sal tab 81.6 mg</i> .....	51	.....	11
<i>methenamine mandelate tab 0.5 gm</i> .....	53	<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	
<i>methenamine mandelate tab 1 gm</i> .....	53	.....	11
<i>methimazole tab 10 mg</i> .....	320	<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	
<i>methimazole tab 5 mg</i> .....	320	.....	11
METHIONAID POW .....	218	<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	
METHITEST TAB 10MG .....	49	.....	12
<i>methocarbamol tab 500 mg</i> .....	293	<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	
<i>methocarbamol tab 750 mg</i> .....	293	.....	12
<i>methotrexate sodium for inj 1 gm</i> .....	117	<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	
<i>methotrexate sodium inj 250 mg/10ml (25</i>		.....	12
<i>mg/ml)</i> .....	117	<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	
<i>methotrexate sodium inj 50 mg/2ml (25</i>		.....	12
<i>mg/ml)</i> .....	117	<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	
<i>methotrexate sodium inj pf 1000 mg/40ml</i>		.....	12
<i>(25 mg/ml)</i> .....	118	<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	
<i>methotrexate sodium inj pf 250 mg/10ml</i>		.....	12
<i>(25 mg/ml)</i> .....	118	<i>methylphenidate hcl cap er 30 mg (cd)</i> .....	12
<i>methotrexate sodium inj pf 50 mg/2ml (25</i>		<i>methylphenidate hcl cap er 40 mg (cd)</i> .....	12
<i>mg/ml)</i> .....	118	<i>methylphenidate hcl cap er 50 mg (cd)</i> .....	12
<i>methotrexate sodium tab 2.5 mg (base</i>		<i>methylphenidate hcl cap er 60 mg (cd)</i> .....	12
<i>equiv)</i> .....	118	<i>methylphenidate hcl chew tab 10 mg</i> .....	12
<i>methoxsalen rapid cap 10 mg</i> .....	191	<i>methylphenidate hcl chew tab 2.5 mg</i> .....	12
<i>methscopolamine bromide tab 2.5 mg</i> ...324		<i>methylphenidate hcl chew tab 5 mg</i> .....	12
<i>methscopolamine bromide tab 5 mg</i> .....	324	<i>methylphenidate hcl soln 10 mg/5ml</i> .....	12
<i>methyl dopa &amp; hydrochlorothiazide tab 250-</i>		<i>methylphenidate hcl soln 5 mg/5ml</i> .....	12
<i>15 mg</i> .....	112	<i>methylphenidate hcl tab 10 mg</i> .....	12
<i>methyl dopa &amp; hydrochlorothiazide tab 250-</i>		<i>methylphenidate hcl tab 20 mg</i> .....	12
<i>25 mg</i> .....	112	<i>methylphenidate hcl tab 5 mg</i> .....	12
<i>methyl dopa tab 250 mg</i> .....	108	<i>methylphenidate hcl tab er 10 mg</i> .....	13
<i>methyl dopa tab 500 mg</i> .....	108	<i>methylphenidate hcl tab er 20 mg</i> .....	13
<i>methylergonovine maleate tab 0.2 mg</i> ...304		<i>methylphenidate hcl tab er 24hr 18 mg</i> .....	13
METHYLIN SOL 10MG/5ML.....	11	<i>methylphenidate hcl tab er 24hr 27 mg</i> .....	13

<i>methylphenidate hcl tab er 24hr 36 mg</i> .....13	<i>metoprolol succinate tab er 24hr 100 mg</i>
<i>methylphenidate hcl tab er 24hr 54 mg</i> .....13	<i>(tartrate equiv)</i> .....160
<i>methylphenidate hcl tab er osmotic release</i>	<i>metoprolol succinate tab er 24hr 200 mg</i>
<i>(osm) 18 mg</i> .....13	<i>(tartrate equiv)</i> .....160
<i>methylphenidate hcl tab er osmotic release</i>	<i>metoprolol succinate tab er 24hr 25 mg</i>
<i>(osm) 27 mg</i> .....13	<i>(tartrate equiv)</i> .....160
<i>methylphenidate hcl tab er osmotic release</i>	<i>metoprolol succinate tab er 24hr 50 mg</i>
<i>(osm) 36 mg</i> .....13	<i>(tartrate equiv)</i> .....160
<i>methylphenidate hcl tab er osmotic release</i>	<i>metoprolol tartrate tab 100 mg</i> .....160
<i>(osm) 54 mg</i> .....13	<i>metoprolol tartrate tab 25 mg</i> .....160
<i>methylphenidate td patch 10 mg/9hr</i> .....13	<i>metoprolol tartrate tab 37.5 mg</i> .....160
<i>methylphenidate td patch 15 mg/9hr</i> .....13	<i>metoprolol tartrate tab 50 mg</i> .....160
<i>methylphenidate td patch 20 mg/9hr</i> .....13	<i>metoprolol tartrate tab 75 mg</i> .....160
<i>methylphenidate td patch 30 mg/9hr</i> .....13	METROCREAM CRE 0.75%.....203
METHYLPHENID TAB 45MG ER.....11	METROGEL GEL 1%.....203
METHYLPHENID TAB 63MG ER.....11	METROLOTION LOT 0.75% .....203
METHYLPHENID TAB 72MG ER .....11	<i>metronidazole cap 375 mg</i> .....51
<i>methylprednisolone tab 16 mg</i> .....179	<i>metronidazole cream 0.75%</i> .....204
<i>methylprednisolone tab 32 mg</i> .....179	<i>metronidazole gel 0.75%</i> .....204
<i>methylprednisolone tab 4 mg</i> .....179	<i>metronidazole gel 1%</i> .....204
<i>methylprednisolone tab 8 mg</i> .....179	<i>metronidazole lotion 0.75%</i> .....204
<i>methylprednisolone tab therapy pack 4 mg</i>	<i>metronidazole tab 250 mg</i> .....51
<i>(21)</i> .....179	<i>metronidazole tab 500 mg</i> .....51
<i>methyltestosterone cap 10 mg</i> .....49	<i>metronidazole vaginal gel 0.75%</i> .....330
<i>metoclopramide hcl orally disintegrating</i>	<i>metyrosine cap 250 mg</i> .....106
<i>tab 5 mg (base eq)</i> .....240	<i>mexiletine hcl cap 150 mg</i> .....57
<i>metoclopramide hcl soln 5 mg/5ml (10</i>	<i>mexiletine hcl cap 200 mg</i> .....57
<i>mg/10ml) (base equiv)</i> .....240	<i>mexiletine hcl cap 250 mg</i> .....57
<i>metoclopramide hcl tab 10 mg (base</i>	MIACALCIN INJ 200/ML .....226
<i>equivalent)</i> .....240	MICARDIS HCT TAB 40/12.5 .....112
<i>metoclopramide hcl tab 5 mg (base</i>	MICARDIS HCT TAB 80/12.5 .....112
<i>equivalent)</i> .....240	MICARDIS HCT TAB 80-25MG.....112
METOCLOPRAMI TAB 10MG ODT .....240	MICARDIS TAB 20MG.....107
<i>metolazone tab 10 mg</i> .....225	MICARDIS TAB 40MG .....107
<i>metolazone tab 2.5 mg</i> .....225	MICARDIS TAB 80MG .....107
<i>metolazone tab 5 mg</i> .....225	<i>miconazole nitrate vaginal suppos 200 mg</i>
<i>metoprolol &amp; hydrochlorothiazide tab 100-</i>	.....330
<i>25 mg</i> .....112	<i>miconazole-zinc oxide-white petrolatum</i>
<i>metoprolol &amp; hydrochlorothiazide tab 100-</i>	<i>oint 0.25-15-81.35%</i> .....187
<i>50 mg</i> .....112	MICROCHAMBER MIS .....279
<i>metoprolol &amp; hydrochlorothiazide tab 50-25</i>	MICRODOT CON SOL HIGH/LOW .....268
<i>mg</i> .....112	MICRODOT TES .....212
	MICRODOT TES XTRA .....212

MICROLET MIS LANCETS .....	268	<i>minocycline hcl tab er 24hr 80 mg</i> .....	319
MICROLET MIS NEXT .....	268	<i>minocycline hcl tab er 24hr 90 mg</i> .....	319
MICRO THIN MIS LANC 33G.....	268	MINOLIRA TAB 105MG .....	319
<i>midodrine hcl tab 10 mg</i> .....	332	MINOLIRA TAB 135MG .....	319
<i>midodrine hcl tab 2.5 mg</i> .....	332	<i>minoxidil tab 10 mg</i> .....	115
<i>midodrine hcl tab 5 mg</i> .....	332	<i>minoxidil tab 2.5 mg</i> .....	115
MIEBO DRO 1.3GM/ML.....	303	MIRAPEX ER TAB 0.375MG .....	136
MIFEPREX TAB 200MG .....	234	MIRAPEX ER TAB 0.75MG .....	136
<i>mifepristone tab 200 mg</i> .....	234	MIRAPEX ER TAB 1.5MG.....	136
<i>miglitol tab 100 mg</i> .....	85	MIRAPEX ER TAB 2.25MG.....	136
<i>miglitol tab 25 mg</i> .....	85	MIRAPEX ER TAB 3.75MG.....	136
<i>miglitol tab 50 mg</i> .....	85	MIRAPEX ER TAB 3MG .....	136
<i>miglustat cap 100 mg</i> .....	248	MIRAPEX ER TAB 4.5MG.....	136
MIGRANAL SPR 4MG/ML .....	280	MIRAPEX TAB 0.125MG.....	136
MILLIPRED TAB 5MG.....	179	MIRAPEX TAB 0.5MG .....	136
MINASTRIN 24 CHW FE .....	176	MIRAPEX TAB 0.75MG .....	136
MINI LANCING MIS DEVICE.....	268	MIRAPEX TAB 1MG.....	137
MINIPRESS CAP 1MG .....	108	MIRCERA INJ 100MCG .....	250
MINIPRESS CAP 2MG.....	108	MIRCERA INJ 120MCG .....	250
MINIPRESS CAP 5MG.....	108	MIRCERA INJ 150MCG .....	250
MINIVELLE DIS 0.025MG .....	238	MIRCERA INJ 200MCG .....	250
MINIVELLE DIS 0.0375MG .....	238	MIRCERA INJ 30MCG.....	250
MINIVELLE DIS 0.05MG.....	238	MIRCERA INJ 50MCG.....	250
MINIVELLE DIS 0.075MG .....	238	MIRCERA INJ 75MCG .....	250
MINIVELLE DIS 0.1MG.....	238	MIRCETTE TAB 28 DAY .....	176
<i>minocycline hcl cap 100 mg</i> .....	318	<i>mirtazapine orally disintegrating tab 15 mg</i> .....	78
<i>minocycline hcl cap 50 mg</i> .....	318	<i>mirtazapine orally disintegrating tab 30 mg</i> .....	78
<i>minocycline hcl cap 75 mg</i> .....	318	<i>mirtazapine orally disintegrating tab 45 mg</i> .....	78
<i>minocycline hcl cap er 24hr 135 mg (base equivalent)</i> .....	319	<i>mirtazapine tab 15 mg</i> .....	78
<i>minocycline hcl cap er 24hr 45 mg (base equivalent)</i> .....	319	<i>mirtazapine tab 30 mg</i> .....	78
<i>minocycline hcl cap er 24hr 90 mg (base equivalent)</i> .....	319	<i>mirtazapine tab 45 mg</i> .....	78
<i>minocycline hcl tab 100 mg</i> .....	319	<i>mirtazapine tab 7.5 mg</i> .....	78
<i>minocycline hcl tab 50 mg</i> .....	319	MIRVASO GEL 0.33%.....	204
<i>minocycline hcl tab 75 mg</i> .....	319	<i>misoprostol tab 100 mcg</i> .....	327
<i>minocycline hcl tab er 24hr 105 mg</i> .....	319	<i>misoprostol tab 200 mcg</i> .....	327
<i>minocycline hcl tab er 24hr 115 mg</i> .....	319	MITIGARE CAP 0.6MG.....	246
<i>minocycline hcl tab er 24hr 135 mg</i> .....	319	MITOSOL KIT 0.2MG.....	299
<i>minocycline hcl tab er 24hr 45 mg</i> .....	319	MMA/PA ANAMI POW ERLY YRS.....	218
<i>minocycline hcl tab er 24hr 55 mg</i> .....	319	MMA/PA MAXAM POW .....	218
<i>minocycline hcl tab er 24hr 65 mg</i> .....	319	MM LANCING MIS DEVICE .....	268

MM TWIST MIS LANCETS .....	268	<i>morphine sulfate cap er 24hr 100 mg</i> .....	40
M-NATAL PLUS TAB .....	289	<i>morphine sulfate cap er 24hr 10 mg</i> .....	39
MOBIC TAB 15MG .....	29	<i>morphine sulfate cap er 24hr 20 mg</i> .....	39
MOBIC TAB 7.5MG .....	29	<i>morphine sulfate cap er 24hr 30 mg</i> .....	39
MOBILE LANCE MIS 30G.....	268	<i>morphine sulfate cap er 24hr 40 mg</i> .....	39
<i>modafinil tab 100 mg</i> .....	13	<i>morphine sulfate cap er 24hr 50 mg</i> .....	40
<i>modafinil tab 200 mg</i> .....	13	<i>morphine sulfate cap er 24hr 60 mg</i> .....	40
MODULEN IBD POW .....	218	<i>morphine sulfate cap er 24hr 80 mg</i> .....	40
<i>moexipril hcl tab 15 mg</i> .....	105	<i>morphine sulfate oral soln 100 mg/5ml (20</i>	
<i>moexipril hcl tab 7.5 mg</i> .....	105	<i>mg/ml)</i> .....	40
<i>molindone hcl tab 10 mg</i> .....	144	<i>morphine sulfate oral soln 10 mg/5ml</i> .....	40
<i>molindone hcl tab 25 mg</i> .....	144	<i>morphine sulfate oral soln 20 mg/5ml</i> .....	40
<i>molindone hcl tab 5 mg</i> .....	144	<i>morphine sulfate suppos 10 mg</i> .....	40
<i>mometasone furoate cream 0.1%</i> .....	199	<i>morphine sulfate suppos 20 mg</i> .....	40
<i>mometasone furoate nasal susp 50</i>		<i>morphine sulfate suppos 30 mg</i> .....	40
<i>mcg/act</i> .....	295	<i>morphine sulfate suppos 5 mg</i> .....	40
<i>mometasone furoate oint 0.1%</i> .....	199	<i>morphine sulfate tab 15 mg</i> .....	40
<i>mometasone furoate solution 0.1% (lotion)</i>		<i>morphine sulfate tab 30 mg</i> .....	40
.....	199	<i>morphine sulfate tab er 100 mg</i> .....	40
MONOLET MIS LANCETS.....	268	<i>morphine sulfate tab er 15 mg</i> .....	40
MONOLET OPD MIS LANCETS.....	268	<i>morphine sulfate tab er 200 mg</i> .....	40
MONOLETTOR MIS LANCETS .....	268	<i>morphine sulfate tab er 30 mg</i> .....	40
<i>montelukast sodium chew tab 4 mg (base</i>		<i>morphine sulfate tab er 60 mg</i> .....	40
<i>equiv)</i> .....	59	MOTEGRITY TAB 1MG.....	239
<i>montelukast sodium chew tab 5 mg (base</i>		MOTEGRITY TAB 2MG.....	239
<i>equiv)</i> .....	59	MOTOFEN TAB 1-0.025 .....	94
<i>montelukast sodium oral granules packet 4</i>		MOTPOLY XR CAP 100MG .....	73
<i>mg (base equiv)</i> .....	59	MOTPOLY XR CAP 150MG .....	73
<i>montelukast sodium tab 10 mg (base equiv)</i>		MOTPOLY XR CAP 200MG .....	73
.....	59	MOUNJARO INJ 10MG/0.5 .....	89
MONUROL PAK GRANULES.....	53	MOUNJARO INJ 12.5/0.5 .....	89
<i>morphine sulfate beads cap er 24hr 120 mg</i>		MOUNJARO INJ 15MG/0.5 .....	89
.....	39	MOUNJARO INJ 2.5/0.5 .....	89
<i>morphine sulfate beads cap er 24hr 30 mg</i>		MOUNJARO INJ 5MG/0.5 .....	89
.....	39	MOUNJARO INJ 7.5/0.5 .....	89
<i>morphine sulfate beads cap er 24hr 45 mg</i>		MOVANTIK TAB 12.5MG.....	243
.....	39	MOVANTIK TAB 25MG .....	243
<i>morphine sulfate beads cap er 24hr 60 mg</i>		MOVIPREP SOL.....	255
.....	39	MOXEZA SOL 0.5% .....	299
<i>morphine sulfate beads cap er 24hr 75 mg</i>		<i>moxifloxacin hcl ophth soln 0.5% (base eq)</i>	
.....	39	<i>(2 times daily)</i> .....	299
<i>morphine sulfate beads cap er 24hr 90 mg</i>		<i>moxifloxacin hcl ophth soln 0.5% (base</i>	
.....	39	<i>equiv)</i> .....	299

<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	MYGLUCOHEALT MIS LANC 30G.....	269
.....	MYGLUCOHEALT SOL LO/NL/HI .....	269
MOXIFLOXACIN SOL 0.5% .....	MYGLUCOHEALT TES BLD GLUC .....	212
MPD SFTY LAN MIS 21G .....	MYLERAN TAB 2MG .....	117
MPD SFTY LAN MIS 23G .....	MYNATAL CAP .....	289
MPD SFTY LAN MIS 28G .....	MYNATAL PLUS TAB .....	289
MPD SFTY LAN MIS 30G .....	MYNATAL-Z TAB .....	289
MS CONTIN TAB 100MG ER.....	MYRBETRIQ SUS 8MG/ML.....	329
MS CONTIN TAB 15MG ER .....	MYRBETRIQ TAB 25MG.....	329
MS CONTIN TAB 200MG ER.....	MYRBETRIQ TAB 50MG .....	329
MS CONTIN TAB 30MG ER .....	MYSOLINE TAB 250MG .....	73
MS CONTIN TAB 60MG ER .....	MYSOLINE TAB 50MG .....	73
MSUD AID POW .....	MYTESI TAB 125MG .....	94
MULPLETA TAB 3MG.....	MYXREDLIN SOL 1UNIT/ML.....	91
MULTAQ TAB 400MG .....	<b>N</b>	
MULTI-LANCET KIT DEVICE .....	<i>nabumetone tab 500 mg</i> .....	29
MULTI-LANCET MIS DEVICE .....	<i>nabumetone tab 750 mg</i> .....	29
<i>multiple vitamins w/ minerals cap</i> .....	<i>nadolol tab 20 mg</i> .....	161
<i>mupirocin calcium cream 2%</i> .....	<i>nadolol tab 40 mg</i> .....	161
<i>mupirocin oint 2%</i> .....	<i>nadolol tab 80 mg</i> .....	161
MUSE SUP 1000MCG.....	NAFRINSE DLY SOL /NEUTRAL .....	287
MUSE SUP 125MCG.....	NAFRINSE SOL DAILY .....	288
MUSE SUP 250MCG.....	NAFRINSE WK SOL 0.2% .....	288
MUSE SUP 500MCG .....	<i>naftifine hcl cream 1%</i> .....	187
MYALEPT INJ 11.3MG.....	<i>naftifine hcl cream 2%</i> .....	187
MYAMBUTOL TAB 400MG.....	<i>naftifine hcl gel 1%</i> .....	187
MYCAPSSA CAP 20MG .....	NAFTIN GEL 1%.....	187
MYCOBUTIN CAP 150MG .....	NAFTIN GEL 2%.....	187
<i>mycophenolate mofetil cap 250 mg</i> .....	NALFON CAP 400MG .....	29
<i>mycophenolate mofetil for oral susp 200</i>	NALFON TAB 600MG.....	29
<i>mg/ml</i> .....	NALOCET TAB 2.5-300.....	46
<i>mycophenolate mofetil tab 500 mg</i> .....	<i>naloxone hcl inj 0.4 mg/ml</i> .....	95
<i>mycophenolate sodium tab dr 180 mg</i>	<i>naloxone hcl inj 4 mg/10ml</i> .....	95
<i>(mycophenolic acid equiv)</i> .....	<i>naloxone hcl nasal spray 4 mg/0.1ml</i> .....	95
<i>mycophenolate sodium tab dr 360 mg</i>	<i>naloxone hcl soln cartridge 0.4 mg/ml</i> .....	95
<i>(mycophenolic acid equiv)</i> .....	<i>naloxone hcl soln prefilled syringe 2</i>	
MYDAYIS CAP 12.5MG .....	<i>mg/2ml</i> .....	95
MYDAYIS CAP 25MG.....	<i>naltrexone hcl tab 50 mg</i> .....	95
MYDAYIS CAP 37.5MG .....	NAMENDA TAB 10MG.....	308
MYDAYIS CAP 50MG .....	NAMENDA TAB 5-10MG.....	308
MYFEMBREE TAB .....	NAMENDA TAB 5MG .....	308
MYFORTIC TAB 180MG .....	NAMENDA XR CAP 14MG .....	308
MYFORTIC TAB 360MG.....	NAMENDA XR CAP 21MG .....	308

NAMENDA XR CAP 28MG.....	308	NATESTO GEL 5.5MG .....	49
NAMENDA XR CAP 7MG .....	308	NATPARA INJ 100MCG.....	227
NAMENDA XR CAP TITRATIO .....	308	NATPARA INJ 25MCG .....	226
NAMZARIC CAP.....	308	NATPARA INJ 50MCG .....	226
NAMZARIC CAP 14-10MG .....	308	NATPARA INJ 75MCG .....	226
NAMZARIC CAP 21-10MG .....	308	NATROBA SUS 0.9%.....	204
NAMZARIC CAP 28-10MG .....	308	NATURE-THROI TAB 113.75MG .....	321
NAMZARIC CAP 7-10MG.....	308	NATURE-THROI TAB 130MG .....	321
NAPRELAN TAB 375MG CR .....	29	NATURE-THROI TAB 146.25MG .....	321
NAPRELAN TAB 500MG CR.....	29	NATURE-THROI TAB 16.25MG .....	321
NAPRELAN TAB 750MG CR.....	29	NATURE THROI TAB 162.5MG .....	321
NAPROSYN SUS 125/5ML .....	29	NATURE-THROI TAB 195MG .....	321
NAPROSYN TAB 500MG .....	29	NATURE-THROI TAB 260MG.....	321
<i>naproxen-esomeprazole magnesium tab dr</i>		NATURE-THROI TAB 32.5MG.....	321
<i>375-20 mg.....</i>	30	NATURE-THROI TAB 325MG.....	321
<i>naproxen-esomeprazole magnesium tab dr</i>		NATURE-THROI TAB 48.75MG .....	321
<i>500-20 mg .....</i>	30	NATURE-THROI TAB 65MG.....	321
<i>naproxen sodium tab 275 mg.....</i>	29	NATURE-THROI TAB 81.25MG .....	321
<i>naproxen sodium tab 550 mg .....</i>	30	NATURE-THROI TAB 97.5MG.....	321
<i>naproxen sodium tab er 24hr 375 mg (base</i>		NAYZILAM SPR 5MG.....	69
<i>equiv) .....</i>	30	<i>nebivolol hcl tab 10 mg (base equivalent)</i>	
<i>naproxen sodium tab er 24hr 500 mg (base</i>		<i>.....</i>	160
<i>equiv) .....</i>	30	<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	
<i>naproxen sodium tab er 24hr 750 mg (base</i>		<i>.....</i>	160
<i>equiv) .....</i>	30	<i>nebivolol hcl tab 20 mg (base equivalent)</i>	
<i>naproxen susp 125 mg/5ml .....</i>	30	<i>.....</i>	160
<i>naproxen tab 250 mg .....</i>	30	<i>nebivolol hcl tab 5 mg (base equivalent)</i>	160
<i>naproxen tab 375 mg .....</i>	30	NEEVO DHA CAP 27-1.13.....	289
<i>naproxen tab 500 mg .....</i>	30	<i>nefazodone hcl tab 100 mg .....</i>	81
<i>naproxen tab ec 375 mg .....</i>	30	<i>nefazodone hcl tab 150 mg .....</i>	81
<i>naproxen tab ec 500 mg.....</i>	30	<i>nefazodone hcl tab 200 mg.....</i>	81
<i>naratriptan hcl tab 1 mg (base equiv).....</i>	281	<i>nefazodone hcl tab 250 mg.....</i>	81
<i>naratriptan hcl tab 2.5 mg (base equiv)...</i>	281	<i>nefazodone hcl tab 50 mg.....</i>	81
NARCAN SPR 4MG.....	95	NEOCATE LIQ SPLASH.....	218
NARDIL TAB 15MG.....	79	NEOKE MCT70 POW.....	218
NASCOBAL SPR 500MCG .....	249	<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i>	
NASONEX SPR 50MCG/AC .....	295	<i>400unt-10000unt op oin .....</i>	299
NATACHEW CHW .....	289	<i>neomycin-polymy-gramicid op sol 1.75-</i>	
NATACYN SUS 5% OP .....	299	<i>10000-0.025mg-unt-mg/ml.....</i>	299
NATALVIT TAB 75-1MG .....	289	<i>neomycin-polymyxin-dexamethasone</i>	
NATAZIA TAB.....	176	<i>ophth oint 0.1% .....</i>	301
<i>nateglinide tab 120 mg .....</i>	93	<i>neomycin-polymyxin-dexamethasone</i>	
<i>nateglinide tab 60 mg.....</i>	93	<i>ophth susp 0.1% .....</i>	301

<i>neomycin-polymyxin-hc ophth susp</i> .....	301	NEUTEK 2TEK TES STRIPS .....	212
<i>neomycin-polymyxin-hc otic soln 1%</i> .....	304	NEVANAC SUS 0.1% .....	303
<i>neomycin-polymyxin-hc otic susp 3.5</i>		NEVANAC SUS 0.1% OP .....	303
<i>mg/ml-10000 unit/ml-1%</i> .....	304	<i>nevirapine susp 50 mg/5ml</i> .....	151
<i>neomycin sulfate tab 500 mg</i> .....	15	<i>nevirapine tab 200 mg</i> .....	151
NEONATAL/DHA MIS .....	289	<i>nevirapine tab er 24hr 100 mg</i> .....	151
NEONATAL 19 TAB .....	289	<i>nevirapine tab er 24hr 400 mg</i> .....	151
NEONATAL FE TAB .....	289	NEXAVAR TAB 200MG .....	129
NEONATAL PLS TAB 27-1MG .....	289	NEXIUM CAP 20MG .....	325
NEONATAL TAB COMPLETE .....	289	NEXIUM CAP 40MG .....	325
NEONATAL TAB COMPLTE .....	289	NEXIUM GRA 10MG DR .....	326
NEORAL CAP 100MG .....	286	NEXIUM GRA 2.5MG DR .....	326
NEORAL CAP 25MG .....	286	NEXIUM GRA 20MG DR .....	326
NEORAL SOL 100MG/ML .....	286	NEXIUM GRA 40MG DR .....	326
NEO-SYNALAR CRE .....	186	NEXIUM GRA 5MG DR .....	326
NEOTUSS PLUS LIQ .....	181	NEXLETOL TAB 180MG .....	99
NEPRO LIQ VANILLA .....	218	NEXLIZET TAB 180/10MG .....	99
NERLYNX TAB 40MG .....	129	NEXOBRID GEL 8.8% .....	201
NESINA TAB 12.5MG .....	88	NGENLA INJ 24/1.2ML .....	230
NESINA TAB 25MG .....	89	NGENLA INJ 60/1.2ML .....	230
NESINA TAB 6.25MG .....	88	<i>niacin (antihyperlipidemic) tab 500 mg</i> ..	104
NESTABS DHA PAK .....	289	<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	
NESTABS ONE CAP .....	289	.....	104
NESTABS TAB .....	289	<i>niacin tab er 500 mg (antihyperlipidemic)</i>	
NEULASTA INJ 6MG/0.6M .....	250	.....	104
NEULASTA KIT 6MG/0.6M .....	250	<i>niacin tab er 750 mg (antihyperlipidemic)</i>	
NEUPOGEN INJ 300/0.5 .....	250	.....	104
NEUPOGEN INJ 300MCG .....	250	NIASPAN TAB 1000 ER .....	104
NEUPOGEN INJ 480/0.8 .....	250	NIASPAN TAB 500MG ER .....	104
NEUPOGEN INJ 480MCG .....	250	NIASPAN TAB 750MG ER .....	104
NEUPRO DIS 1MG/24HR .....	137	NICAPRIN TAB .....	218
NEUPRO DIS 2MG/24HR .....	137	<i>nicardipine hcl cap 20 mg</i> .....	164
NEUPRO DIS 3MG/24HR .....	137	<i>nicardipine hcl cap 30 mg</i> .....	164
NEUPRO DIS 4MG/24HR .....	137	NICAZEL TAB .....	288
NEUPRO DIS 6MG/24HR .....	137	NICAZEL TAB FORTE .....	288
NEUPRO DIS 8MG/24HR .....	137	NICODERM CQ DIS 14MG/24H .....	314
NEURONTIN CAP 100MG .....	73	NICODERM CQ DIS 21MG/24H .....	314
NEURONTIN CAP 300MG .....	73	NICODERM CQ DIS 7MG/24HR .....	314
NEURONTIN CAP 400MG .....	73	NICOMIDE TAB .....	292
NEURONTIN SOL 250/5ML .....	73	NICORETTE GUM 2MG .....	314
NEURONTIN TAB 600MG .....	73	NICORETTE GUM 2MG CINN .....	314
NEURONTIN TAB 800MG .....	73	NICORETTE GUM 2MGFRUIT .....	315
NEUTEK 2TEK SOL CONTROL .....	269	NICORETTE GUM 2MG MINT .....	314



NICORETTE GUM 2MG ORIG.....	315	<i>nisoldipine tab er 24hr 8.5 mg</i> .....	164
NICORETTE GUM 4MG.....	315	<i>nitazoxanide tab 500 mg</i> .....	52
NICORETTE GUM 4MG CINN .....	315	<i>nitisinone cap 10 mg</i> .....	232
NICORETTE GUM 4MGFRUIT .....	315	<i>nitisinone cap 2 mg</i> .....	232
NICORETTE GUM 4MG MINT .....	315	<i>nitisinone cap 5 mg</i> .....	232
NICORETTE GUM 4MG ORIG.....	315	NITRO-BID OIN 2%.....	54
NICORETTE LOZ 2MG MINT .....	315	NITRO-DUR DIS 0.1MG/HR .....	54
NICORETTE LOZ 4MG MINT .....	315	NITRO-DUR DIS 0.2MG/HR.....	54
NICORETTE ST GUM 2MG MINT .....	315	NITRO-DUR DIS 0.3MG/HR.....	54
NICORETTE ST GUM 2MG ORIG .....	315	NITRO-DUR DIS 0.4MG/HR .....	54
NICORETTE ST GUM 4MG ORIG .....	315	NITRO-DUR DIS 0.6MG/HR.....	54
<i>nicotine polacrilex gum 2 mg</i> .....	315	NITRO-DUR DIS 0.8MG/HR.....	54
<i>nicotine polacrilex gum 4 mg</i> .....	315	<i>nitrofurantoin macrocrystalline cap 100 mg</i>	
<i>nicotine polacrilex lozenge 2 mg</i> .....	315	.....	53
<i>nicotine polacrilex lozenge 4 mg</i> .....	315	<i>nitrofurantoin macrocrystalline cap 25 mg</i>	
<i>nicotine td patch 24hr 14 mg/24hr</i> .....	315	.....	53
<i>nicotine td patch 24hr 21 mg/24hr</i> .....	315	<i>nitrofurantoin macrocrystalline cap 50 mg</i>	
<i>nicotine td patch 24hr 7 mg/24hr</i> .....	315	.....	53
NICOTROL INH .....	315	<i>nitrofurantoin monohydrate</i>	
NICOTROL NS SPR 10MG/ML .....	315	<i>macrocrystalline cap 100 mg</i> .....	53
<i>nifedipine cap 10 mg</i> .....	164	<i>nitrofurantoin susp 25 mg/5ml</i> .....	53
<i>nifedipine cap 20 mg</i> .....	164	<i>nitroglycerin sl tab 0.3 mg</i> .....	54
<i>nifedipine tab er 24hr 30 mg</i> .....	164	<i>nitroglycerin sl tab 0.4 mg</i> .....	54
<i>nifedipine tab er 24hr 60 mg</i> .....	164	<i>nitroglycerin sl tab 0.6 mg</i> .....	54
<i>nifedipine tab er 24hr 90 mg</i> .....	164	<i>nitroglycerin td patch 24hr 0.1 mg/hr</i> .....	54
<i>nifedipine tab er 24hr osmotic release 30</i>		<i>nitroglycerin td patch 24hr 0.2 mg/hr</i> .....	54
<i>mg</i> .....	164	<i>nitroglycerin td patch 24hr 0.4 mg/hr</i> .....	54
<i>nifedipine tab er 24hr osmotic release 60</i>		<i>nitroglycerin td patch 24hr 0.6 mg/hr</i> .....	54
<i>mg</i> .....	164	<i>nitroglycerin tl soln 0.4 mg/spray (400</i>	
<i>nifedipine tab er 24hr osmotic release 90</i>		<i>mcg/spray)</i> .....	54
<i>mg</i> .....	164	NITROLINGUAL SPR PUMPSRA.....	54
NILANDRON TAB 150MG.....	121	NITROMIST AER 400MCG.....	54
<i>nilutamide tab 150 mg</i> .....	121	NITROSTAT SUB 0.3MG .....	54
<i>nimodipine cap 30 mg</i> .....	164	NITROSTAT SUB 0.4MG .....	54
NINLARO CAP 2.3MG .....	129	NITROSTAT SUB 0.6MG .....	55
NINLARO CAP 3MG .....	129	NITYR TAB 10MG .....	232
NINLARO CAP 4MG .....	129	NITYR TAB 2MG .....	232
<i>nisoldipine tab er 24hr 17 mg</i> .....	164	NITYR TAB 5MG.....	232
<i>nisoldipine tab er 24hr 20 mg</i> .....	164	NIVA-PLUS TAB .....	289
<i>nisoldipine tab er 24hr 25.5 mg</i> .....	164	NIVA THYROID TAB 120MG .....	321
<i>nisoldipine tab er 24hr 30 mg</i> .....	164	NIVA THYROID TAB 15MG .....	321
<i>nisoldipine tab er 24hr 34 mg</i> .....	164	NIVA THYROID TAB 30MG .....	321
<i>nisoldipine tab er 24hr 40 mg</i> .....	164	NIVA THYROID TAB 60MG .....	321

NIVA THYROID TAB 90MG .....	321	<i>norethindrone acetate-ethinyl estradiol tab</i>	
NIVESTYM INJ 300/0.5.....	250	1 mg-5 mcg .....	236
NIVESTYM INJ 300MCG .....	251	<i>norethindrone acetate tab 5 mg</i> .....	306
NIVESTYM INJ 480/0.8.....	251	<i>norethindrone ac-ethinyl estrad-fe tab 1-</i>	
NIVESTYM INJ 480MCG .....	251	20/1-30/1-35 mg-mcg.....	176
<i>nizatidine cap 150 mg</i> .....	324	<i>norethindrone-eth estradiol tab 0.5-</i>	
<i>nizatidine cap 300 mg</i> .....	324	35/0.75-35/1-35 mg-mcg .....	176
<i>nizatidine oral soln 15 mg/ml</i> .....	324	<i>norethindrone-eth estradiol tab 0.5-35/1-</i>	
NOCDURNA SUB 27.7MCG.....	234	35/0.5-35 mg-mcg .....	176
NOCDURNA SUB 55.3MCG.....	234	<i>norethindrone tab 0.35 mg</i> .....	178
NO CODING TES BLD GLUC .....	212	NORGESIC TAB FORTE.....	294
NORDITROPIN INJ 10/1.5ML .....	230	<i>norgestimate &amp; ethinyl estradiol tab 0.25</i>	
NORDITROPIN INJ 15/1.5ML .....	230	mg-35 mcg .....	176
NORDITROPIN INJ 30/3ML .....	230	<i>norgestimate-eth estrad tab 0.18-25/0.215-</i>	
NORDITROPIN INJ 5/1.5ML.....	230	25/0.25-25 mg-mcg .....	177
<i>norelgestromin-ethinyl estradiol td ptwk</i>		<i>norgestimate-eth estrad tab 0.18-35/0.215-</i>	
150-35 mcg/24hr .....	177	35/0.25-35 mg-mcg.....	177
<i>norethindrone &amp; ethinyl estradiol-fe chew</i>		<i>norgestrel &amp; ethinyl estradiol tab 0.3 mg-30</i>	
tab 0.4 mg-35 mcg.....	176	mcg .....	177
<i>norethindrone &amp; ethinyl estradiol-fe chew</i>		NORITATE CRE 1% .....	204
tab 0.8 mg-25 mcg .....	176	NORLIQVA SOL 1MG/ML .....	164
<i>norethindrone &amp; ethinyl estradiol tab 0.4</i>		NORPACE CAP 100MG .....	57
mg-35 mcg .....	176	NORPACE CAP 100MG CR .....	57
<i>norethindrone &amp; ethinyl estradiol tab 0.5</i>		NORPACE CAP 150MG .....	57
mg-35 mcg .....	176	NORPACE CAP 150MG CR .....	57
<i>norethindrone &amp; ethinyl estradiol tab 1 mg-</i>		NORPRAMIN TAB 10MG.....	84
35 mcg .....	176	NORPRAMIN TAB 25MG .....	84
<i>norethindrone ace &amp; ethinyl estradiol-fe tab</i>		NORTHERA CAP 100MG .....	331
1.5 mg-30 mcg .....	176	NORTHERA CAP 200MG.....	331
<i>norethindrone ace &amp; ethinyl estradiol-fe tab</i>		NORTHERA CAP 300MG.....	331
1 mg-20 mcg.....	176	<i>nortriptyline hcl cap 10 mg</i> .....	84
<i>norethindrone ace &amp; ethinyl estradiol tab 1.5</i>		<i>nortriptyline hcl cap 25 mg</i> .....	84
mg-30 mcg .....	176	<i>nortriptyline hcl cap 50 mg</i> .....	84
<i>norethindrone ace &amp; ethinyl estradiol tab 1</i>		<i>nortriptyline hcl cap 75 mg</i> .....	84
mg-20 mcg .....	176	<i>nortriptyline hcl soln 10 mg/5ml</i> .....	84
<i>norethindrone ace-eth estradiol-fe chew</i>		NORVASC TAB 10MG .....	164
tab 1 mg-20 mcg (24).....	176	NORVASC TAB 2.5MG.....	164
<i>norethindrone ace-ethinyl estradiol-fe cap 1</i>		NORVASC TAB 5MG.....	164
mg-20 mcg (24).....	176	NORVIR POW 100MG .....	151
<i>norethindrone ace-ethinyl estradiol-fe tab 1</i>		NORVIR SOL 80MG/ML .....	151
mg-20 mcg (24) .....	176	NORVIR TAB 100MG .....	152
<i>norethindrone acetate-ethinyl estradiol tab</i>		NOURIANZ TAB 20MG.....	134
0.5 mg-2.5 mcg.....	236	NOURIANZ TAB 40MG .....	134

NOVA MAX GLU LIQ /KET CON .....	269	NUCYNTA ER TAB 50MG .....	41
NOVA MAX PLS TES KETONE .....	212	NUCYNTA TAB 100MG .....	41
NOVA MAX TES GLUCOSE.....	212	NUCYNTA TAB 50MG.....	41
NOVAREL INJ 10000UNT .....	228	NUCYNTA TAB 75MG .....	41
NOVAREL INJ 5000UNIT.....	228	NUDEXTA CAP 20-10MG .....	314
NOVA SAFETY MIS LANC 23G .....	269	NULYTELY SOL LMN/LIME .....	255
NOVA SAFETY MIS LANC 28G .....	269	NUMBRINO SOL 40MG/ML .....	294
NOVASOURCE LIQ RENAL.....	218	NUPLAZID CAP 34MG .....	139
NOVA SUREFLX MIS LANC DEV.....	269	NUPLAZID TAB 10MG.....	140
NOVA SURE MIS LANCETS .....	269	NURTEC TAB 75MG ODT.....	279
NOVOLIN70/30 INJ RELION.....	91	NUTRAMINE PAK .....	218
NOVOLIN INJ 70/30 .....	91	NUTREN 1.0 LIQ UNFLAVOR.....	218
NOVOLIN INJ 70/30 FP .....	92	NUTREN 1.5 LIQ FIBER .....	219
NOVOLIN N INJ 100 UNIT .....	92	NUTREN 2.0 LIQ VANILLA.....	219
NOVOLIN N INJ RELION .....	92	NUTREN JR LIQ .....	219
NOVOLIN N INJ U-100 .....	92	NUTREN LIQ JUNIOR .....	219
NOVOLIN R INJ 100 UNIT .....	92	NUTREN RENAL LIQ.....	219
NOVOLIN R INJ RELION.....	92	NUTRIRENAL LIQ.....	219
NOVOLIN R INJ U-100.....	92	NUTROPIN AQ INJ 10MG/2ML.....	230
NOVOLOG INJ 100/ML .....	92	NUTROPIN AQ INJ 20MG/2ML .....	230
NOVOLOG INJ FLEXPEN .....	92	NUTROPIN AQ INJ NUSPIN 5 .....	230
NOVOLOG INJ FLEX REL .....	92	NUVARING MIS.....	177
NOVOLOG INJ PENFILL.....	92	NUVESSA GEL 1.3%.....	330
NOVOLOG INJ RELION .....	92	NUVIGIL TAB 150MG.....	13
NOVOLOG MIX INJ 70/30.....	92	NUVIGIL TAB 200MG .....	13
NOVOLOG MIX INJ FLEXPEN .....	92	NUVIGIL TAB 250MG .....	13
NOVOLOG MIX INJ FLEX REL .....	92	NUVIGIL TAB 50MG .....	13
NOVOLOG RELI INJ 70/30 .....	92	NUZYRA TAB 150MG .....	317
NOXAFIL SUS 40MG/ML.....	98	NYMALIZE SOL .....	164
NOXAFIL TAB 100MG.....	98	NYNUTEY CRE 23-7%.....	203
NOZIN NASAL MIS SANITIZE.....	294	<i>nystatin cream 100000 unit/gm</i> .....	187
NP THYROID TAB 120MG .....	322	<i>nystatin oint 100000 unit/gm</i> .....	187
NP THYROID TAB 15MG .....	321	<i>nystatin oral powder</i> .....	97
NP THYROID TAB 30MG .....	321	<i>nystatin susp 100000 unit/ml</i> .....	287
NP THYROID TAB 60MG .....	321	<i>nystatin tab 500000 unit</i> .....	97
NP THYROID TAB 90MG .....	321	<i>nystatin topical powder 100000 unit/gm</i>	187
NUBEQA TAB 300MG.....	121	<i>nystatin-triamcinolone cream 100000-0.1</i>	
NUCALA INJ 100MG/ML .....	58	<i>unit/gm-%</i> .....	187
NUCALA INJ 40MG/0.4.....	58	<i>nystatin-triamcinolone oint 100000-0.1</i>	
NUCYNTA ER TAB 100MG .....	41	<i>unit/gm-%</i> .....	187
NUCYNTA ER TAB 150MG.....	41	NYVEPRIA INJ 6/0.6ML .....	251
NUCYNTA ER TAB 200MG.....	41	●	
NUCYNTA ER TAB 250MG.....	41	OA 2 POW .....	219

OB COMPLETE/ CAP DHA .....	290	<i>olanzapine orally disintegrating tab 5 mg</i>	143
OB COMPLETE CAP ONE .....	289	<i>olanzapine tab 10 mg .....</i>	143
OB COMPLETE CAP PETITE .....	289	<i>olanzapine tab 15 mg.....</i>	143
OB COMPLETE TAB .....	289	<i>olanzapine tab 2.5 mg.....</i>	143
OB COMPLETE TAB PREMIER.....	290	<i>olanzapine tab 20 mg.....</i>	143
OBSTETRIX EC TAB.....	290	<i>olanzapine tab 5 mg .....</i>	143
OBSTETRIX MIS DHA.....	290	<i>olanzapine tab 7.5 mg .....</i>	143
OBSTETRX ONE CAP 38-1-225 .....	290	OLINVYK SOL 1MG/ML.....	41
OALIVA TAB 10MG.....	239	OLINVYK SOL 2MG/2ML.....	41
OALIVA TAB 5MG .....	239	OLINVYK SOL 30MG/30 .....	41
O-CAL TAB PRENATAL.....	289	<i>olmesartan-amlodipine-</i>	
<i>octreotide acetate inj 1000 mcg/ml (1</i>		<i>hydrochlorothiazide tab 20-5-12.5 mg .</i>	112
<i>mg/ml).....</i>	234	<i>olmesartan-amlodipine-</i>	
<i>octreotide acetate inj 100 mcg/ml (0.1</i>		<i>hydrochlorothiazide tab 40-10-12.5 mg</i>	113
<i>mg/ml).....</i>	234	<i>olmesartan-amlodipine-</i>	
<i>octreotide acetate inj 200 mcg/ml (0.2</i>		<i>hydrochlorothiazide tab 40-10-25 mg ..</i>	113
<i>mg/ml).....</i>	234	<i>olmesartan-amlodipine-</i>	
<i>octreotide acetate inj 500 mcg/ml (0.5</i>		<i>hydrochlorothiazide tab 40-5-12.5 mg .</i>	113
<i>mg/ml).....</i>	234	<i>olmesartan-amlodipine-</i>	
<i>octreotide acetate inj 50 mcg/ml (0.05</i>		<i>hydrochlorothiazide tab 40-5-25 mg....</i>	113
<i>mg/ml).....</i>	234	<i>olmesartan medoxomil-</i>	
OCUFLOX DRO 0.3% OP .....	299	<i>hydrochlorothiazide tab 20-12.5 mg .....</i>	112
ODACTRA SUB.....	14	<i>olmesartan medoxomil-</i>	
ODEFSEY TAB .....	152	<i>hydrochlorothiazide tab 40-12.5 mg .....</i>	112
ODOMZO CAP 200MG .....	120	<i>olmesartan medoxomil-</i>	
OFEV CAP 100MG .....	317	<i>hydrochlorothiazide tab 40-25 mg .....</i>	112
OFEV CAP 150MG.....	317	<i>olmesartan medoxomil tab 20 mg .....</i>	107
<i>ofloxacin ophth soln 0.3% .....</i>	299	<i>olmesartan medoxomil tab 40 mg .....</i>	107
<i>ofloxacin otic soln 0.3%.....</i>	304	<i>olmesartan medoxomil tab 5 mg .....</i>	107
<i>ofloxacin tab 300 mg.....</i>	239	<i>olopatadine hcl nasal soln 0.6% .....</i>	294
<i>ofloxacin tab 400 mg.....</i>	239	OLPRUVA PAK 2GM .....	232
<i>olanzapine-fluoxetine hcl cap 12-25 mg.</i>	309	OLPRUVA PAK 3GM .....	232
<i>olanzapine-fluoxetine hcl cap 12-50 mg.</i>	309	OLPRUVA PAK 4 GM .....	232
<i>olanzapine-fluoxetine hcl cap 3-25 mg ..</i>	309	OLPRUVA PAK 5GM .....	232
<i>olanzapine-fluoxetine hcl cap 6-25 mg ..</i>	309	OLPRUVA PAK 6.67GM.....	232
<i>olanzapine-fluoxetine hcl cap 6-50 mg ..</i>	309	OLPRUVA PAK 6GM .....	232
<i>olanzapine for im inj 10 mg .....</i>	143	OLUMIANT TAB 1MG .....	22
<i>olanzapine orally disintegrating tab 10 mg</i>		OLUMIANT TAB 2MG .....	22
<i>.....</i>	143	OLUX AER 0.05% .....	199
<i>olanzapine orally disintegrating tab 15 mg</i>		OLUX-E AER 0.05% .....	199
<i>.....</i>	143	OMECLAMOX- MIS PAK.....	327
<i>olanzapine orally disintegrating tab 20 mg</i>		<i>omega-3-acid ethyl esters cap 1 gm .....</i>	100
<i>.....</i>	143		

<i>omeprazole cap delayed release 10 mg</i> .326	ONETOUCH KIT VERIO FL.....269
<i>omeprazole cap delayed release 20 mg</i> .326	ONETOUCH KIT VERIO RE.....269
<i>omeprazole cap delayed release 40 mg</i> 326	ONETOUCH LIQ ULT CONT .....269
<i>omeprazole-sodium bicarbonate cap 20-</i>	ONETOUCH LIQ VERIO .....269
<i>1100 mg</i> .....327	ONETOUCH LIQ VERIO 4.....269
<i>omeprazole-sodium bicarbonate cap 40-</i>	ONETOUCH MIS 30G .....270
<i>1100 mg</i> .....327	ONETOUCH MIS LANC DEV.....270
<i>omeprazole-sodium bicarbonate powd</i>	ONETOUCH MIS LANCETS .....270
<i>pack for susp 20-1680 mg</i> .....327	ONETOUCH SOL KIT COMPLETE.....270
<i>omeprazole-sodium bicarbonate powd</i>	ONETOUCH SOL KIT FIT.....270
<i>pack for susp 40-1680 mg</i> .....327	ONETOUCH SOL KIT REFILL.....270
OMNARIS SPR.....295	ONETOUCH TES ULTRA .....212
OMNIFLEX DPR.....257	ONETOUCH TES VERIO .....212
OMNIPOD 5 G6 KIT INTRO.....269	ONETOUCH US MIS LANCETS .....270
OMNIPOD 5 G6 MIS PODS.....269	ONE VITE TAB 1MG PLUS.....290
OMNIPOD DASH KIT PDM .....269	ONEXTON GEL 1.2-3.75.....184
OMNIPOD GO KIT 10UNT/DY .....269	ONFI SUS 2.5MG/ML.....69
OMNIPOD GO KIT 15UNT/DY .....269	ONFI TAB 10MG .....69
OMNIPOD GO KIT 20UNT/DY .....269	ONFI TAB 20MG.....69
OMNIPOD GO KIT 25UNT/DY.....269	ONGENTYS CAP 25MG .....135
OMNIPOD GO KIT 30UNT/DY .....269	ONGENTYS CAP 50MG.....135
OMNIPOD GO KIT 35UNT/DY.....269	ONGLYZA TAB 2.5MG.....89
OMNIPOD GO KIT 40UNT/DY .....269	ONGLYZA TAB 5MG .....89
OMNIPOD MIS CLASSIC.....269	ON-THE-GO MIS LANC 30G .....269
OMNIPOD PDM KIT CLASSIC.....269	ONUREG TAB 200MG.....118
OMNITROPE INJ 10/1.5ML.....230	ONUREG TAB 300MG.....118
OMNITROPE INJ 5/1.5ML .....230	ONZETRA XSAI MIS 11MG .....281
OMNITROPE INJ 5.8MG .....230	OPSUMIT TAB 10MG.....171
OMNIVEX TAB.....219	OPTICHAMBER MIS DIA MD.....279
<i>ondansetron hcl oral soln 4 mg/5ml</i> .....96	OPTICHAMBER MIS DIAMOND.....279
<i>ondansetron hcl tab 24 mg</i> .....96	OPTICHAMBER MIS DIA SM .....279
<i>ondansetron hcl tab 4 mg</i> .....96	OPTIMENTAL LIQ .....219
<i>ondansetron hcl tab 8 mg</i> .....96	OPTIUMEZ TES.....212
<i>ondansetron orally disintegrating tab 4 mg</i>	OPTIUM TES.....212
.....96	OPVEE SPR 2.7/0.1 .....95
<i>ondansetron orally disintegrating tab 8 mg</i>	OPZELURA CRE 1.5%.....201
.....96	ORACEA CAP 40MG .....204
ONE DROP TES BLD GLUC.....212	ORACIT SOL .....244
ONETOUCH DEL MIS LANC DEV.....269	ORAFATE PST 10%.....288
ONETOUCH DEL MIS PLUS 30G .....269	ORALAIR SUB 300 IR .....14
ONETOUCH DEL MIS PLUS 33G.....269	ORAPRED ODT TAB 10MG .....179
ONETOUCH FP MIS LANCETS.....269	ORAPRED ODT TAB 15MG .....179
ONETOUCH KIT ULTRA 2 .....269	ORAPRED ODT TAB 30MG .....179

ORAVIG TAB 50MG .....	287	<i>oseltamivir phosphate cap 45 mg (base equiv)</i> .....	158
ORENCIA CLCK INJ 125MG/ML .....	31	<i>oseltamivir phosphate cap 75 mg (base equiv)</i> .....	158
ORENCIA INJ 125MG/ML.....	32	<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i> .....	158
ORENCIA INJ 50/0.4ML .....	32	OSENI TAB 12.5-15 .....	86
ORENCIA INJ 87.5/0.7 .....	32	OSENI TAB 12.5-30 .....	86
ORENITRAM TAB 0.125MG .....	170	OSENI TAB 12.5-45 .....	86
ORENITRAM TAB 0.25MG .....	170	OSENI TAB 25-15MG .....	86
ORENITRAM TAB 1MG.....	170	OSENI TAB 25-30MG .....	86
ORENITRAM TAB 2.5MG.....	170	OSENI TAB 25-45MG .....	86
ORENITRAM TAB 5MG .....	170	OSMOLEX ER TAB .....	137
ORENITRAM TAB MONTH 1.....	170	OSMOLEX ER TAB 129MG.....	137
ORENITRAM TAB MONTH 2 .....	170	OSMOLEX ER TAB 193MG.....	137
ORENITRAM TAB MONTH 3 .....	170	OSMOLEX ER TAB 258MG .....	137
ORFADIN CAP 10MG .....	232	OSMOLITE 1.2 LIQ CAL .....	219
ORFADIN CAP 20MG .....	232	OSMOLITE 1.5 LIQ CAL .....	219
ORFADIN CAP 2MG .....	232	OSMOLITE 1 LIQ CAL .....	219
ORFADIN CAP 5MG.....	232	OSMOLITE HN LIQ .....	219
ORFADIN SUS 4MG/ML.....	232	OSMOLITE LIQ .....	219
ORGOVYX TAB 120MG .....	121	OSMOPREP TAB 1.5GM .....	255
ORIAHNN CAP .....	236	OSPHENA TAB 60MG .....	230
ORLISSA TAB 150MG .....	229	OTEZLA TAB 10/20/30 .....	31
ORLISSA TAB 200MG .....	229	OTEZLA TAB 30MG .....	31
ORKAMBI GRA 100-125 .....	316	OTOVEL DRO .....	304
ORKAMBI GRA 150-188 .....	316	OTREXUP INJ 10MG .....	25
ORKAMBI GRA 75-94MG .....	316	OTREXUP INJ 12.5/0.4 .....	25
ORKAMBI TAB 100-125.....	316	OTREXUP INJ 15MG .....	25
ORKAMBI TAB 200-125 .....	316	OTREXUP INJ 17.5/0.4 .....	25
ORLADEYO CAP 110MG.....	247	OTREXUP INJ 20MG.....	25
ORLADEYO CAP 150MG .....	247	OTREXUP INJ 22.5/0.4 .....	25
<i>orlistat cap 120 mg</i> .....	6	OTREXUP INJ 25MG.....	25
<i>orphenadrine citrate tab er 12hr 100 mg</i> .....	293	OVIDE LOT 0.5%.....	204
<i>orphenadrine w/ aspirin &amp; caffeine tab 50-770-60 mg</i> .....	294	OVIDREL INJ.....	228
ORSERDU TAB 345MG .....	121	<i>oxandrolone tab 10 mg</i> .....	49
ORSERDU TAB 86MG .....	121	<i>oxandrolone tab 2.5 mg</i> .....	49
ORTHO DF CAP 1-3775IU .....	252	<i>oxaprozin tab 600 mg</i> .....	30
ORTHO MICRON TAB 0.35MG .....	178	OXAYDO TAB 5MG.....	41
ORTIKOS CAP 6MG ER.....	179	OXAYDO TAB 7.5MG .....	41
ORTIKOS CAP 9MG ER.....	179	<i>oxazepam cap 10 mg</i> .....	56
OS 2 POW .....	219	<i>oxazepam cap 15 mg</i> .....	56
<i>oseltamivir phosphate cap 30 mg (base equiv)</i> .....	158	<i>oxazepam cap 30 mg</i> .....	56

OXBRYTA TAB 300MG .....	249	<i>oxycodone hcl tab er 12hr deter 40 mg</i> ....	42
OXBRYTA TAB 500MG .....	249	<i>oxycodone hcl tab er 12hr deter 60 mg</i> ....	42
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i> .....	73	<i>oxycodone hcl tab er 12hr deter 80 mg</i> ....	42
<i>oxcarbazepine tab 150 mg</i> .....	73	<i>oxycodone w/ acetaminophen soln 5-325 mg/5ml</i> .....	46
<i>oxcarbazepine tab 300 mg</i> .....	73	<i>oxycodone w/ acetaminophen tab 10-325 mg</i> .....	46
<i>oxcarbazepine tab 600 mg</i> .....	73	<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i> .....	46
OXEPA 1.5 LIQ .....	219	<i>oxycodone w/ acetaminophen tab 5-325 mg</i> .....	46
OXEPA LIQ .....	219	<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i> .....	46
OXERVATE SOL 20MCG/ML .....	300	OXYCONTIN TAB 10MG ER .....	42
OXIANUJO CRE 4-0.1% .....	201	OXYCONTIN TAB 15MG ER .....	42
OXIAZAR CRE 4-0.1% .....	184	OXYCONTIN TAB 20MG ER .....	42
<i>oxiconazole nitrate cream 1%</i> .....	187	OXYCONTIN TAB 30MG ER .....	42
OXISTAT CRE 1% .....	187	OXYCONTIN TAB 40MG ER .....	42
OXISTAT LOT 1% .....	187	OXYCONTIN TAB 60MG ER .....	42
OXSORALEN-UL CAP 10MG .....	191	OXYCONTIN TAB 80MG ER .....	42
OXTELLAR XR TAB 150MG .....	74	<i>oxymorphone hcl tab 10 mg</i> .....	42
OXTELLAR XR TAB 300MG .....	74	<i>oxymorphone hcl tab 5 mg</i> .....	42
OXTELLAR XR TAB 600MG .....	74	<i>oxymorphone hcl tab er 12hr 10 mg</i> .....	43
<i>oxybutynin chloride solution 5 mg/5ml</i> ..	328	<i>oxymorphone hcl tab er 12hr 15 mg</i> .....	43
<i>oxybutynin chloride tab 2.5 mg</i> .....	328	<i>oxymorphone hcl tab er 12hr 20 mg</i> .....	43
<i>oxybutynin chloride tab 5 mg</i> .....	328	<i>oxymorphone hcl tab er 12hr 30 mg</i> .....	43
<i>oxybutynin chloride tab er 24hr 10 mg</i> ..	328	<i>oxymorphone hcl tab er 12hr 40 mg</i> .....	43
<i>oxybutynin chloride tab er 24hr 15 mg</i> ..	328	<i>oxymorphone hcl tab er 12hr 5 mg</i> .....	43
<i>oxybutynin chloride tab er 24hr 5 mg</i> ....	328	<i>oxymorphone hcl tab er 12hr 7.5 mg</i> .....	43
OXYCOD/ACETA SOL 10/300MG .....	46	OXYTROL DIS 3.9MG/24 .....	328
OXYCOD/APAP TAB 10-300MG .....	46	OZEMPIC INJ 2/1.5ML .....	90
OXYCOD/APAP TAB 5-300MG .....	46	OZEMPIC INJ 2MG/3ML .....	89
OXYCOD-APAP TAB 2.5-300 .....	46	OZEMPIC INJ 4MG/3ML .....	90
<i>oxycodone-aspirin tab 4.8355-325 mg</i> ....	47	OZEMPIC INJ 8MG/3ML .....	90
<i>oxycodone hcl cap 5 mg</i> .....	41	OZOBAX DS SOL 10MG/5ML .....	293
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i> .....	41	OZOBAX SOL 5MG/5ML .....	293
<i>oxycodone hcl soln 5 mg/5ml</i> .....	41	<b>P</b>	
<i>oxycodone hcl tab 10 mg</i> .....	41	PALFORZIA CAP ESCALAT .....	14
<i>oxycodone hcl tab 15 mg</i> .....	41	PALFORZIA CAP LEVEL 1 .....	14
<i>oxycodone hcl tab 20 mg</i> .....	42	PALFORZIA CAP LEVEL 10 .....	15
<i>oxycodone hcl tab 30 mg</i> .....	42	PALFORZIA CAP LEVEL 2 .....	14
<i>oxycodone hcl tab 5 mg</i> .....	41	PALFORZIA CAP LEVEL 3 .....	14
<i>oxycodone hcl tab er 12hr deter 10 mg</i> ....	42	PALFORZIA CAP LEVEL 4 .....	14
<i>oxycodone hcl tab er 12hr deter 15 mg</i> ....	42		
<i>oxycodone hcl tab er 12hr deter 20 mg</i> ..	42		
<i>oxycodone hcl tab er 12hr deter 30 mg</i> ....	42		

PALFORZIA CAP LEVEL 5.....	14	<i>paroxetine hcl tab 20 mg</i> .....	80
PALFORZIA CAP LEVEL 6.....	15	<i>paroxetine hcl tab 30 mg</i> .....	80
PALFORZIA CAP LEVEL 7.....	15	<i>paroxetine hcl tab 40 mg</i> .....	80
PALFORZIA CAP LEVEL 8.....	15	<i>paroxetine hcl tab er 24hr 12.5 mg</i> .....	80
PALFORZIA CAP LEVEL 9.....	15	<i>paroxetine hcl tab er 24hr 25 mg</i> .....	80
PALFORZIA POW LEVEL 11.....	15	<i>paroxetine hcl tab er 24hr 37.5 mg</i> .....	80
<i>paliperidone tab er 24hr 1.5 mg</i> .....	141	<i>paroxetine mesylate cap 7.5 mg (base</i>	
<i>paliperidone tab er 24hr 3 mg</i> .....	141	<i>equiv)</i> .....	316
<i>paliperidone tab er 24hr 6 mg</i> .....	141	PASER GRA 4GM.....	116
<i>paliperidone tab er 24hr 9 mg</i> .....	141	PATANASE SPR 0.6%.....	294
PALYNZIQ INJ 10/0.5ML.....	232	PAXIL CR TAB 12.5MG.....	80
PALYNZIQ INJ 2.5/0.5.....	232	PAXIL CR TAB 25MG.....	80
PALYNZIQ INJ 20MG/ML.....	232	PAXIL CR TAB 37.5MG.....	80
PAMELOR CAP 10MG.....	84	PAXIL SUS 10MG/5ML.....	80
PAMELOR CAP 25MG.....	84	PAXIL TAB 10MG.....	80
PAMELOR CAP 50MG.....	84	PAXIL TAB 20MG.....	80
PAMELOR CAP 75MG.....	84	PAXIL TAB 30MG.....	80
PANCREAZE CAP 10500UNT.....	223	PAXIL TAB 40MG.....	80
PANCREAZE CAP 16800UNT.....	223	PAXLOVID TAB 150-100.....	155
PANCREAZE CAP 21000UNT.....	223	PAXLOVID TAB 300-100.....	155
PANCREAZE CAP 2600UNIT.....	223	PC LANCETS MIS 30G.....	270
PANCREAZE CAP 37000.....	223	PEDIAPRED SOL 5MG/5ML.....	179
PANCREAZE CAP 4200UNIT.....	223	PEDIASURE EN LIQ /FIBER.....	219
PANDEL CRE 0.1%.....	199	PEDIASURE LIQ PEPTIDE.....	220
PANRETIN GEL 0.1%.....	188	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>	
<i>pantoprazole sodium ec tab 20 mg (base</i>		<i>soln 236 gm</i> .....	255
<i>equiv)</i> .....	326	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>	
<i>pantoprazole sodium ec tab 40 mg (base</i>		<i>soln 240 gm</i> .....	255
<i>equiv)</i> .....	326	<i>peg 3350-kcl-nacl-na sulfate-na ascorbate-</i>	
<i>pantoprazole sodium for delayed release</i>		<i>c for soln 100 gm</i> .....	255
<i>susp packet 40 mg</i> .....	326	<i>peg 3350-kcl-sod bicarb-nacl for soln 420</i>	
<i>pantoprazole sodium for iv soln 40 mg</i>		<i>gm</i> .....	255
<i>(base equiv)</i> .....	326	PEGASYS INJ.....	157
<i>paricalcitol cap 1 mcg</i> .....	232	PEGASYS INJ 180MCG/M.....	157
<i>paricalcitol cap 2 mcg</i> .....	232	PEGINTRON KIT 50MCG.....	157
<i>paricalcitol cap 4 mcg</i> .....	232	PEG-PREP KIT.....	255
PARLODEL CAP 5MG.....	137	PEMAZYRE TAB 13.5MG.....	129
PARLODEL TAB 2.5MG.....	137	PEMAZYRE TAB 4.5MG.....	129
PARNATE TAB 10MG.....	79	PEMAZYRE TAB 9MG.....	129
<i>paromomycin sulfate cap 250 mg</i> .....	15	<i>penciclovir cream 1%</i> .....	194
<i>paroxetine hcl oral susp 10 mg/5ml (base</i>		<i>penicillamine cap 250 mg</i> .....	284
<i>equiv)</i> .....	80	<i>penicillamine tab 250 mg</i> .....	284
<i>paroxetine hcl tab 10 mg</i> .....	80		



<i>penicillin v potassium for soln 125 mg/5ml</i>	<i>perphenazine tab 2 mg</i> .....	145
.....305	<i>perphenazine tab 4 mg</i> .....	145
<i>penicillin v potassium for soln 250 mg/5ml</i>	<i>perphenazine tab 8 mg</i> .....	145
.....305	PERSERIS INJ 120MG .....	141
<i>penicillin v potassium tab 250 mg</i> .....	PERSERIS INJ 90MG .....	141
305	PERTZYE CAP 16000U .....	223
<i>penicillin v potassium tab 500 mg</i> .....	PERTZYE CAP 24000U .....	223
305	PERTZYE CAP 4000UNIT .....	223
PENLET II KIT BLOOD .....	PERTZYE CAP 8000UNIT .....	223
270	PEXEVA TAB 10MG.....	80
PENLET II MIS REPL CAP.....	PEXEVA TAB 20MG.....	80
270	PEXEVA TAB 30MG.....	80
PENNSAID SOL 2% .....	PEXEVA TAB 40MG.....	80
185	PFD 2 POW .....	220
PENTASA CAP 250MG CR .....	PHARMACY COU MIS LANCETS.....	270
242	PHEBURANE MIS 483/GM .....	232
PENTASA CAP 500MG CR.....	PHENACTIN AA LIQ PLUS.....	220
242	<i>phenazopyridine hcl tab 200 mg</i> .....	245
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	PHENDIMETRAZ CAP 105MG ER.....	6
.....48	<i>phendimetrazine tartrate tab 35 mg</i> .....	6
PENTETATE CA SOL 200MG/ML.....	<i>phenelzine sulfate tab 15 mg</i> .....	79
95	PHENEX-1 POW .....	220
PENTETATE ZI SOL 200MG/ML .....	PHENEX-2 POW .....	220
95	<i>phenobarbital elixir 20 mg/5ml</i> .....	252
PENTOSAN CAP 150MG.....	<i>phenobarbital tab 100 mg</i> .....	253
245	<i>phenobarbital tab 15 mg</i> .....	252
PENTOSAN CAP 200MG .....	<i>phenobarbital tab 16.2 mg</i> .....	252
245	<i>phenobarbital tab 30 mg</i> .....	253
<i>pentoxifylline tab er 400 mg</i> .....	<i>phenobarbital tab 32.4 mg</i> .....	253
247	<i>phenobarbital tab 60 mg</i> .....	253
PEPCID TAB 40MG.....	<i>phenobarbital tab 64.8 mg</i> .....	253
324	<i>phenobarbital tab 97.2 mg</i> .....	253
PEPTAMEN LIQ PREBIO1.....	<i>phenoxybenzamine hcl cap 10 mg</i> .....	106
220	<i>phentermine hcl cap 15 mg</i> .....	6
PEPTAMEN LIQ UNFLAVOR.....	<i>phentermine hcl cap 30 mg</i> .....	6
220	<i>phentermine hcl cap 37.5 mg</i> .....	6
PEPTINEX DT LIQ.....	<i>phentermine hcl tab 37.5 mg</i> .....	6
220	PHENYLAD60 POW .....	220
PEPTINEX DT LIQ VANILLA.....	<i>phenylephrine hcl ophth soln 10%</i> .....	298
220	<i>phenylephrine hcl ophth soln 2.5%</i> .....	298
PERATIVE LIQ.....	PHENYL-FREE POW 2.....	220
220	<i>phenytoin chew tab 50 mg</i> .....	77
PERCOCET TAB 10-325MG.....	<i>phenytoin sodium extended cap 100 mg</i> ..	77
47		
PERCOCET TAB 2.5-325.....		
47		
PERCOCET TAB 5-325MG.....		
47		
PERCOCET TAB 7.5-325.....		
47		
PERFECT 28G MIS LANCETS.....		
270		
PERFECT 30G MIS LANCETS.....		
270		
PERFOROMIST NEB 20MCG.....		
64		
PERIDEX SOL 0.12% .....		
287		
PERIFLEX POW ADVANCE.....		
220		
<i>perindopril erbumine tab 2 mg</i> .....		
105		
<i>perindopril erbumine tab 4 mg</i> .....		
106		
<i>perindopril erbumine tab 8 mg</i> .....		
106		
<i>permethrin cream 5%</i> .....		
204		
<i>perphenazine-amitriptyline tab 2-10 mg</i>		309
<i>perphenazine-amitriptyline tab 2-25 mg</i>		309
<i>perphenazine-amitriptyline tab 4-10 mg</i>		309
<i>perphenazine-amitriptyline tab 4-25 mg</i>		309
<i>perphenazine-amitriptyline tab 4-50 mg</i>		309
<i>perphenazine tab 16 mg</i> .....		145

<i>phenytoin sodium extended cap 200 mg</i>	77	PLEGRIDY INJ .....	312
<i>phenytoin sodium extended cap 300 mg</i>	77	PLEGRIDY INJ PEN.....	312
<i>phenytoin susp 125 mg/5ml</i> .....	77	PLEGRIDY INJ STARTER .....	312
PHOSLYRA SOL .....	243	PLEGRIDY PEN INJ STARTER.....	312
PHOSPHOLINE SOL 0.125%OP .....	298	PLENVU SOL.....	255
PHOTREXA/PHO SOL VISC KIT .....	300	PLIAGLIS CRE 7-7% .....	203
PHOTREXA VIS SOL 0.146-20 .....	300	PNV-DHA CAP DOCUSATE.....	290
<i>phytonadione tab 5 mg</i> .....	332	PNV-OMEGA CAP .....	290
PICATO GEL 0.015%.....	188	PNV TAB 20-1 TAB .....	290
PICATO GEL 0.05% .....	188	PNV TABS TAB 29-1MG.....	290
PIFELTRO TAB 100MG.....	152	POCKET CHAMB MIS.....	279
<i>pilocarpine hcl ophth soln 1%</i> .....	298	POCKETCHEM SOL EZ .....	270
<i>pilocarpine hcl ophth soln 2%</i> .....	298	POCKETCHEM TES EZ.....	212
<i>pilocarpine hcl ophth soln 4%</i> .....	298	POCKET SPACE MIS .....	279
<i>pilocarpine hcl tab 5 mg</i> .....	288	<i>podofilox soln 0.5%</i> .....	202
<i>pilocarpine hcl tab 7.5 mg</i> .....	288	<i>polymyxin b-trimethoprim ophth soln</i> <i>10000 unit/ml-0.1%</i> .....	299
<i>pimecrolimus cream 1%</i> .....	201	POLYTRIM SOL OP.....	299
<i>pimozide tab 1 mg</i> .....	314	POMALYST CAP 1MG .....	122
<i>pimozide tab 2 mg</i> .....	314	POMALYST CAP 2MG.....	122
<i>pindolol tab 10 mg</i> .....	161	POMALYST CAP 3MG.....	122
<i>pindolol tab 5 mg</i> .....	161	POMALYST CAP 4MG.....	122
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	86	PONVORY TAB 20MG.....	312
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	86	PONVORY TAB STARTER.....	312
<i>pioglitazone hcl-metformin hcl tab 15-500</i> <i>mg</i> .....	86	PORTAGEN POW .....	220
<i>pioglitazone hcl-metformin hcl tab 15-850</i> <i>mg</i> .....	86	<i>posaconazole susp 40 mg/ml</i> .....	98
<i>pioglitazone hcl tab 15 mg (base equiv)</i> ....	92	<i>posaconazole tab delayed release 100 mg</i> .....	98
<i>pioglitazone hcl tab 30 mg (base equiv)</i> ...92		<i>pot &amp; sod citrates w/ cit ac soln 550-500-</i> <i>334 mg/5ml</i> .....	244
<i>pioglitazone hcl tab 45 mg (base equiv)</i> ...93		<i>potassium chloride cap er 10 meq</i> .....	283
PIP LANCETS MIS 28G.....	270	<i>potassium chloride cap er 8 meq</i> .....	283
PIP LANCETS MIS 30G .....	270	<i>potassium chloride microencapsulated crys</i> <i>er tab 10 meq</i> .....	283
PIQRAY 200MG TAB DOSE.....	129	<i>potassium chloride microencapsulated crys</i> <i>er tab 15 meq</i> .....	283
PIQRAY 250MG TAB DOSE.....	129	<i>potassium chloride microencapsulated crys</i> <i>er tab 20 meq</i> .....	283
PIQRAY 300MG TAB DOSE.....	129	<i>potassium chloride oral soln 10% (20</i> <i>meq/15ml)</i> .....	283
<i>pirfenidone tab 267 mg</i> .....	317	<i>potassium chloride oral soln 20% (40</i> <i>meq/15ml)</i> .....	283
<i>pirfenidone tab 801 mg</i> .....	317		
<i>piroxicam cap 10 mg</i> .....	30		
<i>piroxicam cap 20 mg</i> .....	30		
PIVOT LIQ 1.5 CAL .....	220		
PKU EXPLORE5 POW UNFLAVOR .....	220		
PLAQUENIL TAB 200MG .....	115		
PLAVIX TAB 75MG .....	248		

<i>potassium chloride powder packet 20 meq</i> .....283	<i>pramipexole dihydrochloride tab er 24hr</i> 3.75 mg.....137
<i>potassium chloride tab er 10 meq</i> .....283	<i>pramipexole dihydrochloride tab er 24hr 3</i> <i>mg</i> .....137
<i>potassium chloride tab er 20 meq (1500</i> <i>mg)</i> .....283	<i>pramipexole dihydrochloride tab er 24hr</i> 4.5 mg.....137
<i>potassium chloride tab er 8 meq (600 mg)</i> .....283	PRAMOSONE CRE 1-1% .....199
<i>potassium citrate &amp; citric acid powder pack</i> 3300-1002 mg.....244	PRAMOSONE LOT 1%.....199
<i>potassium citrate &amp; citric acid soln 1100-</i> 334 mg/5ml .....244	PRAMOSONE LOT 2.5%.....199
<i>potassium citrate tab er 10 meq (1080 mg)</i> .....244	PRAMOX GEL 1% .....203
<i>potassium citrate tab er 15 meq (1620 mg)</i> .....244	<i>prasugrel hcl tab 10 mg (base equiv)</i> .....248
<i>potassium citrate tab er 5 meq (540 mg)</i> .....244	<i>prasugrel hcl tab 5 mg (base equiv)</i> .....248
POTASSIUM POW CHLORIDE .....283	<i>pravastatin sodium tab 10 mg</i> .....103
POVIDONE IOD SOL 5% .....299	<i>pravastatin sodium tab 20 mg</i> .....103
PPA/MMA POW EXPRESS .....220	<i>pravastatin sodium tab 40 mg</i> .....103
PRADAXA CAP 110MG .....68	<i>pravastatin sodium tab 80 mg</i> .....103
PRADAXA CAP 150MG.....68	<i>praziquantel tab 600 mg</i> .....51
PRADAXA CAP 75MG .....68	<i>prazosin hcl cap 1 mg</i> .....108
PRALUENT INJ 150MG/ML.....104	<i>prazosin hcl cap 2 mg</i> .....108
PRALUENT INJ 75MG/ML .....104	<i>prazosin hcl cap 5 mg</i> .....108
<i>pramipexole dihydrochloride tab 0.125 mg</i> .....137	PR BENZOYL LIQ 7% WASH.....184
<i>pramipexole dihydrochloride tab 0.25 mg</i> .....137	PRECISION LIQ CONTROL .....270
<i>pramipexole dihydrochloride tab 0.5 mg</i> 137	PRECISION LIQ GLUC/KET .....270
<i>pramipexole dihydrochloride tab 0.75 mg</i> .....137	PRECISION LIQ NRML/MID .....270
<i>pramipexole dihydrochloride tab 1.5 mg</i> .137	PRECISION PT TES OF CARE.....213
<i>pramipexole dihydrochloride tab 1 mg</i> ...137	PRECISION TES PCX.....213
<i>pramipexole dihydrochloride tab er 24hr</i> 0.375 mg .....137	PRECISION TES PCX PLUS .....213
<i>pramipexole dihydrochloride tab er 24hr</i> 0.75 mg .....137	PRECISION TES QID .....213
<i>pramipexole dihydrochloride tab er 24hr 1.5</i> <i>mg</i> .....137	PRECISION TES SOF-TACT.....213
<i>pramipexole dihydrochloride tab er 24hr</i> 2.25 mg.....137	PRECISION TES XTRA.....213
	PRECISN XTRA TES KETONE.....213
	PRECOSE TAB 100MG .....85
	PRECOSE TAB 25MG .....85
	PRECOSE TAB 50MG .....85
	PRED/NEPAFEN DRO 1-0.1%.....302
	PRED FORTE SUS 1% OP.....301
	PRED-GATIFL- SUS BROMFENA .....302
	PRED-GATI SUS 1-0.5% .....301
	PRED-G S.O.P OIN OP .....301
	PRED-G SUS OP .....301
	PRED MILD SUS 0.12% OP .....301
	PRED MOXIFLO SOL 1-0.5%.....301
	PRED MOXIFLO SUS BROMFEN .....301

PREDNI/MOXI/ DRO NEPAFENA .....	302	<i>pregabalin cap 300 mg</i> .....	74
PREDNI/MOXIF DRO 1-0.5% .....	302	<i>pregabalin cap 50 mg</i> .....	74
<i>prednicarbate cream 0.1%</i> .....	199	<i>pregabalin cap 75 mg</i> .....	74
<i>prednicarbate oint 0.1%</i> .....	199	<i>pregabalin soln 20 mg/ml</i> .....	74
<i>prednisolone acetate ophth susp 1%</i> .....	302	<i>pregabalin tab er 24hr 165 mg</i> .....	314
<i>prednisolone sodium phosphate oral soln</i> <i>25 mg/5ml (base eq)</i> .....	180	<i>pregabalin tab er 24hr 330 mg</i> .....	314
<i>prednisolone sod phos orally disintegr tab</i> <i>10 mg (base eq)</i> .....	179	<i>pregabalin tab er 24hr 82.5 mg</i> .....	314
<i>prednisolone sod phos orally disintegr tab</i> <i>15 mg (base eq)</i> .....	179	PREGEN DHA CAP .....	290
<i>prednisolone sod phos orally disintegr tab</i> <i>30 mg (base eq)</i> .....	180	PREGENNA TAB.....	290
<i>prednisolone sod phosphate oral soln 10</i> <i>mg/5ml (base equiv)</i> .....	180	PREGNYL INJ 10000UNT .....	228
<i>prednisolone sod phosphate oral soln 15</i> <i>mg/5ml (base equiv)</i> .....	180	PREMARIN INJ 25MG .....	238
<i>prednisolone sod phosphate oral soln 20</i> <i>mg/5ml (base equiv)</i> .....	180	PREMARIN TAB 0.3MG.....	238
<i>prednisolone sod phosph oral soln 6.7</i> <i>mg/5ml (5 mg/5ml base)</i> .....	180	PREMARIN TAB 0.45MG .....	238
PREDNISOLONE SOL MOX-BROM.....	302	PREMARIN TAB 0.625MG .....	238
<i>prednisolone soln 15 mg/5ml</i> .....	180	PREMARIN TAB 0.9MG.....	238
PREDNISOLONE SUS 1% .....	302	PREMARIN TAB 1.25MG .....	238
PREDNISON CON 5MG/ML.....	180	PREMARIN VAG CRE 0.625MG .....	330
<i>prednisone oral soln 5 mg/5ml</i> .....	180	PREMESISRX TAB .....	290
<i>prednisone tab 10 mg</i> .....	180	PREMIUM BLOO MIS GLUCOSE.....	213
<i>prednisone tab 1 mg</i> .....	180	PREMPHASE TAB .....	236
<i>prednisone tab 2.5 mg</i> .....	180	PREMPRO TAB.....	236
<i>prednisone tab 20 mg</i> .....	180	PREMPRO TAB 0.3-1.5.....	236
<i>prednisone tab 50 mg</i> .....	180	PREMPRO TAB 0.45-1.5 .....	236
<i>prednisone tab 5 mg</i> .....	180	PREMPRO TAB 0.625-5.....	236
<i>prednisone tab therapy pack 10 mg (21)</i> .180		PRENA1 CHW .....	290
<i>prednisone tab therapy pack 10 mg (48)</i> 180		PRENA1 PEARL CAP.....	290
<i>prednisone tab therapy pack 5 mg (21)</i> ...180		PRENA 1 TRUE MIS .....	290
<i>prednisone tab therapy pack 5 mg (48)</i> ..180		PRENAISSANCE CAP.....	290
PRED SOD PHO SOL 1% OP.....	301	PRENAISSANCE CAP PLUS .....	290
PREFEST TAB .....	236	PRENARA CAP PRENATAL .....	290
<i>pregabalin cap 100 mg</i> .....	74	PRENATAL+FE TAB 29-1MG.....	290
<i>pregabalin cap 150 mg</i> .....	74	PRENATAL 19 CHW 29-1MG.....	290
<i>pregabalin cap 200 mg</i> .....	74	PRENATAL 19 TAB 29-1MG.....	290
<i>pregabalin cap 225 mg</i> .....	74	PRENATAL TAB 27-1MG.....	290
<i>pregabalin cap 25 mg</i> .....	74	PRENATAL-U CAP 106.5-1 .....	290
		PRENATAL VIT TAB LOW IRON .....	290
		<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1</i> <i>mg</i> .....	290
		<i>prenatal vit w/ fe fumarate-fa chew tab 29-1</i> <i>mg</i> .....	290
		<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i> .....	290

<i>prenatal vit w/ fe fum-methylfolate-fa tab</i>	PRILOSEC POW 10MG .....	326
27-0.6-0.4 mg .....	PRILOSEC POW 2.5MG.....	326
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	PRIMACARE CAP .....	291
.....	<i>primaquine phosphate tab 26.3 mg (15 mg</i>	
PRENATE AM TAB 1MG .....	<i>base)</i> .....	115
PRENATE CAP ENHANCE .....	PRIMAQUINE TAB 26.3MG .....	115
PRENATE CAP ESSENT .....	<i>primidone tab 125 mg</i> .....	74
PRENATE CAP PIXIE .....	<i>primidone tab 250 mg</i> .....	74
PRENATE CAP RESTORE .....	<i>primidone tab 50 mg</i> .....	74
PRENATE CHW 0.6-0.4.....	PRIMSOL SOL 50MG/5ML.....	51
PRENATE DHA CAP .....	PRINIVIL TAB 20MG .....	106
PRENATE MINI CAP .....	PRISTIQ TAB 100MG .....	82
PRENATE TAB ELITE.....	PRISTIQ TAB 25MG .....	82
PRENATRIX TAB.....	PRISTIQ TAB 50MG .....	82
PRENATRYL TAB.....	PROAIR DIGIH AER.....	64
PRENATVITE TAB COMPLETE .....	PROAIR HFA AER.....	64
PRENATVITE TAB PLUS .....	PROAIR RESPI AER.....	64
PRENATVITE TAB RX.....	<i>probenecid tab 500 mg</i> .....	246
<i>prenat w/o a w/fefum-methfol-fa-dha cap</i>	PROCARDIA CAP 10MG .....	164
27-0.6-0.4-300 mg.....	PROCARDIA XL TAB 30MG CR .....	164
PREPIDIL GEL 0.5MG/3G.....	PROCARDIA XL TAB 60MG CR.....	164
PREPLUS TAB 27-1MG.....	PROCARDIA XL TAB 90MG CR.....	164
PREP PADS PAD .....	<i>prochlorperazine edisylate inj 10 mg/2ml</i>	
PRESSURE ACT MIS LANCET .....	.....	145
PRESSURE ACT MIS LANCETS.....	<i>prochlorperazine edisylate inj 50 mg/10ml</i>	
PRESTALIA TAB 14-10MG.....	.....	145
PRESTALIA TAB 3.5-2.5 .....	<i>prochlorperazine maleate tab 10 mg (base</i>	
PRESTALIA TAB 7-5MG .....	<i>equivalent)</i> .....	145
PRETAB TAB 29-1MG.....	<i>prochlorperazine maleate tab 5 mg (base</i>	
PRETOMANID TAB 200MG .....	<i>equivalent)</i> .....	145
PREVACID CAP 15MG DR.....	<i>prochlorperazine suppos 25 mg</i> .....	145
PREVACID CAP 30MG DR.....	PRO COMFORT MIS 31G.....	270
PREVACID TAB 15MG STB .....	PRO COMFORT MIS LANC 30G .....	270
PREVACID TAB 30MG STB.....	PRO COMFORT MIS LANCETS.....	270
PREVYMIS TAB 240MG.....	PRO COMFORT PAD ALCOHOL.....	277
PREVYMIS TAB 480MG.....	PROCORT CRE .....	50
PREZCOBIX TAB 800-150 .....	PROCRIT INJ 10000/ML .....	251
PREZISTA SUS 100MG/ML.....	PROCRIT INJ 2000/ML .....	251
PREZISTA TAB 150MG .....	PROCRIT INJ 20000/ML.....	251
PREZISTA TAB 600MG .....	PROCRIT INJ 3000/ML .....	251
PREZISTA TAB 75MG.....	PROCRIT INJ 4000/ML .....	251
PREZISTA TAB 800MG.....	PROCRIT INJ 40000/ML.....	251
PRIFTIN TAB 150MG.....	PROCTOCORT CRE 1%.....	50

PROCTOCORT SUP 30MG .....	50	<i>promethazine hcl tab 50 mg</i> .....	99
PROCTOFOAM AER HC 1%.....	50	<i>promethazine-phenylephrine-codeine</i>	
PROCYSBI CAP 25MG .....	245	<i>syrup 6.25-5-10 mg/5ml</i> .....	181
PROCYSBI CAP 75MG .....	245	<i>promethazine w/ codeine syrup 6.25-10</i>	
PROCYSBI GRA 300MG .....	245	<i>mg/5ml</i> .....	181
PROCYSBI GRA 75MG .....	245	PROMETRIUM CAP 100MG.....	306
PRODIGEN CAP .....	94	PROMETRIUM CAP 200MG.....	306
PRODIGY MIS 26G.....	270	PROMOTE/ LIQ FIBER.....	221
PRODIGY MIS 28G.....	270	PROMOTE 1.0 LIQ W/ FIBER.....	221
PRODIGY MIS LANC DEV .....	270	PROMOTE LIQ VANILLA.....	221
PRODIGY NO TES CODING .....	213	PROMOTE W/FB LIQ VANILLA.....	221
PRODIGY SOL HIGH.....	270	PROMOTE W/ LIQ FIBER.....	221
PRODIGY SOL LOW.....	270	<i>propafenone hcl cap er 12hr 225 mg</i> .....	57
<i>progesterone cap 100 mg</i> .....	306	<i>propafenone hcl cap er 12hr 325 mg</i> .....	57
<i>progesterone cap 200 mg</i> .....	306	<i>propafenone hcl cap er 12hr 425 mg</i> .....	57
<i>progesterone im in oil 50 mg/ml</i> .....	306	<i>propafenone hcl tab 150 mg</i> .....	57
PROGLYCEM SUS 50MG/ML.....	88	<i>propafenone hcl tab 225 mg</i> .....	57
PROGRAF CAP 0.5MG .....	286	<i>propafenone hcl tab 300 mg</i> .....	57
PROGRAF CAP 1MG .....	286	<i>proparacaine hcl ophth soln 0.5%</i> .....	300
PROGRAF CAP 5MG .....	286	PRO-PHREE POW .....	220
PROGRAF GRA 0.2MG .....	286	PROPIMEX-1 POW .....	221
PROGRAF GRA 1MG .....	286	PROPIMEX-2 POW .....	221
PROLATE SOL 10/300MG .....	47	<i>propranolol &amp; hydrochlorothiazide tab 40-</i>	
PROLATE TAB 10-300MG.....	47	<i>25 mg</i> .....	113
PROLATE TAB 5-300MG .....	47	<i>propranolol &amp; hydrochlorothiazide tab 80-</i>	
PROLATE TAB 7.5-300 .....	47	<i>25 mg</i> .....	113
PROLENSA SOL 0.07%.....	303	<i>propranolol hcl cap er 24hr 120 mg</i> .....	161
PROMACTA PAK 25MG.....	251	<i>propranolol hcl cap er 24hr 160 mg</i> .....	161
PROMACTA POW 12.5MG.....	251	<i>propranolol hcl cap er 24hr 60 mg</i> .....	161
PROMACTA TAB 12.5MG .....	251	<i>propranolol hcl cap er 24hr 80 mg</i> .....	161
PROMACTA TAB 25MG.....	251	<i>propranolol hcl oral soln 20 mg/5ml</i> .....	161
PROMACTA TAB 50MG.....	251	<i>propranolol hcl oral soln 40 mg/5ml</i> .....	161
PROMACTA TAB 75MG.....	251	<i>propranolol hcl tab 10 mg</i> .....	161
PROMACTIN AA SUS PLUS.....	221	<i>propranolol hcl tab 20 mg</i> .....	161
<i>promethazine &amp; phenylephrine syrup 6.25-</i>		<i>propranolol hcl tab 40 mg</i> .....	161
<i>5 mg/5ml</i> .....	181	<i>propranolol hcl tab 60 mg</i> .....	161
<i>promethazine-dm syrup 6.25-15 mg/5ml</i> .....	181	<i>propranolol hcl tab 80 mg</i> .....	161
<i>promethazine hcl suppos 12.5 mg</i> .....	99	<i>propylthiouracil tab 50 mg</i> .....	320
<i>promethazine hcl suppos 25 mg</i> .....	99	PROSCAR TAB 5MG.....	245
<i>promethazine hcl suppos 50 mg</i> .....	99	PROSOURCE LIQ TF .....	221
<i>promethazine hcl syrup 6.25 mg/5ml</i> .....	99	PROSTIN E2 SUP 20MG.....	304
<i>promethazine hcl tab 12.5 mg</i> .....	99	PROTHELIAL PST 10%.....	288
<i>promethazine hcl tab 25 mg</i> .....	99	PROTONIX INJ 40MG .....	326

PROTONIX PAK 40MG.....	326	<i>pyridostigmine bromide tab 30 mg</i> .....	116
PROTONIX TAB 20MG .....	327	<i>pyridostigmine bromide tab 60 mg</i> .....	116
PROTONIX TAB 40MG .....	327	<i>pyridostigmine bromide tab er 180 mg</i> ....	116
PROTOPIC OIN 0.03%.....	201	PYRIME/LEUCO CAP 12.5/2.5.....	115
PROTOPIC OIN 0.1%.....	201	PYRIME/LEUCO CAP 25/10MG .....	115
<i>protriptyline hcl tab 10 mg</i> .....	84	PYRIME/LEUCO CAP 25/5MG .....	115
<i>protriptyline hcl tab 5 mg</i> .....	84	PYRIME/LEUCO CAP 50/10MG .....	115
PROVAD CAP .....	94	PYRIME/LEUCO CAP 50/20MG .....	115
PROVENTIL AER HFA .....	65	PYRIME/LEUCO CAP 50/25MG.....	115
PROVERA TAB 10MG .....	306	PYRIME/LEUCO CAP 75/25MG.....	115
PROVERA TAB 2.5MG.....	306	<i>pyrimethamine tab 25 mg</i> .....	115
PROVERA TAB 5MG.....	306	PYROGALL ACD OIN.....	202
PROVIDA OB CAP.....	291	PYRUKYND TAB 20MG.....	248
PROVIGIL TAB 100MG .....	13	PYRUKYND TAB 50MG.....	248
PROVIGIL TAB 200MG.....	13	PYRUKYND TAB 5MG .....	248
PROVIMIN POW.....	221	<b>Q</b>	
PRO VOICE TES V8/V9 .....	213	QBRELIS SOL 1MG/ML .....	106
PROZAC CAP 10MG .....	81	QBREXZA PAD 2.4% .....	203
PROZAC CAP 20MG.....	81	QC ALCOHOL PAD SWABS.....	277
PROZAC CAP 40MG .....	81	QC LANCETS MIS 28G.....	270
PRUDOXIN CRE 5% .....	188	QC LANCETS MIS 30G.....	271
<i>pseudoephed-bromphen-dm syrup 30-2-10</i> <i>mg/5ml</i> .....	181	QC LANCING MIS DEVICE.....	271
PSORCON CRE 0.05% .....	199	QDOLO SOL 5MG/ML .....	43
PSS SAFE LAN MIS.....	270	QELBREE CAP 100MG ER .....	7
PSS SEL LANC MIS.....	270	QELBREE CAP 150MG ER.....	7
PSS SEL PLAT MIS.....	270	QELBREE CAP 200MG ER.....	7
PTS PANELS TES GLUCOSE .....	213	QINLOCK TAB 50MG.....	130
PTS PANELS TES KETONE .....	213	QMIIZ ODT TAB 15 MG.....	30
PULMICORT INH 180MCG.....	61	QMIIZ ODT TAB 7.5MG .....	30
PULMICORT INH 90MCG .....	61	QNASL AER 80MCG.....	295
PULMICORT SUS 0.25MG/2 .....	61	QNASL CHILD SPR 40MCG .....	295
PULMICORT SUS 0.5MG/2 .....	61	QSYMIA CAP 11.25-69 .....	6
PULMICORT SUS 1MG/2ML.....	61	QSYMIA CAP 15-92MG.....	6
PULMOZYME SOL 1MG/ML.....	316	QSYMIA CAP 3.75-23 .....	6
PURE COMFORT PAD .....	277	QSYMIA CAP 7.5-46MG.....	6
PURIXAN SUS 20MG/ML .....	118	QTERN TAB 10-5MG.....	86
PX LANCETS MIS 28G.....	270	QTERN TAB 5-5MG .....	86
PX LANCETS MIS ULT THIN.....	270	QUALAQUIN CAP 324MG .....	116
PYLERA CAP.....	327	QUARTETTE TAB .....	177
<i>pyrazinamide tab 500 mg</i> .....	116	<i>quazepam tab 15 mg</i> .....	253
<i>pyridostigmine bromide oral soln 60</i> <i>mg/5ml</i> .....	116	QUDEXY XR CAP 100/24HR.....	74
		QUDEXY XR CAP 150/24HR.....	74
		QUDEXY XR CAP 200/24HR .....	74

QUDEXY XR CAP 25/24HR.....	74	QUZYTIR INJ 10MG/ML.....	99
QUDEXY XR CAP 50/24HR .....	74	QVAR REDIIHA AER 80MCG .....	61
QUESTRAN POW 4GM .....	100	QVAR REDIIHAL AER 40MCG.....	61
QUESTRAN POW 4GM LITE .....	100	<b>R</b>	
<i>quetiapine fumarate tab 100 mg</i> .....	143	RABEPRAZOLE CAP 10MG DR.....	327
<i>quetiapine fumarate tab 200 mg</i> .....	143	<i>rabeprazole sodium ec tab 20 mg</i> .....	327
<i>quetiapine fumarate tab 25 mg</i> .....	143	RADICAVA ORS SUS 105/5ML .....	295
<i>quetiapine fumarate tab 300 mg</i> .....	143	RADICAVA ORS SUS STARTER .....	295
<i>quetiapine fumarate tab 400 mg</i> .....	143	RADIOGARDASE CAP 0.5GM .....	95
<i>quetiapine fumarate tab 50 mg</i> .....	143	RA E-ZJECT MIS 28G .....	271
<i>quetiapine fumarate tab er 24hr 150 mg</i> .	143	RA E-ZJECT MIS THIN 26G .....	271
<i>quetiapine fumarate tab er 24hr 200 mg</i>	143	RA E-ZJECT MIS THIN 28G .....	271
<i>quetiapine fumarate tab er 24hr 300 mg</i>	143	RA E-ZJECT MIS ULT THIN .....	271
<i>quetiapine fumarate tab er 24hr 400 mg</i>	143	RAGWITEK SUB .....	15
<i>quetiapine fumarate tab er 24hr 50 mg</i> ...	143	<i>raloxifene hcl tab 60 mg</i> .....	230
QUICKTEK LIQ SOLUTION .....	271	<i>ramelteon tab 8 mg</i> .....	254
QUICKTEK TES.....	213	<i>ramipril cap 1.25 mg</i> .....	106
QUILLICHEW CHW 20MG ER .....	14	<i>ramipril cap 10 mg</i> .....	106
QUILLICHEW CHW 30MG ER .....	14	<i>ramipril cap 2.5 mg</i> .....	106
QUILLICHEW CHW 40MG ER .....	14	<i>ramipril cap 5 mg</i> .....	106
QUILLIVANT SUS 25MG/5ML.....	14	RANEXA TAB 1000MG .....	53
<i>quinapril hcl tab 10 mg</i> .....	106	RANEXA TAB 500MG.....	53
<i>quinapril hcl tab 20 mg</i> .....	106	<i>ranolazine tab er 12hr 1000 mg</i> .....	53
<i>quinapril hcl tab 40 mg</i> .....	106	<i>ranolazine tab er 12hr 500 mg</i> .....	53
<i>quinapril hcl tab 5 mg</i> .....	106	RAPAFLO CAP 4MG .....	245
<i>quinapril-hydrochlorothiazide tab 10-12.5</i>		RAPAFLO CAP 8MG .....	245
<i>mg</i> .....	113	RAPAMUNE SOL 1MG/ML.....	286
<i>quinapril-hydrochlorothiazide tab 20-12.5</i>		RAPAMUNE TAB 0.5MG.....	286
<i>mg</i> .....	113	RAPAMUNE TAB 1MG .....	286
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>		RAPAMUNE TAB 2MG .....	286
.....	113	RAPID-SAFE MIS LANCING .....	271
<i>quinidine gluconate tab er 324 mg</i> .....	57	<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	
<i>quinidine sulfate tab 200 mg</i> .....	57	.....	138
<i>quinidine sulfate tab 300 mg</i> .....	57	<i>rasagiline mesylate tab 1 mg (base equiv)</i>	
<i>quinine sulfate cap 324 mg</i> .....	116	.....	138
QUINTET AC TES BLD GLUC.....	213	RASUVO INJ 10MG .....	26
QUINTET CONT SOL HGH/NORM .....	271	RASUVO INJ 12.5MG .....	26
QUINTET TES BLD GLUC .....	213	RASUVO INJ 15MG.....	26
QULIPTA TAB 10MG .....	280	RASUVO INJ 17.5MG .....	26
QULIPTA TAB 30MG .....	280	RASUVO INJ 20MG.....	26
QULIPTA TAB 60MG .....	280	RASUVO INJ 22.5MG.....	26
QUVIVIQ TAB 25MG .....	254	RASUVO INJ 25MG.....	26
QUVIVIQ TAB 50MG.....	254	RASUVO INJ 30MG.....	26



RASUVO INJ 7.5MG.....	26	RELEXXII TAB 72MG .....	14
RAVICTI LIQ 1.1GM/ML .....	233	RELION BLOOD TES GLUCOSE .....	213
RAYASAL CRE 5.9%.....	202	RELION KIT LANCING .....	271
RAYOS TAB 1MG .....	180	RELION LANCE MIS THIN 26G .....	271
RAYOS TAB 2MG.....	180	RELION LANCE MIS THIN 30G .....	271
RAYOS TAB 5MG.....	180	RELION LANCI MIS DEVICE .....	271
RAZADYNE ER CAP 16MG.....	308	RELION MICRO MIS THIN 33G .....	271
RAZADYNE ER CAP 24MG .....	308	RELION PREMI TES GLUCOSE.....	213
RAZADYNE ER CAP 8MG .....	308	RELION PRIME TES .....	213
READYLANCE MIS 21G .....	271	RELION PRIME TES GLUCOSE .....	214
READYLANCE MIS 23G .....	271	RELION TES KETONE.....	214
READYLANCE MIS 26G .....	271	RELION TES ULTIMA.....	214
READYLANCE MIS 28G .....	271	RELION TRUE TES METRIX .....	214
READYLANCE MIS 30G .....	271	RELION ULTRA MIS THIN 30G.....	271
REALITY MIS LANCETS .....	271	RELION ULTRA MIS THIN PLS .....	271
REALITY SWAB PAD.....	277	RELISTOR INJ 12/0.6ML .....	243
REALITY TRIG MIS LANCETS.....	271	RELISTOR INJ 8/0.4ML .....	243
REALSIL-6 MIS .....	257	RELISTOR TAB 150MG.....	243
REBIF INJ 22/0.5 .....	312	RELNATE DHA CAP.....	291
REBIF INJ 44/0.5 .....	312	RELPAK TAB 20MG.....	281
REBIF REBIDO INJ 22/0.5 .....	312	RELPAK TAB 40MG.....	281
REBIF REBIDO INJ 44/0.5 .....	312	RELTONE CAP 200MG .....	239
REBIF REBIDO INJ TITRATN .....	313	RELTONE CAP 400MG .....	239
REBIF TITRTN INJ PACK .....	313	RELYVRIO PAK 3-1GM .....	295
RECTIV OIN 0.4% .....	50	REMERON SLTB TAB 15MG.....	78
RECURA CRE.....	187	REMERON SLTB TAB 30MG.....	78
REDICHEW RX CHW .....	291	REMERON SLTB TAB 45MG.....	78
REDITREX INJ 10/.4ML .....	26	REMERON TAB 15MG.....	78
REDITREX INJ 12.5/0.5.....	26	REMERON TAB 30MG.....	78
REDITREX INJ 15/.6ML .....	26	RENAGEL TAB 800MG.....	243
REDITREX INJ 17.5/0.7.....	26	RENASTART POW .....	221
REDITREX INJ 20/.8ML.....	26	REVELA POW 0.8GM .....	244
REDITREX INJ 22.5/0.9.....	26	REVELA POW 2.4GM.....	244
REDITREX INJ 25MG/ML.....	26	REVELA TAB 800MG.....	244
REDITREX INJ 7.5/.3ML.....	26	<i>repaglinide tab 0.5 mg .....</i>	93
REFUAH PLUS SOL CONTROL .....	271	<i>repaglinide tab 1 mg.....</i>	93
REFUAH PLUS TES BLD GLUC.....	213	<i>repaglinide tab 2 mg.....</i>	93
REGIMEX TAB 25MG .....	6	REPATHA INJ 140MG/ML.....	104
REGLAN TAB 10MG.....	240	REPATHA PUSH INJ 420/3.5 .....	104
REGLAN TAB 5MG .....	240	REPATHA SURE INJ 140MG/ML .....	104
REGANEX GEL 0.01% .....	204	REplete FIBE LIQ 1 CAL.....	221
RELAFEN DS TAB 1000MG.....	30	REplete LIQ ULTRAPAK.....	221
RELENZA MIS DISKHALE .....	158	RESOURCE DIA LIQ TF.....	221

RESTASIS EMU 0.05% OP .....	300	REYATAZ CAP 150MG .....	152
RESTASIS MUL EMU 0.05% OP .....	300	REYATAZ CAP 200MG .....	152
RESTORA RX CAP 60-1.25 .....	94	REYATAZ CAP 300MG .....	152
RESTORIL CAP 15MG .....	253	REYATAZ POW 50MG .....	152
RESTORIL CAP 22.5MG .....	254	REYVOW TAB 100MG .....	281
RESTORIL CAP 30MG .....	254	REYVOW TAB 50MG.....	281
RESTORIL CAP 7.5MG .....	253	REZLIDHIA CAP 150MG.....	130
RETACRIT INJ 10000UNT .....	251	REZUROCK TAB 200MG.....	286
RETACRIT INJ 20000UNI.....	251	REZVOGLAR INJ 100UT/ML.....	92
RETACRIT INJ 2000UNIT .....	251	RHEUMATE CAP .....	221
RETACRIT INJ 3000UNIT .....	251	RHOFADE CRE 1% .....	204
RETACRIT INJ 40000UNT .....	251	RHOPRESSA SOL 0.02%.....	300
RETACRIT INJ 4000UNIT .....	251	RIAX AER 5.5% .....	185
RETEVMO CAP 40MG .....	130	RIAX AER 9.5% .....	185
RETEVMO CAP 80MG .....	130	<i>ribavirin cap 200 mg</i> .....	157
RETIN-A CRE 0.025% .....	184	<i>ribavirin tab 200 mg</i> .....	157
RETIN-A CRE 0.05% .....	184	RIBOZEL CAP .....	221
RETIN-A CRE 0.1% .....	184	RIDAURA CAP 3MG .....	26
RETIN-A GEL 0.01% .....	184	<i>rifabutin cap 150 mg</i> .....	116
RETIN-A GEL 0.025% .....	184	<i>rifampin cap 150 mg</i> .....	116
RETIN-A MICR GEL 0.04%.....	184	<i>rifampin cap 300 mg</i> .....	116
RETIN-A MICR GEL 0.04%PMP .....	184	RIGHTEST ALT MIS ADAPTOR .....	271
RETIN-A MICR GEL 0.06%.....	184	RIGHTEST LIQ HIGH CON .....	271
RETIN-A MICR GEL 0.08%.....	185	RIGHTEST LIQ NORM CON .....	271
RETIN-A MICR GEL 0.1%.....	184	RIGHTEST MIS GD500.....	271
RETIN-A MICR GEL 0.1%PUMP.....	184	RIGHTEST MIS GL300 .....	271
RETROVIR CAP 100MG.....	152	RIGHTEST TES GS100 .....	214
RETROVIR SYP 50MG/5ML .....	152	RIGHTEST TES GS300 .....	214
REVATIO SUS 10MG/ML.....	172	RIGHTEST TES GS550 .....	214
REVATIO TAB 20MG .....	172	RILUTEK TAB 50MG .....	296
REVCovi INJ 1.6MG/ML.....	233	<i>riluzole tab 50 mg</i> .....	296
REVLIMID CAP 10MG .....	284	<i>rimantadine hydrochloride tab 100 mg</i> ...	158
REVLIMID CAP 15MG .....	284	RIMSO-50 SOL 50%.....	245
REVLIMID CAP 2.5MG .....	284	RINVOQ TAB 15MG ER .....	23
REVLIMID CAP 20MG .....	284	RINVOQ TAB 30MG ER .....	23
REVLIMID CAP 25MG .....	284	RINVOQ TAB 45MG ER .....	23
REVLIMID CAP 5MG.....	284	RIOMET SOL 500/5ML .....	88
REXULTI TAB 0.25MG.....	147	<i>risedronate sodium tab 150 mg</i> .....	227
REXULTI TAB 0.5MG.....	147	<i>risedronate sodium tab 30 mg</i> .....	227
REXULTI TAB 1MG .....	147	<i>risedronate sodium tab 35 mg</i> .....	227
REXULTI TAB 2MG .....	147	<i>risedronate sodium tab 5 mg</i> .....	227
REXULTI TAB 3MG .....	147	<i>risedronate sodium tab delayed release 35</i>	
REXULTI TAB 4MG .....	147	<i>mg</i> .....	227

RISPERDAL INJ 12.5MG .....	141	<i>rivastigmine tartrate cap 6 mg (base equivalent)</i> .....	308
RISPERDAL INJ 25MG.....	141	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i> .....	309
RISPERDAL INJ 37.5MG.....	141	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i> .....	309
RISPERDAL INJ 50MG.....	141	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i> .....	309
RISPERDAL SOL 1MG/ML .....	141	<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i> .....	282
RISPERDAL TAB 0.5MG .....	141	<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i> .....	282
RISPERDAL TAB 1MG .....	141	<i>rizatriptan benzoate tab 10 mg (base equivalent)</i> .....	282
RISPERDAL TAB 2MG.....	141	<i>rizatriptan benzoate tab 5 mg (base equivalent)</i> .....	282
RISPERDAL TAB 3MG.....	141	ROAOXIA GEL 3-4% .....	188
RISPERDAL TAB 4MG.....	141	ROCALTROL CAP 0.25MCG .....	233
<i>risperidone orally disintegrating tab 0.25 mg</i> .....	141	ROCALTROL CAP 0.5MCG.....	233
<i>risperidone orally disintegrating tab 0.5 mg</i> .....	141	ROCALTROL SOL 1MCG/ML.....	233
<i>risperidone orally disintegrating tab 1 mg</i> .....	141	ROCKLATAN DRO .....	300
<i>risperidone orally disintegrating tab 2 mg</i> .....	141	<i>roflumilast tab 250 mcg</i> .....	59
<i>risperidone orally disintegrating tab 3 mg</i> .....	141	<i>roflumilast tab 500 mcg</i> .....	59
<i>risperidone orally disintegrating tab 4 mg</i> .....	141	<i>ropinirole hydrochloride tab 0.25 mg</i> .....	137
<i>risperidone soln 1 mg/ml</i> .....	141	<i>ropinirole hydrochloride tab 0.5 mg</i> .....	137
<i>risperidone tab 0.25 mg</i> .....	141	<i>ropinirole hydrochloride tab 1 mg</i> .....	137
<i>risperidone tab 0.5 mg</i> .....	141	<i>ropinirole hydrochloride tab 2 mg</i> .....	137
<i>risperidone tab 1 mg</i> .....	141	<i>ropinirole hydrochloride tab 3 mg</i> .....	137
<i>risperidone tab 2 mg</i> .....	141	<i>ropinirole hydrochloride tab 4 mg</i> .....	138
<i>risperidone tab 3 mg</i> .....	141	<i>ropinirole hydrochloride tab 5 mg</i> .....	138
<i>risperidone tab 4 mg</i> .....	141	<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i> .....	138
RITALIN LA CAP 10MG .....	14	<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i> .....	138
RITALIN LA CAP 20MG.....	14	<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i> .....	138
RITALIN LA CAP 30MG.....	14	<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i> .....	138
RITALIN LA CAP 40MG.....	14	<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i> .....	138
RITALIN TAB 10MG.....	14	<i>rosuvastatin calcium tab 10 mg</i> .....	103
RITALIN TAB 20MG.....	14	<i>rosuvastatin calcium tab 20 mg</i> .....	103
RITALIN TAB 5MG .....	14	<i>rosuvastatin calcium tab 40 mg</i> .....	103
RITEFLO MIS.....	279	<i>rosuvastatin calcium tab 5 mg</i> .....	103
<i>ritonavir tab 100 mg</i> .....	152	ROSZET TAB 10-10MG .....	99
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i> .....	308		
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i> .....	308		
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i> .....	308		

ROSZET TAB 20-10MG.....	100	SAFE-T-LANCE MIS NOR FLOW .....	271
ROSZET TAB 40-10MG.....	100	SAFE-T-PRO MIS LANCETS .....	271
ROSZET TAB 5-10MG .....	99	SAFE-T-PRO MIS PLUS .....	272
ROWASA KIT 4GM.....	242	SAFETY 21G MIS LANCETS .....	272
ROXICODONE TAB 15MG .....	43	SAFETY 23G MIS LANCETS.....	272
ROXICODONE TAB 30MG .....	43	SAFETY 28G MIS LANCETS.....	272
ROXICODONE TAB 5MG.....	43	SAFETY 30G MIS LANCETS .....	272
ROXYBOND TAB 5MG.....	43	SAFETY MIS LANCETS.....	272
ROZEREM TAB 8MG.....	254	SAFYRAL TAB .....	177
ROZLYTREK CAP 100MG .....	130	SAIZEN INJ 5MG .....	230
ROZLYTREK CAP 200MG .....	130	SAIZEN INJ 8.8MG.....	230
RUBRACA TAB 200MG.....	130	SAIZENPREP INJ 8.8MG.....	230
RUBRACA TAB 250MG.....	130	SALAGEN TAB 5MG .....	288
RUBRACA TAB 300MG .....	130	SALAGEN TAB 7.5MG .....	288
RUCONEST INJ 2100UNIT .....	247	SALIMEZ CRE 6% .....	202
<i>rufinamide susp 40 mg/ml .....</i>	<i>74</i>	SALIMEZ FORT CRE 10%.....	202
RUKOBIA TAB 600MG ER .....	152	<i>salsalate tab 500 mg .....</i>	<i>35</i>
RUZURGI TAB 10MG .....	116	<i>salsalate tab 750 mg.....</i>	<i>35</i>
RYBELSUS TAB 14MG .....	90	SAMSCA TAB 15MG .....	235
RYBELSUS TAB 3MG.....	90	SAMSCA TAB 30MG .....	235
RYBELSUS TAB 7MG.....	90	SANCUSO DIS 3.1MG .....	96
RYDAPT CAP 25MG.....	130	SANDIMMUNE CAP 100MG .....	286
RYKINDO INJ 25MG .....	141	SANDIMMUNE CAP 25MG.....	286
RYKINDO INJ 37.5MG .....	141	SANDIMMUNE SOL 100MG/ML.....	286
RYKINDO INJ 50MG .....	141	SANDOSTATIN INJ 100MCG .....	235
RYSTIGGO INJ 280/2ML .....	284	SANDOSTATIN INJ 500MCG.....	235
RYTARY CAP 145MG.....	138	SANDOSTATIN INJ 50MCG/ML.....	235
RYTARY CAP 195MG.....	138	SANTYL OIN 250/GM .....	201
RYTARY CAP 245MG.....	138	SAPHRIS SUB 10MG.....	143
RYTARY CAP 95MG .....	138	SAPHRIS SUB 2.5MG .....	143
RYTHMOL SR CAP 225MG.....	57	SAPHRIS SUB 5MG .....	143
RYTHMOL SR CAP 325MG.....	57	<i>sapropterin dihydrochloride powder packet</i>	
RYTHMOL SR CAP 425MG.....	57	<i>100 mg .....</i>	<i>233</i>
RYVENT TAB 6MG .....	99	<i>sapropterin dihydrochloride powder packet</i>	
<b>S</b>		<i>500 mg .....</i>	<i>233</i>
S.O.S. 20 POW .....	221	<i>sapropterin dihydrochloride tab 100 mg</i>	<i>233</i>
S.O.S. 25 POW.....	221	SAPSCARE MIS TWIST.....	272
SABRIL POW 500MG .....	76	SAPS CARE PAD ALCOHOL .....	277
SABRIL TAB 500MG .....	76	SAPS HEALTH MIS TWIST.....	272
SAFE-T-LANCE MIS 21G.....	271	SAPS HEALTH PAD ALCOHOL .....	277
SAFE-T-LANCE MIS 25G .....	271	SAPS TWIST MIS 30G .....	272
SAFE-T-LANCE MIS HI FLOW.....	271	SAVAYSA TAB 15MG .....	66
SAFE-T-LANCE MIS LOW FLOW.....	271	SAVAYSA TAB 30MG .....	66

SAVAYSA TAB 60MG .....	66	SERNIVO SPR 0.05% .....	199
SAVELLA MIS TITR PAK .....	309	SEROQUEL TAB 100MG .....	144
SAVELLA TAB 100MG .....	309	SEROQUEL TAB 200MG .....	144
SAVELLA TAB 12.5MG .....	309	SEROQUEL TAB 25MG .....	143
SAVELLA TAB 25MG .....	309	SEROQUEL TAB 300MG .....	144
SAVELLA TAB 50MG .....	309	SEROQUEL TAB 400MG .....	144
SAXENDA INJ 18MG/3ML .....	5	SEROQUEL TAB 50MG .....	143
SB ALCOHOL PAD PREP .....	277	SEROQUEL XR TAB 150MG .....	144
SB LANCETS MIS THIN .....	272	SEROQUEL XR TAB 200MG .....	144
SB LANCETS MIS ULTR THN .....	272	SEROQUEL XR TAB 300MG .....	144
SCEMBLIX TAB 40MG .....	130	SEROQUEL XR TAB 400MG .....	144
<i>scopolamine td patch 72hr 1 mg/3days</i> .....	96	SEROQUEL XR TAB 50MG .....	144
SEASONIQUE TAB .....	177	SEROSTIM INJ 4MG .....	230
SECUADO DIS 3.8MG .....	143	SEROSTIM INJ 5MG .....	230
SECUADO DIS 5.7MG .....	143	SEROSTIM INJ 6MG .....	230
SECUADO DIS 7.6MG .....	143	<i>sertraline hcl oral concentrate for solution</i>	
SEEBRI NEOHA CAP 15.6MCG .....	58	<i>20 mg/ml</i> .....	81
SEGLENTIS TAB 56-44MG .....	47	<i>sertraline hcl tab 100 mg</i> .....	81
SEGLUROMET TAB 2.5-1000 .....	87	<i>sertraline hcl tab 25 mg</i> .....	81
SEGLUROMET TAB 2.5-500 .....	86	<i>sertraline hcl tab 50 mg</i> .....	81
SEGLUROMET TAB 7.5-1000 .....	87	<i>sevelamer carbonate packet 0.8 gm</i> .....	244
SEGLUROMET TAB 7.5-500 .....	87	<i>sevelamer carbonate packet 2.4 gm</i> .....	244
SELECT-LITE KIT DEV/LANC .....	272	<i>sevelamer carbonate tab 800 mg</i> .....	244
SELECT-LITE MIS LANC DEV .....	272	<i>sevelamer hcl tab 400 mg</i> .....	244
SELECT-OB+ PAK DHA .....	291	<i>sevelamer hcl tab 800 mg</i> .....	244
SELECT-OB CHW .....	291	SEYSARA TAB 100MG .....	319
<i>selegiline hcl cap 5 mg</i> .....	138	SEYSARA TAB 150MG .....	319
<i>selegiline hcl tab 5 mg</i> .....	138	SEYSARA TAB 60MG .....	319
<i>selenium sulfide lotion 2.5%</i> .....	194	SFROWASA ENE 4GM .....	242
SELZENTRY SOL 20MG/ML .....	152	SHOPKO LANC MIS DEVICE .....	272
SELZENTRY TAB 150MG .....	153	SHUR-SEAL GEL 2% .....	329
SELZENTRY TAB 25MG .....	153	SIDE BUTTON MIS SAFETY .....	272
SELZENTRY TAB 300MG .....	153	SIGNIFOR INJ 0.3MG/ML .....	235
SELZENTRY TAB 75MG .....	153	SIGNIFOR INJ 0.6MG/ML .....	235
SEMGLEE INJ 100U/ML .....	92	SIGNIFOR INJ 0.9MG/ML .....	235
SEMGLEE SOL 100U/ML .....	92	SIKLOS TAB 1000MG .....	249
SE-NATAL 19 CHW .....	291	SIKLOS TAB 100MG .....	249
SE-NATAL 19 TAB .....	291	<i>sildenafil citrate for suspension 10 mg/ml</i>	
SENSIPAR TAB 30MG .....	233	.....	172
SENSIPAR TAB 60MG .....	233	<i>sildenafil citrate tab 100 mg</i> .....	168
SENSIPAR TAB 90MG .....	233	<i>sildenafil citrate tab 20 mg</i> .....	172
SEREVENT DIS AER 50MCG .....	65	<i>sildenafil citrate tab 25 mg</i> .....	168
SERNIVO SPR .....	199	<i>sildenafil citrate tab 50 mg</i> .....	168

SILENOR TAB 3MG .....	253	SMART SENSE MIS LANC 21G .....	272
SILENOR TAB 6MG .....	253	SMART SENSE MIS LANC 26G .....	272
SILIQ INJ 210/1.5 .....	191	SMART SENSE MIS LANC 30G .....	272
<i>silodosin cap 4 mg</i> .....	245	SMART SENSE MIS LANC 33G .....	272
<i>silodosin cap 8 mg</i> .....	245	SMART SENSE TES TEST .....	214
SILVADENE CRE 1% .....	195	SM LANCETS MIS 33G .....	272
<i>silver sulfadiazine cream 1%</i> .....	195	SM TRUEDRAW MIS LANC DEV .....	272
SIMBRINZA SUS 1-0.2% .....	298	<i>sodium chloride soln nebu 0.9%</i> .....	182
SIMPLE DIAG MIS LANCING .....	272	<i>sodium chloride soln nebu 10%</i> .....	182
SIMPONI INJ 100MG/ML .....	22	<i>sodium chloride soln nebu 3%</i> .....	182
SIMPONI INJ 50/0.5ML .....	22	<i>sodium chloride soln nebu 7%</i> .....	182
<i>simvastatin tab 10 mg</i> .....	103	<i>sodium citrate &amp; citric acid soln 500-334</i>	
<i>simvastatin tab 20 mg</i> .....	103	<i>mg/5ml</i> .....	244
<i>simvastatin tab 40 mg</i> .....	103	<i>sodium fluoride gel 1.1% (0.5% f)</i> .....	288
<i>simvastatin tab 5 mg</i> .....	103	<i>sodium phenylbutyrate oral powder 3</i>	
<i>simvastatin tab 80 mg</i> .....	103	<i>gm/teaspoonful</i> .....	233
SINEMET TAB 10-100MG .....	138	<i>sodium phenylbutyrate tab 500 mg</i> .....	233
SINEMET TAB 25-100MG .....	138	<i>sodium polystyrene sulfonate oral susp 15</i>	
SINGLE-LET MIS 23G .....	272	<i>gm/60ml</i> .....	287
SINGULAIR CHW 4MG .....	59	<i>sodium polystyrene sulfonate powder</i> .....	287
SINGULAIR CHW 5MG .....	59	SODIUM SULFA LIQ 10% WASH .....	194
SINGULAIR GRA 4MG .....	59	SOD OXYBATE SOL 500MG/ML .....	307
SINGULAIR TAB 10MG .....	59	<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-</i>	
<i>sirolimus oral soln 1 mg/ml</i> .....	286	<i>3.13-1.6 gm/177ml</i> .....	255
<i>sirolimus tab 0.5 mg</i> .....	286	SOFTCLIX MIS LANCETS .....	272
<i>sirolimus tab 1 mg</i> .....	286	SOGROYA INJ 10MG/1.5 .....	230
<i>sirolimus tab 2 mg</i> .....	286	SOGROYA INJ 15MG/1.5 .....	230
SIRTURO TAB 100MG .....	116	SOGROYA INJ 5MG/1.5 .....	230
SIRTURO TAB 20MG .....	116	SOHONOS CAP 1.5MG .....	294
SITAVIG TAB 50MG .....	158	SOHONOS CAP 10MG .....	294
SIVEXTRO TAB 200MG .....	53	SOHONOS CAP 1MG .....	294
SKELAXIN TAB 800MG .....	293	SOHONOS CAP 2.5MG .....	294
SKYCLARYS CAP 50MG .....	296	SOHONOS CAP 5MG .....	294
SKYRIZI INJ 150DOSE .....	191	SOL CARB POW .....	221
SKYRIZI INJ 150MG/ML .....	191	<i>solifenacin succinate tab 10 mg</i> .....	328
SKYRIZI INJ 180/1.2 .....	242	<i>solifenacin succinate tab 5 mg</i> .....	328
SKYRIZI INJ 360/2.4 .....	242	SOLIQUA INJ 100/33 .....	87
SKYRIZI PEN INJ 150MG/ML .....	192	SOLODYN TAB 105MG .....	319
SLYND TAB 4MG .....	178	SOLODYN TAB 115MG .....	319
SM ALCOHOL PAD PREP .....	277	SOLODYN TAB 55MG .....	319
SMARTEST MIS LANCETS .....	272	SOLODYN TAB 65MG .....	319
SMARTEST SOL CONTROL .....	272	SOLODYN TAB 80MG .....	319
SMARTEST TES BLD GLUC .....	214	SOLOSEC GRA 2GM .....	15

SOLTAMOX SOL 10MG/5ML.....	121	<i>spironolactone tab 100 mg</i> .....	225
SOLU-CORTEF INJ 1000MG.....	180	<i>spironolactone tab 25 mg</i> .....	225
SOLU-CORTEF INJ 100MG .....	180	<i>spironolactone tab 50 mg</i> .....	225
SOLU-CORTEF INJ 250MG.....	180	SPORANOX CAP 100MG .....	98
SOLU-CORTEF INJ 500MG .....	180	SPORANOX CAP PULSEPAK .....	98
SOLUS V2 MIS LANC 28G.....	272	SPORANOX SOL 10MG/ML.....	98
SOLUS V2 MIS LANC 30G.....	272	SPRAVATO SOL 56MG DOS.....	79
SOLUS V2 MIS LANC DEV .....	272	SPRAVATO SOL 84MG DOS.....	79
SOLUS V2 SOL HIGH .....	272	SPRITAM TAB 1000MG.....	74
SOLUS V2 SOL LOW .....	272	SPRITAM TAB 250MG.....	74
SOLUS V2 TES AUDIBLE .....	214	SPRITAM TAB 500MG .....	74
SOMA TAB 250MG .....	293	SPRITAM TAB 750MG.....	74
SOMA TAB 350MG .....	293	SPRIX SPR 15.75MG .....	30
SOMAVERT INJ 10MG.....	229	SPRYCEL TAB 100MG .....	130
SOMAVERT INJ 15MG.....	229	SPRYCEL TAB 140MG.....	130
SOMAVERT INJ 20MG .....	229	SPRYCEL TAB 20MG .....	130
SOMAVERT INJ 25MG .....	229	SPRYCEL TAB 50MG .....	130
SOMAVERT INJ 30MG .....	229	SPRYCEL TAB 70MG .....	130
SOOLANTRA CRE 1%.....	204	SPRYCEL TAB 80MG .....	130
<i>sorafenib tosylate tab 200 mg (base</i>		STALEVO 100 TAB.....	138
<i>equivalent)</i> .....	130	STALEVO 125 TAB .....	138
SORIATANE CAP 10MG .....	192	STALEVO 150 TAB .....	138
SORIATANE CAP 25MG.....	192	STALEVO 200 TAB .....	138
SORILUX AER 0.005% .....	192	STALEVO 50 TAB .....	138
<i>sotalol hcl (afib/afl) tab 120 mg</i> .....	161	STALEVO 75 TAB.....	138
<i>sotalol hcl (afib/afl) tab 160 mg</i> .....	161	STARLIX TAB 120MG.....	93
<i>sotalol hcl (afib/afl) tab 80 mg</i> .....	161	<i>stavudine cap 15 mg</i> .....	153
<i>sotalol hcl tab 120 mg</i> .....	162	<i>stavudine cap 20 mg</i> .....	153
<i>sotalol hcl tab 160 mg</i> .....	162	<i>stavudine cap 30 mg</i> .....	153
<i>sotalol hcl tab 240 mg</i> .....	162	<i>stavudine cap 40 mg</i> .....	153
<i>sotalol hcl tab 80 mg</i> .....	162	STAXYN TAB 10MG.....	169
SOTYKTU TAB 6MG .....	192	STEGLATRO TAB 15MG .....	93
SOTYLIZE SOL 5MG/ML.....	162	STEGLATRO TAB 5MG.....	93
SOVALDI PAK 150MG .....	157	STEGLUJAN TAB 15-100MG.....	87
SOVALDI PAK 200MG .....	157	STEGLUJAN TAB 5-100MG .....	87
SOVALDI TAB 200MG.....	157	STELARA INJ 45MG/0.5 .....	192
SOVALDI TAB 400MG .....	157	STELARA INJ 90MG/ML .....	193
<i>spinosad susp 0.9%</i> .....	204	STENDRA TAB 100MG.....	169
SPIRIVA AER 1.25MCG .....	58	STENDRA TAB 200MG .....	169
SPIRIVA CAP HANDIHLR.....	58	STENDRA TAB 50MG .....	169
SPIRIVA SPR 2.5MCG.....	58	STERILANCE MIS 1.8MM .....	272
<i>spironolactone &amp; hydrochlorothiazide tab</i>		STERILANCE MIS TL 28G .....	272
<i>25-25 mg</i> .....	224	STERILANCE MIS TL 30G .....	272

STERILANCE MIS TL 32G.....	272	<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4% .....</i>	185
STIMATE SOL 1.5MG/ML.....	234	<i>sulfacetamide sodium w/ sulfur emulsion 10-1% .....</i>	185
STIMUFEND INJ 6/0.6ML .....	251	<i>sulfadiazine tab 500 mg .....</i>	317
STIOLTO AER 2.5-2.5 .....	65	<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml .....</i>	51
STIVARGA TAB 40MG .....	131	<i>sulfamethoxazole-trimethoprim tab 400-80 mg.....</i>	52
STRATTERA CAP 100MG.....	8	<i>sulfamethoxazole-trimethoprim tab 800-160 mg .....</i>	52
STRATTERA CAP 10MG.....	7	SULFAMYLON CRE 85MG/GM .....	195
STRATTERA CAP 18MG.....	7	SULFAMYLON PAK 5% .....	195
STRATTERA CAP 25MG .....	7	<i>sulfasalazine tab 500 mg .....</i>	242
STRATTERA CAP 40MG.....	7	<i>sulfasalazine tab delayed release 500 mg .....</i>	242
STRATTERA CAP 60MG.....	7	SULF LIME SOL .....	204
STRATTERA CAP 80MG.....	7	<i>sulindac tab 150 mg .....</i>	30
STRENSIQ INJ 18/0.45.....	233	<i>sulindac tab 200 mg .....</i>	30
STRENSIQ INJ 28/0.7ML.....	233	<i>sumatriptan-naproxen sodium tab 85-500 mg .....</i>	280
STRENSIQ INJ 40MG/ML.....	233	<i>sumatriptan nasal spray 20 mg/act .....</i>	282
STRENSIQ INJ 80/0.8ML.....	233	<i>sumatriptan nasal spray 5 mg/act.....</i>	282
STRIBILD TAB .....	153	<i>sumatriptan succinate inj 6 mg/0.5ml ....</i>	282
STRIVERDI AER 2.5MCG.....	65	<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml .....</i>	282
STROMECTOL TAB 3MG.....	51	<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml .....</i>	282
SUBOXONE MIS 12-3MG .....	49	<i>sumatriptan succinate solution cartridge 4 mg/0.5ml.....</i>	282
SUBOXONE MIS 2-0.5MG .....	48	<i>sumatriptan succinate solution cartridge 6 mg/0.5ml.....</i>	282
SUBOXONE MIS 4-1MG.....	48	<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml .....</i>	282
SUBOXONE MIS 8-2MG.....	49	<i>sumatriptan succinate tab 100 mg .....</i>	282
SUBSYS SPR 100MCG.....	43	<i>sumatriptan succinate tab 25 mg .....</i>	282
SUBSYS SPR 1200MCG.....	43	<i>sumatriptan succinate tab 50 mg.....</i>	282
SUBSYS SPR 1600MCG .....	43	<i>sunitinib malate cap 12.5 mg (base equivalent) .....</i>	131
SUBSYS SPR 200MCG .....	43	<i>sunitinib malate cap 25 mg (base equivalent) .....</i>	131
SUBSYS SPR 400MCG .....	43	<i>sunitinib malate cap 37.5 mg (base equivalent) .....</i>	131
SUBSYS SPR 600MCG.....	43		
SUBSYS SPR 800MCG .....	43		
SUCRAID SOL 8500/ML .....	223		
<i>sucralfate susp 1 gm/10ml .....</i>	324		
<i>sucralfate tab 1 gm.....</i>	324		
SULAR TAB 17MG.....	164		
SULAR TAB 34MG .....	164		
SULAR TAB 8.5MG .....	164		
<i>sulconazole nitrate cream 1% .....</i>	187		
<i>sulconazole nitrate solution 1% .....</i>	187		
<i>sulfacetamide sodium lotion 10% (acne)</i>	185		
<i>sulfacetamide sodium ophth oint 10% ...</i>	299		
<i>sulfacetamide sodium ophth soln 10% ...</i>	299		
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)% .....</i>	302		



<i>sunitinib malate cap 50 mg (base equivalent)</i> .....	131	SUTENT CAP 37.5MG.....	131
SUNLENCA TAB 300MG .....	153	SUTENT CAP 50MG.....	131
SUNOSI TAB 150MG .....	8	SYMAX DUOTAB TAB .....	324
SUNOSI TAB 75MG .....	8	SYMBICORT AER 160-4.5.....	65
SUPER THIN MIS LANC 28G .....	273	SYMBICORT AER 80-4.5 .....	65
SUPER THIN MIS LANCETS.....	273	SYMBYAX CAP 12-50MG .....	309
SUPLENA LIQ VANILLA.....	222	SYMBYAX CAP 3-25MG.....	309
SUPRAX CAP 400MG .....	174	SYMBYAX CAP 6-25MG.....	309
SUPRAX CHW 100MG .....	174	SYMBYAX CAP 6-50MG.....	309
SUPRAX CHW 200MG.....	174	SYMDEKO TAB 100-150 .....	317
SUPRAX SUS 100/5ML .....	174	SYMDEKO TAB 50-75MG .....	316
SUPRAX SUS 200/5ML.....	174	SYMFI LO TAB.....	153
SUPRAX SUS 500/5ML .....	174	SYMFI TAB.....	153
SUPREME II LIQ HIGH/LOW .....	273	SYMJEPI INJ 0.15MG .....	331
SUPREME TES.....	214	SYMJEPI INJ 0.3MG.....	331
SUPREP BOWEL SOL PREP KIT .....	255	SYMLINPEN 60 INJ 1000MCG.....	85
SURE COMFORT MIS LANC 18G.....	273	SYMLNPEN 120 INJ 1000MCG .....	85
SURE COMFORT MIS LANC 21G.....	273	SYMPAZAN MIS 10MG.....	69
SURE COMFORT MIS LANC 23G .....	273	SYMPAZAN MIS 20MG .....	69
SURE COMFORT MIS LANC 30G.....	273	SYMPAZAN MIS 5MG.....	69
SURE COMFORT MIS LANCETS .....	273	SYMPROIC TAB 0.2MG.....	243
SURE COMFORT MIS LANC PEN.....	273	SYMTUZA TAB .....	153
SUREFLEX MIS LANCETS .....	273	SYNALAR CRE 0.025% .....	199
SURE-LANCE MIS 26G .....	273	SYNALAR OIN 0.025% .....	199
SURE-LANCE MIS LANCETS.....	273	SYNALAR SOL 0.01%.....	199
SURELITE MIS LANCETS .....	273	SYNAREL SOL 2MG/ML .....	231
SURE-PEN MIS .....	273	SYNDROS SOL 5MG/ML.....	97
SURESTEP GLU SOL .....	273	SYNERA DIS 70-70MG.....	203
SURESTEP GLU SOL HIGH/LOW .....	273	SYNJARDY TAB .....	87
SURESTEP PRO TES HIGH CON .....	273	SYNJARDY TAB 12.5-500 .....	87
SURESTEP PRO TES LOW CON .....	273	SYNJARDY TAB 5-1000MG.....	87
SURESTEP PRO TES NORM CON .....	273	SYNJARDY TAB 5-500MG .....	87
SURESTEP SOL CONTROL .....	273	SYNJARDY XR TAB.....	87
SURE-TEST TES EASYPLUS .....	214	SYNJARDY XR TAB 10-1000 .....	87
SURE-TOUCH MIS UNV LANC .....	273	SYNJARDY XR TAB 25-1000 .....	87
SUSTIVA CAP 200MG.....	153	SYNJARDY XR TAB 5-1000MG.....	87
SUSTIVA CAP 50MG .....	153	SYNTHROID TAB 100MCG .....	322
SUSTIVA TAB 600MG.....	153	SYNTHROID TAB 112MCG .....	322
SUSTOL INJ 10/0.4ML .....	96	SYNTHROID TAB 125MCG.....	322
SUTAB TAB .....	255	SYNTHROID TAB 137MCG.....	322
SUTENT CAP 12.5MG.....	131	SYNTHROID TAB 150MCG .....	322
SUTENT CAP 25MG .....	131	SYNTHROID TAB 175MCG.....	322
		SYNTHROID TAB 200MCG .....	322

SYNTHROID TAB 25MCG .....	322	TALZENNA CAP 0.75MG .....	131
SYNTHROID TAB 300MCG .....	322	TALZENNA CAP 1MG .....	132
SYNTHROID TAB 50MCG .....	322	TAMIFLU CAP 30MG .....	158
SYNTHROID TAB 75MCG .....	322	TAMIFLU CAP 45MG .....	158
SYNTHROID TAB 88MCG .....	322	TAMIFLU CAP 75MG.....	158
SYPRINE CAP 250MG .....	284	TAMIFLU SUS 6MG/ML .....	158
SYRINGE MIS 0.5/30G .....	278	<i>tamoxifen citrate tab 10 mg (base</i>	
<b>T</b>		<i>equivalent)</i> .....	122
TABLOID TAB 40MG.....	118	<i>tamoxifen citrate tab 20 mg (base</i>	
TABRECTA TAB 150MG.....	131	<i>equivalent)</i> .....	122
TABRECTA TAB 200MG.....	131	<i>tamsulosin hcl cap 0.4 mg</i> .....	245
TACHOSIL PAD 4.8X4.8 .....	252	TAPAZOLE TAB 10MG.....	320
TACHOSIL PAD 9.5X4.8 .....	252	TAPAZOLE TAB 5MG .....	320
TACLONEX OIN .....	199	TARCEVA TAB 100MG.....	120
TACLONEX SUS.....	199	TARCEVA TAB 150MG .....	120
<i>tacrolimus cap 0.5 mg</i> .....	286	TARCEVA TAB 25MG.....	120
<i>tacrolimus cap 1 mg</i> .....	286	TARGRETIN CAP 75MG.....	134
<i>tacrolimus cap 5 mg</i> .....	286	TARGRETIN GEL 1% .....	188
<i>tacrolimus oint 0.03%</i> .....	201	TARKA TAB 2-180 CR .....	113
<i>tacrolimus oint 0.1%</i> .....	201	TARKA TAB 2-240 CR .....	113
<i>tadalafil tab 10 mg</i> .....	169	TARKA TAB 4-240 CR .....	113
<i>tadalafil tab 2.5 mg</i> .....	169	TARON-PREX CAP .....	291
<i>tadalafil tab 20 mg</i> .....	169	TASCENSO ODT TAB 0.25MG.....	313
<i>tadalafil tab 20 mg (pah)</i> .....	172	TASCENSO ODT TAB 0.5MG.....	313
<i>tadalafil tab 5 mg</i> .....	169	TASIGNA CAP 150MG.....	132
TADLIQ SUS 20MG/5ML .....	172	TASIGNA CAP 200MG .....	132
TAFINLAR CAP 50MG .....	131	TASIGNA CAP 50MG .....	132
TAFINLAR CAP 75MG.....	131	<i>tasimelteon capsule 20 mg</i> .....	254
TAFINLAR TAB 10MG .....	131	TASMAR TAB 100MG.....	135
<i>tafluprost preservative free (pf) ophth soln</i>		<i>tavaborole soln 5%</i> .....	187
<i>0.0015%</i> .....	303	TAVALISSE TAB 100MG.....	247
TAGRISSE TAB 40MG .....	120	TAVALISSE TAB 150MG.....	247
TAGRISSE TAB 80MG .....	120	TAYTULLA CAP 1MG/20MC .....	177
TAI DOC SOL NORM CON .....	273	TAZAROTENE AER 0.1%.....	185
TAKHZYRO INJ 150MG/ML .....	247	<i>tazarotene cream 0.1%</i> .....	193
TAKHZYRO INJ 300/2ML.....	247	<i>tazarotene gel 0.05%</i> .....	193
TALICIA CAP.....	327	<i>tazarotene gel 0.1%</i> .....	193
TALIVA CAP .....	252	TAZORAC CRE 0.05% .....	193
TALTZ INJ 80MG/ML.....	193	TAZORAC CRE 0.1%.....	193
TALZENNA CAP 0.1MG .....	131	TAZORAC GEL 0.05%.....	193
TALZENNA CAP 0.25MG .....	131	TAZORAC GEL 0.1% .....	193
TALZENNA CAP 0.35MG .....	131	TAZVERIK TAB 200MG.....	132
TALZENNA CAP 0.5MG.....	131	TECFIDERA CAP 120MG.....	313

TECFIDERA CAP 240MG .....	313	<i>temozolomide cap 100 mg</i> .....	117
TECFIDERA CAP STARTER .....	313	<i>temozolomide cap 140 mg</i> .....	117
TECHLITE AST MIS LANCETS .....	273	<i>temozolomide cap 180 mg</i> .....	117
TECHLITE MIS LANC 30G.....	273	<i>temozolomide cap 20 mg</i> .....	117
TECHLITE MIS LANCETS .....	273	<i>temozolomide cap 250 mg</i> .....	117
TEGRETOL SUS 100/5ML .....	74	<i>temozolomide cap 5 mg</i> .....	117
TEGRETOL TAB 200MG.....	74	<i>tenofovir disoproxil fumarate tab 300 mg</i> .....	154
TEGRETOL-XR TAB 100MG.....	75	TENORETIC TAB 100 .....	113
TEGRETOL-XR TAB 200MG .....	75	TENORETIC TAB 50 .....	113
TEGRETOL-XR TAB 400MG .....	75	TENORMIN TAB 100MG .....	160
TEGSEDI INJ 284/1.5.....	315	TENORMIN TAB 25MG .....	160
TEKTURNA HCT TAB 150-12.5 .....	113	TENORMIN TAB 50MG.....	160
TEKTURNA HCT TAB 150-25MG.....	113	TEPMETKO TAB 225MG.....	132
TEKTURNA HCT TAB 300-12.5 .....	113	<i>terazosin hcl cap 10 mg (base equivalent)</i> .....	109
TEKTURNA HCT TAB 300-25MG.....	113	<i>terazosin hcl cap 1 mg (base equivalent)</i>	108
TEKTURNA TAB 150MG .....	114	<i>terazosin hcl cap 2 mg (base equivalent)</i>	108
TEKTURNA TAB 300MG .....	114	<i>terazosin hcl cap 5 mg (base equivalent)</i>	108
<i>telmisartan-amlodipine tab 40-10 mg</i> .....	113	<i>terbinafine hcl tab 250 mg</i> .....	97
<i>telmisartan-amlodipine tab 40-5 mg</i> .....	113	<i>terbutaline sulfate tab 2.5 mg</i> .....	65
<i>telmisartan-amlodipine tab 80-10 mg</i> .....	113	<i>terbutaline sulfate tab 5 mg</i> .....	65
<i>telmisartan-amlodipine tab 80-5 mg</i> .....	113	<i>terconazole vaginal cream 0.4%</i> .....	330
<i>telmisartan-hydrochlorothiazide tab 40- 12.5 mg</i> .....	113	<i>terconazole vaginal cream 0.8%</i> .....	330
<i>telmisartan-hydrochlorothiazide tab 80-12.5 mg</i> .....	113	<i>terconazole vaginal suppos 80 mg</i> .....	330
<i>telmisartan-hydrochlorothiazide tab 80-25 mg</i> .....	113	<i>teriflunomide tab 14 mg</i> .....	313
<i>telmisartan tab 20 mg</i> .....	107	<i>teriflunomide tab 7 mg</i> .....	313
<i>telmisartan tab 40 mg</i> .....	107	TERIPARATIDE INJ .....	227
<i>telmisartan tab 80 mg</i> .....	107	TESSALON PER CAP 100MG.....	181
<i>temazepam cap 15 mg</i> .....	254	TESTIM GEL 1%(50MG) .....	49
<i>temazepam cap 22.5 mg</i> .....	254	TESTOST CYP INJ 200MG/ML.....	49
<i>temazepam cap 30 mg</i> .....	254	<i>testosterone cypionate im inj in oil 100 mg/ml</i> .....	49
<i>temazepam cap 7.5 mg</i> .....	254	<i>testosterone cypionate im inj in oil 200 mg/ml</i> .....	49
TEMBEXA SUS 10MG/ML.....	158	<i>testosterone enanthate im inj in oil 200 mg/ml</i> .....	49
TEMBEXA TAB 100MG.....	158	<i>testosterone td gel 10mg/act (2%)</i> .....	50
TEMIXYS TAB 300-300 .....	153	<i>testosterone td gel 12.5 mg/act (1%)</i> .....	50
TEMODAR CAP 100MG .....	117	<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i> .....	50
TEMODAR CAP 140MG .....	117	<i>testosterone td gel 20.25 mg/act (1.62%)</i>	50
TEMODAR CAP 180MG .....	117	<i>testosterone td gel 25 mg/2.5gm (1%)</i> .....	50
TEMODAR CAP 250MG.....	117		
TEMOVATE CRE 0.05%.....	199		
TEMOVATE OIN 0.05% .....	199		

<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	<i>thiothixene cap 5 mg</i> .....147
.....50	THRIVITE RX TAB 29-1MG.....291
<i>testosterone td gel 50 mg/5gm (1%)</i> .....50	THYQUIDITY SOL 100MCG .....322
<i>testosterone td soln 30 mg/act</i> .....50	<i>tiagabine hcl tab 12 mg</i> .....76
<i>tetrabenazine tab 12.5 mg</i> .....310	<i>tiagabine hcl tab 16 mg</i> .....76
<i>tetrabenazine tab 25 mg</i> .....310	<i>tiagabine hcl tab 2 mg</i> .....76
<i>tetracaine hcl ophth soln 0.5%</i> .....300	<i>tiagabine hcl tab 4 mg</i> .....76
<i>tetracycline hcl cap 250 mg</i> .....319	TIAZAC CAP 120MG/24 .....165
<i>tetracycline hcl cap 500 mg</i> .....319	TIAZAC CAP 180MG/24 .....165
TEXACORT SOL 2.5%.....199	TIAZAC CAP 240MG/24.....165
TEZSPIRE INJ 210MG .....58	TIAZAC CAP 300MG/24 .....165
TGT LANCET MIS 26G.....273	TIAZAC CAP 360MG/24.....165
TGT LANCET MIS 30G .....273	TIAZAC CAP 420MG/24.....165
TGT LANCET MIS 33G.....273	TIBSOVO TAB 250MG.....132
TGT LANCING MIS DEVICE .....273	TIGAN CAP 300MG .....96
THALOMID CAP 100MG .....284	TIGLUTIK SUS 50/10ML.....296
THALOMID CAP 150MG .....284	TIKOSYN CAP 125MCG.....57
THALOMID CAP 200MG.....285	TIKOSYN CAP 250MCG.....57
THALOMID CAP 50MG.....284	TIKOSYN CAP 500MCG.....57
THEO-24 CAP 100MG CR .....65	TIM/BRIM/DOR SOL .....297
THEO-24 CAP 200MG CR .....65	TIM/DORZ/LAT SOL.....297
THEO-24 CAP 300MG CR .....65	TIMOL/BRIM SOL DORZ/LAT .....297
THEO-24 CAP 400MG ER.....65	TIMOL/LATAN SOL .....297
<i>theophylline elixir 80 mg/15ml</i> .....65, 66	<i>timolol maleate ophth gel forming soln</i>
<i>theophylline tab er 12hr 100 mg</i> .....66	0.25% .....297
<i>theophylline tab er 12hr 200 mg</i> .....66	<i>timolol maleate ophth gel forming soln</i>
<i>theophylline tab er 12hr 300 mg</i> .....66	0.5%.....297
<i>theophylline tab er 12hr 450 mg</i> .....66	<i>timolol maleate ophth soln 0.25%</i> .....297
<i>theophylline tab er 24hr 400 mg</i> .....66	<i>timolol maleate ophth soln 0.5%</i> .....297
<i>theophylline tab er 24hr 600 mg</i> .....66	<i>timolol maleate ophth soln 0.5% (once-</i>
THIN LANCETS MIS.....273	<i>daily)</i> .....297
THIN LANCETS MIS 26G.....273	<i>timolol maleate preservative free ophth soln</i>
THIN LANCETS MIS 30G .....273	0.25% .....297
THINLETS GP MIS 26G.....273	<i>timolol maleate preservative free ophth soln</i>
THIOLA EC TAB 100MG .....246	0.5%.....297
THIOLA EC TAB 300MG .....246	<i>timolol maleate tab 10 mg</i> .....162
<i>thioridazine hcl tab 100 mg</i> .....145	<i>timolol maleate tab 20 mg</i> .....162
<i>thioridazine hcl tab 10 mg</i> .....145	<i>timolol maleate tab 5 mg</i> .....162
<i>thioridazine hcl tab 25 mg</i> .....145	TIMOPTIC OCU SOL 0.25% OP .....297
<i>thioridazine hcl tab 50 mg</i> .....145	TIMOPTIC OCU SOL 0.5% OP .....297
<i>thiothixene cap 10 mg</i> .....147	TIMOPTIC SOL 0.25% OP .....297
<i>thiothixene cap 1 mg</i> .....147	TIMOPTIC SOL 0.5% OP.....297
<i>thiothixene cap 2 mg</i> .....147	TIMOPTIC-XE SOL 0.25% OP .....297

TIMOPTIC-XE SOL 0.5% OP .....	297	<i>tizanidine hcl cap 6 mg (base equivalent)</i>	
<i>tinidazole tab 250 mg</i> .....	51	.....	293
<i>tinidazole tab 500 mg</i> .....	51	<i>tizanidine hcl tab 2 mg (base equivalent)</i>	
<i>tiopronin tab 100 mg</i> .....	246	.....	293
TIROSINT CAP 100MCG .....	322	<i>tizanidine hcl tab 4 mg (base equivalent)</i>	
TIROSINT CAP 112MCG.....	322	.....	293
TIROSINT CAP 125MCG.....	322	TOBI NEB 300/5ML.....	15
TIROSINT CAP 137MCG.....	322	TOBI PODHALR CAP 28MG .....	15
TIROSINT CAP 13MCG .....	322	TOBRADEX OIN 0.3-0.1%.....	302
TIROSINT CAP 150MCG.....	322	TOBRADEX ST SUS 0.3-0.05 .....	302
TIROSINT CAP 175MCG.....	322	TOBRADEX SUS 0.3-0.1% .....	302
TIROSINT CAP 200.....	322	<i>tobramycin-dexamethasone ophth susp</i>	
TIROSINT CAP 25MCG .....	322	0.3-0.1% .....	302
TIROSINT CAP 50MCG .....	322	<i>tobramycin nebu soln 300 mg/4ml</i> .....	15
TIROSINT CAP 75MCG .....	322	<i>tobramycin nebu soln 300 mg/5ml</i> .....	15
TIROSINT CAP 88MCG .....	322	<i>tobramycin ophth soln 0.3%</i> .....	299
TIROSINT-SOL SOL 100MCG.....	322	TOBREX OIN 0.3% OP .....	299
TIROSINT-SOL SOL 112MCG.....	322	TOBREX SOL 0.3% OP .....	299
TIROSINT-SOL SOL 125MCG .....	322	TODAY SPONGE MIS .....	329
TIROSINT-SOL SOL 137MCG .....	322	TOLAK CRE 4%.....	188
TIROSINT-SOL SOL 13MCG/ML .....	322	<i>tolbutamide tab 500 mg</i> .....	94
TIROSINT-SOL SOL 150MCG.....	323	<i>tolcapone tab 100 mg</i> .....	135
TIROSINT-SOL SOL 175MCG .....	323	TOLEREX POW .....	222
TIROSINT-SOL SOL 200MCG .....	323	<i>tolmetin sodium cap 400 mg</i> .....	30
TIROSINT-SOL SOL 25MCG/ML .....	322	<i>tolmetin sodium tab 600 mg</i> .....	30
TIROSINT-SOL SOL 50MCG/ML .....	322	TOLSURA CAP 65MG.....	98
TIROSINT-SOL SOL 75MCG/ML .....	322	<i>tolterodine tartrate cap er 24hr 2 mg</i> .....	328
TIROSINT-SOL SOL 88MCG/ML .....	322	<i>tolterodine tartrate cap er 24hr 4 mg</i> .....	328
TISSEEL KIT 10ML.....	252	<i>tolterodine tartrate tab 1 mg</i> .....	328
TISSEEL KIT 2ML.....	252	<i>tolterodine tartrate tab 2 mg</i> .....	329
TISSEEL KIT 4ML .....	252	<i>tolvaptan tab 30 mg</i> .....	235
TISSEEL SOL 10ML .....	252	TOPAMAX SPR CAP 15MG .....	75
TISSEEL SOL 2ML .....	252	TOPAMAX SPR CAP 25MG .....	75
TISSEEL SOL 4ML .....	252	TOPAMAX TAB 100MG .....	75
TIVICAY PD TAB 5MG.....	154	TOPAMAX TAB 200MG .....	75
TIVICAY TAB 10MG .....	154	TOPAMAX TAB 25MG.....	75
TIVICAY TAB 25MG.....	154	TOPAMAX TAB 50MG.....	75
TIVICAY TAB 50MG .....	154	TOPCARE MIS LANC 33G.....	273
TIVORBEX CAP 20MG.....	30	TOPICAL GEL L.E.T .....	203
<i>tizanidine hcl cap 2 mg (base equivalent)</i>		TOPICORT CRE 0.05% .....	199
.....	293	TOPICORT CRE 0.25% .....	199
<i>tizanidine hcl cap 4 mg (base equivalent)</i>		TOPICORT GEL 0.05% .....	200
.....	293	TOPICORT OIN 0.05%.....	200

TOPICORT OIN 0.25% .....	200	<i>tramadol hcl tab er 24hr biphasic release</i>	
TOPICORT SPR 0.25%.....	200	100 mg .....	44
<i>topiramate cap er 24hr 200 mg</i> .....	75	<i>tramadol hcl tab er 24hr biphasic release</i>	
<i>topiramate cap er 24hr sprinkle 100 mg</i> ...	75	200 mg .....	44
<i>topiramate cap er 24hr sprinkle 150 mg</i> ...	75	<i>tramadol hcl tab er 24hr biphasic release</i>	
<i>topiramate cap er 24hr sprinkle 200 mg</i> ..	75	300 mg .....	44
<i>topiramate cap er 24hr sprinkle 25 mg</i> .....	75	<i>trandolapril tab 1 mg</i> .....	106
<i>topiramate cap er 24hr sprinkle 50 mg</i> .....	75	<i>trandolapril tab 2 mg</i> .....	106
<i>topiramate sprinkle cap 15 mg</i> .....	75	<i>trandolapril tab 4 mg</i> .....	106
<i>topiramate sprinkle cap 25 mg</i> .....	75	<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	
<i>topiramate tab 100 mg</i> .....	75	.....	113
<i>topiramate tab 200 mg</i> .....	75	<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	
<i>topiramate tab 25 mg</i> .....	75	.....	114
<i>topiramate tab 50 mg</i> .....	75	<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	
TOPROL XL TAB 100MG .....	160	.....	114
TOPROL XL TAB 200MG.....	160	<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	
TOPROL XL TAB 25MG .....	160	.....	114
TOPROL XL TAB 50MG .....	160	<i>tranexamic acid tab 650 mg</i> .....	252
<i>toremifene citrate tab 60 mg (base</i>		TRANSDERM SC DIS 1MG/3DAY.....	96
<i>equivalent)</i> .....	122	TRANSDERM-SC DIS 1MG/3DAY .....	96
<i>toremide tab 100 mg</i> .....	225	TRANXENE T TAB 7.5MG .....	56
<i>toremide tab 10 mg</i> .....	225	<i>tranylcypromine sulfate tab 10 mg</i> .....	79
<i>toremide tab 20 mg</i> .....	225	TRAVATAN Z DRO 0.004%.....	303
<i>toremide tab 5 mg</i> .....	225	TRAVEL LANCE MIS 30G.....	273
TOSYMRA SOL 10MG.....	282	TRAVEL LANCE MIS ADV 28G .....	274
TOUJEO MAX INJ 300IU/ML .....	92	<i>travoprost ophth soln 0.004%</i>	
TOUJEO SOLO INJ 300IU/ML.....	92	<i>(benzalkonium free) (bak free)</i> .....	303
TOVIAZ TAB 4MG .....	329	<i>trazodone hcl tab 100 mg</i> .....	81
TOVIAZ TAB 8MG .....	329	<i>trazodone hcl tab 150 mg</i> .....	81
TPOXX CAP 200MG.....	159	<i>trazodone hcl tab 300 mg</i> .....	81
TPOXX INJ.....	159	<i>trazodone hcl tab 50 mg</i> .....	81
TRACLEER TAB 125MG .....	171	TRECTOR TAB 250MG.....	117
TRACLEER TAB 32MG .....	171	TRELEGY AER 100MCG .....	65
TRACLEER TAB 62.5MG.....	171	TRELEGY AER 200MCG.....	65
TRADJENTA TAB 5MG.....	89	TREMFYA INJ 100MG/ML.....	194
<i>tramadol-acetaminophen tab 37.5-325 mg</i>		TRESIBA FLEX INJ 100UNIT .....	92
.....	47	TRESIBA FLEX INJ 200UNIT .....	92
<i>tramadol hcl tab 100 mg</i> .....	43	TRESIBA INJ 100UNIT .....	92
<i>tramadol hcl tab 50 mg</i> .....	43	<i>tretinoin cap 10 mg</i> .....	134
<i>tramadol hcl tab er 24hr 100 mg</i> .....	43	<i>tretinoin cream 0.025%</i> .....	185
<i>tramadol hcl tab er 24hr 200 mg</i> .....	43	<i>tretinoin cream 0.05%</i> .....	185
<i>tramadol hcl tab er 24hr 300 mg</i> .....	43	<i>tretinoin cream 0.1%</i> .....	185
		<i>tretinoin gel 0.01%</i> .....	185

<i>tretinoin gel 0.025%</i> .....	185	<i>trientine hcl cap 250 mg</i> .....	284
<i>tretinoin gel 0.05%</i> .....	185	<i>trifluoperazine hcl tab 10 mg (base</i>	
<i>tretinoin microsphere gel 0.04%</i> .....	185	<i>equivalent)</i> .....	145
<i>tretinoin microsphere gel 0.1%</i> .....	185	<i>trifluoperazine hcl tab 1 mg (base</i>	
TREXALL TAB 10MG .....	118	<i>equivalent)</i> .....	145
TREXALL TAB 15MG .....	118	<i>trifluoperazine hcl tab 2 mg (base</i>	
TREXALL TAB 5MG.....	118	<i>equivalent)</i> .....	145
TREXALL TAB 7.5MG.....	118	<i>trifluoperazine hcl tab 5 mg (base</i>	
TREXIMET TAB 85-500MG .....	280	<i>equivalent)</i> .....	145
<i>triamcinolone acetone aerosol soln 0.147</i>		<i>trifluridine ophth soln 1%</i> .....	299
<i>mg/gm</i> .....	200	<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i> ..	135
<i>triamcinolone acetone cream 0.025%</i>	200	<i>trihexyphenidyl hcl tab 2 mg</i> .....	135
<i>triamcinolone acetone cream 0.1%</i> ....	200	<i>trihexyphenidyl hcl tab 5 mg</i> .....	135
<i>triamcinolone acetone cream 0.5%</i> ....	200	TRIJARDY XR TAB .....	87
<i>triamcinolone acetone dental paste 0.1%</i>		TRIKAFTA PAK 59.5MG.....	317
.....	288	TRIKAFTA PAK 75MG .....	317
<i>triamcinolone acetone lotion 0.025%</i> .	200	TRIKAFTA TAB .....	317
<i>triamcinolone acetone lotion 0.1%</i> ....	200	TRILEPTAL SUS 300MG/5M .....	75
<i>triamcinolone acetone oint 0.025%</i> ....	200	TRILEPTAL TAB 150MG .....	75
<i>triamcinolone acetone oint 0.05%</i> ....	200	TRILEPTAL TAB 300MG.....	75
<i>triamcinolone acetone oint 0.1%</i> .....	200	TRILEPTAL TAB 600MG .....	75
<i>triamcinolone acetone oint 0.5%</i> .....	200	TRILIPIX CAP 135MG.....	101
<i>triamterene &amp; hydrochlorothiazide cap</i>		TRILIPIX CAP 45MG .....	101
<i>37.5-25 mg</i> .....	224	<i>trimethobenzamide hcl cap 300 mg</i> .....	96
<i>triamterene &amp; hydrochlorothiazide tab 37.5-</i>		<i>trimethoprim tab 100 mg</i> .....	51
<i>25 mg</i> .....	224	<i>trimipramine maleate cap 100 mg</i> .....	84
<i>triamterene &amp; hydrochlorothiazide tab 75-</i>		<i>trimipramine maleate cap 25 mg</i> .....	84
<i>50 mg</i> .....	224	<i>trimipramine maleate cap 50 mg</i> .....	84
<i>triamterene cap 100 mg</i> .....	225	TRINAZ TAB 12-1MG.....	291
<i>triamterene cap 50 mg</i> .....	225	TRINTELLIX TAB 10MG .....	81
<i>triazolam tab 0.125 mg</i> .....	254	TRINTELLIX TAB 20MG .....	81
<i>triazolam tab 0.25 mg</i> .....	254	TRINTELLIX TAB 5MG.....	81
TRIBENZOR20- TAB 5-12.5MG .....	114	TRISTART CAP FREE.....	291
TRIBENZOR40- TAB 10-12.5 .....	114	TRISTART DHA CAP.....	291
TRIBENZOR40- TAB 10-25MG .....	114	TRISTART ONE CAP 35-1-215.....	291
TRIBENZOR40- TAB 5-12.5MG .....	114	TRIUMEQ PD TAB.....	154
TRIBENZOR40- TAB 5-25MG.....	114	TRIUMEQ TAB .....	154
TRICARE PRE CAP 27-1-500 .....	291	TRIZIVIR TAB.....	154
TRICARE TAB PRENATAL .....	291	TROKENDI XR CAP 100MG .....	75
TRICHOSOL SOL .....	306	TROKENDI XR CAP 200MG.....	75
TRICOR TAB 145MG .....	101	TROKENDI XR CAP 25MG .....	75
TRICOR TAB 48MG.....	101	TROKENDI XR CAP 50MG .....	75
TRIDESILON CRE 0.05% .....	200	TROP/CYC/PE/ SOL KETO/PRO .....	298

TROP/CYC/PE/ SOL KETOROLA.....	298	TUSSICAPS CAP 10-8MG.....	181
TROP/CYCL/PE SOL KETOROLA.....	298	TUXARIN ER TAB 54.3-8MG.....	181
TROP-CYC-PE DRO 1-1-2.5.....	298	TUZISTRA XR SUS.....	181
TROP-PHENYL SOL 1-2.5%.....	298	TWIRLA DIS 120-30.....	177
<i>tropium chloride cap er 24hr 60 mg</i> .....	329	TWIST LANCET MIS 30G MULT.....	274
<i>tropium chloride tab 20 mg</i> .....	329	TWOCAL HN LIQ.....	222
TRUDHESA AER 0.725MG.....	280	TWYNEO CRE 0.1-3%.....	185
TRUECONTROL LIQ LEVEL 0.....	274	TWYNSTA TAB 40-10MG.....	114
TRUECONTROL LIQ LEVEL 1.....	274	TWYNSTA TAB 40-5MG.....	114
TRUEDRAW MIS LANC DEV.....	274	TWYNSTA TAB 80-10MG.....	114
TRUE FOCUS MIS BLOOD.....	214	TWYNSTA TAB 80-5MG.....	114
TRUE METRIX SOL LEVEL 1.....	274	TYBLUME CHW 0.1-0.02.....	177
TRUE METRIX SOL LEVEL 2.....	274	TYBOST TAB 150MG.....	154
TRUE METRIX SOL LEVEL 3.....	274	TYKERB TAB 250MG.....	132
TRUE METRIX TES GLUCOSE.....	214	TYLACTIN POW BLD 20PE.....	222
TRUETEST TES.....	214	TYMLOS INJ.....	227
TRUETRACK TES.....	214	TYR ANAMIX POW ERLY YRS.....	222
TRUETRACK TES BLD GLUC.....	214	TYREX-1 POW.....	222
TRULANCE TAB 3MG.....	239	TYREX-2 POW.....	222
TRULICITY INJ 0.75/0.5.....	90	TYROS 2 POW.....	222
TRULICITY INJ 1.5/0.5.....	90	TYRVAYA SOL 0.03MG.....	297
TRULICITY INJ 3/0.5.....	90	TYVASO DPI POW 16-32-48.....	170
TRULICITY INJ 4.5/0.5.....	90	TYVASO DPI POW 16-32MCG.....	170
TRUPLUS LANC MIS 26G.....	274	TYVASO DPI POW 16MCG.....	170
TRUPLUS LANC MIS 28G.....	274	TYVASO DPI POW 32-48MCG.....	170
TRUPLUS LANC MIS 30G.....	274	TYVASO DPI POW 32MCG.....	170
TRUPLUS LANC MIS 33G.....	274	TYVASO DPI POW 48MCG.....	170
TRUSELTIQ CAP 100MG.....	132	TYVASO DPI POW 64MCG.....	171
TRUSELTIQ CAP 125MG.....	132	TYVASO REFIL SOL 0.6MG/ML.....	171
TRUSELTIQ CAP 50MG.....	132	TYVASO SOL 0.6MG/ML.....	171
TRUSELTIQ CAP 75MG.....	132	TYVASO START SOL 0.6MG/ML.....	171
TRUSOPT SOL 2% OP.....	303	<b>U</b>	
TRUVADA TAB 100-150.....	154	UBRELVY TAB 100MG.....	280
TRUVADA TAB 133-200.....	154	UBRELVY TAB 50MG.....	280
TRUVADA TAB 167-250.....	154	UCD ANAMIX POW JUNIOR.....	222
TRUVADA TAB 200-300.....	154	UCERIS AER 2MG/ACT.....	50
TRUZONE PEAK MIS FLOW MTR.....	279	UCERIS TAB 9MG.....	180
TUDORZA PRES AER 400/ACT.....	59	UDENYCA INJ 6MG/.6ML.....	251
TUKYSA TAB 150MG.....	119	UKONIQ TAB 200MG.....	132
TUKYSA TAB 50MG.....	119	ULORIC TAB 40MG.....	246
TURALIO CAP 125MG.....	132	ULORIC TAB 80MG.....	246
TURALIO CAP 200MG.....	132	ULTICARE PAD ALCOHOL.....	277
TURPENTINE SOL SPIRITS.....	202	ULTI-LANCE MIS CLR TIP.....	274



ULTILET MIS 26G.....	274	UNISTIK 2 MIS .....	275
ULTILET MIS 28G.....	274	UNISTIK 2 MIS 1.8MM.....	275
ULTILET MIS 30G.....	274	UNISTIK 2 MIS 2.4MM.....	275
ULTILET MIS 33G.....	274	UNISTIK 2 MIS COMFORT .....	275
ULTILET MIS LANCETS .....	274	UNISTIK 2 MIS EXTRA .....	275
ULTILET MIS SAFETY .....	274	UNISTIK 2 MIS NEONATAL.....	275
ULTILET PAD ALCOHOL .....	277	UNISTIK 2 MIS NORMAL.....	275
ULTILET SAFE MIS 21G.....	274	UNISTIK 2 MIS SUPER .....	275
ULTRACAL HN LIQ PLUS.....	222	UNISTIK 3 MIS 1.8MM.....	275
ULTRACAL LIQ .....	222	UNISTIK 3 MIS COMFORT .....	275
ULTRACET TAB 37.5-325 .....	47	UNISTIK 3 MIS EXTRA .....	275
ULTRAMINO POW SOY PROT.....	222	UNISTIK 3 MIS GENT 30G.....	275
ULTRAM TAB 50MG.....	44	UNISTIK 3 MIS NEONATAL.....	275
ULTRA THIN MIS 28G.....	274	UNISTIK 3 MIS NORMAL.....	275
ULTRA THIN MIS 30G .....	274	UNISTIK 3 MIS XTR 21G.....	275
ULTRA THIN MIS 31G .....	274	UNISTIK CZT MIS COMFORT .....	275
ULTRA THIN MIS 33G.....	274	UNISTIK CZT MIS NORMAL.....	275
ULTRA THIN MIS LAN 31G.....	274	UNISTIK II MIS LANCETS.....	275
ULTRA THIN MIS LANC 28G .....	274	UNISTIK PRO MIS LANC 21G.....	275
ULTRA THIN MIS LANC 30G.....	274	UNISTIK PRO MIS LANC 28G .....	275
ULTRA THIN MIS LANCETS.....	274	UNISTIK SAFE MIS LANC 28G .....	275
ULTRAVATE LOT 0.05% .....	200	UNISTIK SAFE MIS LANC 30G .....	275
ULTRIENT 1.5 LIQ SAFE-T .....	222	UNISTIK TOUC MIS LANC 21G .....	276
UNILET CMFR MIS TCH 28G.....	274	UNISTIK TOUC MIS LANC 23G .....	276
UNILET CMFR MIS TCH 30G.....	274	UNISTIK TOUC MIS LANC 28G .....	276
UNILET EXCEL MIS 23G.....	274	UNISTIK TOUC MIS LANC 30G.....	276
UNILET EX II MIS 28G .....	274	UNISTRIP1 TES GENERIC.....	214
UNILET G.P. MIS 21G .....	274	UNITSTIK PRO MIS LANC 25G.....	276
UNILET G.P MIS SUPR 23G.....	274	UNIVERSAL 1 MIS 33G.....	276
UNILET GP 28 MIS ULT THIN .....	274	UNIVERSAL 1 MIS LANC 26G .....	276
UNILET LANCE MIS 21G.....	275	UNIVERSAL 1 MIS LANC 30G .....	276
UNILET LANCE MIS 28G .....	275	UPNEEQ SOL 0.1% .....	303
UNILET LANCE MIS 33G .....	275	UPTRAVI PACK TAB 200/800 .....	172
UNILET LANC MIS 33G .....	275	UPTRAVI TAB 1000MCG .....	172
UNILET LANCT MIS 28G.....	275	UPTRAVI TAB 1200MCG.....	172
UNILET LANCT MIS 30G.....	275	UPTRAVI TAB 1400MCG .....	172
UNILET LANCT MIS 33G .....	275	UPTRAVI TAB 1600MCG .....	172
UNILET MICRO MIS 33G.....	275	UPTRAVI TAB 200MCG .....	172
UNILET MIS 21G .....	275	UPTRAVI TAB 400MCG.....	172
UNILET SUPER MIS 23G.....	275	UPTRAVI TAB 600MCG.....	172
UNILET SUPER MIS G.P. 23G .....	275	UPTRAVI TAB 800MCG.....	172
UNISTIK 1 MIS 2.4MM.....	275	UREA/SALICY CRE 39.5-2% .....	202
UNISTIK 1 MIS 3.0MM .....	275	<i>urea cream 39%</i> .....	201

<i>urea lotion 40%</i> .....	201	<i>valsartan-hydrochlorothiazide tab 80-12.5</i>	
UROCIT-K 10 TAB .....	244	<i>mg</i> .....	114
UROCIT-K 15 TAB .....	244	VALSARTAN SOL 20MG/5ML.....	107
UROCIT-K 5 TAB.....	244	<i>valsartan tab 160 mg</i> .....	108
UROXATRAL TAB 10MG .....	245	<i>valsartan tab 320 mg</i> .....	108
URSO 250 TAB 250MG .....	239	<i>valsartan tab 40 mg</i> .....	108
<i>ursodiol cap 300 mg</i> .....	239	<i>valsartan tab 80 mg</i> .....	108
<i>ursodiol tab 250 mg</i> .....	239	VALTOCO SPR 10MG .....	69
<i>ursodiol tab 500 mg</i> .....	239	VALTOCO SPR 15MG .....	69
URSO FORTE TAB 500MG.....	239	VALTOCO SPR 20MG.....	69
UTIBRON CAP NEOHALER.....	65	VALTOCO SPR 5MG.....	69
UZEDY INJ 100MG .....	141	VALTREX TAB 1GM .....	158
UZEDY INJ 125MG .....	142	VALTREX TAB 500MG.....	158
UZEDY INJ 150MG.....	142	VANCOCIN CAP 125MG.....	52
UZEDY INJ 200MG .....	142	VANCOCIN CAP 250MG.....	52
UZEDY INJ 250MG .....	142	<i>vancomycin hcl cap 125 mg (base</i>	
UZEDY INJ 50MG .....	141	<i>equivalent)</i> .....	52
UZEDY INJ 75MG .....	141	<i>vancomycin hcl cap 250 mg (base</i>	
<b>V</b>		<i>equivalent)</i> .....	52
VAGIFEM TAB 10MCG .....	330	<i>vancomycin hcl for oral soln 50 mg/ml</i>	
<i>valacyclovir hcl tab 1 gm</i> .....	158	<i>(base equivalent)</i> .....	52
<i>valacyclovir hcl tab 500 mg</i> .....	158	VANCOMYCIN SOL 10MG/ML .....	299
VALCHLOR GEL 0.016%.....	188	VANDAZOLE GEL 0.75% .....	330
VALCYTE SOL 50MG/ML.....	155	VANFLYTA TAB 17.7MG .....	132
VALCYTE TAB 450MG.....	155	VANFLYTA TAB 26.5MG.....	132
<i>valganciclovir hcl for soln 50 mg/ml (base</i>		VANISH LIQ 5%.....	288
<i>equiv)</i> .....	155	VANOS CRE 0.1% .....	200
<i>valganciclovir hcl tab 450 mg (base</i>		VANTAGE LANC MIS DEVICE .....	276
<i>equivalent)</i> .....	155	<i>ardenafil hcl orally disintegrating tab 10</i>	
VALIUM TAB 10MG .....	56	<i>mg</i> .....	169
VALIUM TAB 2MG.....	56	<i>ardenafil hcl tab 10 mg</i> .....	170
VALIUM TAB 5MG.....	56	<i>ardenafil hcl tab 2.5 mg</i> .....	169
<i>valproate sodium oral soln 250 mg/5ml</i>		<i>ardenafil hcl tab 20 mg</i> .....	170
<i>(base equiv)</i> .....	78	<i>ardenafil hcl tab 5 mg</i> .....	169
<i>valproic acid cap 250 mg</i> .....	78	VARUBI TAB 90MG.....	97
<i>valsartan-hydrochlorothiazide tab 160-12.5</i>		VASCEPA CAP 0.5GM.....	100
<i>mg</i> .....	114	VASCEPA CAP 1GM .....	100
<i>valsartan-hydrochlorothiazide tab 160-25</i>		VASCULERA TAB .....	222
<i>mg</i> .....	114	VASERETIC TAB 10-25MG .....	114
<i>valsartan-hydrochlorothiazide tab 320-12.5</i>		VASOTEC TAB 10MG .....	106
<i>mg</i> .....	114	VASOTEC TAB 2.5MG.....	106
<i>valsartan-hydrochlorothiazide tab 320-25</i>		VASOTEC TAB 20MG .....	106
<i>mg</i> .....	114	VASOTEC TAB 5MG.....	106

VCF VAGINAL AER CONTRACP .....	329	<i>verapamil hcl cap er 24hr 100 mg</i> .....	165
VCF VAGINAL GEL CONTRACE.....	329	<i>verapamil hcl cap er 24hr 120 mg</i> .....	165
VCF VAGINAL MIS CONTRACP .....	329	<i>verapamil hcl cap er 24hr 180 mg</i> .....	165
VECAMYL TAB 2.5MG .....	114	<i>verapamil hcl cap er 24hr 200 mg</i> .....	165
VECTICAL OIN 3MCG/GM .....	194	<i>verapamil hcl cap er 24hr 240 mg</i> .....	165
VELPHORO CHW 500MG .....	244	<i>verapamil hcl cap er 24hr 300 mg</i> .....	165
VELTASSA POW 16.8GM .....	287	<i>verapamil hcl cap er 24hr 360 mg</i> .....	165
VELTASSA POW 25.2GM.....	287	<i>verapamil hcl tab 120 mg</i> .....	165
VELTASSA POW 8.4GM.....	287	<i>verapamil hcl tab 40 mg</i> .....	165
VELTIN GEL .....	185	<i>verapamil hcl tab 80 mg</i> .....	165
VEMLIDY TAB 25MG.....	157	<i>verapamil hcl tab er 120 mg</i> .....	165
VENCLEXTA TAB 100MG.....	119	<i>verapamil hcl tab er 180 mg</i> .....	165
VENCLEXTA TAB 10MG .....	119	<i>verapamil hcl tab er 240 mg</i> .....	165
VENCLEXTA TAB 50MG.....	119	VERASENS LIQ LEVEL 1 .....	276
VENCLEXTA TAB START PK.....	119	VERASENS TES .....	215
<i>venlafaxine hcl cap er 24hr 150 mg (base</i>		VERDESO AER 0.05% .....	200
<i>equivalent)</i> .....	83	VEREGEN OIN 15% .....	185
<i>venlafaxine hcl cap er 24hr 37.5 mg (base</i>		VERELAN CAP 120MG SR .....	165
<i>equivalent)</i> .....	82	VERELAN CAP 180MG SR .....	165
<i>venlafaxine hcl cap er 24hr 75 mg (base</i>		VERELAN CAP 240MG SR .....	165
<i>equivalent)</i> .....	82	VERELAN CAP 360MG SR .....	165
<i>venlafaxine hcl tab 100 mg (base</i>		VERELAN PM CAP 100MG ER .....	165
<i>equivalent)</i> .....	83	VERELAN PM CAP 200MG ER.....	165
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>		VERELAN PM CAP 300MG ER.....	165
.....	83	VERIFINE MIS UNIV 30G .....	276
<i>venlafaxine hcl tab 37.5 mg (base</i>		VERQUVO TAB 10MG.....	173
<i>equivalent)</i> .....	83	VERQUVO TAB 2.5MG .....	173
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>		VERQUVO TAB 5MG .....	173
.....	83	VERSACLOZ SUS 50MG/ML .....	144
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>		VERZENIO TAB 100MG .....	132
.....	83	VERZENIO TAB 150MG .....	133
<i>venlafaxine hcl tab er 24hr 150 mg (base</i>		VERZENIO TAB 200MG .....	133
<i>equivalent)</i> .....	83	VERZENIO TAB 50MG.....	132
<i>venlafaxine hcl tab er 24hr 225 mg (base</i>		VESICARE LS SUS 5MG/5ML.....	329
<i>equivalent)</i> .....	83	VESICARE TAB 10MG .....	329
<i>venlafaxine hcl tab er 24hr 37.5 mg (base</i>		VESICARE TAB 5MG.....	329
<i>equivalent)</i> .....	83	VFEND SUS 40MG/ML.....	98
<i>venlafaxine hcl tab er 24hr 75 mg (base</i>		VFEND TAB 200MG.....	98
<i>equivalent)</i> .....	83	VFEND TAB 50MG .....	98
VENTAVIS SOL 10MCG/ML .....	171	V-GO 20 KIT .....	276
VENTAVIS SOL 20MCG/ML .....	171	V-GO 30 KIT .....	276
VENTOLIN HFA AER .....	65	V-GO 40 KIT.....	276
VEOZAH TAB 45MG .....	231	VIAGRA TAB 100MG .....	170

VIAGRA TAB 25MG .....	170	VIREAD TAB 250MG .....	155
VIAGRA TAB 50MG .....	170	VIREAD TAB 300MG .....	155
VIBERZI TAB 100MG .....	243	VIRT-C DHA CAP .....	291
VIBERZI TAB 75MG .....	243	VIRT-NATE CAP DHA .....	291
VIBRAMYCIN CAP 100MG .....	319	VIRT-PN DHA CAP .....	292
VIBRAMYCIN SUS 25MG/5ML .....	319	VIRT-PN PLUS CAP .....	292
VIBRAMYCIN SYP 50MG/5ML .....	319	VISIONBLUE INJ 0.06% .....	302
VICTOZA INJ 18MG/3ML .....	90	VISTARIL CAP 25MG .....	55
VIDAZA INJ 100MG .....	118	VISTARIL CAP 50MG .....	55
VIEKIRA PAK TAB .....	157	VISTOGARD PAK 10GM .....	95
<i>vigabatrin powd pack 500 mg</i> .....	76	VITAFOL CAP ULTRA .....	292
<i>vigabatrin tab 500 mg</i> .....	77	VITAFOL CHW GUMMIES .....	292
VIGAMOX DRO 0.5% .....	299	VITAFOL FE+ CAP .....	292
VIIBRYD KIT STARTER .....	81	VITAFOL-NANO TAB .....	292
VIIBRYD TAB 10MG .....	81	VITAFOL-OB PAK +DHA .....	292
VIIBRYD TAB 20MG .....	81	VITAFOL-OB TAB 65-1MG .....	292
VIIBRYD TAB 40MG .....	81	VITAFOL-ONE CAP .....	292
VIJOICE TAB 125MG .....	287	VITAFOL STRP MIS 1MG .....	292
VIJOICE TAB 250MG .....	287	VITAL HN POW .....	222
VIJOICE TAB 50MG .....	286	VITAMEDMD CAP ONE RX .....	292
VILACTIN AA LIQ PLUS .....	222	VITAPEARL CAP .....	292
<i>vilazodone hcl tab 10 mg</i> .....	81	VITATHELY TAB .....	292
<i>vilazodone hcl tab 20 mg</i> .....	81	VITATRUE MIS .....	292
<i>vilazodone hcl tab 40 mg</i> .....	81	VITRAKVI CAP 100MG .....	133
VIMOVO TAB 375-20MG .....	30	VITRAKVI CAP 25MG .....	133
VIMOVO TAB 500-20MG .....	30	VITRAKVI SOL 20MG/ML .....	133
VIMPAT SOL 10MG/ML .....	75	VIVA DHA CAP .....	292
VIMPAT TAB 100MG .....	75	VIVAGUARD LIQ CONTROL .....	276
VIMPAT TAB 150MG .....	75	VIVAGUARD MIS 28G .....	276
VIMPAT TAB 200MG .....	75	VIVAGUARD MIS 30G .....	276
VIMPAT TAB 50MG .....	75	VIVAGUARD MIS LANCING .....	276
VINATE DHA CAP 27-1.13 .....	291	VIVAGUARD TES INO .....	215
VINATE II TAB .....	291	VIVELLE-DOT DIS 0.025MG .....	238
VINATE ONE TAB .....	291	VIVELLE-DOT DIS 0.0375MG .....	238
VIKACE TAB 10440 .....	223	VIVELLE-DOT DIS 0.05MG .....	238
VIKACE TAB 20880 .....	223	VIVELLE-DOT DIS 0.075MG .....	238
VIRACEPT TAB 250MG .....	154	VIVELLE-DOT DIS 0.1MG .....	238
VIRACEPT TAB 625MG .....	154	VIVJOA CAP 150MG .....	98
VIRAMUNE SUS 50MG/5ML .....	154	VIVLODEX CAP 10MG .....	30
VIRAMUNE XR TAB 400MG .....	154	VIVLODEX CAP 5MG .....	30
VIREAD POW 40MG/GM .....	154	VIVONEX RTF LIQ .....	222
VIREAD TAB 150MG .....	155	VIZIMPRO TAB 15MG .....	120
VIREAD TAB 200MG .....	155	VIZIMPRO TAB 30MG .....	120

VIZIMPRO TAB 45MG.....	120	VYVANSE CHW 60MG .....	5
VOGELXO GEL 1%(50MG).....	50	VYZULTA SOL 0.024% .....	303
VOGELXO GEL PUMP 1%.....	50	<b>W</b>	
VONJO CAP 100MG.....	133	WAKIX TAB 17.8MG .....	8
VOQUEZNA PAK DUAL PAK.....	327	WAKIX TAB 4.45MG .....	8
VOQUEZNA PAK TRIP PK .....	327	<i>warfarin sodium tab 10 mg</i> .....	66
<i>voriconazole for susp 40 mg/ml</i> .....	98	<i>warfarin sodium tab 1 mg</i> .....	66
<i>voriconazole tab 200 mg</i> .....	98	<i>warfarin sodium tab 2.5 mg</i> .....	66
<i>voriconazole tab 50 mg</i> .....	98	<i>warfarin sodium tab 2 mg</i> .....	66
VOSEVI TAB.....	157	<i>warfarin sodium tab 3 mg</i> .....	66
VOTRIENT TAB 200MG .....	133	<i>warfarin sodium tab 4 mg</i> .....	66
VOWST CAP .....	243	<i>warfarin sodium tab 5 mg</i> .....	66
VOXZOGO INJ 0.4MG .....	233	<i>warfarin sodium tab 6 mg</i> .....	66
VOXZOGO INJ 0.56MG.....	233	<i>warfarin sodium tab 7.5 mg</i> .....	66
VOXZOGO INJ 1.2MG .....	234	WEBCOL PREP PAD LARGE.....	277
VP-PNV-DHA CAP .....	292	WEBCOL PREP PAD MEDIUM.....	277
VRAYLAR CAP 1.5-3MG .....	140	WEGOVY INJ 0.25MG .....	5
VRAYLAR CAP 1.5MG.....	140	WEGOVY INJ 0.5MG.....	5
VRAYLAR CAP 3MG.....	140	WEGOVY INJ 1.7MG.....	5
VRAYLAR CAP 4.5MG .....	140	WEGOVY INJ 1MG.....	5
VRAYLAR CAP 6MG .....	140	WEGOVY INJ 2.4MG.....	5
VTAMA CRE 1% .....	194	WELCHOL PAK 3.75GM.....	100
VUMERITY CAP 231MG .....	313	WELCHOL TAB 625MG.....	100
VUSION OIN .....	187	WELIREG TAB 40MG .....	122
VYLEESI INJ 1.75/0.3 .....	309	WELLBUTRIN TAB 100MG SR .....	79
VYNDAMAX CAP 61MG .....	173	WELLBUTRIN TAB 150MG SR .....	79
VYNDAQEL CAP 20MG .....	173	WELLBUTRIN TAB 200MG SR .....	79
VYTORIN TAB 10-10MG .....	100	WELLBUTRIN TAB XL 150MG .....	79
VYTORIN TAB 10-20MG.....	100	WELLBUTRIN TAB XL 300MG .....	79
VYTORIN TAB 10-40MG.....	100	WESTAB PLUS TAB 27-1MG.....	292
VYTORIN TAB 10-80MG.....	100	WESTGEL DHA CAP .....	292
VYVANSE CAP 10MG.....	4	WESTHROID TAB 130MG .....	323
VYVANSE CAP 20MG.....	4	WESTHROID TAB 195MG .....	323
VYVANSE CAP 30MG.....	4	WESTHROID TAB 32.5MG.....	323
VYVANSE CAP 40MG.....	4	WESTHROID TAB 65MG.....	323
VYVANSE CAP 50MG.....	4	WESTHROID TAB 97.5MG.....	323
VYVANSE CAP 60MG.....	4	WIDE-SEAL DPR KIT 60.....	257
VYVANSE CAP 70MG.....	4	WIDE-SEAL DPR KIT 65.....	257
VYVANSE CHW 10MG .....	4	WIDE-SEAL DPR KIT 70.....	257
VYVANSE CHW 20MG .....	5	WIDE-SEAL DPR KIT 75.....	257
VYVANSE CHW 30MG .....	5	WIDE-SEAL DPR KIT 80.....	257
VYVANSE CHW 40MG .....	5	WIDE-SEAL DPR KIT 85.....	257
VYVANSE CHW 50MG .....	5	WIDE-SEAL DPR KIT 90.....	257

WIDE-SEAL DPR KIT 95 .....	257	XELJANZ SOL 1MG/ML.....	24
WINLEVI CRE 1% .....	185	XELJANZ TAB 10MG.....	24
WND 2 POW .....	222	XELJANZ TAB 5MG .....	24
WP THYROID TAB 113.75MG.....	323	XELJANZ XR TAB 11MG.....	25
WP THYROID TAB 130MG .....	323	XELJANZ XR TAB 22MG .....	25
WP THYROID TAB 16.25MG .....	323	XELODA TAB 150MG .....	118
WP THYROID TAB 32.5MG.....	323	XELODA TAB 500MG .....	118
WP THYROID TAB 48.75MG .....	323	XELPROS EMU 0.005% .....	303
WP THYROID TAB 65MG.....	323	XENAZINE TAB 12.5MG .....	310
WP THYROID TAB 81.25MG .....	323	XENAZINE TAB 25MG.....	310
WP THYROID TAB 97.5MG.....	323	XENICAL CAP 120MG.....	6
WYNZORA CRE.....	200	XENLETA TAB 600MG .....	53
<b>X</b>		XEPI CRE 1%.....	186
XACIATO GEL 2% .....	330	XERAC-AC SOL 6.25% .....	203
XADAGO TAB 100MG .....	138	XERESE CRE 5-1%.....	194
XADAGO TAB 50MG.....	138	XERMELO TAB 250MG .....	244
XALATAN SOL 0.005% .....	303	XHANCE MIS 93MCG.....	295
XALKORI CAP 200MG .....	133	XIFAXAN TAB 200MG.....	51
XALKORI CAP 250MG .....	133	XIFAXAN TAB 550MG.....	51
XANAX TAB 0.25MG .....	56	XIGDUO XR TAB 10-1000 .....	87
XANAX TAB 0.5MG .....	56	XIGDUO XR TAB 10-500MG .....	87
XANAX TAB 1MG.....	56	XIGDUO XR TAB 2.5-1000 .....	87
XANAX TAB 2MG.....	56	XIGDUO XR TAB 5-1000MG .....	87
XANAX XR TAB 0.5MG.....	56	XIGDUO XR TAB 5-500MG.....	87
XANAX XR TAB 1MG.....	56	XIIDRA DRO 5%.....	300
XANAX XR TAB 2MG .....	56	XIMINO CAP 135MG ER .....	320
XANAX XR TAB 3MG.....	56	XIMINO CAP 45MG ER .....	319
XARELTO STAR TAB 15/20MG.....	66	XIMINO CAP 90MG ER .....	320
XARELTO TAB 10MG .....	66	XLYS-XTRP POW MAXAMAID .....	223
XARELTO TAB 15MG .....	66	XMET XCYS POW MAXAMAID .....	223
XARELTO TAB 2.5MG.....	66	XOFLUZA TAB 20MG .....	158
XARELTO TAB 20MG .....	66	XOFLUZA TAB 40MG .....	158
XATMEP SOL 2.5MG/ML .....	118	XOLEGEL GEL 2%.....	188
XCOPRI PAK 100-150 .....	76	XOPENEX CONC NEB 1.25/0.5 .....	65
XCOPRI PAK 12.5-25 .....	76	XOPENEX HFA AER .....	65
XCOPRI PAK 150-200 .....	76	XOPENEX NEB 0.31MG .....	65
XCOPRI PAK 50-100MG .....	76	XOPENEX NEB 0.63MG .....	65
XCOPRI PAK 50-200MG.....	76	XOPENEX NEB 1.25/3ML .....	65
XCOPRI TAB 100MG.....	76	XOSPATA TAB 40MG .....	133
XCOPRI TAB 150MG .....	76	XPHE-XTYR POW MAXAMAID .....	223
XCOPRI TAB 200MG .....	76	XPOVIO PAK 100MG .....	123
XCOPRI TAB 50MG.....	76	XPOVIO PAK 40MG.....	123
XDEMVY DRO 0.25%.....	300	XPOVIO PAK 50MG.....	123

XPOVIO PAK 60MG.....	123	ZARXIO INJ 300/0.5 .....	251
XPOVIO PAK 80MG.....	123	ZARXIO INJ 480/0.8 .....	251
XTAMPZA ER CAP 13.5MG .....	44	ZAVESCA CAP 100MG .....	249
XTAMPZA ER CAP 18MG .....	44	ZAVZPRET SPR 10MG .....	280
XTAMPZA ER CAP 27MG.....	44	ZCORT 7-DAY TAB 1.5MG.....	180
XTAMPZA ER CAP 36MG .....	44	ZEGALOGUE INJ 0.6/0.6 .....	88
XTAMPZA ER CAP 9MG.....	44	ZEGERID CAP 20-1100 .....	327
XTANDI CAP 40MG.....	122	ZEGERID CAP 40-1100 .....	328
XTANDI TAB 40MG .....	122	ZEGERID POW 20-1680 .....	328
XTANDI TAB 80MG .....	122	ZEGERID POW 40-1680 .....	328
XULTOPHY INJ 100/3.6 .....	87	ZEJULA CAP 100MG .....	133
XURIDEN POW 2GM.....	233	ZEJULA TAB 100MG.....	133
XYLIDERM KIT.....	203	ZEJULA TAB 200MG.....	133
XYOSTED INJ 100/0.5 .....	50	ZEJULA TAB 300MG.....	133
XYOSTED INJ 50/0.5 .....	50	ZELAC CAP .....	94
XYOSTED INJ 75/0.5 .....	50	ZELAPAR TAB 1.25MG .....	138
XYREM SOL 500MG/ML .....	307	ZELBORAF TAB 240MG.....	133
XYWAV SOL 0.5GM/ML .....	307	ZELNORM TAB 6MG .....	243
XYZBAC TAB.....	223	ZEMBRACE SYM INJ 3/0.5ML.....	282
<b>Y</b>		ZEMPLAR CAP 1MCG.....	233
YASMIN 28 TAB 3-0.03MG .....	177	ZEMPLAR CAP 2MCG .....	233
YAZ TAB 3-0.02MG.....	177	ZENPEP CAP 10000UNT .....	223
YCANTH SOL 0.7% .....	202	ZENPEP CAP 15000UNT .....	223
YONSA TAB 125MG.....	122	ZENPEP CAP 20000UNT .....	223
YOSPRALA TAB 325-40MG .....	248	ZENPEP CAP 25000UNT .....	223
YOSPRALA TAB 81-40MG.....	248	ZENPEP CAP 3000UNIT .....	223
YUFLYMA 1PEN KIT 40/0.4ML .....	22	ZENPEP CAP 40000UNT .....	223
YUFLYMA 2SYR KIT 40/0.4ML .....	22	ZENPEP CAP 5000UNIT .....	223
YUPELRI SOL .....	59	ZEPATIER TAB 50-100MG.....	157
YUSIMRY INJ 40/0.8ML .....	22	ZEPOSIA 7DAY CAP STR PACK.....	313
<b>Z</b>		ZEPOSIA CAP .92MG .....	313
ZACLIR LOT 8% .....	185	ZEPOSIA CAP STR KIT .....	313
<i>zafirlukast tab 10 mg</i> .....	59	ZERVIAE DRO 0.24% .....	303
<i>zafirlukast tab 20 mg</i> .....	59	ZESTORETIC TAB 10-12.5.....	114
<i>zaleplon cap 10 mg</i> .....	254	ZESTORETIC TAB 20-12.5 .....	114
<i>zaleplon cap 5 mg</i> .....	254	ZESTORETIC TAB 20-25MG .....	114
ZALVIT TAB 13-1MG.....	292	ZESTRIL TAB 10MG.....	106
ZANAFLEX CAP 2MG .....	293	ZESTRIL TAB 2.5MG .....	106
ZANAFLEX CAP 4MG .....	293	ZESTRIL TAB 20MG .....	106
ZANAFLEX CAP 6MG .....	293	ZESTRIL TAB 30MG .....	106
ZANAFLEX TAB 4MG .....	293	ZESTRIL TAB 40MG.....	106
ZARONTIN CAP 250MG.....	77	ZESTRIL TAB 5MG.....	106
ZARONTIN SOL 250/5ML.....	77	ZETIA TAB 10MG .....	104

ZETONNA AER 37MCG .....	295	<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	282
ZIAC TAB 10/6.25 .....	114	<i>zolmitriptan nasal spray 5 mg/spray unit</i>	282
ZIAC TAB 2.5/6.25 .....	114	<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	282
ZIAC TAB 5-6.25MG .....	114	<i>zolmitriptan orally disintegrating tab 5 mg</i>	282
ZIAGEN SOL 20MG/ML .....	155	<i>zolmitriptan tab 2.5 mg</i>	282
ZIAGEN TAB 300MG .....	155	<i>zolmitriptan tab 5 mg</i>	283
ZIANA GEL .....	185	ZOLOFT CON 20MG/ML .....	81
<i>zidovudine cap 100 mg</i> .....	155	ZOLOFT TAB 100MG .....	81
<i>zidovudine syrup 10 mg/ml</i> .....	155	ZOLOFT TAB 25MG .....	81
<i>zidovudine tab 300 mg</i> .....	155	ZOLOFT TAB 50MG .....	81
ZIEXTENZO INJ 6/0.6ML .....	252	ZOLPIDEM TAR CAP 7.5MG .....	254
<i>zileuton tab er 12hr 600 mg</i> .....	59	<i>zolpidem tartrate sl tab 1.75 mg</i> .....	254
ZILXI AER 1.5% .....	204	<i>zolpidem tartrate sl tab 3.5 mg</i> .....	254
ZIOPTAN DRO 0.0015% .....	303	<i>zolpidem tartrate tab 10 mg</i> .....	254
<i>ziprasidone hcl cap 20 mg</i> .....	140	<i>zolpidem tartrate tab 5 mg</i> .....	254
<i>ziprasidone hcl cap 40 mg</i> .....	140	<i>zolpidem tartrate tab er 12.5 mg</i> .....	254
<i>ziprasidone hcl cap 60 mg</i> .....	140	<i>zolpidem tartrate tab er 6.25 mg</i> .....	254
<i>ziprasidone hcl cap 80 mg</i> .....	140	ZOLPIMIST SPR 5MG .....	254
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i> .....	140	ZOMACTON INJ 10MG .....	230
ZIPSOR CAP 25MG .....	30	ZOMACTON INJ 5MG .....	230
ZIRGAN GEL 0.15% .....	300	ZOMIG SPR 2.5MG .....	283
ZITHROMAX POW 1GM PAK .....	256	ZOMIG SPR 5MG .....	283
ZITHROMAX SUS 100/5ML .....	256	ZOMIG TAB 2.5MG .....	283
ZITHROMAX SUS 200/5ML .....	256	ZOMIG TAB 5MG .....	283
ZITHROMAX TAB 250MG .....	256	ZOMIG ZMT TAB 2.5 MG .....	283
ZITHROMAX TAB 500MG .....	256	ZOMIG ZMT TAB 5MG ODT .....	283
ZITHROMAX TAB TRI-PAK .....	256	ZONALON CRE 5% .....	188
ZITHROMAX TAB Z-PAK .....	256	ZONEGRAN CAP 100MG .....	76
ZOCOR TAB 10MG .....	103	ZONEGRAN CAP 25MG .....	75
ZOCOR TAB 20MG .....	103	<i>zonisamide cap 100 mg</i> .....	76
ZOCOR TAB 40MG .....	103	<i>zonisamide cap 25 mg</i> .....	76
ZOFRAN TAB 4MG .....	96	<i>zonisamide cap 50 mg</i> .....	76
ZOHYDRO ER CAP 10MG .....	44	ZONTIVITY TAB 2.08MG .....	248
ZOHYDRO ER CAP 15MG .....	44	ZORBTIVE INJ 8.8MG .....	230
ZOHYDRO ER CAP 20MG .....	44	ZORTRESS TAB 0.25MG .....	286
ZOHYDRO ER CAP 30MG .....	44	ZORTRESS TAB 0.5MG .....	286
ZOHYDRO ER CAP 40MG .....	44	ZORTRESS TAB 0.75MG .....	286
ZOHYDRO ER CAP 50MG .....	44	ZORTRESS TAB 1MG .....	286
ZOKINVY CAP 50MG .....	287	ZORVOLEX CAP 18MG .....	30
ZOKINVY CAP 75MG .....	287		
ZOLINZA CAP 100MG .....	133		



ZORVOLEX CAP 35MG .....	31	ZYLOPRIM TAB 300MG.....	246
ZORYVE CRE 0.3%.....	194	ZYMAXID SOL 0.5%.....	300
ZOVIRAX CRE 5%.....	194	ZYPITAMAG TAB 2MG.....	103
ZOVIRAX OIN 5% .....	194	ZYPITAMAG TAB 4MG .....	103
ZOVIRAX SUS 200/5ML .....	158	ZYPREXA INJ 10MG .....	144
ZTLIDO PAD 1.8% .....	203	ZYPREXA RELP INJ 210MG.....	144
ZUBSOLV SUB 0.7-0.18.....	49	ZYPREXA RELP INJ 300MG.....	144
ZUBSOLV SUB 1.4-0.36 .....	49	ZYPREXA RELP INJ 405MG.....	144
ZUBSOLV SUB 11.4-2.9.....	49	ZYPREXA TAB 10MG.....	144
ZUBSOLV SUB 2.9-0.71 .....	49	ZYPREXA TAB 15MG.....	144
ZUBSOLV SUB 5.7-1.4 .....	49	ZYPREXA TAB 2.5MG .....	144
ZUBSOLV SUB 8.6-2.1 .....	49	ZYPREXA TAB 20MG .....	144
ZUPLENZ MIS 4MG.....	96	ZYPREXA TAB 5MG .....	144
ZUPLENZ MIS 8MG.....	96	ZYPREXA TAB 7.5MG .....	144
ZYCLARA CRE 3.75% .....	201	ZYPREXA ZYDI TAB 10MG .....	144
ZYCLARA PUMP CRE 2.5%.....	201	ZYPREXA ZYDI TAB 15MG.....	144
ZYCLARA PUMP CRE 3.75% .....	201	ZYPREXA ZYDI TAB 20MG.....	144
ZYDELIG TAB 100MG.....	133	ZYPREXA ZYDI TAB 5MG .....	144
ZYDELIG TAB 150MG .....	133	ZYTIGA TAB 250MG.....	122
ZYFLO TAB 600MG .....	59	ZYTIGA TAB 500MG .....	122
ZYKADIA TAB 150MG .....	134	ZYVIT TAB .....	223
ZYLET SUS 0.5-0.3%.....	302	ZYVOX SUS 100MG/5M .....	53
ZYLOPRIM TAB 100MG .....	246	ZYVOX TAB 600MG.....	53

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.

SUM5464-1S (12/23) ■ 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](mailto: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 yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déèti pàtó o sì le ní láti gbé igbésé ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèé. Àwọn omọ-egbé gbòdò pe nóm̀bà fòdùn tò wà lèyìn kààdì idánimò wòn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tí tí a ó fì sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pò mó 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 nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.*

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

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

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

Bàsòò-wùdù (Bassa) Tò Dùù Cáo! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiǐn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàè d́éin nyε. Nyò t̀òò séin m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa ḱε m̄ gbo ćé b́é m̄ kè nòbà m̀òà 0 ḱε dyi pàd̀àn hwè. Ǿ j̀ú kè nyò d̀ò dyi m̄ g̀ǎ j̀ùǐn, pò wuqu m̄ ḿ pòε dyie, kè nyò d̀ò mu bó nìin b́é Ǿ 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 ník'ist'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aaahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowoł t'áa nínizaad bee t'áa jii'k'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nitł'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náánałta' éí kójjí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį́ áádóo éí bikéé'dóo naasbaąs bił adidiilchil. Áká'ánidaalwó'ígíí neidiitáągo, saad bee yániłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowoł.