

CareFirst Formulary 2

2023

This formulary is for members of an employer group with 51 or more employees OR individuals or families who have a “grandfathered” plan (purchased before the March 23, 2010 Affordable Care Act date). For your specific prescription benefit plan information, log into your account at carefirst.com.

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

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 four drug tiers which determines the price you pay.

Using Your Formulary

The first column of the formulary lists drugs by name. If the drugs are shown in lowercase italics, they are *generic drugs*. If the drugs are bold and capitalized, they are **BRAND-NAME DRUGS**.

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

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

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

- **Prior Authorization** from CareFirst is required before you fill prescriptions for

certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CareFirst, your drugs may not be covered.

- **Step Therapy** requires that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your doctor will need to provide information to CareFirst about your experience with these alternatives prior to dispensing a more expensive drug.
- **Quantity Limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. For example, quantity limits apply to specialty drugs. Specialty drugs are medications that may be used to treat complex and/or rare health conditions and require special handling, administration or monitoring. Specialty drugs are typically covered for a one-month supply.

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

Tier 0: \$0 Drugs	<ul style="list-style-type: none"> ■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share.
Tier 1: Generic Drugs \$	<ul style="list-style-type: none"> ■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs \$\$	<ul style="list-style-type: none"> ■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-preferred Brand Drugs \$\$\$	<ul style="list-style-type: none"> ■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.
Tier 4: Self-Injectible Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Self-injectible drugs (excluding insulin) are drugs that do not require professional administration. Insulin is covered at the generic, preferred brand or non-preferred brand drug tier.

Drug Name	Drug Tier	Requirements/Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
ADDERALL TAB 5MG	3	PA, QL (120 tabs every 30 days); MNPA
ADDERALL TAB 7.5MG	3	PA, QL (120 tabs every 30 days); MNPA
ADDERALL TAB 10MG	3	PA, QL (120 tabs every 30 days); MNPA
ADDERALL TAB 12.5MG	3	PA, QL (120 tabs every 30 days); MNPA
ADDERALL TAB 15MG	3	PA, QL (60 tabs every 30 days); MNPA
ADDERALL TAB 20MG	3	PA, QL (60 tabs every 30 days); MNPA
ADDERALL TAB 30MG	3	PA, QL (30 tabs every 30 days); MNPA
ADDERALL XR CAP 5MG	1	PA, QL (120 caps every 30 days); MNPA
ADDERALL XR CAP 10MG	1	PA, QL (120 caps every 30 days); MNPA
ADDERALL XR CAP 15MG	1	PA, QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 20MG	1	PA, QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 25MG	1	PA, QL (30 caps every 30 days); MNPA
ADDERALL XR CAP 30MG	1	PA, QL (30 caps every 30 days); MNPA
ADZENYS ER SUS 1.25MG	3	PA, QL (540 mL every 30 days); MNPA
ADZENYS XR TAB 3.1MG	3	PA, QL (60 ea every 30 days); MNPA
ADZENYS XR TAB 6.3MG	3	PA, QL (60 ea every 30 days); MNPA
ADZENYS XR TAB 9.4MG	3	PA, 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ADZENYS XR TAB 12.5MG	3	PA, QL (30 ea every 30 days); MNPA
ADZENYS XR TAB 15.7 MG	3	PA, QL (30 ea every 30 days); MNPA
ADZENYS XR TAB 18.8MG	3	PA, 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA, QL (150 tabs every 30 days); MNPA
<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	PA, QL (150 tabs every 30 days); MNPA
<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	PA, QL (60 tabs every 30 days); MNPA
<i>dextroamphetamine sulfate tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	3	PA, QL (60 tabs every 30 days); MNPA
<i>dextroamphetamine sulfate tab 30 mg</i>	1	QL (30 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	3	PA, QL (30 tabs every 30 days); MNPA

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

3

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DYANAVEL XR CHW 5MG	3	QL (60 tabs every 30 days); MNPA
DYANAVEL XR CHW 10MG	3	QL (60 tabs every 30 days); MNPA
DYANAVEL XR CHW 15MG	3	QL (30 tabs every 30 days); MNPA
DYANAVEL XR CHW 20MG	3	QL (30 tabs every 30 days); MNPA
DYANAVEL XR SUS 2.5MG/ML	3	QL (300 mL every 30 days); MNPA
EVEKEO ODT TAB 5MG	3	PA, QL (150 tabs every 30 days); MNPA
EVEKEO ODT TAB 10MG	3	PA, QL (150 tabs every 30 days); MNPA
EVEKEO ODT TAB 15MG	3	PA, QL (60 tabs every 30 days); MNPA
EVEKEO ODT TAB 20MG	3	PA, QL (60 tabs every 30 days); MNPA
EVEKEO TAB 5MG	3	PA, QL (150 tabs every 30 days); MNPA
EVEKEO TAB 10MG	3	PA, 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); MNPA
MYDAYIS CAP 25MG	2	QL (60 caps every 30 days); MNPA
MYDAYIS CAP 37.5MG	2	QL (30 caps every 30 days); MNPA
MYDAYIS CAP 50MG	2	QL (30 caps every 30 days); MNPA
VYVANSE CAP 10MG	3	QL (60 caps every 30 days)
VYVANSE CAP 20MG	3	QL (60 caps 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VYVANSE CAP 30MG	3	QL (60 caps every 30 days)
VYVANSE CAP 40MG	3	QL (30 caps every 30 days)
VYVANSE CAP 50MG	3	QL (30 caps every 30 days)
VYVANSE CAP 60MG	3	QL (30 caps every 30 days)
VYVANSE CAP 70MG	3	QL (30 caps every 30 days)
VYVANSE CHW 10MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 20MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 30MG	3	QL (60 tabs every 30 days)
VYVANSE CHW 40MG	3	QL (30 tabs every 30 days)
VYVANSE CHW 50MG	3	QL (30 tabs every 30 days)
VYVANSE CHW 60MG	3	QL (30 tabs every 30 days)
ANALEPTICS		
<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	1	
ANTI-OBESITY AGENTS		
WEGOVY INJ 0.5MG	4	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 0.25MG	4	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1.7MG	4	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1MG	4	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 2.4MG	4	PA; Coverage is subject to your plan/benefits
ANTI-OBESITY AGENTS, INJECTABLE		
SAXENDA INJ 18MG/3ML	4	PA; Coverage is subject to your plan/benefits

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

5

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTI-OBESITY AGENTS, ORAL		
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
<i>diethylpropion hcl tab 25 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA; 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

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

6

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
REGIMEX TAB 25MG	3	PA; Coverage is subject to your plan/benefits
XENICAL CAP 120MG	3	PA; MNPA; Coverage is subject to your plan/benefits
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	QL (60 caps every 30 days)
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	
INTUNIV TAB 1MG	3	PA; MNPA
INTUNIV TAB 2MG	3	PA; MNPA
INTUNIV TAB 3MG	3	PA; MNPA
INTUNIV TAB 4MG	3	PA; MNPA
KAPVAY TAB 0.1 MG	3	
QELBREE CAP 100MG ER	3	
QELBREE CAP 150MG ER	3	
QELBREE CAP 200MG ER	2	
QELBREE CAP 200MG ER	3	

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

7

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
STRATTERA CAP 100MG	3	QL (30 caps every 30 days)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG	2	
SUNOSI TAB 150MG	2	
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG	2	QL (60 TABLETS PER 30 DAYS)
WAKIX TAB 17.8MG	2	QL (60 TABLETS PER 30 DAYS)
STIMULANTS - MISC.		
ADHANSIA XR CAP 25MG	3	PA, QL (60 caps every 30 days); MNPA
ADHANSIA XR CAP 35MG	3	PA, QL (60 caps every 30 days); MNPA
ADHANSIA XR CAP 45MG	3	PA, QL (60 caps every 30 days); MNPA
ADHANSIA XR CAP 55MG	3	PA, QL (30 caps every 30 days); MNPA
ADHANSIA XR CAP 70MG	3	PA, QL (30 caps every 30 days); MNPA
ADHANSIA XR CAP 85MG	3	PA, 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
APTENSIO XR CAP 10MG	3	PA, QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 15MG	3	PA, QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 20MG	3	PA, QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 30MG	3	PA, QL (60 caps every 30 days); MNPA
APTENSIO XR CAP 40MG	3	PA, QL (30 caps every 30 days); MNPA
APTENSIO XR CAP 50MG	3	PA, QL (30 caps every 30 days); MNPA
APTENSIO XR CAP 60MG	3	PA, 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	1	PA, QL (60 tabs every 30 days); MNPA
CONCERTA TAB 27MG	1	PA, QL (60 tabs every 30 days); MNPA
CONCERTA TAB 36MG	1	PA, QL (60 tabs every 30 days); MNPA
CONCERTA TAB 54MG	1	PA, QL (30 tabs every 30 days); MNPA
COTEMPLA XR TAB 8.6MG	3	PA, QL (60 ea every 30 days); MNPA

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

9

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COTEMPLA XR TAB 17.3MG	3	PA, QL (60 ea every 30 days); MNPA
COTEMPLA XR TAB 25.9MG	3	PA, QL (60 ea every 30 days); MNPA
DAYTRANA DIS 10MG/9HR	3	PA, QL (30 patches every 30 days); MNPA
DAYTRANA DIS 15MG/9HR	3	PA, QL (30 patches every 30 days); MNPA
DAYTRANA DIS 20MG/9HR	3	PA, QL (30 patches every 30 days); MNPA
DAYTRANA DIS 30MG/9HR	3	PA, 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 5 mg</i>	1	PA, QL (60 caps every 30 days); MNPA
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	PA, QL (60 caps every 30 days); MNPA
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	PA, QL (60 caps every 30 days); MNPA
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	PA, QL (60 caps every 30 days); MNPA
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	PA, QL (30 caps every 30 days); MNPA
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	PA, 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
dexamethylphenidate hcl cap er 24 hr 35 mg	1	QL (30 caps every 30 days)
dexamethylphenidate hcl cap er 24 hr 35 mg	1	PA, QL (30 caps every 30 days); MNPA
dexamethylphenidate hcl cap er 24 hr 40 mg	1	QL (30 caps every 30 days)
dexamethylphenidate hcl cap er 24 hr 40 mg	1	PA, QL (30 caps every 30 days); MNPA
dexamethylphenidate hcl tab 2.5 mg	1	QL (150 tabs every 30 days)
dexamethylphenidate hcl tab 5 mg	1	QL (150 tabs every 30 days)
dexamethylphenidate 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	PA, QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 10MG	3	PA, QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 15MG	3	PA, QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 20MG	3	PA, QL (60 caps every 30 days); MNPA
FOCALIN XR CAP 25MG	3	PA, QL (30 caps every 30 days); MNPA
FOCALIN XR CAP 30MG	3	PA, QL (30 caps every 30 days); MNPA
FOCALIN XR CAP 35MG	3	PA, QL (30 caps every 30 days); MNPA
FOCALIN XR CAP 40MG	3	PA, QL (30 caps every 30 days); MNPA
JORNAY PM CAP 20MG ER	2	QL (60 caps every 30 days); MNPA

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

11

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
JORNAY PM CAP 40MG ER	2	QL (60 caps every 30 days); MNPA
JORNAY PM CAP 60MG ER	2	QL (30 caps every 30 days); MNPA
JORNAY PM CAP 80MG ER	2	QL (30 caps every 30 days); MNPA
JORNAY PM CAP 100MG ER	2	QL (30 caps every 30 days); MNPA
METHYLIN SOL 5MG/5ML	3	QL (2160 mL every 30 days)
METHYLIN SOL 10MG/5ML	3	QL (1080 mL every 30 days)
METHYLPHENID TAB 72MG ER	3	QL (30 tabs every 30 days)
<i>methylphenidate hcl cap er 10 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 20 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	1	QL (60 caps every 30 days)
<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)

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

12

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
<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)

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

13

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl tab er 24hr 36 mg</i>	1	QL (60 tabs every 30 days); MNPA
<i>methylphenidate hcl tab er 24hr 54 mg</i>	1	QL (30 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	1	QL (60 tabs every 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>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
QUILLICHEW CHW 20MG ER	3	PA, QL (60 tabs every 30 days); MNPA
QUILLICHEW CHW 30MG ER	3	PA, QL (60 tabs every 30 days); MNPA
QUILLICHEW CHW 40MG ER	3	PA, QL (30 tabs every 30 days); MNPA
QUILLIVANT SUS 25MG/5ML	3	PA, QL (420 mL every 30 days); MNPA

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

14

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RELEXXII TAB 72MG	3	PA, QL (30 tabs every 30 days); MNPA
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**

GRASTEK SUB 2800BAU	2	
ORALAIR SUB 300 IR	2	
PALFORZIA CAP ESCALAT	3	PA; MNPA
PALFORZIA CAP LEVEL 1	3	PA; MNPA
PALFORZIA CAP LEVEL 2	3	PA; MNPA
PALFORZIA CAP LEVEL 3	3	PA; MNPA
PALFORZIA CAP LEVEL 4	3	PA; MNPA
PALFORZIA CAP LEVEL 5	3	PA; MNPA
PALFORZIA CAP LEVEL 6	3	PA; MNPA
PALFORZIA CAP LEVEL 7	3	PA; MNPA
PALFORZIA CAP LEVEL 8	3	PA; MNPA
PALFORZIA CAP LEVEL 9	3	PA; MNPA
PALFORZIA CAP LEVEL 10	3	PA; MNPA
PALFORZIA POW LEVEL 11	3	PA; MNPA
RAGWITEK SUB	2	

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

15

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRA 2GM	3	PA; MNPA
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
ARIKAYCE SUS	3	PA
BETHKIS NEB 300/4ML	2	PA, QL (56 AMPULES PER 28 DAYS); MNPA
KITABIS PAK NEB 300/5ML	3	PA, QL (56 AMPULES PER 28 DAYS); MNPA
<i>neomycin sulfate tab 500 mg</i>	1	
<i>paromomycin sulfate cap 250 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)
<i>tobramycin nebu soln 300 mg/5ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS); MNPA
ANALGESICS - ANTI-INFLAMMATORY		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
AMJEVITA INJ 10/0.2ML	4	PA, QL (2 syringes per 28 days)
AMJEVITA INJ 20/0.4ML	4	PA, QL (4 SYRINGES PER 28 DAYS)
AMJEVITA INJ 40/0.8ML	4	PA, QL (4 PENS PER 28 DAYS); Loading dose: 8 per 14 days
AMJEVITA INJ 40/0.8ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Loading dose: 8 per 14 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA INJ 10/0.1ML	4	PA, QL (2 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 20/0.2ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 40/0.4ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA KIT 40MG/0.8	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

17

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

18

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN INJ 80/0.8ML	4	PA, QL (2 PENS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ CD/UC/HS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 6 pens per 28 days.
HUMIRA PEN INJ PS/UV	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 4 pens per 28 days.
HUMIRA PEN KIT CD/UC/HS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 3 pens per 28 days.

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

19

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN KIT PED UC	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN KIT PS/UV	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HYRIMOZ	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
HYRIMOZ INJ 10/0.1ML	4	PA, QL (2 syringes per 28 days)
HYRIMOZ INJ 20/0.2ML	4	PA, QL (4 syringes per 28 days)
HYRIMOZ INJ 40/0.4ML	4	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HYRIMOZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HYRIMOZ INJ 40/0.8ML	4	PA, QL (4 pen autoinjectors per 28 days)
HYRIMOZ INJ 40/0.8ML	4	PA, QL (4 syringes per 28 days)

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

20

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ INJ 80/0.8ML	4	PA, QL (2 pens PER 28 days); LOADING DOSE: 4 pens per 14 days
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 2 syringes per 28 days
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
ANTIRHEUMATIC - ENZYME INHIBITORS		
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.

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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.

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

22

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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.
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		
RASUVO INJ 7.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 10MG	4	PA, QL (4 INJ PER 28 DAYS)

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

23

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RASUVO INJ 12.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 15MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 17.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 20MG	4	PA, QL (4 PENS PER 28 DAYS); MNPA
RASUVO INJ 22.5MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 25MG	4	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 30MG	4	PA, QL (4 INJ PER 28 DAYS)
REDITREX INJ 7.5/.3ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 10/.4ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 12.5/0.5	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 15/.6ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 17.5/0.7	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 20/.8ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 22.5/0.9	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
REDITREX INJ 25MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
GOLD COMPOUNDS		
RIDAURA CAP 3MG	3	
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ 220MG	4	PA, QL (8 VIALS PER 28 DAYS); MNPA

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

24

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INTERLEUKIN-6 RECEPTOR INHIBITORS		
KEVZARA INJ 150/1.14	4	PA, QL (2 PENS 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 150/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	4	PA, QL (2 PENS PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

25

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
ARTHROTEC 50 TAB	3	PA; MNPA
ARTHROTEC 75 TAB	3	PA; MNPA
CELEBREX CAP 50MG	3	PA; MNPA
CELEBREX CAP 100MG	3	PA; MNPA
CELEBREX CAP 200MG	3	PA; MNPA
CELEBREX CAP 400MG	3	PA; MNPA
<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	1	PA; MNPA
<i>diclofenac potassium cap 25 mg</i>	3	PA; MNPA
<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	

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

26

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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; MNPA
<i>flurbiprofen tab 50 mg</i>	1	
<i>flurbiprofen tab 100 mg</i>	1	
<i>ibuprofen susp 100 mg/5ml</i>	1	
<i>ibuprofen tab 400 mg</i>	1	
<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; MNPA
<i>ketorolac tromethamine tab 10 mg</i>	1	
LODINE TAB 400MG	3	PA; MNPA
<i>meclofenamate sodium cap 50 mg</i>	1	
<i>meclofenamate sodium cap 100 mg</i>	1	
<i>mefenamic acid cap 250 mg</i>	1	PA; MNPA
<i>meloxicam cap 5 mg</i>	1	PA; MNPA
<i>meloxicam cap 10 mg</i>	1	PA; 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 500 mg</i>	1	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>nabumetone tab 750 mg</i>	1	
<i>nabumetone tab 750 mg</i>	1	PA; MNPA
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	PA; MNPA
NAPROSYN SUS 125/5ML	3	
NAPROSYN TAB 500MG	3	
<i>naproxen sodium tab 275 mg</i>	1	
<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	PA; 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	PA; MNPA
QMIIZ ODT TAB 15 MG	3	PA; MNPA
RELAFEN DS TAB 1000MG	3	PA; MNPA
SPRIX SPR 15.75MG	3	PA; MNPA
<i>sulindac tab 150 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sulindac tab 200 mg</i>	1	
TIVORBEX CAP 20MG	3	PA; MNPA
<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	PA; MNPA
VIVLODEX CAP 10MG	3	PA; MNPA
ZIPSOR CAP 25MG	3	
ZORVOLEX CAP 18MG	3	PA; MNPA
ZORVOLEX CAP 35MG	3	PA; MNPA
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
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.
PYRIMIDINE SYNTHESIS INHIBITORS		
ARAVA TAB 10MG	2	
ARAVA TAB 20MG	2	
<i>leflunomide tab 10 mg</i>	1	
<i>leflunomide tab 20 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLCK INJ 125MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
ORENCIA INJ 50/0.4ML	4	PA, QL (4 PFS PER 28 DAYS); MNPA
ORENCIA INJ 87.5/0.7	4	PA, QL (4 PFS PER 28 DAYS); MNPA
ORENCIA INJ 125MG/ML	4	PA, QL (4 PFS PER 28 DAYS); MNPA
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25/0.5ML	4	PA, QL (8 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ENBREL INJ 25MG	4	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

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

ANALGESICS - NONNARCOTIC**ANALGESIC COMBINATIONS**

ALLZITAL TAB 25-325MG	3	PA; MNPA
BUT/ASA/CAF TAB	3	PA; MNPA
<i>butalbital-acetaminophen cap 50-300 mg</i>	1	PA; MNPA
<i>butalbital-acetaminophen tab 25-325 mg</i>	1	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
<i>butalbital-acetaminophen-caffeine cap 50-325-40 mg</i>	1	PA; MNPA
<i>butalbital-acetaminophen-caffeine soln 50-325-40 mg/15ml</i>	1	PA; MNPA
<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	PA; MNPA
SALICYLATES		
<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	
ANALGESICS - OPIOID		
OPIOID AGONISTS		
ACTIQ LOZ 200MCG	3	PA
ACTIQ LOZ 400MCG	3	PA
ACTIQ LOZ 600MCG	3	PA
ACTIQ LOZ 800MCG	3	PA
ACTIQ LOZ 1200MCG	3	PA
ACTIQ LOZ 1600MCG	3	PA
CODEINE SULF TAB 15MG	3	PA, QL (42 tabs every 25 days)
CODEINE SULF TAB 60MG	3	PA, QL (42 tabs every 25 days)

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

32

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>codeine sulfate tab 30 mg</i>	1	PA, QL (42 tabs every 25 days)
CONZIP CAP 100MG	3	PA, QL (30 caps every 25 days)
CONZIP CAP 200MG	3	PA, QL (30 caps every 25 days)
CONZIP CAP 300MG	3	PA, QL (30 caps every 25 days)
DILAUDID LIQ 1MG/ML	3	PA, QL (16 mL per day)
DILAUDID TAB 2MG	3	PA, QL (180 tabs every 25 days)
DILAUDID TAB 4MG	3	PA, QL (4 tabs per day)
DILAUDID TAB 8MG	3	PA, QL (60 tabs every 25 days)
DURAGESIC DIS 12MCG/HR	3	PA, QL (10 patches every 25 days)
DURAGESIC DIS 25MCG/HR	3	PA, QL (10 patches every 25 days)
DURAGESIC DIS 50MCG/HR	3	PA
DURAGESIC DIS 75MCG/HR	3	PA
DURAGESIC DIS 100MCG/H	3	PA
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	1	PA

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

33

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl td patch 72hr 12 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
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)

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

34

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
<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

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

35

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
<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

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

36

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

37

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
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	MNPA
OLINVYK SOL 2MG/2ML	3	MNPA
OLINVYK SOL 30MG/30	3	MNPA
OXAYDO TAB 5MG	3	PA, QL (180 tabs every 25 days); MNPA
OXAYDO TAB 7.5MG	3	PA, QL (180 tabs every 25 days); MNPA
<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)

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

38

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
oxycodone hcl soln 5 mg/5ml	1	PA, QL (900 mL every 25 days)
oxycodone hcl tab 5 mg	1	PA, QL (180 tabs every 25 days)
oxycodone hcl tab 10 mg	1	PA, QL (180 tabs every 25 days)
oxycodone hcl tab 15 mg	1	PA, QL (120 tabs every 25 days)
oxycodone hcl tab 20 mg	1	PA, QL (90 tabs every 25 days)
oxycodone hcl tab 30 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 10 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 10 mg	3	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 15 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 20 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 20 mg	3	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 30 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 40 mg	1	PA, QL (120 tabs every 30 days)
oxycodone hcl tab er 12hr deter 40 mg	3	PA, QL (120 tabs every 30 days)
oxycodone hcl tab er 12hr deter 60 mg	1	PA, QL (60 tabs every 25 days)
oxycodone hcl tab er 12hr deter 80 mg	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

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

39

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
<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	PA; MNPA
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)
SUBSYS SPR 100MCG	2	PA; MNPA
SUBSYS SPR 200MCG	2	PA; MNPA
SUBSYS SPR 400MCG	2	PA; MNPA
SUBSYS SPR 600MCG	2	PA; MNPA

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

40

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SUBSYS SPR 800MCG	2	PA; MNPA
SUBSYS SPR 1200MCG	2	PA; MNPA
SUBSYS SPR 1600MCG	2	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)
<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

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

41

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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

OPIOID COMBINATIONS

<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	PA, QL (2700 mL every 30 days)
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	PA, QL (390 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	PA, QL (300 caps every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	1	PA, QL (300 tabs every 30 days)
APADAZ TAB 4.08-325	3	PA, QL (360 tabs every 30 days); MNPA
APADAZ TAB 6.12-325	3	PA, QL (360 tabs every 30 days); MNPA
APADAZ TAB 8.16-325	3	PA, QL (360 tabs every 30 days); MNPA
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	

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

42

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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); MNPA
<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)
<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); MNPA
OXYCOD-APAP TAB 2.5-300	3	PA, QL (360 tabs every 30 days); MNPA
OXYCOD/ACETA SOL 10/300MG	3	PA, QL (900 mL every 30 days); MNPA

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

43

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OXYCOD/APAP TAB 5-300MG	3	PA, QL (360 tabs every 30 days); MNPA
OXYCOD/APAP TAB 10-300MG	3	PA, QL (180 tabs every 30 days); MNPA
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	1	PA, QL (360 tabs every 30 days)
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	PA, QL (900 mL every 30 days); MNPA
PROLATE TAB 5-300MG	3	PA, QL (360 tabs every 30 days); MNPA
PROLATE TAB 7.5-300	3	PA, QL (240 tabs every 30 days); MNPA
PROLATE TAB 10-300MG	3	PA, QL (180 tabs every 30 days); MNPA
<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)

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

44

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	3	
BUNAVAIL MIS 6.3-1MG	3	
<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

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

45

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
SUBOXONE MIS 4-1MG	3	PA; MNPA
SUBOXONE MIS 8-2MG	3	PA; MNPA
SUBOXONE MIS 12-3MG	3	PA; 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

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

46

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	4	PA; MNPA
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	4	PA
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	4	PA
<i>testosterone enanthate im inj in oil 200 mg/ml</i>	4	PA
<i>testosterone td gel 10mg/act (2%)</i>	1	PA
<i>testosterone td gel 12.5 mg/act (1%)</i>	1	PA
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1	PA
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	1	PA
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	1	PA
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	1	PA
<i>testosterone td gel 50 mg/5gm (1%)</i>	1	PA
<i>testosterone td soln 30 mg/act</i>	1	PA
VOGELXO GEL 1%(50MG)	3	PA; MNPA
VOGELXO GEL PUMP 1%	3	PA; MNPA
XYOSTED INJ 50/0.5	4	PA
XYOSTED INJ 75/0.5	4	PA
XYOSTED INJ 100/0.5	4	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	

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

47

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
ANTHELMINTICS		
ANTHELMINTICS		
<i>albendazole tab 200 mg</i>	1	QL (336 tabs every year)
ALBENZA TAB 200MG	3	QL (336 tabs every year)
BENZNIDAZOLE TAB 12.5MG	3	
BENZNIDAZOLE TAB 100MG	3	
BILTRICIDE TAB 600MG	3	QL (24 tabs every year)
EMVERM CHW 100MG	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)
STROMECTION TAB 3MG	3	PA, QL (9 tabs every 90 days)
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
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	
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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
ANTI-INFECTIVE MISC. - COMBINATIONS		
BACTRIM DS TAB 800-160	3	
BACTRIM TAB 400-80MG	3	
<i>methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg</i>	1	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
ANTIPROTOZOAL AGENTS		
ALINIA SUS 100/5ML	3	
ALINIA TAB 500MG	3	
<i>atovaquone susp 750 mg/5ml</i>	1	
LAMPIT TAB 30MG	3	
LAMPIT TAB 120MG	3	
MEPRON SUS	3	
<i>nitazoxanide tab 500 mg</i>	1	
GLYCOPEPTIDES		
FIRVANQ SOL 25MG/ML	3	PA, QL (450 mL every 10 days); MNPA
FIRVANQ SOL 50MG/ML	3	PA, QL (450 mL every 10 days); MNPA
VANCOGIN CAP 125MG	2	QL (80 caps every 10 days)
VANCOGIN 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)
LEPROSTATICS		
<i>dapsone tab 25 mg</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dapsone tab 100 mg</i>	1	
LINCOSAMIDES		
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	
MONOBACTAMS		
CAYSTON INH 75MG	3	PA, QL (84 VIALS PER 28 DAYS); MNPA
OXAZOLIDINONES		
<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
PLEUROMUTILINS		
XENLETA TAB 600MG	3	
URINARY ANTI-INFECTIVES		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	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	

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	

ANTIANGINAL AGENTS

ANTIANGINALS-OTHER

RANEXA TAB 500MG	3	
RANEXA TAB 1000MG	3	
<i>ranolazine tab er 12hr 500 mg</i>	1	
<i>ranolazine tab er 12hr 1000 mg</i>	1	

NITRATES

DILATRATE SR CAP 40MG	3	
GONITRO POW 400MCG	3	PA; 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	

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	
NITROSTAT SUB 0.6MG	3	

ANTIANSXIETY AGENTS**ANTIANSXIETY AGENTS - MISC.**

<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	

BENZODIAZEPINES

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

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

52

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	2	PA; MNPA
ATIVAN TAB 1MG	2	PA; MNPA
ATIVAN TAB 2MG	2	PA; 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	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XANAX TAB 0.25MG	3	PA; MNPA
XANAX TAB 1MG	3	PA; MNPA
XANAX TAB 2MG	3	PA; MNPA
XANAX XR TAB 0.5MG	3	PA; MNPA
XANAX XR TAB 1MG	3	PA; MNPA
XANAX XR TAB 2MG	3	PA; MNPA
XANAX XR TAB 3MG	3	PA; MNPA

ANTIARRHYTHMICS**ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i>	1	
<i>disopyramide phosphate cap 150 mg</i>	1	
NORPACE CAP 100MG	2	PA; MNPA
NORPACE CAP 100MG CR	2	
NORPACE CAP 150MG	2	PA; 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	

ANTIARRHYTHMICS TYPE I-B

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

ANTIARRHYTHMICS TYPE I-C

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

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTIARRHYTHMICS TYPE III		
<i>amiodarone hcl tab 100 mg</i>	1	
<i>amiodarone hcl tab 200 mg</i>	1	
<i>amiodarone hcl tab 400 mg</i>	1	
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	PA
MULTAQ TAB 400MG	2	PA; MNPA
TIKOSYN CAP 125MCG	3	PA
TIKOSYN CAP 250MCG	3	PA
TIKOSYN CAP 500MCG	3	PA
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (240 mL every 30 days)
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
DUPIXENT INJ 100/0.67	4	PA, QL (2 SYRINGES PER 28 DAYS)
DUPIXENT INJ 200/1.14	4	PA, QL (2 PFS PER 28 DAYS); LOADING DOSE: 2 PFS PER 14 DAYS
FASENRA PEN INJ 30MG/ML	4	PA, QL (1 PENS PER 56 DAYS); LOADING DOSE: 3 PENS PER 84 DAYS
NUCALA INJ 40MG/0.4	4	PA, QL (1 SYRINGE PER 28 DAYS)
NUCALA INJ 100MG	2	PA, QL (3 VIALS PER 28 DAYS); MNPA
NUCALA INJ 100MG/ML	4	PA, QL (3 INJ PER 28 DAYS)
NUCALA INJ 100MG/ML	4	PA, QL (3 PFS PER 28 DAYS)
TEZSPIRE INJ 210MG	4	PA, QL (1 PEN PER 28 DAYS)

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

55

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BRONCHODILATORS - ANTICHOLINERGICS		
ATROVENT HFA AER 17MCG	3	QL (2 packages every 25 days)
INCRUSE ELPT INH 62.5MCG	3	PA, 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	PA, QL (60 mL every 30 days); MNPA
SEEBRI NEOHA CAP 15.6MCG	3	PA, QL (60 ea every 30 days); MNPA
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)
TUDORZA PRES AER 400/ACT	3	PA, QL (1 inhaler every 30 days); MNPA
YUPELRI SOL	2	QL (90 mL every 30 days)
LEUKOTRIENE MODULATORS		
ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	
SINGULAIR CHW 4MG	3	PA; MNPA
SINGULAIR CHW 5MG	3	PA; MNPA
SINGULAIR GRA 4MG	3	PA; MNPA
SINGULAIR TAB 10MG	3	PA; MNPA
<i>zafirlukast tab 10 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>zafirlukast tab 20 mg</i>	1	
<i>zileuton tab er 12hr 600 mg</i>	1	PA; MNPA
ZYFLO TAB 600MG	3	

SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS

DALIRESP TAB 250MCG	2	MNPA
DALIRESP TAB 500MCG	2	MNPA

STEROID INHALANTS

ALVESCO AER 80MCG	3	PA, QL (3 packages every 25 days); MNPA
ALVESCO AER 160MCG	3	PA, QL (2 inhalers every 25 days); MNPA
ARMONAIR DIG AER 55MCG	3	PA, QL (1 inhaler every 25 days); MNPA
ARMONAIR DIG AER 113MCG	3	PA, QL (1 inhaler every 25 days); MNPA
ARMONAIR DIG AER 232MCG	3	PA, QL (1 inhaler every 25 days); MNPA
ARNUIITY ELPT INH 50MCG	2	PA, QL (1 inhaler every 30 days); MNPA
ARNUIITY ELPT INH 100MCG	2	PA, QL (30 blisters every 30 days); MNPA
ARNUIITY ELPT INH 200MCG	2	PA, QL (30 blisters every 30 days); MNPA
ASMANEX 7 AER 110MCG	3	PA, QL (2 inhalers every 25 days); MNPA
ASMANEX 14 AER 220MCG	3	PA; MNPA
ASMANEX 30 AER 110MCG	3	PA, QL (2 inhalers every 25 days); MNPA
ASMANEX 30 AER 220MCG	3	PA, QL (4 inhalers every 25 days); MNPA
ASMANEX 60 AER 220MCG	3	PA, QL (2 inhalers every 25 days); MNPA
ASMANEX 120 AER 220MCG	3	PA, QL (1 inhaler every 25 days); MNPA
ASMANEX HFA AER 50MCG	3	PA, QL (1 package every 25 days); MNPA

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

57

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ASMANEX HFA AER 100 MCG	3	PA, QL (1 inhaler every 25 days); MNPA
ASMANEX HFA AER 200 MCG	3	PA, QL (1 inhaler every 25 days); MNPA
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (2 mL every 25 days); 2 packages / 25 days
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (3 mL every 25 days); 3 packages / 25 days
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (1 mL every 25 days); 1 packages / 25 days
FLOVENT DISK AER 50MCG	2	PA, QL (3 inhalations every 25 days); MNPA
FLOVENT DISK AER 100MCG	2	PA, QL (4 inhalations every 25 days); MNPA
FLOVENT DISK AER 250MCG	2	PA, QL (4 inhalations every 25 days); MNPA
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125/valve)</i>	1	QL (2 packages every 25 days); MPNA, Covered for members 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250/valve)</i>	1	QL (2 packages every 25 days); MNPA, Covered for member 6 years of age and younger

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

58

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50/valve)</i>	1	QL (2 packages every 25 days); MPNA, Covered for members 6 years of age and younger
PULMICORT INH 90MCG	2	QL (3 inhalers every 25 days)
PULMICORT INH 180MCG	2	QL (2 inhalers every 25 days)
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	PA, QL (2 packages every 25 days); MNPA, Covered for members 6 years of age and younger
QVAR REDIIHAL AER 40MCG	2	PA, QL (2 packages every 25 days); MNPA, Covered for members 6 years of age and younger

SYMPATHOMIMETICS

ADVAIR DISKU AER 100/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR DISKU AER 250/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR DISKU AER 500/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR HFA AER 45/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 115/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 230/21	2	QL (1 package every 25 days)
AIRDUO DGHLR INH 55-14	3	PA, QL (60 inhalers every 25 days); MNPA
AIRDUO DGHLR INH 113-14	3	PA, QL (60 inhalers every 25 days); MNPA

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

59

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AIRDUO DGHLR INH 232-14	3	PA, QL (60 inhalers every 25 days); MNPA
AIRDUO RESPI INH 55-14	3	PA, QL (1 inhaler every 30 days); MNPA
AIRDUO RESPI INH 113-14	3	PA, QL (1 inhaler every 30 days); MNPA
AIRDUO RESPI INH 232-14	3	PA, QL (1 inhaler every 30 days); MNPA
AIRSUPRA AER 90-80MCG	2	QL (3 packages per 30 days)
ALBUTEROL NEB 0.5%	3	PA, 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 ELLIPTA AER 62.5-25	2	QL (60 blisters every 30 days)
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (120 mL every 30 days)
BEVESPI AER 9-4.8MCG	3	PA, QL (1 package every 25 days); MNPA
BREO ELLIPTA INH 50-25MCG	2	QL (60 blisters every 30 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
COMBIVENT AER 20-100	3	QL (2 packages every 25 days)
DUAKLIR AER 400/12	3	PA, QL (1 inhaler every 30 days); MNPA
DULERA AER 50-5MCG	3	PA, QL (1 package every 25 days); MNPA
DULERA AER 100-5MCG	3	PA, QL (1 package every 25 days); MNPA
DULERA AER 200-5MCG	3	PA, QL (1 package every 25 days); MNPA
<i>fluticasone-salmeterol aer powder ba 55-14 mcg/act</i>	1	PA, QL (1 inhaler every 30 days); MNPA
<i>fluticasone-salmeterol aer powder ba 113-14 mcg/act</i>	1	PA, QL (1 inhaler every 30 days); MNPA
<i>fluticasone-salmeterol aer powder ba 232-14 mcg/act</i>	1	PA, QL (1 inhaler every 30 days); MNPA
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (60 mL every 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (540 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (90 ea every 30 days)
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (2 inhalers every 30 days)

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

61

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PERFOROMIST NEB 20MCG	3	QL (120 mL every 30 days)
PROAIR DIGIH AER	3	PA, QL (2 packages every 25 days); MNPA
PROAIR HFA AER	3	PA, QL (2 packages every 25 days); MNPA
PROAIR RESPI AER	3	PA, QL (2 packages every 25 days); MNPA
PROVENTIL AER HFA	3	PA, 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	PA, QL (60 ea every 30 days); MNPA
VENTOLIN HFA AER	3	PA, QL (2 packages every 25 days); MNPA
VENTOLIN HFA AER	3	PA, 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	PA, 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)

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

62

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
XOPENEX NEB 1.25/3ML	3	QL (300 mL every 30 days)
XANTHINES		
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	
<i>theophylline elixir 80 mg/15ml</i>	3	
<i>theophylline tab er 12hr 300 mg</i>	1	
<i>theophylline tab er 12hr 450 mg</i>	1	
<i>theophylline tab er 24hr 400 mg</i>	1	
<i>theophylline tab er 24hr 600 mg</i>	1	
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
<i>warfarin sodium tab 1 mg</i>	1	
<i>warfarin sodium tab 2 mg</i>	1	
<i>warfarin sodium tab 2.5 mg</i>	1	
<i>warfarin sodium tab 3 mg</i>	1	
<i>warfarin sodium tab 4 mg</i>	1	
<i>warfarin sodium tab 5 mg</i>	1	
<i>warfarin sodium tab 6 mg</i>	1	
<i>warfarin sodium tab 7.5 mg</i>	1	
<i>warfarin sodium tab 10 mg</i>	1	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS TAB 2.5MG	2	
ELIQUIS TAB 5MG	2	
SAVAYSA TAB 15MG	3	PA; MNPA
SAVAYSA TAB 30MG	3	PA; MNPA
SAVAYSA TAB 60MG	3	PA; MNPA
XARELTO STAR TAB 15/20MG	2	
XARELTO TAB 2.5MG	2	
XARELTO TAB 10MG	2	
XARELTO TAB 15MG	2	
XARELTO TAB 20MG	2	

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

63

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HEPARINS AND HEPARINOID-LIKE AGENTS		
ARIXTRA INJ 2.5/0.5	4	
ARIXTRA INJ 5/0.4ML	4	
ARIXTRA INJ 7.5/0.6	4	
ARIXTRA INJ 10/0.8ML	4	
<i>enoxaparin sodium inj 300 mg/3ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 30 mg/0.3ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 60 mg/0.6ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 80 mg/0.8ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 100 mg/ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 120 mg/0.8ml</i>	4	
<i>enoxaparin sodium inj soln pref syr 150 mg/ml</i>	4	
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml</i>	4	
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml</i>	4	
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml</i>	4	
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i>	4	
FRAGMIN INJ 2500/0.2	4	
FRAGMIN INJ 5000/0.2	4	
FRAGMIN INJ 7500/0.3	4	
FRAGMIN INJ 10000/ML	4	
FRAGMIN INJ 12500UNT	4	
FRAGMIN INJ 15000UNT	4	
FRAGMIN INJ 18000UNT	4	
FRAGMIN INJ 95000UNT	4	
HEPARIN SOD INJ 5000/0.5	4	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HEPARIN SOD INJ 5000/ML	4	PA; MNPA
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	4	PA
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	4	PA
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	4	PA
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	4	PA
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	4	PA
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	4	PA; MNPA
LOVENOX INJ 30/0.3ML	4	
LOVENOX INJ 40/0.4ML	4	
LOVENOX INJ 60/0.6ML	4	
LOVENOX INJ 80/0.8ML	4	
LOVENOX INJ 100MG/ML	4	
LOVENOX INJ 120/0.8	4	
LOVENOX INJ 150MG/ML	4	
LOVENOX INJ 300/3ML	4	
THROMBIN INHIBITORS		
PRADAXA CAP 75MG	3	PA; MNPA
PRADAXA CAP 110MG	3	PA; MNPA
PRADAXA CAP 150MG	3	PA; MNPA
ANTICONSULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
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	
ANTICONSULSANTS - BENZODIAZEPINES		
<i>clobazam suspension 2.5 mg/ml</i>	1	
<i>clobazam tab 10 mg</i>	1	
<i>clobazam tab 20 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	

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

65

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	
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	2	PA, QL (10 bottles every 25 days)
ONFI SUS 2.5MG/ML	3	PA; MNPA
ONFI TAB 10MG	3	PA; MNPA
ONFI TAB 20MG	3	PA; MNPA
SYMPAZAN MIS 5MG	3	PA; MNPA
SYMPAZAN MIS 10MG	3	PA; MNPA
SYMPAZAN MIS 20MG	3	PA; MNPA
VALTOCO SPR 5MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 10MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 15MG	2	PA, QL (5 ea every 25 days)
VALTOCO SPR 20MG	2	PA, QL (5 ea every 25 days)
ANTICONVULSANTS - MISC.		
APTIOM TAB 200MG	2	
APTIOM TAB 400MG	2	
APTIOM TAB 600MG	2	
APTIOM TAB 800MG	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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BANZEL SUS 40MG/ML	3	PA; MNPA
BANZEL TAB 200MG	3	MNPA
BANZEL TAB 400MG	3	MNPA
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	
BRIVIACT TAB 75MG	3	
BRIVIACT TAB 100MG	3	
<i>carbamazepine cap er 12hr 100 mg</i>	1	
<i>carbamazepine cap er 12hr 200 mg</i>	1	
<i>carbamazepine cap er 12hr 200 mg</i>	1	PA
<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); MNPA
DIACOMIT CAP 500MG	3	QL (180 CAPSULES PER 30 DAYS); MNPA
DIACOMIT PAK 250MG	3	QL (360 PACKETS PER 30 DAYS); MNPA
DIACOMIT PAK 500MG	3	QL (180 PACKETS PER 30 DAYS); MNPA
ELEPSIA XR TAB 1000MG	3	MNPA
ELEPSIA XR TAB 1500MG	3	MNPA
EPIDIOLEX SOL 100MG/ML	3	PA, QL (800 ML PER 30 DAYS)

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

67

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FINTEPLA SOL 2.2MG/ML	3	PA, QL (360ML PER 30 DAYS); MNPA
<i>gabapentin cap 100 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 300 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 400 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin oral soln 250 mg/5ml</i>	1	
<i>gabapentin oral soln 250 mg/5ml</i>	1	QL (72 mL per day)
<i>gabapentin tab 600 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin tab 800 mg</i>	1	QL (120 tablets per 30 days)
KEPPRA SOL 100MG/ML	3	PA; MNPA
KEPPRA TAB 250MG	3	PA; MNPA
KEPPRA TAB 500MG	3	PA; MNPA
KEPPRA TAB 750MG	3	PA; MNPA
KEPPRA TAB 1000MG	3	PA; MNPA
KEPPRA XR TAB 500MG	3	PA; MNPA
KEPPRA XR TAB 750MG	3	PA; MNPA
<i>lacosamide oral solution 10 mg/ml</i>	1	
<i>lacosamide tab 50 mg</i>	1	
<i>lacosamide tab 100 mg</i>	1	
<i>lacosamide tab 150 mg</i>	1	
<i>lacosamide tab 200 mg</i>	1	
LAMICTAL CHW 5MG	3	PA; MNPA
LAMICTAL CHW 25MG	3	PA; MNPA
LAMICTAL KIT START 35	3	PA; MNPA
LAMICTAL KIT START 49	3	PA; MNPA
LAMICTAL KIT START 98	3	PA; MNPA
LAMICTAL ODT KIT	3	PA; MNPA
LAMICTAL ODT TAB 25MG	3	PA; MNPA
LAMICTAL ODT TAB 50MG	3	PA; MNPA
LAMICTAL ODT TAB 100MG	3	PA; MNPA

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

68

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL ODT TAB 200MG	3	PA; MNPA
LAMICTAL TAB 25MG	3	PA; MNPA
LAMICTAL TAB 100MG	3	PA; MNPA
LAMICTAL TAB 150MG	3	PA; MNPA
LAMICTAL TAB 200MG	3	PA; MNPA
LAMICTAL XR KIT	3	PA; MNPA
LAMICTAL XR TAB 25MG	3	PA; MNPA
LAMICTAL XR TAB 50MG	3	PA; MNPA
LAMICTAL XR TAB 100MG	3	PA; MNPA
LAMICTAL XR TAB 200MG	3	PA; MNPA
LAMICTAL XR TAB 250MG	3	PA; MNPA
LAMICTAL XR TAB 300MG	3	PA; 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) & 100 mg (7) starter kit</i>	1	
<i>lamotrigine tab 35 x 25 mg starter kit</i>	1	
<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit</i>	1	
<i>lamotrigine tab 100 mg</i>	1	
<i>lamotrigine tab 150 mg</i>	1	
<i>lamotrigine tab 200 mg</i>	1	
<i>lamotrigine tab chewable dispersible 5 mg</i>	1	
<i>lamotrigine tab chewable dispersible 25 mg</i>	1	
<i>lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit</i>	1	
<i>lamotrigine tab er 24hr 25 mg</i>	1	
<i>lamotrigine tab er 24hr 50 mg</i>	1	
<i>lamotrigine tab er 24hr 100 mg</i>	1	
<i>lamotrigine tab er 24hr 200 mg</i>	1	
<i>lamotrigine tab er 24hr 250 mg</i>	1	
<i>lamotrigine tab er 24hr 300 mg</i>	1	

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

69

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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 500 mg</i>	1	PA; MNPA
<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	PA, QL (120 caps every 30 days); MNPA
LYRICA CAP 50MG	3	PA, QL (120 caps every 30 days); MNPA
LYRICA CAP 75MG	3	PA, QL (120 caps every 30 days); MNPA
LYRICA CAP 100MG	3	PA, QL (120 caps every 30 days); MNPA
LYRICA CAP 150MG	3	PA, QL (120 caps every 30 days); MNPA
LYRICA CAP 200MG	3	PA, QL (90 caps every 30 days); MNPA
LYRICA CAP 225MG	3	PA, QL (60 caps every 30 days); MNPA
LYRICA CAP 300MG	3	PA, QL (60 caps every 30 days); MNPA
LYRICA SOL 20MG/ML	3	PA, QL (1080 mL every 30 days); MNPA
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	
NEURONTIN CAP 100MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 300MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 400MG	3	QL (180 capsules per 30 days)
NEURONTIN SOL 250/5ML	3	QL (72 mL per day)

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

70

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NEURONTIN TAB 600MG	3	QL (180 tablets per 30 days)
NEURONTIN TAB 800MG	3	QL (120 tablets per 30 days)
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	1	
<i>oxcarbazepine tab 150 mg</i>	1	
<i>oxcarbazepine tab 300 mg</i>	1	
<i>oxcarbazepine tab 600 mg</i>	1	
OXTELLAR XR TAB 150MG	2	
OXTELLAR XR TAB 300MG	2	
OXTELLAR XR TAB 600MG	2	
<i>pregabalin cap 25 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 50 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 75 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 100 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 150 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 200 mg</i>	1	QL (90 caps every 30 days)
<i>pregabalin cap 225 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin cap 300 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin soln 20 mg/ml</i>	1	QL (1080 mL every 30 days)
<i>primidone tab 50 mg</i>	1	
<i>primidone tab 250 mg</i>	1	
QUDEXY XR CAP 25/24HR	3	
QUDEXY XR CAP 50/24HR	3	
QUDEXY XR CAP 100/24HR	3	
QUDEXY XR CAP 150/24HR	3	
QUDEXY XR CAP 200/24HR	3	

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

71

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>rufinamide susp 40 mg/ml</i>	1	
SPRITAM TAB 250MG	3	PA; MNPA
SPRITAM TAB 500MG	3	PA; MNPA
SPRITAM TAB 750MG	3	PA; MNPA
SPRITAM TAB 1000MG	3	PA; MNPA
TEGRETOL SUS 100/5ML	3	MNPA
TEGRETOL TAB 200MG	3	MNPA
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	

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

72

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TROKENDI XR CAP 200MG	2	
VIMPAT SOL 10MG/ML	2	MNPA
VIMPAT TAB 50MG	2	MNPA
VIMPAT TAB 100MG	2	MNPA
VIMPAT TAB 150MG	2	MNPA
VIMPAT TAB 200MG	2	MNPA
ZONEGRAN CAP 25MG	3	PA; MNPA
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	
CARBAMATES		
<i>felbamate susp 600 mg/5ml</i>	1	
<i>felbamate tab 400 mg</i>	1	
<i>felbamate tab 600 mg</i>	1	
FELBATOL SUS 600/5ML	3	
FELBATOL TAB 400MG	3	
FELBATOL TAB 600MG	3	
XCOPRI PAK 12.5-25	2	
XCOPRI PAK 50-100MG	2	
XCOPRI PAK 50-200MG	2	
XCOPRI PAK 100-150	2	
XCOPRI PAK 150-200	2	
XCOPRI TAB 50MG	2	
XCOPRI TAB 100MG	2	
XCOPRI TAB 150MG	2	
XCOPRI TAB 200MG	2	
GABA MODULATORS		
GABITRIL TAB 2MG	3	
GABITRIL TAB 4MG	3	
GABITRIL TAB 12MG	3	
GABITRIL TAB 16MG	3	
<i>tiagabine hcl tab 2 mg</i>	1	
<i>tiagabine hcl tab 4 mg</i>	1	
<i>tiagabine hcl tab 12 mg</i>	1	

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

73

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>tiagabine hcl tab 16 mg</i>	1	
<i>vigabatrin powd pack 500 mg</i>	1	PA, QL (180 PACKETS PER 30 DAYS)
<i>vigabatrin tab 500 mg</i>	1	PA, QL (180 TABLETS PER 30 DAYS)

HYDANTOINS

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	

SUCCINIMIDES

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	

VALPROIC ACID

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	

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

74

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>divalproex sodium tab er 24 hr 250 mg</i>	1	
<i>divalproex sodium tab er 24 hr 500 mg</i>	1	
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1	
<i>valproic acid cap 250 mg</i>	1	

ANTIDEPRESSANTS**ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)**

<i>mirtazapine orally disintegrating tab 15 mg</i>	1	
<i>mirtazapine orally disintegrating tab 30 mg</i>	1	
<i>mirtazapine orally disintegrating tab 45 mg</i>	1	
<i>mirtazapine tab 7.5 mg</i>	1	
<i>mirtazapine tab 15 mg</i>	1	
<i>mirtazapine tab 30 mg</i>	1	
<i>mirtazapine tab 45 mg</i>	1	
REMERON SLTB TAB 15MG	3	
REMERON SLTB TAB 30MG	3	
REMERON SLTB TAB 45MG	3	
REMERON TAB 15MG	3	
REMERON TAB 30MG	3	

ANTIDEPRESSANTS - MISC.

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	
<i>maprotiline hcl tab 75 mg</i>	1	

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

75

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM DIS 6MG/24HR	3	
EMSAM DIS 9MG/24HR	3	
EMSAM DIS 12MG/24H	3	
MARPLAN TAB 10MG	3	
NARDIL TAB 15MG	2	
PARNATE TAB 10MG	2	
<i>phenelzine sulfate tab 15 mg</i>	1	
<i>tranylcypromine sulfate tab 10 mg</i>	1	
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO SOL 56MG DOS	3	PA
SPRAVATO SOL 84MG DOS	3	PA
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
CELEXA TAB 10MG	3	
CELEXA TAB 20MG	3	
CELEXA TAB 40MG	3	
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1	
<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	1	
<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	1	
<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	1	
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1	
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	
<i>fluoxetine hcl cap 10 mg</i>	1	
<i>fluoxetine hcl cap 20 mg</i>	1	

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

76

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
<i>fluoxetine hcl tab 20 mg</i>	1	
<i>fluoxetine hcl tab 60 mg</i>	1	PA; MNPA
FLUOXETINE TAB 60MG	3	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	PA; MNPA
LEXAPRO TAB 10MG	3	PA; MNPA
LEXAPRO TAB 20MG	3	PA; 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	PA; MNPA
PAXIL CR TAB 25MG	3	PA; MNPA
PAXIL CR TAB 37.5MG	3	PA; MNPA
PAXIL SUS 10MG/5ML	3	PA; MNPA
PAXIL TAB 10MG	3	PA; MNPA
PAXIL TAB 20MG	3	PA; MNPA
PAXIL TAB 30MG	3	PA; MNPA
PAXIL TAB 40MG	3	PA; MNPA
PEXEVA TAB 10MG	3	PA; MNPA
PEXEVA TAB 20MG	3	PA; MNPA
PEXEVA TAB 30MG	3	PA; MNPA
PEXEVA TAB 40MG	3	PA; MNPA

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

77

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PROZAC CAP 10MG	3	PA; MNPA
PROZAC CAP 20MG	3	PA; MNPA
PROZAC CAP 40MG	3	PA; 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	PA; MNPA
ZOLOFT TAB 25MG	3	PA; MNPA
ZOLOFT TAB 50MG	3	PA; MNPA
ZOLOFT TAB 100MG	3	PA; MNPA
SEROTONIN MODULATORS		
<i>nefazodone hcl tab 50 mg</i>	1	
<i>nefazodone hcl tab 100 mg</i>	1	
<i>nefazodone hcl tab 150 mg</i>	1	
<i>nefazodone hcl tab 200 mg</i>	1	
<i>nefazodone hcl tab 250 mg</i>	1	
<i>trazodone hcl tab 50 mg</i>	1	
<i>trazodone hcl tab 100 mg</i>	1	
<i>trazodone hcl tab 150 mg</i>	1	
<i>trazodone hcl tab 300 mg</i>	1	
TRINTELLIX TAB 5MG	2	
TRINTELLIX TAB 10MG	2	
TRINTELLIX TAB 20MG	2	
VIIBRYD KIT STARTER	3	PA; MNPA
VIIBRYD TAB 10MG	3	PA; MNPA
VIIBRYD TAB 20MG	3	PA; MNPA
VIIBRYD TAB 40MG	3	PA; 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	
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
CYMBALTA CAP 20MG	3	PA; MNPA
CYMBALTA CAP 30MG	3	PA; MNPA

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

78

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CYMBALTA CAP 60MG	3	PA; 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	PA; MNPA
DRIZALMA CAP 30MG DR	3	PA; MNPA
DRIZALMA CAP 40MG DR	3	PA; MNPA
DRIZALMA CAP 60MG DR	3	PA; MNPA
<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	PA; MNPA
EFFEXOR XR CAP 75MG	3	PA; MNPA
EFFEXOR XR CAP 150MG	3	PA; MNPA
FETZIMA CAP 20MG	3	
FETZIMA CAP 40MG	3	
FETZIMA CAP 80MG	3	
FETZIMA CAP 120MG	3	
FETZIMA CAP TITRATIO	3	
PRISTIQ TAB 25MG	3	PA; MNPA
PRISTIQ TAB 50MG	3	PA; MNPA
PRISTIQ TAB 100MG	3	PA; 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

79

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	PA; MNPA
<i>venlafaxine hcl tab er 24hr 75 mg (base equivalent)</i>	1	PA; MNPA
<i>venlafaxine hcl tab er 24hr 150 mg (base equivalent)</i>	1	PA; 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

80

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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

81

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
<i>acarbose tab 25 mg</i>	1	
<i>acarbose tab 50 mg</i>	1	
<i>acarbose tab 100 mg</i>	1	
<i>miglitol tab 25 mg</i>	1	
<i>miglitol tab 50 mg</i>	1	
<i>miglitol tab 100 mg</i>	1	
PRECOSE TAB 25MG	2	
PRECOSE TAB 50MG	2	
PRECOSE TAB 100MG	2	
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN 60 INJ 1000MCG	4	ST
SYMLNPEN 120 INJ 1000MCG	4	ST
ANTIDIABETIC COMBINATIONS		
ACTOPLUS MET TAB 15-500MG	3	
ACTOPLUS MET TAB 15-850MG	3	
<i>alogliptin-metformin hcl tab 12.5-500 mg</i>	1	ST, PA; MNPA
<i>alogliptin-metformin hcl tab 12.5-1000 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 12.5-15 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 12.5-30 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 12.5-45 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 25-15 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 25-30 mg</i>	1	ST, PA; MNPA
<i>alogliptin-pioglitazone tab 25-45 mg</i>	1	ST, PA; MNPA
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

82

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

83

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SEGLUROMET TAB 2.5-1000	3	ST, PA; MNPA
SEGLUROMET TAB 7.5-500	3	ST, PA; MNPA
SEGLUROMET TAB 7.5-1000	3	ST, PA; MNPA
SOLIQUA INJ 100/33	4	ST, QL (10 pens every 30 days)
STEGLUJAN TAB 5-100MG	3	ST, PA; MNPA
STEGLUJAN TAB 15-100MG	3	ST, PA; MNPA
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	4	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

84

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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
RIOMET SOL 500/5ML	3	PA; MNPA
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
<i>diazoxide susp 50 mg/ml</i>	1	
GLUCAGEN INJ HYPOKIT	4	PA; MNPA
<i>glucagon (rdna) for inj kit 1 mg</i>	4	
GLUCAGON EMR SOL 1MG	4	PA; MNPA
GLUCAGON KIT 1MG	4	PA; MNPA
GVOKE HYPO 1 INJ 1MG/.2ML	4	
GVOKE HYPO 1 INJ .5/.1ML	4	
GVOKE HYPO 2 INJ 1MG/.2ML	4	
GVOKE HYPO 2 INJ .5/.1ML	4	
GVOKE KIT SOL 1MG/0.2M	2	
GVOKE PFS INJ	4	
KORLYM TAB 300MG	3	PA, QL (120 TABLETS PER 30 DAYS); MNPA
PROGLYCEM SUS 50MG/ML	3	
ZEGALOGUE INJ 0.6/0.6	4	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
<i>alogliptin benzoate tab 6.25 mg (base equiv)</i>	1	ST, PA; MNPA
<i>alogliptin benzoate tab 12.5 mg (base equiv)</i>	1	ST, PA; MNPA
<i>alogliptin benzoate tab 25 mg (base equiv)</i>	1	ST, PA; MNPA
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST
JANUVIA TAB 100MG	2	ST
NESINA TAB 6.25MG	3	ST, PA; MNPA
NESINA TAB 12.5MG	3	ST, PA; MNPA
NESINA TAB 25MG	3	ST, PA; MNPA

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

85

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ONGLYZA TAB 2.5MG	3	ST, PA; MNPA
ONGLYZA TAB 5MG	3	ST, PA; MNPA
TRADJENTA TAB 5MG	3	ST, PA; MNPA
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB 0.8MG	3	
INCRETIN MIMETIC AGENTS		
BYDUREON PEN INJ 2MG	4	ST, PA, QL (4 pens every 28 days); MNPA
MOUNJARO INJ 2.5/0.5	4	ST, QL (4 pens every 30 days)
MOUNJARO INJ 5MG/0.5	4	ST, QL (4 pens every 30 day)
MOUNJARO INJ 7.5/0.5	4	ST, QL (4 pens every 30 days)
MOUNJARO INJ 10MG/0.5	4	ST, QL (4 pens every 30 days)
MOUNJARO INJ 12.5/0.5	4	ST, QL (4 pens every 30 days)
MOUNJARO INJ 15MG/0.5	4	ST, QL (4 pens every 30 days)
OZEMPIC INJ 2MG/3ML	4	ST, QL (1 pen every 30 days)
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
ADLYXIN INJ 10/20MCG	4	ST, PA, QL (1 injection every 30 days); MNPA
ADLYXIN INJ 20MCG	4	ST, PA, QL (2 pens every 30 days); MNPA
BYDUREON BC INJ 2/0.85ML	3	ST, PA, QL (4 auto-injectors every 30 days); MNPA
BYETTA INJ 5MCG	4	ST, PA, QL (1 pen every 30 days); MNPA
BYETTA INJ 10MCG	4	ST, PA, QL (1 pen every 30 days); MNPA

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

86

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OZEMPIC INJ 2/1.5ML	4	ST, QL (1 pen every 30 days); Starter Pen
OZEMPIC INJ 4MG/3ML	4	ST, QL (1 pen every 30 days)
OZEMPIC INJ 8MG/3ML	4	ST, QL (1 pen every 25 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	4	ST, QL (4 pens every 30 days)
TRULICITY INJ 1.5/0.5	4	ST, QL (4 pens every 30 days)
TRULICITY INJ 3/0.5	4	ST, QL (4 pens every 30 days)
TRULICITY INJ 4.5/0.5	4	ST, QL (4 pens every 30 days)
VICTOZA INJ 18MG/3ML	4	ST, QL (3 pens every 30 days)

INSULIN

ADMELOG INJ 100U/ML	3	PA; MNPA
ADMELOG SOLO INJ 100U/ML	3	PA; MNPA
AFREZZA POW 4-8 UNIT	3	PA; MNPA
AFREZZA POW 4-8-12	3	PA; MNPA
AFREZZA POW 4UNIT	3	PA; MNPA
AFREZZA POW 8 UNIT	3	PA; MNPA
AFREZZA POW 8-12UNIT	3	PA; MNPA
AFREZZA POW 12 UNIT	3	PA; MNPA
APIDRA INJ SOLOSTAR	3	PA; MNPA
BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	
FIASP INJ 100/ML	2	

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

87

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

88

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG INJ 100/ML	2	
NOVOLOG INJ FLEX REL	3	MNPA
NOVOLOG INJ FLEXPEN	2	
NOVOLOG INJ PENFILL	2	
NOVOLOG INJ RELION	3	MNPA
NOVOLOG MIX INJ 70/30	2	
NOVOLOG MIX INJ FLEX REL	3	MNPA
NOVOLOG MIX INJ FLEXPEN	2	
NOVOLOG RELI INJ 70/30	3	MNPA
SEMGLEE INJ 100U/ML	3	PA; MNPA
SEMGLEE SOL 100U/ML	3	PA; MNPA
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	
INSULIN SENSITIZING AGENTS		
ACTOS TAB 15MG	3	PA; MNPA
ACTOS TAB 30MG	3	PA; MNPA
ACTOS TAB 45MG	3	PA; 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	
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	
MEGLITINIDE ANALOGUES		
<i>nateglinide tab 60 mg</i>	1	
<i>nateglinide tab 120 mg</i>	1	
<i>repaglinide tab 0.5 mg</i>	1	
<i>repaglinide tab 1 mg</i>	1	
<i>repaglinide tab 2 mg</i>	1	
STARLIX TAB 120MG	3	
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB 5MG	2	ST
FARXIGA TAB 10MG	2	ST

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

89

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INVOKANA TAB 100MG	3	ST, PA; MNPA
INVOKANA TAB 300MG	3	ST, PA; MNPA
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
STEGLATRO TAB 5MG	3	ST, PA; MNPA
STEGLATRO TAB 15MG	3	ST, PA; MNPA

SULFONYLUREAS

AMARYL TAB 1MG	3	
AMARYL TAB 2MG	3	
AMARYL TAB 4MG	3	
<i>glimepiride tab 1 mg</i>	1	
<i>glimepiride tab 2 mg</i>	1	
<i>glimepiride tab 4 mg</i>	1	
<i>glipizide tab 5 mg</i>	1	
<i>glipizide tab 10 mg</i>	1	
<i>glipizide tab er 24hr 2.5 mg</i>	1	
<i>glipizide tab er 24hr 5 mg</i>	1	
<i>glipizide tab er 24hr 10 mg</i>	1	
GLUCOTROL TAB 10MG	3	
GLUCOTROL XL TAB 2.5MG	3	
GLUCOTROL XL TAB 5MG	3	
GLUCOTROL XL TAB 10MG	3	
<i>glyburide micronized tab 1.5 mg</i>	1	
<i>glyburide micronized tab 3 mg</i>	1	
<i>glyburide micronized tab 6 mg</i>	1	
<i>glyburide tab 1.25 mg</i>	1	
<i>glyburide tab 2.5 mg</i>	1	
<i>glyburide tab 5 mg</i>	1	
GLYNASE TAB 1.5MG	3	
GLYNASE TAB 3MG	3	
GLYNASE TAB 6MG	3	
<i>tolbutamide tab 500 mg</i>	1	

ANTIDIARRHEAL/PROBIOTIC AGENTS**ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS**

MYTESI TAB 125MG	3	PA; MNPA
------------------	---	----------

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

90

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTIDIARRHEAL/PROBIOTIC COMBINATIONS		
RESTORA RX CAP 60-1.25	3	
ANTIPERISTALTIC AGENTS		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
LOMOTIL TAB 2.5MG	2	
MOTOFEN TAB 1-0.025	3	PA; MNPA
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP 100MG	3	
<i>deferasirox granules packet 90 mg</i>	1	PA
<i>deferasirox granules packet 180 mg</i>	1	PA
<i>deferasirox granules packet 360 mg</i>	1	PA
<i>deferasirox tab 90 mg</i>	1	PA
<i>deferasirox tab 180 mg</i>	1	PA
<i>deferasirox tab 360 mg</i>	1	PA
<i>deferasirox tab for oral susp 125 mg</i>	1	PA
<i>deferasirox tab for oral susp 250 mg</i>	1	PA
<i>deferasirox tab for oral susp 500 mg</i>	1	PA
<i>deferiprone tab 500 mg</i>	1	PA
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	PA; MNPA
PENTETATE ZI SOL 200MG/ML	3	PA; MNPA

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

91

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTIDOTES AND SPECIFIC ANTAGONISTS		
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	2	QL (20 PACKETS PER 5 DAYS)
OPIOID ANTAGONISTS		
KLOXXADO SPR 8MG	3	
<i>naloxone hcl inj 0.4 mg/ml</i>	4	
<i>naloxone hcl inj 4 mg/10ml</i>	4	
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	4	
<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	4	
<i>naltrexone hcl tab 50 mg</i>	0	
NARCAN SPR 4MG	3	
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
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	PA, QL (2.5 injections every 21 days); MNPA
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)
ZUPLENZ MIS 4MG	3	PA, QL (18 films every 21 days); MNPA
ZUPLENZ MIS 8MG	3	PA, QL (18 films every 21 days); MNPA
ANTIEMETICS - ANTICHOLINERGIC		
MECLIZINE TAB 50MG	3	PA; MNPA

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

92

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
TIGAN CAP 300MG	3	
TRANSDERM SC DIS 1MG/3DAY	3	PA; MNPA
TRANSDERM-SC DIS 1MG/3DAY	3	PA; 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	PA; MNPA
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	
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	
SYNDROS SOL 5MG/ML	3	PA; MNPA
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 ea every 21 days)
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	QL (6 caps every 21 days)
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	3	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	
BIO-STATIN CAP 500000	3	

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

93

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	
DIFLUCAN TAB 100MG	3	
DIFLUCAN TAB 150MG	3	
DIFLUCAN TAB 200MG	3	
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	
<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	PA; MNPA

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

94

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VFEND SUS 40MG/ML	2	PA
VFEND TAB 50MG	2	PA
VFEND TAB 200MG	2	PA
VIVJOA CAP 150MG	3	
<i>voriconazole for susp 40 mg/ml</i>	1	PA
<i>voriconazole tab 50 mg</i>	1	PA
<i>voriconazole tab 200 mg</i>	1	PA

ANTI-HISTAMINES**ANTI-HISTAMINES - 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	
<i>clemastine fumarate tab 2.68 mg</i>	1	
KARBINAL ER SUS 4MG/5ML	3	
RYVENT TAB 6MG	3	PA; MNPA

ANTI-HISTAMINES - NON-SEDATING

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

ANTI-HISTAMINES - PHENOTHIAZINES

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

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

95

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
FIBRIC ACID DERIVATIVES		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	
<i>fenofibrate cap 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	

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

97

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>fenofibric acid tab 105 mg</i>	1	PA; MNPA
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	PA; MNPA
TRICOR TAB 145MG	3	PA; MNPA
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	
HMG COA REDUCTASE INHIBITORS		
ALTOPREV TAB 20MG ER	3	PA; MNPA
ALTOPREV TAB 40MG ER	3	PA; MNPA
ALTOPREV TAB 60MG ER	3	PA; MNPA
<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	PA; MNPA
CRESTOR TAB 10MG	3	PA; MNPA
CRESTOR TAB 20MG	3	PA; MNPA
CRESTOR TAB 40MG	3	PA; MNPA
EZALLOR SPR CAP 5MG	3	PA; MNPA
EZALLOR SPR CAP 10MG	3	PA; MNPA
EZALLOR SPR CAP 20MG	3	PA; MNPA
EZALLOR SPR CAP 40MG	3	PA; MNPA
FLOLIPID SUS 20MG/5ML	3	PA; MNPA
FLOLIPID SUS 40MG/5ML	3	PA; MNPA

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

98

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	PA; MNPA
LIPITOR TAB 10MG	3	PA; MNPA
LIPITOR TAB 20MG	3	PA; MNPA
LIPITOR TAB 40MG	3	PA; MNPA
LIPITOR TAB 80MG	3	PA; MNPA
LIVALO TAB 1MG	3	PA; MNPA
LIVALO TAB 2MG	3	PA; MNPA
LIVALO TAB 4MG	3	PA; MNPA
<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

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

99

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
ZYPITAMAG TAB 4MG	3	PA; MNPA
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
<i>ezetimibe tab 10 mg</i>	1	
ZETIA TAB 10MG	3	PA; MNPA
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
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
JUXTAPID CAP 40MG	3	PA, QL (28 CAPSULES PER 28 DAYS); MNPA
JUXTAPID CAP 60MG	3	PA, QL (28 CAPSULES PER 28 DAYS); MNPA
NICOTINIC ACID DERIVATIVES		
<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	

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

100

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NIASPAN TAB 750MG ER	3	
NIASPAN TAB 1000 ER	3	
PROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
PRALUENT INJ 75MG/ML	4	PA, QL (2 PENS PER 28 DAYS); MNPA
PRALUENT INJ 150MG/ML	4	PA, QL (2 PENS PER 28 DAYS); MNPA
REPATHA INJ 140MG/ML	4	PA, QL (3 SYRINGES PER 28 DAYS)
REPATHA PUSH INJ 420/3.5	4	PA, QL (1 CARTRIDGES PER 28 DAYS)
REPATHA SURE INJ 140MG/ML	4	PA, QL (3 PENS PER 28 DAYS)
ANTIHYPERTENSIVES		
ACE INHIBITORS		
ACCUPRIL TAB 5MG	3	
ACCUPRIL TAB 10MG	3	
ACCUPRIL TAB 20MG	3	
ACCUPRIL TAB 40MG	3	
ALTACE CAP 1.25MG	3	
ALTACE CAP 2.5MG	3	
ALTACE CAP 5MG	3	
ALTACE CAP 10MG	3	
<i>benazepril hcl tab 5 mg</i>	1	
<i>benazepril hcl tab 10 mg</i>	1	
<i>benazepril hcl tab 20 mg</i>	1	
<i>benazepril hcl tab 40 mg</i>	1	
<i>captopril tab 12.5 mg</i>	1	
<i>captopril tab 25 mg</i>	1	
<i>captopril tab 50 mg</i>	1	
<i>captopril tab 100 mg</i>	1	
<i>enalapril maleate oral soln 1 mg/ml</i>	1	
<i>enalapril maleate tab 2.5 mg</i>	1	
<i>enalapril maleate tab 5 mg</i>	1	
<i>enalapril maleate tab 10 mg</i>	1	

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

101

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>enalapril maleate tab 20 mg</i>	1	
EPANED SOL 1MG/ML	3	PA; 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	
<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	

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

102

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VASOTEC TAB 20MG	3	
ZESTRIL TAB 2.5MG	3	
ZESTRIL TAB 5MG	3	
ZESTRIL TAB 10MG	3	
ZESTRIL TAB 20MG	3	
ZESTRIL TAB 30MG	3	
ZESTRIL TAB 40MG	3	
AGENTS FOR PHEOCHROMOCYTOMA		
DEMSEER CAP 250MG	3	
DIBENZYLINE CAP 10MG	3	
<i>metirosine cap 250 mg</i>	1	
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
ATACAND TAB 4MG	3	PA; MNPA
ATACAND TAB 8MG	3	PA; MNPA
ATACAND TAB 16MG	3	PA; MNPA
ATACAND TAB 32MG	3	PA; MNPA
AVAPRO TAB 75MG	3	
AVAPRO TAB 150MG	3	
AVAPRO TAB 300MG	3	
BENICAR TAB 5MG	3	PA; MNPA
BENICAR TAB 20MG	3	PA; MNPA
BENICAR TAB 40MG	3	PA; 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	PA; MNPA
COZAAR TAB 50MG	3	PA; MNPA
COZAAR TAB 100MG	3	PA; MNPA
DIOVAN TAB 40MG	3	PA; MNPA
DIOVAN TAB 80MG	3	PA; MNPA
DIOVAN TAB 160MG	3	PA; MNPA
DIOVAN TAB 320MG	3	PA; MNPA
EDARBI TAB 40MG	3	PA; MNPA

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

103

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EDARBI TAB 80MG	3	PA; 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	PA; MNPA
MICARDIS TAB 40MG	3	PA; MNPA
MICARDIS TAB 80MG	3	PA; 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	
<i>valsartan tab 40 mg</i>	1	
<i>valsartan tab 80 mg</i>	1	
<i>valsartan tab 160 mg</i>	1	
<i>valsartan tab 320 mg</i>	1	
ANTIADRENERGIC ANTIHYPERTENSIVES		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	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	

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

104

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

105

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>benazepril & hydrochlorothiazide tab 20-25 mg</i>	1	
BENICAR HCT TAB 20-12.5	3	PA; MNPA
BENICAR HCT TAB 40-12.5	3	PA; MNPA
BENICAR HCT TAB 40-25MG	3	PA; MNPA
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	1	
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	1	
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	
DIOVAN HCT TAB 80/12.5	3	PA; MNPA
DIOVAN HCT TAB 160-12.5	3	PA; MNPA
DIOVAN HCT TAB 160-25MG	3	PA; MNPA
DIOVAN HCT TAB 320-12.5	3	PA; MNPA
DIOVAN HCT TAB 320-25MG	3	PA; 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	PA; MNPA
EDARBYCLOR TAB 40-25MG	3	PA; MNPA
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	
EXFORGE HCT TAB 5-160-12.5	3	PA; MNPA
EXFORGE HCT TAB 5-160-25	3	PA; MNPA

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

107

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
EXFORGE HCT TAB 10-160-12.5	3	PA; MNPA
EXFORGE HCT TAB 10-160-25	3	PA; MNPA
EXFORGE HCT TAB 10-320-25	3	PA; MNPA
EXFORGE TAB 5-160MG	3	PA; MNPA
EXFORGE TAB 5-320MG	3	PA; MNPA
EXFORGE TAB 10-160MG	3	PA; MNPA
EXFORGE TAB 10-320MG	3	PA; MNPA
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	
HYZAAR TAB 50-12.5	3	PA; MNPA
HYZAAR TAB 100-12.5	3	PA; MNPA
HYZAAR TAB 100-25	3	PA; MNPA
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	
LOTENSIN HCT TAB 10-12.5	3	
LOTENSIN HCT TAB 20-12.5	3	
LOTENSIN HCT TAB 20-25MG	3	
LOTREL CAP 5-10MG	2	
LOTREL CAP 5-20MG	2	
LOTREL CAP 10-20MG	2	
LOTREL CAP 10-40MG	2	
<i>methyldopa & hydrochlorothiazide tab 250-15 mg</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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>methyldopa & hydrochlorothiazide tab 250-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	
MICARDIS HCT TAB 40/12.5	3	PA; MNPA
MICARDIS HCT TAB 80-25MG	3	PA; MNPA
MICARDIS HCT TAB 80/12.5	3	PA; 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	
<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	PA; MNPA
PRESTALIA TAB 7-5MG	3	PA; MNPA
PRESTALIA TAB 14-10MG	3	PA; MNPA
<i>propranolol & hydrochlorothiazide tab 40-25 mg</i>	1	
<i>propranolol & hydrochlorothiazide tab 80-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	

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

109

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
<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	

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

110

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZESTORETIC TAB 10-12.5	3	PA; MNPA
ZESTORETIC TAB 20-12.5	3	PA; MNPA
ZESTORETIC TAB 20-25MG	3	PA; MNPA
ZIAC TAB 2.5/6.25	2	
ZIAC TAB 5-6.25MG	2	
ZIAC TAB 10/6.25	2	
ANTIHYPERTENSIVES - MISC.		
VECAMYL TAB 2.5MG	3	
DIRECT RENIN INHIBITORS		
<i>aliskiren fumarate tab 150 mg (base equivalent)</i>	1	
<i>aliskiren fumarate tab 300 mg (base equivalent)</i>	1	
TEKTURNA TAB 150MG	3	
TEKTURNA TAB 300MG	3	
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
<i>eplerenone tab 25 mg</i>	1	
<i>eplerenone tab 50 mg</i>	1	
INSPRA TAB 25MG	2	
INSPRA TAB 50MG	2	
VASODILATORS		
<i>hydralazine hcl tab 10 mg</i>	1	
<i>hydralazine hcl tab 25 mg</i>	1	
<i>hydralazine hcl tab 50 mg</i>	1	
<i>hydralazine hcl tab 100 mg</i>	1	
<i>minoxidil tab 2.5 mg</i>	1	
<i>minoxidil tab 10 mg</i>	1	
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
COARTEM TAB 20-120MG	3	
MALARONE TAB 62.5-25	2	
MALARONE TAB 250-100	2	
PYRIME/LEUCO CAP 12.5/2.5	3	PA; MNPA
PYRIME/LEUCO CAP 25/5MG	3	PA; MNPA

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

111

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PYRIME/LEUCO CAP 25/10MG	3	PA; MNPA
PYRIME/LEUCO CAP 50/10MG	3	PA; MNPA
PYRIME/LEUCO CAP 50/20MG	3	PA; MNPA
PYRIME/LEUCO CAP 50/25MG	3	PA; MNPA
PYRIME/LEUCO CAP 75/25MG	3	PA; MNPA

ANTIMALARIALS

ARAKODA TAB 100MG	3	PA; MNPA
ARTESUNATE SOL 110MG	3	MNPA
<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	PA; MNPA
<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
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	PA; MNPA
<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)

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

112

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
TRECTOR TAB 250MG	3	
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
ALKERAN TAB 2MG	0	
CYCLOPHOSPH TAB 25MG	0	
CYCLOPHOSPH TAB 50MG	0	
<i>cyclophosphamide cap 25 mg</i>	0	
<i>cyclophosphamide cap 50 mg</i>	0	
GLEOSTINE CAP 10MG	0	
GLEOSTINE CAP 40MG	0	
GLEOSTINE CAP 100MG	0	
LEUKERAN TAB 2MG	0	
<i>melphalan tab 2 mg</i>	0	
MYLERAN TAB 2MG	0	
TEMODAR CAP 100MG	0	PA
TEMODAR CAP 140MG	0	PA

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

113

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TEMODAR CAP 180MG	0	PA
TEMODAR CAP 250MG	0	PA
<i>temozolomide cap 5 mg</i>	0	PA
<i>temozolomide cap 20 mg</i>	0	PA
<i>temozolomide cap 100 mg</i>	0	PA
<i>temozolomide cap 140 mg</i>	0	PA
<i>temozolomide cap 180 mg</i>	0	PA
<i>temozolomide cap 250 mg</i>	0	PA
ANTIMETABOLITES		
<i>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>	4	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	4	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	4	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	4	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	4	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	4	\$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	

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

114

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TREXALL TAB 15MG	0	
XATMEP SOL 2.5MG/ML	0	
XELODA TAB 150MG	0	PA, QL (120 tabs every 30 days)
XELODA TAB 500MG	0	PA, QL (300 tabs every 30 days)
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG	0	PA, QL (240 TABLETS PER 30 DAYS)
INLYTA TAB 5MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LENVIMA CAP 4MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 8 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 10 MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 12MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 14 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 18 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 20 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 24 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA TAB 10MG	0	PA, QL (120 TABLETS PER 30 DAYS)

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

115

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 100MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VENCLEXTA TAB START PK	0	PA, QL (1 PACK EVERY 28 DAYS)
ANTINEOPLASTIC - EGFR INHIBITORS		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
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)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ODOMZO CAP 200MG	0	PA, QL (30 CAPSULES PER 30 DAYS)

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

116

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
<i>abiraterone acetate tab 250 mg</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>abiraterone acetate tab 500 mg</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>anastrozole tab 1 mg</i>	0	
ARIMIDEX TAB 1MG	0	
AROMASIN TAB 25MG	0	
<i>bicalutamide tab 50 mg</i>	0	
CASODEX TAB 50MG	0	
EMCYT CAP 140MG	0	
ERLEADA TAB 60MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ERLEADA TAB 240MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>exemestane tab 25 mg</i>	0	
FARESTON TAB 60MG	0	
FEMARA TAB 2.5MG	0	
<i>flutamide cap 125 mg</i>	0	
<i>letrozole tab 2.5 mg</i>	0	
<i>leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)</i>	4	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

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

117

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SOLTAMOX SOL 10MG/5ML	0	
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>toremifene citrate tab 60 mg (base equivalent)</i>	0	
XTANDI CAP 40MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XTANDI TAB 40MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XTANDI TAB 80MG	0	PA, QL (60 TABLETS PER 30 DAYS)
YONSA TAB 125MG	0	PA, QL (120 tabs every 30 days)
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 2MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 3MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 4MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB 25MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AYVAKIT TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AYVAKIT TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AYVAKIT TAB 200MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA

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

118

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AYVAKIT TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK 40MG	0	PA, QL (16 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 40MG	0	PA, QL (4 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 40MG	0	PA, QL (8 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 40MG	0	PA, QL (8 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 50MG	0	PA, QL (8 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 60MG	0	PA, QL (12 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 60MG	0	PA, QL (24 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 60MG	0	PA, QL (4 TABLETS PER 28 DAYS); Therapy Pack
XPOVIO PAK 80MG	0	PA, QL (16 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 80MG	0	PA, QL (32 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 100MG	0	PA, QL (20 TABLETS PER 28 DAYS); Once Weekly
ANTINEOPLASTIC COMBINATIONS		
INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (49 TABLETS PER 28 DAYS)
KISQALI 400 PAK FEMARA	0	PA, QL (70 TABLETS PER 28 DAYS)
KISQALI 600 PAK FEMARA	0	PA, QL (91 TABLETS PER 28 DAYS)
LONSURF TAB 15-6.14	0	PA, QL (100 TABLETS 28 DAYS)

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

119

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
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)

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

120

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

121

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>everolimus tab 7.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
FOTIVDA CAP 0.89MG	0	PA, QL (21 PER 28 DAYS); MNPA
FOTIVDA CAP 1.34MG	0	PA, QL (21 PER 28 DAYS); MNPA
GAVRETO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
IBRANCE CAP 75MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 100MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 125MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE TAB 75MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 100MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 125MG	0	PA, QL (21 TABLETS PER 28 DAYS)
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)

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

122

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
JAKAFI TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 10MG	0	PA, QL (60 TABLETS PER 30 DAYS)
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)
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)

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

123

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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)
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); MNPA
PEMAZYRE TAB 9MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA
PEMAZYRE TAB 13.5MG	0	PA, QL (30 TABLETS PER 30 DAYS); MNPA

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

124

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
QINLOCK TAB 50MG	0	PA, QL (90 TABLETS PER 30 DAYS); MNPA
RETEVMO CAP 40MG	0	PA, QL (60 TABLETS PER 30 DAYS)
RETEVMO CAP 80MG	0	PA, QL (120 TABLETS 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)
<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)

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

125

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
STIVARGA TAB 40MG	0	PA, QL (84 TABLETS PER 28 DAYS)
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 25 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 50 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
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
TAFINLAR CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TAFINLAR CAP 75MG	0	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
TAZVERIK TAB 200MG	0	PA, QL (240 TABLETS PER 30 DAYS); MNPA
TEPMETKO TAB 225MG	0	PA, QL (60 TABS PER 30 DAYS); MNPA
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TRUSELTIQ CAP 50MG	0	PA, QL (42 CAPS PER 28 DAYS); MNPA
TRUSELTIQ CAP 75MG	0	PA, QL (63 CAPS PER 28 DAYS); MNPA
TRUSELTIQ CAP 100MG	0	PA, QL (21 CAPS PER 28 DAYS); MNPA

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

126

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TRUSELTIQ CAP 125MG	0	PA, QL (42 CAPS PER 28 DAYS); MNPA
TURALIO CAP 200MG	0	PA, QL (120 caps every 30 days); MNPA
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 150MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 200MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VITRAKVI CAP 25MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
VITRAKVI CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
VITRAKVI SOL 20MG/ML	0	PA, QL (300 ML PER 30 DAYS)
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)

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

127

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZEJULA TAB 300MG	0	PA, QL (30 TABS PER 30 DAYS)
ZELBORAF TAB 240MG	0	PA, QL (240 TABLETS PER 30 DAYS)
ZOLINZA CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
ZYDELIG TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYDELIG TAB 150MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ 2MU/0.5	4	PA
BESREMI SOL 500MCG	4	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	4	PA
INTRON A INJ 18MU	4	PA
INTRON A INJ 25MU	4	PA
INTRON A INJ 50MU	4	PA
MATULANE CAP 50MG	0	
TARGRETIN CAP 75MG	0	PA; MNPA
<i>tretinoin cap 10 mg</i>	0	
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
<i>leucovorin calcium tab 5 mg</i>	0	
<i>leucovorin calcium tab 10 mg</i>	0	
<i>leucovorin calcium tab 15 mg</i>	0	
<i>leucovorin calcium tab 25 mg</i>	0	
MESNEX TAB 400MG	0	
MITOTIC INHIBITORS		
<i>etoposide cap 50 mg</i>	0	

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

128

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ADJUNCTIVE THERAPY		
<i>carbidopa tab 25 mg</i>	1	
LODOSYN TAB 25MG	3	
NOURIANZ TAB 20MG	3	PA; MNPA
NOURIANZ TAB 40MG	3	PA; MNPA
ANTIPARKINSON ANTICHOLINERGICS		
<i>benztropine mesylate tab 0.5 mg</i>	1	
<i>benztropine mesylate tab 1 mg</i>	1	
<i>benztropine mesylate tab 2 mg</i>	1	
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl tab 2 mg</i>	1	
<i>trihexyphenidyl hcl tab 5 mg</i>	1	
ANTIPARKINSON COMT INHIBITORS		
COMTAN TAB 200MG	3	
<i>entacapone tab 200 mg</i>	1	
ONGENTYS CAP 25MG	3	PA; MNPA
ONGENTYS CAP 50MG	3	PA; MNPA
TASMAR TAB 100MG	3	
<i>tolcapone tab 100 mg</i>	1	
ANTIPARKINSON DOPAMINERGICS		
<i>amantadine hcl cap 100 mg</i>	1	
<i>amantadine hcl soln 50 mg/5ml</i>	1	
<i>amantadine hcl tab 100 mg</i>	1	
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	1	

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

129

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
carbidopa & levodopa orally disintegrating tab 25-250 mg	1	
carbidopa & levodopa tab 10-100 mg	1	
carbidopa & levodopa tab 25-100 mg	1	
carbidopa & levodopa tab 25-250 mg	1	
carbidopa & levodopa tab er 25-100 mg	1	
carbidopa & levodopa tab er 50-200 mg	1	
carbidopa-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	PA; MNPA
GOCOVRI CAP 137MG	3	PA; MNPA
INBRIJA CAP 42MG	2	PA, QL (300 CAPSULES PER 30 DAYS)
MIRAPEX ER TAB 0.75MG	3	
MIRAPEX ER TAB 0.375MG	3	
MIRAPEX ER TAB 1.5MG	3	
MIRAPEX ER TAB 2.25MG	3	
MIRAPEX ER TAB 3.75MG	3	
MIRAPEX ER TAB 3MG	3	
MIRAPEX ER TAB 4.5MG	3	
MIRAPEX TAB 0.5MG	3	
MIRAPEX TAB 0.75MG	3	
MIRAPEX TAB 0.125MG	3	
MIRAPEX TAB 1MG	3	
NEUPRO DIS 1MG/24HR	2	

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

130

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
OSMOLEX ER TAB 129MG	3	PA; MNPA
OSMOLEX ER TAB 193MG	3	PA; MNPA
OSMOLEX ER TAB 258MG	3	PA; MNPA
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	
<i>ropinirole hydrochloride tab 4 mg</i>	1	
<i>ropinirole hydrochloride tab 5 mg</i>	1	

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

131

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
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	PA; MNPA
XADAGO TAB 100MG	3	PA; MNPA
ZELAPAR TAB 1.25MG	3	
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
<i>lithium carbonate cap 150 mg</i>	1	

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

132

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	
ANTIPSYCHOTICS - MISC.		
CAPLYTA CAP 10.5MG	2	
CAPLYTA CAP 21MG	2	
CAPLYTA CAP 42MG	2	
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	2	MNPA
LATUDA TAB 40MG	2	MNPA
LATUDA TAB 60MG	2	MNPA
LATUDA TAB 80MG	2	MNPA
LATUDA TAB 120MG	2	MNPA
<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)
NUPLAZID TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
VRAYLAR CAP 1.5-3MG	2	
VRAYLAR CAP 1.5MG	2	

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

133

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
BENZISOXAZOLES		
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	PA; MNPA
INVEGA TRINZ INJ 410MG	3	PA; MNPA
INVEGA TRINZ INJ 546MG	3	PA; MNPA
INVEGA TRINZ INJ 819MG	3	PA; MNPA
<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	

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

134

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PERSERIS INJ 90MG	2	
PERSERIS INJ 120MG	2	
RISPERDAL INJ 12.5MG	3	
RISPERDAL INJ 25MG	3	
RISPERDAL INJ 37.5MG	3	
RISPERDAL INJ 50MG	3	
RISPERDAL SOL 1MG/ML	3	
RISPERDAL TAB 0.5MG	3	
RISPERDAL TAB 1MG	3	
RISPERDAL TAB 2MG	3	
RISPERDAL TAB 3MG	3	
RISPERDAL TAB 4MG	3	
<i>risperidone orally disintegrating tab 0.5 mg</i>	1	
<i>risperidone orally disintegrating tab 0.25 mg</i>	1	
<i>risperidone orally disintegrating tab 1 mg</i>	1	
<i>risperidone orally disintegrating tab 2 mg</i>	1	
<i>risperidone orally disintegrating tab 3 mg</i>	1	
<i>risperidone orally disintegrating tab 4 mg</i>	1	
<i>risperidone soln 1 mg/ml</i>	1	
<i>risperidone tab 0.5 mg</i>	1	
<i>risperidone tab 0.25 mg</i>	1	
<i>risperidone tab 1 mg</i>	1	
<i>risperidone tab 2 mg</i>	1	
<i>risperidone tab 3 mg</i>	1	
<i>risperidone tab 4 mg</i>	1	
BUTYROPHENONES		
HALDOL DECAN INJ 50MG/ML	3	
HALDOL DECAN INJ 100MG/ML	3	
<i>haloperidol decanoate im soln 50 mg/ml</i>	1	
<i>haloperidol decanoate im soln 100 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	

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

135

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>haloperidol tab 10 mg</i>	1	
<i>haloperidol tab 20 mg</i>	1	
DIBENZAPINES		
ADASUVE INH 10MG	3	
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	
<i>clozapine tab 200 mg</i>	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	
CLOZARIL TAB 200MG	3	
<i>loxapine succinate cap 5 mg</i>	1	
<i>loxapine succinate cap 10 mg</i>	1	
<i>loxapine succinate cap 25 mg</i>	1	
<i>loxapine succinate cap 50 mg</i>	1	
<i>olanzapine for im inj 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 5 mg</i>	1	
<i>olanzapine orally disintegrating tab 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 15 mg</i>	1	
<i>olanzapine orally disintegrating tab 20 mg</i>	1	
<i>olanzapine tab 2.5 mg</i>	1	
<i>olanzapine tab 5 mg</i>	1	
<i>olanzapine tab 7.5 mg</i>	1	
<i>olanzapine tab 10 mg</i>	1	
<i>olanzapine tab 15 mg</i>	1	
<i>olanzapine tab 20 mg</i>	1	

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

136

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
quetiapine fumarate tab 25 mg	1	
quetiapine fumarate tab 50 mg	1	
quetiapine fumarate tab 100 mg	1	
quetiapine fumarate tab 200 mg	1	
quetiapine fumarate tab 300 mg	1	
quetiapine fumarate tab 400 mg	1	
quetiapine fumarate tab er 24hr 50 mg	1	
quetiapine fumarate tab er 24hr 150 mg	1	
quetiapine fumarate tab er 24hr 200 mg	1	
quetiapine fumarate tab er 24hr 300 mg	1	
quetiapine fumarate tab er 24hr 400 mg	1	
SAPHRIS SUB 2.5MG	3	
SAPHRIS SUB 5MG	3	
SAPHRIS SUB 10MG	3	
SECUADO DIS 3.8MG	3	PA; MNPA
SECUADO DIS 5.7MG	3	PA; MNPA
SECUADO DIS 7.6MG	3	PA; MNPA
SEROQUEL TAB 25MG	3	
SEROQUEL TAB 50MG	3	
SEROQUEL TAB 100MG	3	
SEROQUEL TAB 200MG	3	
SEROQUEL TAB 300MG	3	
SEROQUEL TAB 400MG	3	
SEROQUEL XR TAB 50MG	3	PA; MNPA
SEROQUEL XR TAB 150MG	3	PA; MNPA
SEROQUEL XR TAB 200MG	3	PA; MNPA
SEROQUEL XR TAB 300MG	3	PA; MNPA
SEROQUEL XR TAB 400MG	3	PA; 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	

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

137

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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 tab 10 mg</i>	1	
<i>chlorpromazine hcl tab 25 mg</i>	1	
<i>chlorpromazine hcl tab 50 mg</i>	1	
<i>chlorpromazine hcl tab 100 mg</i>	1	
<i>chlorpromazine hcl tab 200 mg</i>	1	
<i>fluphenazine hcl elixir 2.5 mg/5ml</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 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	

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

138

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>thioridazine hcl tab 50 mg</i>	1	
<i>thioridazine hcl tab 100 mg</i>	1	
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	
QUINOLINONE DERIVATIVES		
ABILIFY MAIN INJ 300MG	2	
ABILIFY MAIN INJ 400MG	2	
ABILIFY MYCI TAB 2MG	3	PA; MNPA
ABILIFY MYCI TAB 5MG	3	PA; MNPA
ABILIFY MYCI TAB 10MG	3	PA; MNPA
ABILIFY MYCI TAB 15MG	3	PA; MNPA
ABILIFY MYCI TAB 20MG	3	PA; MNPA
ABILIFY MYCI TAB 30MG	3	PA; MNPA
ABILIFY TAB 2MG	3	PA; MNPA
ABILIFY TAB 5MG	3	PA; MNPA
ABILIFY TAB 10MG	3	PA; MNPA
ABILIFY TAB 15MG	3	PA; MNPA
ABILIFY TAB 20MG	3	PA; MNPA
ABILIFY TAB 30MG	3	PA; 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.	3	
ARISTADA INJ 662MG/2	3	
ARISTADA INJ 882MG/3	3	
ARISTADA INJ 1064MG	3	QL (23.077 injections every year)

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

139

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ARISTADA INJ INITIO	3	
REXULTI TAB 0.5MG	3	
REXULTI TAB 0.25MG	3	
REXULTI TAB 1MG	3	
REXULTI TAB 2MG	3	
REXULTI TAB 3MG	3	
REXULTI TAB 4MG	3	
THIOXANTHENES		
<i>thiothixene cap 1 mg</i>	1	
<i>thiothixene cap 2 mg</i>	1	
<i>thiothixene cap 5 mg</i>	1	
<i>thiothixene cap 10 mg</i>	1	
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
<i>formaldehyde solution 10%</i>	1	
GLUTARALDEHY SOL 25%	3	
CHLORINE ANTISEPTICS		
BENZALKONIUM SOL NF	3	
ANTIVIRALS		
ANTIRETROVIRALS		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	QL (900 ML PER 30 DAYS)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
APTIVUS CAP 250MG	3	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
APTIVUS SOL	3	PA, QL (285 ML PER 28 DAYS); MNPA
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	QL (60 CAPSULES PER 30 DAYS)

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

140

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

141

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine caps 200 mg</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	0	QL (30 TABLETS PER 30 DAYS); \$0 copay for pre exposure prophylaxis
EMTRIVA CAP 200MG	2	QL (30 CAPSULES PER 30 DAYS)
EMTRIVA SOL 10MG/ML	2	QL (680 ML PER 28 DAYS)
EPIVIR SOL 10MG/ML	3	QL (960 ML PER 30 DAYS)
EPIVIR TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
EPIVIR TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
EPZICOM TAB 600-300	3	QL (30 TABLETS PER 30 DAYS)
<i>etravirine tab 100 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>etravirine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
EVOTAZ TAB 300-150	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	4	PA, QL (60 VIALS PER 30 DAYS)

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

142

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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 TABLETS PER 30 DAYS)
INVIRASE TAB 500MG	3	PA, 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)
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	PA, QL (1575 ML PER 28 DAYS); MNPA

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

143

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LEXIVA TAB 700MG	3	PA, 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)
NORVIR TAB 100MG	2	QL (360 TABLETS PER 30 DAYS)
ODEFSEY TAB	2	QL (30 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	3	QL (180 CAPSULES PER 30 DAYS)

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

144

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RETROVIR SYP 50MG/5ML	3	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	PA, QL (60 TABLETS PER 30 DAYS)
SELZENTRY SOL 20MG/ML	3	QL (1840 ML PER 30 DAYS); MNPA
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)
SUSTIVA CAP 50MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA CAP 200MG	3	QL (90 CAPSULES PER 30 DAYS)

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

145

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
<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	PA, QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 133-200	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 167-250	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
TRUVADA TAB 200-300	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
TYBOST TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)

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

146

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VIRACEPT TAB 250MG	3	PA, QL (300 TABLETS PER 30 DAYS); MNPA
VIRACEPT TAB 625MG	3	PA, 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	3	QL (240 GM PER 30 DAYS)
VIREAD TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 200MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 250MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
ZIAGEN SOL 20MG/ML	3	QL (900 ML PER 30 DAYS)
ZIAGEN TAB 300MG	3	QL (60 TABLETS PER 30 DAYS)
<i>zidovudine cap 100 mg</i>	1	QL (180 CAPSULES PER 30 DAYS)
<i>zidovudine syrup 10 mg/ml</i>	1	QL (1920 ML PER 30 DAYS)
<i>zidovudine tab 300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100	3	QL (40 tabs every 30 days)
PAXLOVID TAB 300-100	3	QL (60 tabs every 30 days)
CMV AGENTS		
LIVTENCITY TAB 200MG	3	PA, QL (120 TABLETS PER 30 DAYS)
PREVYMIS TAB 240MG	3	
PREVYMIS TAB 480MG	3	
VALCYTE SOL 50MG/ML	3	PA, QL (1000 ML PER 30 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VALCYTE TAB 450MG	3	PA, 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)

HEPATITIS AGENTS

<i>adefovir dipivoxil tab 10 mg</i>	1	
BARACLUDE SOL	3	QL (630 ML PER 30 DAYS)
<i>entecavir tab 0.5 mg</i>	1	QL (30 TABS PER 30 DAYS)
<i>entecavir tab 1 mg</i>	1	QL (30 TABS PER 30 DAYS)
EPCLUSA PAK 150-37.5	2	PA, QL (28 TABLETS PER 28 DAYS)
EPCLUSA PAK 200-50MG	2	PA, QL (28 TABLETS PER 28 DAYS)
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
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
<i>lamivudine tab 100 mg (hbv)</i>	1	

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

148

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PEGINTRON KIT 50MCG	4	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)
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)

HERPES AGENTS

<i>acyclovir cap 200 mg</i>	1	
<i>acyclovir susp 200 mg/5ml</i>	1	
<i>acyclovir tab 400 mg</i>	1	
<i>acyclovir tab 800 mg</i>	1	
<i>famciclovir tab 125 mg</i>	1	
<i>famciclovir tab 250 mg</i>	1	
<i>famciclovir tab 500 mg</i>	1	
SITAVIG TAB 50MG	3	
<i>valacyclovir hcl tab 1 gm</i>	1	
<i>valacyclovir hcl tab 500 mg</i>	1	
VALTREX TAB 1GM	3	PA; MNPA
VALTREX TAB 500MG	3	PA; MNPA
ZOVIRAX SUS 200/5ML	3	

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

149

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INFLUENZA AGENTS		
<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	QL (28 caps every 90 days)
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	QL (180 mL every 90 days)
RELENZA MIS DISKHALE	2	QL (2 inhalers every 90 days)
<i>rimantadine hydrochloride tab 100 mg</i>	1	
TAMIFLU CAP 30MG	3	QL (28 caps every 90 days)
TAMIFLU CAP 45MG	3	QL (14 caps every 90 days)
TAMIFLU CAP 75MG	3	QL (14 caps every 90 days)
TAMIFLU SUS 6MG/ML	3	QL (180 mL every 90 days)
XOFLUZA TAB 20MG	3	PA; MNPA
XOFLUZA TAB 40MG	3	PA; MNPA
MISC. ANTIVIRALS		
FAVIPIRAVIR TAB 200MG	3	
LAGEVRIO CAP 200MG	3	QL (40 caps every 30 days)
TEMBEXA SUS 10MG/ML	3	
TEMBEXA TAB 100MG	3	
TPOXX CAP 200MG	3	
TPOXX INJ	3	
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	
<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	PA; MNPA
COREG CR CAP 20MG	3	PA; MNPA

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

150

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COREG CR CAP 40MG	3	PA; MNPA
COREG CR CAP 80MG	3	PA; 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
BYSTOLIC TAB 10MG	3	MNPA
BYSTOLIC TAB 20MG	3	MNPA
KAPSPARGO CAP 25MG	3	PA; MNPA
KAPSPARGO CAP 50MG	3	PA; MNPA
KAPSPARGO CAP 100MG	3	PA; MNPA
KAPSPARGO CAP 200MG	3	PA; MNPA
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	

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

151

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
TOPROL XL TAB 50MG	3	PA; MNPA
TOPROL XL TAB 100MG	3	PA; MNPA
TOPROL XL TAB 200MG	3	PA; MNPA
BETA BLOCKERS NON-SELECTIVE		
BETAPACE AF TAB 80MG	3	PA; MNPA
BETAPACE AF TAB 120MG	3	PA; MNPA
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	PA; MNPA
INDERAL LA CAP 80MG	3	PA; MNPA
INDERAL LA CAP 120MG	3	PA; MNPA
INDERAL LA CAP 160MG	3	PA; MNPA
INDERAL XL CAP 80MG	3	PA; MNPA
INDERAL XL CAP 120MG	3	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INNOPRAN XL CAP 80MG	3	PA; MNPA
INNOPRAN XL CAP 120MG	3	PA; MNPA
nadolol tab 20 mg	1	
nadolol tab 40 mg	1	
nadolol tab 80 mg	1	
pindolol tab 5 mg	1	
pindolol tab 10 mg	1	
propranolol hcl cap er 24hr 60 mg	1	
propranolol hcl cap er 24hr 80 mg	1	
propranolol hcl cap er 24hr 120 mg	1	
propranolol hcl cap er 24hr 160 mg	1	
propranolol hcl oral soln 20 mg/5ml	1	
propranolol hcl oral soln 40 mg/5ml	1	
propranolol hcl tab 10 mg	1	
propranolol hcl tab 20 mg	1	
propranolol hcl tab 40 mg	1	
propranolol hcl tab 60 mg	1	
propranolol hcl tab 80 mg	1	
sotalol hcl (afib/afI) tab 80 mg	1	
sotalol hcl (afib/afI) tab 120 mg	1	
sotalol hcl (afib/afI) tab 160 mg	1	
sotalol hcl tab 80 mg	1	
sotalol hcl tab 120 mg	1	
sotalol hcl tab 160 mg	1	
sotalol hcl tab 240 mg	1	
SOTYLIZE SOL 5MG/ML	3	
timolol maleate tab 5 mg	1	
timolol maleate tab 10 mg	1	
timolol maleate tab 20 mg	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

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

153

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
CARDIZEM CD CAP 180MG/24	3	PA; MNPA
CARDIZEM CD CAP 240MG/24	3	PA; MNPA
CARDIZEM CD CAP 300MG/24	3	PA; MNPA
CARDIZEM CD CAP 360MG/24	3	PA; MNPA
CARDIZEM LA TAB 120MG	3	PA; MNPA
CARDIZEM LA TAB 180MG	3	PA; MNPA
CARDIZEM LA TAB 240MG	3	PA; MNPA
CARDIZEM LA TAB 300MG/24	3	PA; MNPA
CARDIZEM LA TAB 360MG	3	PA; MNPA
CARDIZEM LA TAB 420MG/24	3	PA; MNPA
CARDIZEM TAB 30MG	3	PA; MNPA
CARDIZEM TAB 60MG	3	PA; MNPA
CARDIZEM TAB 120MG	3	PA; MNPA
CONJUPRI TAB 2.5MG	3	PA; MNPA
CONJUPRI TAB 5MG	3	MNPA
CONJUPRI TAB 5MG	3	PA; MNPA
<i>diltiazem hcl cap er 12hr 60 mg</i>	1	
<i>diltiazem hcl cap er 12hr 90 mg</i>	1	
<i>diltiazem hcl cap er 12hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	1	

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

154

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>	1	
<i>diltiazem hcl tab 30 mg</i>	1	
<i>diltiazem hcl tab 60 mg</i>	1	
<i>diltiazem hcl tab 90 mg</i>	1	
<i>diltiazem hcl tab 120 mg</i>	1	
<i>diltiazem hcl tab er 24hr 180 mg</i>	1	PA; MNPA
<i>diltiazem hcl tab er 24hr 240 mg</i>	1	PA; MNPA
<i>diltiazem hcl tab er 24hr 300 mg</i>	1	PA; MNPA
<i>diltiazem hcl tab er 24hr 360 mg</i>	1	PA; MNPA
<i>diltiazem hcl tab er 24hr 420 mg</i>	1	PA; MNPA
<i>felodipine tab er 24hr 2.5 mg</i>	1	
<i>felodipine tab er 24hr 5 mg</i>	1	
<i>felodipine tab er 24hr 10 mg</i>	1	
<i>isradipine cap 2.5 mg</i>	1	
<i>isradipine cap 5 mg</i>	1	
KATERZIA SUS 1MG/ML	3	PA; MNPA
<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	

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

155

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	
NORVASC TAB 2.5MG	3	PA; MNPA
NORVASC TAB 5MG	3	PA; MNPA
NORVASC TAB 10MG	3	PA; 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	
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	

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

156

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	

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

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)

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	
---	---	--

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

157

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	
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	
IMPOTENCE AGENTS		
CAVERJECT IM KIT 10MCG	4	QL (6 each every 30 days); Coverage is subject to your plan/benefits

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

158

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CAVERJECT INJ 40MCG	4	QL (6 vials every 30 days); Coverage is subject to your plan/benefits
CAVERJECT KIT 20MCG	4	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
CIALIS TAB 2.5MG	3	ST, PA, QL (30 tabs every 30 days); MNPA; Coverage is subject to your plan/benefits
CIALIS TAB 5MG	3	ST, PA, QL (30 tabs every 30 days); MNPA; Coverage is subject to your plan/benefits
CIALIS TAB 10MG	3	PA, QL (6 tabs every 30 days); MNPA
CIALIS TAB 20MG	3	PA, QL (6 tabs every 30 days); MNPA
EDEX KIT 10MCG	4	QL (6 each every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 20MCG	4	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 40MCG	4	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

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

159

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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); MNPA
STENDRA TAB 100MG	3	PA, QL (6 tabs every 30 days); MNPA
STENDRA TAB 200MG	3	PA, QL (6 tabs every 30 days); 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

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

160

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>tadalafil tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>vardenafil hcl orally disintegrating tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>vardenafil hcl tab 2.5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>vardenafil hcl tab 5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<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	PA, QL (6 tabs every 30 days); MNPA
VIAGRA TAB 50MG	3	PA, QL (6 tabs every 30 days); MNPA
VIAGRA TAB 100MG	3	PA, QL (6 tabs every 30 days); MNPA
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

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

161

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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)
OPSUMIT TAB 10MG	2	PA, QL (30 TABLETS PER 30 DAYS)

PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS

<i>sildenafil citrate for suspension 10 mg/ml</i>	1	PA, QL (784 ML PER 30 DAYS); 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sildenafil citrate tab 20 mg</i>	1	PA, QL (360 TABLETS PER 30 DAYS); MNPA
<i>tadalafil tab 20 mg (pah)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>tadalafil tab 20 mg (pah)</i>	1	PA, QL (60 TABLETS PER 30 DAYS); Coverage is subject to your plan/benefits
TADLIQ SUS 20MG/5ML	3	PA, QL (300 ML PER 30 DAYS)

PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST

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)

PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR

ADEMPAS TAB 0.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	2	PA, QL (90 TABLETS PER 30 DAYS)

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

163

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ADEMPAS TAB 2.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2MG	2	PA, QL (90 TABLETS PER 30 DAYS)
SINUS NODE INHIBITORS		
CORLANOR SOL 5MG/5ML	3	PA
CORLANOR TAB 5MG	2	PA
CORLANOR TAB 7.5MG	2	PA
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP 61MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG	2	
VERQUVO TAB 2.5MG	2	PA; MNPA
VERQUVO TAB 5MG	2	
VERQUVO TAB 5MG	2	PA; MNPA
VERQUVO TAB 10MG	2	
VERQUVO TAB 10MG	2	PA; MNPA
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
<i>cefadroxil cap 500 mg</i>	1	
<i>cefadroxil for susp 250 mg/5ml</i>	1	
<i>cefadroxil for susp 500 mg/5ml</i>	1	
<i>cefadroxil tab 1 gm</i>	1	
<i>cephalexin cap 250 mg</i>	1	
<i>cephalexin cap 500 mg</i>	1	
<i>cephalexin cap 750 mg</i>	1	
<i>cephalexin for susp 125 mg/5ml</i>	1	
<i>cephalexin for susp 250 mg/5ml</i>	1	
<i>cephalexin tab 250 mg</i>	1	
<i>cephalexin tab 500 mg</i>	1	
KEFLEX CAP 750MG	3	
CEPHALOSPORINS - 2ND GENERATION		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	

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

164

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

165

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	0	
ESTROSTEP FE TAB	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	0	
GENERESS FE CHW	0	
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	0	
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	0	
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	0	
LO LOESTRIN TAB 1-10-10	0	
LOSEASONIQUE TAB	0	
MINASTRIN 24 CHW FE	0	PA; MNPA
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	

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

166

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

167

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>norgestrel & 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	PA; MNPA
TYBLUME CHW 0.1-0.02	0	PA
YASMIN 28 TAB 3-0.03MG	0	PA; MNPA
YAZ TAB 3-0.02MG	0	PA; MNPA
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	0	
TWIRLA DIS 120-30	0	PA; MNPA
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS	0	QL (1 ring every 300 days)
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	0	PA, QL (13 rings every 300 days); MNPA
NUVARING MIS	0	QL (13 rings every 300 days); Tier 1 with DAW9
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG	0	
<i>levonorgestrel tab 1.5 mg</i>	0	
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
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)
PROGESTIN CONTRACEPTIVES - ORAL		
<i>norethindrone tab 0.35 mg</i>	0	
ORTHO MICRON TAB 0.35MG	0	
SLYND TAB 4MG	0	PA; MNPA

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

168

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
ALKINDI SPRI CAP 0.5MG	3	PA; MNPA
ALKINDI SPRI CAP 1MG	3	PA; MNPA
ALKINDI SPRI CAP 2MG	3	PA; MNPA
ALKINDI SPRI CAP 5MG	3	PA; MNPA
<i>budesonide delayed release particles cap 3 mg</i>	1	
<i>budesonide tab er 24hr 9 mg</i>	1	PA; MNPA
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	3	
DEXABLISS TAB 1.5MG	3	PA; MNPA
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 (21)</i>	1	PA; MNPA
<i>dexamethasone tab therapy pack 1.5 mg (27)</i>	1	PA; MNPA
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (49)</i>	1	PA; MNPA
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
DXEVO 11-DAY PAK 1.5MG	3	PA; MNPA
ENTOCORT EC CAP 3MG DR	3	
HEMADY TAB 20MG	3	PA; MNPA
<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	

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

169

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
ORTIKOS CAP 9MG ER	3	PA; MNPA
PEDIAPRED SOL 5MG/5ML	3	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i>	1	
<i>prednisolone sod phosphate oral soln 10 mg/5ml (base equiv)</i>	1	PA; 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	PA; 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	

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

170

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
RAYOS TAB 2MG	3	PA; MNPA
RAYOS TAB 5MG	3	PA; MNPA
SOLU-CORTEF INJ 100MG	4	PA
SOLU-CORTEF INJ 250MG	4	PA
SOLU-CORTEF INJ 500MG	4	PA
SOLU-CORTEF INJ 1000MG	4	PA
UCERIS TAB 9MG	1	Tier 1 with DAW9
ZCORT 7-DAY TAB 1.5MG	3	PA; MNPA
MINERALOCORTICOIDS		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
HYCODAN SYP 5-1.5/5	3	PA, 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	
COUGH/COLD/ALLERGY COMBINATIONS		
CLARINEX-D TAB 2.5-120	3	

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

171

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
NEOTUSS PLUS LIQ	3	
<i>promethazine & phenylephrine syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	QL (210 mL every 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	PA, QL (14 tabs every 25 days); MNPA
TUZISTRA XR SUS	3	QL (140 mL every 25 days)
MISC. RESPIRATORY INHALANTS		
HYPERSAL NEB 3.5%	3	
HYPERSAL NEB 7%	3	
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
<i>sodium chloride soln nebu 7%</i>	1	
<i>sodium chloride soln nebu 10%</i>	1	
MUCOLYTICS		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
DERMATOLOGICALS		
ACNE PRODUCTS		
ABSORICA CAP 10MG	3	
ABSORICA CAP 20MG	3	
ABSORICA CAP 25MG	3	
ABSORICA CAP 30MG	3	
ABSORICA CAP 35MG	3	
ABSORICA CAP 40MG	3	

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

172

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ABSORICA LD CAP 8MG	3	PA; MNPA
ABSORICA LD CAP 16MG	3	PA; MNPA
ABSORICA LD CAP 24MG	3	PA; MNPA
ABSORICA LD CAP 32MG	3	PA; MNPA
ACANYA GEL 1.2-2.5%	3	PA, 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; MNPA
<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; MNPA
AMZEEQ AER 4%	3	PA; MNPA
ARAZLO LOT 0.045%	2	PA
ATRALIN GEL 0.05%	3	PA
AZELEX CRE 20%	3	PA; MNPA
BENZ PER FOR LOT HC 7.5-1	3	PA; MNPA
BENZ PEROXID GEL 6.5%	3	PA; MNPA
BENZAACLIN GEL 1-5%	3	PA, QL (50 gm every 25 days); MNPA
BENZAACLIN GEL 1-5%PUMP	3	PA, QL (50 gm every 25 days); MNPA
BENZAMYCIN GEL 5-3%	3	QL (47 gm every 25 days)
BENZEPRO AER 5.2%	3	PA; MNPA
BENZEPRO AER 9.7%	3	PA; MNPA
BENZEPRO LIQ 6.8%	3	PA; MNPA
BENZEPRO MIS 5.8%	3	PA; MNPA
<i>benzoyl peroxide foam 5.3%</i>	1	
<i>benzoyl peroxide foam 9.8%</i>	1	

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

173

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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	PA; MNPA
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	PA, QL (60 gm every 30 days); MNPA
<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)
<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
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	

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

174

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
PR BENZOYL LIQ 7% WASH	1	
<i>resorcinol-sulfur lotion 2-5%</i>	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
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; MNPA
<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

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

175

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>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
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		
VEREGEN OIN 15%	3	PA; MNPA
ANTI-INFLAMMATORY AGENTS - TOPICAL		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	PA, QL (150 mL every 21 days)
<i>diclofenac sodium soln 2%</i>	1	PA, QL (112 gm every 21 days); MNPA
FLECTOR DIS 1.3%	3	
LICART DIS 1.3%	3	PA; MNPA
PENNSAID SOL 2%	3	PA, QL (112 gm every 21 days); MNPA
ANTIBIOTICS - TOPICAL		
ALTABAX OIN 1%	3	
CENTANY OIN 2%	3	QL (30 gm every 25 days)
<i>gentamicin sulfate cream 0.1%</i>	1	QL (120 gm every 25 days)
<i>gentamicin sulfate oint 0.1%</i>	1	QL (120 gm every 25 days)
<i>mupirocin 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
ANTIFUNGALS - TOPICAL		
<i>ciclopirox gel 0.77%</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	QL (120 mL every 25 days)
<i>ciclopirox shampoo 1%</i>	1	QL (120 mL every 25 days)
<i>ciclopirox solution 8%</i>	1	
<i>clotrimazole soln 1%</i>	1	QL (120 mL every 25 days)

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

176

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
FUNGIMEZ SOL	3	PA; MNPA
HIXDEFRIMA SOL 8-1-1%	3	PA; MNPA
<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)
<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	PA, QL (120 gm every 25 days); MNPA
LOPROX SHA 1%	3	QL (120 mL every 25 days)
LOPROX SUS 0.77%	3	PA, QL (120 mL every 25 days); MNPA
<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)

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

177

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
<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)
XOLEGEL GEL 2%	3	PA, QL (45 gm every 25 days); MNPA
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
AMELUZ GEL 10%	3	PA; MNPA
CARAC CRE 0.5%	3	PA; 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	PA; 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); MNPA
LEVULAN KERA SOL 20%	3	

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

178

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PANRETIN GEL 0.1%	3	
PICATO GEL 0.05%	2	
PICATO GEL 0.015%	2	
ROAOXIA GEL 3-4%	3	PA; MNPA
TARGRETIN GEL 1%	3	PA; MNPA
VALCHLOR GEL 0.016%	3	PA, QL (2 TUBES PER 30 DAYS)
ANTIPRURITICS - TOPICAL		
doxepin hcl cream 5%	1	ST, PA, QL (90 gm every 25 days); MNPA
PRUDOXIN CRE 5%	3	ST, QL (90 gm every 25 days)
ZONALON CRE 5%	3	ST, QL (90 gm every 25 days)
ANTIPSORIATICS		
acitretin cap 10 mg	1	
acitretin cap 17.5 mg	1	
acitretin cap 25 mg	1	
calcipotriene cream 0.005%	1	PA; MNPA
calcipotriene foam 0.005%	1	PA; MNPA
calcipotriene oint 0.005%	1	PA
calcipotriene soln 0.005% (50 mcg/ml)	1	PA
calcitriol oint 3 mcg/gm	1	PA; MNPA
COSENTYX INJ 75MG/0.5	4	PA, QL (1 SYRINGE PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:5 SYRINGES PER 35 DAYS

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

179

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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

180

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
COSENTYX PEN INJ 300DOSE	4	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
COSENTYX UNO INJ 300/2ML	4	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits.
DOVONEX CRE 0.005%	3	PA
<i>methoxsalen rapid cap 10 mg</i>	1	
OXSORALEN-UL CAP 10MG	3	
SKYRIZI INJ 150DOSE	4	PA, QL (2 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 4 SYRINGES PER 28 DAYS

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

181

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI INJ 150MG/ML	4	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS
SKYRIZI PEN INJ 150MG/ML	4	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS
SORIATANE CAP 10MG	3	
SORIATANE CAP 25MG	3	
SORILUX AER 0.005%	3	PA; MNPA
SOTYKTU TAB 6MG	3	PA, QL (30 TABLETS PER 30 DAYS)
STELARA INJ 45MG/0.5	4	PA, QL (1 SYRINGES PER 12 WEEKS (84 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent

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

182

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
STELARA INJ 45MG/0.5	4	PA, QL (1 VIALS PER 12 WEEKS); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
STELARA INJ 90MG/ML	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
TALTZ INJ 80MG/ML	4	PA, QL (1 PFS PER 28 DAYS); LOADING DOSE: Diagnosis Dependent
TALTZ INJ 80MG/ML	4	PA, QL (1 SYRINGES PER 28 DAYS); LOADING DOSE: Diagnosis Dependent
<i>tazarotene cream 0.1%</i>	1	PA
TAZORAC CRE 0.1%	3	PA; MNPA
TAZORAC CRE 0.05%	3	PA; MNPA
TAZORAC GEL 0.1%	3	PA; MNPA
TAZORAC GEL 0.05%	3	PA; MNPA

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

183

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TREMFYA INJ 100MG/ML	4	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	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
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)
ANTISEBORRHEIC PRODUCTS		
ESKATA SOL 40%	3	PA; MNPA
GLYCOLIC ACID SOL 70%	3	
selenium sulfide lotion 2.5%	1	
SODIUM SULFA LIQ 10% WASH	3	
ANTIVIRALS - TOPICAL		
acyclovir cream 5%	1	PA; MNPA
acyclovir oint 5%	1	
DENAVIR CRE 1%	3	
penciclovir cream 1%	1	
XERESE CRE 5-1%	3	
ZOVIRAX CRE 5%	3	
ZOVIRAX OIN 5%	3	

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

184

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BURN PRODUCTS		
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	
SILVADENE CRE 1%	2	
<i>silver sulfadiazine cream 1%</i>	1	
SULFAMYLON CRE 85MG/GM	3	
SULFAMYLON PAK 5%	3	
CORTICOSTEROIDS - TOPICAL		
ALA-SCALP LOT 2%	1	PA, QL (120 mL every 30 days); MNPA
ALA-SCALP LOT 2%	3	PA, QL (120 mL every 30 days); MNPA
<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	PA, 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	PA, 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)

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

185

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
BRYHALI LOT 0.01%	2	QL (120 gm every 30 days)
<i>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	PA, 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	PA, 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	PA, 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	PA, QL (1.002 ea every 30 days); MNPA
CORDRAN CRE 0.05%	3	PA, QL (120 gm every 30 days); MNPA
CORDRAN CRE 0.025%	3	PA, QL (120 gm every 30 days); MNPA

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

186

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CORDRAN LOT 0.05%	3	PA, 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)
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	PA, 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	3	PA; 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)

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

187

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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)
<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	PA, QL (120 gm every 30 days); MNPA
<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	PA, QL (120 gm every 30 days); MNPA
HALOG OIN 0.1%	3	PA, QL (120 gm every 30 days); MNPA
HALOG SOL 0.1%	3	PA, QL (120 mL every 30 days); MNPA
HC/PRAMOXINE CRE 1-2.35%	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)

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

188

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone butyrate soln 0.1%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone cream 1%</i>	1	QL (120 gm 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 1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone oint 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate cream 0.2%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate oint 0.2%</i>	1	QL (120 gm every 30 days)
IMPEKLO LOT 0.05%	3	PA, QL (120 gm every 30 days); MNPA
IMPOYZ CRE 0.025%	3	PA, QL (120 gm every 30 days); MNPA
KENALOG AER SPRAY	3	QL (120 gm every 30 days)
LEXETTE AER 0.05%	3	PA, QL (120 gm every 30 days); MNPA
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	PA, 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)

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

189

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
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	PA, 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; MNPA
ECZEMA AGENTS		
ADBRY INJ 150MG/ML	4	PA, QL (4 SYRINGES PER 28 DAYS); LOADING DOSE: 4 SYRINGES PER 14 DAYS

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

190

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
DUPIXENT INJ 200MG	4	PA, QL (2 PENS (400 MG) PER 28 DAYS); LOADING DOSE:2 PENS (400 MG) PER 14 DAYS
DUPIXENT INJ 300/2ML	4	PA, QL (4 PENS PER 28 DAYS)
DUPIXENT INJ 300/2ML	4	PA, QL (4 PFS PER 28 DAYS)
OPZELURA CRE 1.5%	3	PA
EMOLLIENT/KERATOLYTIC AGENTS		
<i>urea cream 39%</i>	1	
<i>urea lotion 40%</i>	1	
EMOLLIENTS		
<i>lactic acid (ammonium lactate) cream 12%</i>	1	
LACTIC ACID CRE E	3	
LACTIC ACID LOT 10%	3	
ENZYMES - TOPICAL		
SANTYL OIN 250/GM	3	
HAIR GROWTH AGENTS		
LITFULO CAP 50MG	3	PA, QL (28 caps per 28 days)
IMMUNOMODULATING AGENTS - TOPICAL		
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	

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

191

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
ELIDEL CRE 1%	3	ST, PA; MNPA
OXIANUJO CRE 4-0.1%	3	PA; MNPA
<i>pimecrolimus cream 1%</i>	1	ST
PROTOPIC OIN 0.1%	3	ST
PROTOPIC OIN 0.03%	3	ST
<i>tacrolimus oint 0.1%</i>	1	ST
<i>tacrolimus oint 0.03%</i>	1	ST
KERATOLYTIC/ANTIMITOTIC AGENTS		
CANTHARIDIN SOL 0.7%	3	PA; MNPA
CONDYLOX GEL 0.5%	2	
GEAMETDRAY GEL 5-2-17%	3	PA; MNPA
GORDOFILM SOL	3	
<i>podofilox soln 0.5%</i>	1	
PYROGALL ACD OIN	3	
SALIMEZ CRE 6%	3	PA
SALIMEZ FORT CRE 10%	3	
LINIMENTS		
TURPENTINE SOL SPIRITS	3	
LOCAL ANESTHETICS - TOPICAL		
ANACAINE OIN	3	
ASTERO GEL 4%	3	PA, QL (30 mL every 25 days); MNPA
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	
GEBAUERS SPR AER /STRETCH	3	
LDO PLUS GEL 4%	3	PA, QL (30 mL every 25 days); MNPA
LIDOCA/TETRA CRE 7/7%	3	PA, QL (30 gm every 25 days); MNPA

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

192

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LIDOCAINE CRE TETRACAI	3	PA, QL (30 gm every 25 days); MNPA
<i>lidocaine hcl gel 2%</i>	1	QL (30 gm every 25 days)
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel 2%</i>	1	QL (60 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (10 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (12 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (3 injections every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 25 days)
<i>lidocaine patch 5%</i>	1	QL (90 ea every 30 days)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
LIDODERM DIS 5%	2	QL (90 ea every 30 days)
PAIN EASE AER MD STRM	3	
PAIN EASE AER MIST	3	
PLIAGLIS CRE 7-7%	3	PA, QL (30 gm every 25 days); MNPA
PRAMOX GEL 1%	3	PA; MNPA
SYNERA DIS 70-70MG	3	QL (2 patches every 25 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 ea every 30 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 patches every 30 days)
MISC. TOPICAL		
BORIC ACID GRA	3	
DRYSOL SOL 20%	3	
EPICYN SPR	3	PA; MNPA
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2%	2	

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

193

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ROSACEA AGENTS		
<i>azelaic acid gel 15%</i>	1	PA
FINACEA AER 15%	2	PA
FINACEA GEL 15%	3	PA; MNPA
METROCREAM CRE 0.75%	3	
METROGEL GEL 1%	3	
METROLOTION LOT 0.75%	3	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
MIRVASO GEL 0.33%	3	PA; MNPA
NORITATE CRE 1%	3	PA; MNPA
ORACEA CAP 40MG	1	Tier 1 with DAW9
RHOFADE CRE 1%	2	PA
SOOLANTRA CRE 1%	1	PA; Tier 1 with DAW9
ZILXI AER 1.5%	3	PA; MNPA
SCABICIDES & PEDICULICIDES		
<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	
TAR PRODUCTS		
<i>coal tar soln 20%</i>	1	
WOUND CARE PRODUCTS		
REGRANEX GEL 0.01%	3	

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

194

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC TESTS		
ACCU-CHEK GUIDE	0	QL (150 strips every 30 days)
ACCU-CHEK TES AVIVA PL	0	QL (150 strips every 30 days)
ACCU-CHEK TES COMPACT	0	QL (150 strips every 30 days)
ACCU-CHEK TES SMART	0	QL (150 strips every 30 days)
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

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

195

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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

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

196

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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

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

197

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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 strips every 30 days); MNPA
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

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

198

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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	PA, 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	

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

199

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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

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

200

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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	

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

201

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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	QL (150 strips every 30 days)

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

202

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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 strips 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

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

203

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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	PA, 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

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

204

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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
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**

CAMINO PRO LIQ 15PE	3	Coverage is subject to your plan/benefits
COMPLEAT LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
COMPLEAT PED LIQ ORG BLND	3	PA; Coverage is subject to your plan/benefits
CRUCIAL LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
DIABETIC TF LIQ	3	PA; Coverage is subject to your plan/benefits
DIABETISOURC LIQ	3	PA; Coverage is subject to your plan/benefits
EAA SUPPLEME POW TROPICAL	3	Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
ENTERAGAM POW 5GM	3	PA; Coverage is subject to your plan/benefits
EO28 SPLASH LIQ ORANGE	3	PA; Coverage is subject to your plan/benefits
F.A.A. LIQ	3	PA; Coverage is subject to your plan/benefits
FIBERSOUR HN LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits

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

205

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FIBERSOURCE LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FOSTEUM CAP	3	PA; Coverage is subject to your plan/benefits
FOSTEUM PLUS CAP	3	PA; Coverage is subject to your plan/benefits
GLUCERNA 1.0 LIQ CARB VAN	3	PA; Coverage is subject to your plan/benefits
GLUCERNA LIQ 1.2 CAL	3	PA; Coverage is subject to your plan/benefits
GLUCERNA SEL LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
GLYTACTIN PAK BTMK/DLT	3	Coverage is subject to your plan/benefits
GLYTACTIN POW BETMLK15	3	Coverage is subject to your plan/benefits
GLYTACTIN POW RST LT10	3	Coverage is subject to your plan/benefits
GLYTROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
HCU EXP20 PAK UNFLAVOR	3	Coverage is subject to your plan/benefits
HCU EXPRESS PAK	3	Coverage is subject to your plan/benefits
HOMACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
ISOSOURCE HN LIQ	3	PA; Coverage is subject to your plan/benefits
ISOSOURCE LIQ	3	PA; Coverage is subject to your plan/benefits
ISOVACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
JEVITY 1 CAL LIQ	3	PA; Coverage is subject to your plan/benefits
JEVITY 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits

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

206

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
JEVITY 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
LANAFLEX PAK	3	Coverage is subject to your plan/benefits
LIQUID HOPE LIQ	3	PA; Coverage is subject to your plan/benefits
LOPHLEX POW	3	Coverage is subject to your plan/benefits
LORMATE CAP	3	PA; Coverage is subject to your plan/benefits
MCT PRO-CAL PAK	3	PA; Coverage is subject to your plan/benefits
NEOCATE LIQ SPLASH	3	PA; Coverage is subject to your plan/benefits
NEOKE MCT70 POW	3	PA; Coverage is subject to your plan/benefits
NEPRO LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NOVASOURCE LIQ RENAL	3	PA; Coverage is subject to your plan/benefits
NUTRAMINE PAK	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.0 LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.5 LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
NUTREN 2.0 LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NUTREN JR LIQ	3	PA; Coverage is subject to your plan/benefits
NUTREN LIQ JUNIOR	3	PA; Coverage is subject to your plan/benefits
NUTREN RENAL LIQ	3	PA; Coverage is subject to your plan/benefits
NUTRIRENAL LIQ	3	PA; Coverage is subject to your plan/benefits

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

207

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OPTIMENTAL LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE HN LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA 1.5 LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA LIQ	3	PA; Coverage is subject to your plan/benefits
PEDIASURE EN LIQ /FIBER	3	PA; Coverage is subject to your plan/benefits
PEDIASURE LIQ PEPTIDE	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PERATIVE LIQ	3	PA; Coverage is subject to your plan/benefits
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHLEXY-10 POW	3	PA; Coverage is subject to your plan/benefits
PIVOT LIQ 1.5 CAL	3	PA; Coverage is subject to your plan/benefits

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

208

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PKU EXPLORE5 POW UNFLAVOR	3	Coverage is subject to your plan/benefits
PPA/MMA POW EXPRESS	3	Coverage is subject to your plan/benefits
PRO-PHREE POW	3	Coverage is subject to your plan/benefits
PROLEEVA CAP	3	PA; Coverage is subject to your plan/benefits
PROMACTIN AA SUS PLUS	3	Coverage is subject to your plan/benefits
PROMOTE 1.0 LIQ W/ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/FB LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
REPLETE FIBE LIQ 1 CAL	3	PA; Coverage is subject to your plan/benefits
REPLETE LIQ ULTRAPAK	3	PA; Coverage is subject to your plan/benefits
RESOURCE DIA LIQ TF	3	PA; Coverage is subject to your plan/benefits
RHEUMATE CAP	3	PA; Coverage is subject to your plan/benefits
RIBOZEL CAP	3	PA; Coverage is subject to your plan/benefits
S.O.S. 20 POW	3	Coverage is subject to your plan/benefits
S.O.S. 25 POW	3	Coverage is subject to your plan/benefits

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

209

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SUPLINA LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
TOBAIKIENT CAP	3	PA; Coverage is subject to your plan/benefits
TOLEREX POW	3	PA; Coverage is subject to your plan/benefits
TWOCAL HN LIQ	3	PA; Coverage is subject to your plan/benefits
TYLACTIN POW BLD 20PE	3	Coverage is subject to your plan/benefits
ULTRACAL HN LIQ PLUS	3	PA; Coverage is subject to your plan/benefits
ULTRACAL LIQ	3	PA; Coverage is subject to your plan/benefits
ULTRIEN 1.5 LIQ SAFE-T	3	PA; Coverage is subject to your plan/benefits
VILACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
VITAL HN POW	3	PA; Coverage is subject to your plan/benefits
VIVONEX RTF LIQ	3	PA; Coverage is subject to your plan/benefits

NUTRITIONAL SUPPLEMENTS

ENU PRO3 POW PLUS	3	PA; MNPA
EQUACARE JR POW CHOCOLA	3	PA; MNPA
EQUACARE JR POW UNFLAVO	3	PA; MNPA
EQUACARE JR POW VANILLA	3	PA; MNPA
ESSENTIAL POW CARE JR	3	PA; MNPA

DIGESTIVE AIDS**DIGESTIVE ENZYMES**

CREON CAP 3000UNIT	2	
CREON CAP 6000UNIT	2	
CREON CAP 12000UNT	2	
CREON CAP 24000UNT	2	
CREON CAP 36000UNT	2	

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

210

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	

DIURETICS**CARBONIC ANHYDRASE INHIBITORS**

<i>acetazolamide cap er 12hr 500 mg</i>	1	
<i>acetazolamide tab 125 mg</i>	1	
<i>acetazolamide tab 250 mg</i>	1	
<i>dichlorphenamide tab 50 mg</i>	1	PA, QL (120 tabs every 30 days)
KEVEYIS TAB 50MG	3	PA, QL (120 TABLETS PER 30 DAYS)
<i>methazolamide tab 25 mg</i>	1	
<i>methazolamide tab 50 mg</i>	1	

DIURETIC COMBINATIONS

ALDACTAZIDE TAB 25/25	3	
ALDACTAZIDE TAB 50/50	3	
<i>amiloride & hydrochlorothiazide tab 5-50 mg</i>	1	

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

211

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MAXZIDE TAB 75-50	3	
MAXZIDE-25 TAB	3	
<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i>	1	
<i>triamterene & hydrochlorothiazide cap 37.5-25 mg</i>	1	
<i>triamterene & hydrochlorothiazide tab 37.5-25 mg</i>	1	
<i>triamterene & hydrochlorothiazide tab 75-50 mg</i>	1	
LOOP DIURETICS		
<i>bumetanide tab 0.5 mg</i>	1	
<i>bumetanide tab 1 mg</i>	1	
<i>bumetanide tab 2 mg</i>	1	
BUMEX TAB 0.5MG	3	
EDECRIN TAB 25MG	3	
<i>ethacrynic acid tab 25 mg</i>	1	
<i>furosemide oral soln 8 mg/ml</i>	1	
<i>furosemide oral soln 10 mg/ml</i>	1	
<i>furosemide tab 20 mg</i>	1	
<i>furosemide tab 40 mg</i>	1	
<i>furosemide tab 80 mg</i>	1	
LASIX TAB 20MG	3	
LASIX TAB 40MG	3	
LASIX TAB 80MG	3	
<i>toremide tab 5 mg</i>	1	
<i>toremide tab 10 mg</i>	1	
<i>toremide tab 20 mg</i>	1	
<i>toremide tab 100 mg</i>	1	
POTASSIUM SPARING DIURETICS		
ALDACTONE TAB 25MG	2	
ALDACTONE TAB 50MG	2	
ALDACTONE TAB 100MG	2	
<i>amiloride hcl tab 5 mg</i>	1	
CAROSPIR SUS 25MG/5ML	3	PA; 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
<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	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB 1MG	3	PA, QL (240 TABLETS PER 30 DAYS); MNPA
ISTURISA TAB 5MG	3	PA, QL (360 TABLETS PER 30 DAYS); MNPA
ISTURISA TAB 10MG	3	PA, QL (180 TABLETS PER 30 DAYS); MNPA
BONE DENSITY REGULATORS		
ACTONEL TAB 35MG	3	
ACTONEL TAB 150MG	3	
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	
<i>alendronate sodium tab 5 mg</i>	1	
<i>alendronate sodium tab 10 mg</i>	1	
<i>alendronate sodium tab 35 mg</i>	1	

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

213

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	4	PA, QL (1 PENS FOR 28 DAYS)
FOSAMAX + D TAB 70-2800	3	
FOSAMAX + D TAB 70-5600	3	
FOSAMAX TAB 70MG	3	
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	
MIACALCIN INJ 200/ML	4	PA; MNPA
NATPARA INJ 25MCG	4	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	4	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 75MCG	4	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 100MCG	4	PA, QL (2 CARTRIDGES PER 28 DAYS)
<i>risedronate sodium tab 5 mg</i>	1	
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	
<i>risedronate sodium tab 150 mg</i>	1	
<i>risedronate sodium tab delayed release 35 mg</i>	1	
TYMLOS INJ	4	PA, QL (1 PEN PER 30 DAYS)
CORTICOTROPIN		
ACTHAR INJ 80UNIT	4	PA, QL (35ML PER 21 DAYS)
CORTROPHIN GEL 80UNIT	4	PA, QL (35ML PER 21 DAYS)

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

214

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FERTILITY REGULATORS		
<i>clomiphene citrate tab 50 mg</i>	1	Coverage is subject to your plan/benefits
GONAL-F INJ 450UNIT	4	PA, QL (10 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F INJ 1050UNIT	4	PA, QL (6 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 75UNIT	4	PA, QL (60 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 300/0.5	4	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 450/0.75	4	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 900/1.5	4	PA, QL (7 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	4	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	4	PA; Coverage is subject to your plan/benefits
GNRH/LHRH ANTAGONISTS		
CETROTIDE KIT 0.25MG	4	PA
GANIRELIX AC INJ 250/0.5	4	PA
<i>ganirelix acetate soln prefilled syringe 250 mcg/0.5ml</i>	4	PA

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

215

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ORLISSA TAB 150MG	2	PA
ORLISSA TAB 200MG	2	PA
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA SV INJ 2MG	4	PA, QL (30 VIALS PER 30 DAYS)
GROWTH HORMONES		
GENOTROPIN INJ 0.2MG	4	PA
GENOTROPIN INJ 0.4MG	4	PA
GENOTROPIN INJ 0.6MG	4	PA
GENOTROPIN INJ 0.8MG	4	PA
GENOTROPIN INJ 1.2MG	4	PA
GENOTROPIN INJ 1.4MG	4	PA
GENOTROPIN INJ 1.6MG	4	PA
GENOTROPIN INJ 1.8MG	4	PA
GENOTROPIN INJ 1MG	4	PA
GENOTROPIN INJ 2MG	4	PA
GENOTROPIN INJ 5MG	4	PA
GENOTROPIN INJ 12MG	4	PA
NORDITROPIN INJ 5/1.5ML	4	PA
NORDITROPIN INJ 10/1.5ML	4	PA
NORDITROPIN INJ 15/1.5ML	4	PA
NORDITROPIN INJ 30/3ML	4	PA
SEROSTIM INJ 4MG	4	PA
SEROSTIM INJ 5MG	4	PA
SEROSTIM INJ 6MG	4	PA
SOGROYA INJ 5MG/1.5	4	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 10MG/1.5	4	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 15MG/1.5	4	PA, QL (4 PENS PER 28 DAYS)
ZORBTIVE INJ 8.8MG	4	PA
HORMONE RECEPTOR MODULATORS		
EVISTA TAB 60MG	0	
OSPHENA TAB 60MG	3	PA; MNPA

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

216

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>raloxifene hcl tab 60 mg</i>	0	
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ 40MG/4ML	4	PA
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL SOL 2MG/ML	3	
METABOLIC MODIFIERS		
<i>calcitriol cap 0.5 mcg</i>	1	
<i>calcitriol cap 0.25 mcg</i>	1	
<i>calcitriol oral soln 1 mcg/ml</i>	1	
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)
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	
MYALEPT INJ 11.3MG	4	PA, QL (30 VIALS PER 30 DAYS)
<i>nitisinone cap 2 mg</i>	1	PA
<i>nitisinone cap 5 mg</i>	1	PA

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

217

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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
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
<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)
REVCovi INJ 1.6MG/ML	4	
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	4	PA
STRENSIQ INJ 28/0.7ML	4	PA

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

218

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
STRENSIQ INJ 40MG/ML	4	PA
STRENSIQ INJ 80/0.8ML	4	PA
XURIDEN POW 2GM	3	QL (4 PACKETS PER DAY)
ZEMPLAR CAP 1MCG	2	
ZEMPLAR CAP 2MCG	2	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG	2	PA
KERENDIA TAB 20MG	2	PA
NATRIURETIC PEPTIDES		
VOXZOGO INJ 0.4MG	4	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 0.56MG	4	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 1.2MG	4	PA, QL (30 VIALS PER 30 DAYS)
POSTERIOR PITUITARY HORMONES		
DDAVP SOL 0.01%	3	
DDAVP TAB 0.1MG	3	
DDAVP TAB 0.2MG	3	
<i>desmopressin acetate nasal spray soln 0.01%</i>	1	
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	1	
<i>desmopressin acetate tab 0.1 mg</i>	1	
<i>desmopressin acetate tab 0.2 mg</i>	1	
NOCDURNA SUB 27.7MCG	3	
NOCDURNA SUB 55.3MCG	3	
STIMATE SOL 1.5MG/ML	3	PA
PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX TAB 200MG	3	
<i>mifepristone tab 200 mg</i>	1	\$0 copay based on your plan/benefit
PROLACTIN INHIBITORS		
<i>cabergoline tab 0.5 mg</i>	1	

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

219

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SOMATOSTATIC AGENTS		
MYCAPSSA CAP 20MG	3	PA, QL (112 caps every 28 days); MNPA
<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml)</i>	4	PA, QL (90 vials every 30 days)
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml)</i>	4	PA, QL (90 VIALS PER 30 DAYS)
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	4	PA, QL (45 VIALS (45,000 UNITS) PER 30 DAYS)
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml)</i>	4	PA, QL (90 AMPULES PER 30 DAYS)
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	4	PA, QL (9 VIALS (45,000) PER 30 DAYS)
SANDOSTATIN INJ 50MCG/ML	4	PA, QL (90 ampules every 30 days)
SANDOSTATIN INJ 100MCG	4	PA, QL (90 VIALS PER 30 DAYS)
SANDOSTATIN INJ 500MCG	4	PA, QL (90 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.3MG/ML	4	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.6MG/ML	4	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.9MG/ML	4	PA, QL (60 AMPULES PER 30 DAYS)
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK 15MG	3	PA, QL (56 TABLETS PER 28 DAYS); MNPA
JYNARQUE PAK 30-15MG	3	PA, QL (56 TABLETS PER 28 DAYS); MNPA
JYNARQUE PAK 45-15MG	3	PA, QL (56 TABLETS PER 28 DAYS); MNPA
JYNARQUE PAK 60-30MG	3	PA, QL (56 TABLETS PER 28 DAYS); MNPA
JYNARQUE PAK 90-30MG	3	PA, QL (56 TABLETS PER 28 DAYS); MNPA

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

220

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
JYNARQUE TAB 15MG	3	PA, QL (60 TABLETS PER 30 DAYS); MNPA
JYNARQUE TAB 30MG	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
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	
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	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	
FEMHRT TAB 0.5-2.5	3	
MYFEMBREE TAB	3	PA
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	
ORIAHNN CAP	2	PA
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	

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

221

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ESTROGENS		
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	MNPA
CLIMARA DIS 0.025MG	3	MNPA
CLIMARA DIS 0.075MG	3	MNPA
CLIMARA DIS 0.0375MG	3	MNPA
DELESTROGEN INJ 10MG/ML	4	PA
DELESTROGEN INJ 20MG/ML	4	PA
DELESTROGEN INJ 40MG/ML	4	PA
DEPO-ESTRADI INJ 5MG/ML	4	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	

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

222

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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>	4	PA
<i>estradiol valerate im in oil 40 mg/ml</i>	4	PA
ESTROGEL GEL	3	
EVAMIST SPR 1.53MG	2	
MENEST TAB 0.3MG	3	PA; MNPA
MENEST TAB 0.625MG	3	PA; MNPA
MENEST TAB 1.25MG	3	PA; MNPA
MENOSTAR DIS 14MCG	3	
MINIVELLE DIS 0.1MG	3	PA; MNPA
MINIVELLE DIS 0.05MG	3	PA; MNPA
MINIVELLE DIS 0.025MG	3	PA; MNPA
MINIVELLE DIS 0.075MG	3	PA; MNPA
MINIVELLE DIS 0.0375MG	3	PA; MNPA
PREMARIN INJ 25MG	4	PA
PREMARIN TAB 0.3MG	3	PA; MNPA
PREMARIN TAB 0.9MG	3	PA; MNPA
PREMARIN TAB 0.45MG	3	PA; MNPA
PREMARIN TAB 0.625MG	3	PA; MNPA
PREMARIN TAB 1.25MG	3	PA; MNPA
VIVELLE-DOT DIS 0.1MG	3	PA; MNPA
VIVELLE-DOT DIS 0.05MG	3	PA; MNPA
VIVELLE-DOT DIS 0.025MG	3	PA; MNPA
VIVELLE-DOT DIS 0.075MG	3	PA; MNPA
VIVELLE-DOT DIS 0.0375MG	3	PA; MNPA

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

223

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FLUOROQUINOLONES		
FLUOROQUINOLONES		
BAXDELA TAB 450MG	3	
CIPRO (5%) SUS 250MG/5	3	
CIPRO (10%) SUS 500MG/5	3	
CIPRO TAB 250MG	3	
CIPRO TAB 500MG	3	
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	1	
<i>levofloxacin oral soln 25 mg/ml</i>	1	
<i>levofloxacin tab 250 mg</i>	1	
<i>levofloxacin tab 500 mg</i>	1	
<i>levofloxacin tab 750 mg</i>	1	
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1	
<i>ofloxacin tab 300 mg</i>	1	
<i>ofloxacin tab 400 mg</i>	1	
GASTROINTESTINAL AGENTS - MISC.		
5-HT₄ RECEPTOR AGONISTS		
MOTEGRITY TAB 1MG	3	PA; MNPA
MOTEGRITY TAB 2MG	3	PA; MNPA
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB 3MG	3	
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP 50MG	3	PA
CHOLBAM CAP 250MG	3	PA
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OCALIVA TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
GALLSTONE SOLUBILIZING AGENTS		
CHENODAL TAB 250MG	3	PA

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

224

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
GASTROINTESTINAL ANTIALLERGY AGENTS		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	
GASTROCROM CON 100/5ML	3	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
AMITIZA CAP 8MCG	3	PA; MNPA
AMITIZA CAP 24MCG	3	PA; MNPA
<i>lubiprostone cap 8 mcg</i>	1	
<i>lubiprostone cap 24 mcg</i>	1	
GASTROINTESTINAL STIMULANTS		
GIMOTI SPR 15MG	3	PA; MNPA
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	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 200MCG	3	PA, QL (360 caps per 30 days); MNPA
BYLVAY CAP 400MCG	3	PA, QL (540 caps per 30 days); MNPA
BYLVAY CAP 600MCG	3	PA, QL (120 caps per 30 days); MNPA
BYLVAY CAP 1200MCG	3	PA, QL (180 caps per 30 days); MNPA

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

225

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
INFLAMMATORY BOWEL AGENTS		
APRISO CAP 0.375GM	3	
ASACOL HD TAB 800MG	1	PA; MNPA
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
<i>balsalazide disodium cap 750 mg</i>	1	
CANASA SUP 1000MG	3	
CIMZIA KIT 200MG	4	PA, QL (2 KITS PER 28 DAYS); MNPA; LOADING DOSE:3 KITS (6 VIALS) PER 28 DAYS
CIMZIA PREFL KIT 200MG/ML	4	PA, QL (2 KITS PER 28 DAYS); MNPA
CIMZIA START KIT 200MG/ML	4	PA, QL (1 KIT PER 28 DAYS); MNPA
COLAZAL CAP 750MG	3	PA; MNPA
DELZICOL CAP 400MG	3	PA; MNPA
DIPENTUM CAP 250MG	3	
LIALDA TAB 1.2GM	3	PA; 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	
<i>mesalamine rectal enema 4 gm & cleanser wipe kit</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	
<i>mesalamine tab delayed release 800 mg</i>	1	
PENTASA CAP 250MG CR	2	PA; MNPA
PENTASA CAP 500MG CR	2	MNPA
ROWASA KIT 4GM	3	
SFROWASA ENE 4GM	3	

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

226

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
INTESTINAL ACIDIFIERS		
<i>lactulose (encephalopathy) solution 10 gm/15ml</i>	1	
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
<i>alosetron hcl tab 0.5 mg (base equiv)</i>	1	
<i>alosetron hcl tab 1 mg (base equiv)</i>	1	
LINZESS CAP 72MCG	2	
LINZESS CAP 145MCG	2	
LINZESS CAP 290MCG	2	
LOTRONEX TAB 0.5MG	3	
LOTRONEX TAB 1MG	3	
VIBERZI TAB 75MG	2	
VIBERZI TAB 100MG	2	
ZELNORM TAB 6MG	3	PA; MNPA
LIVE FECAL MICROBIOTA		
VOWST CAP	3	PA, QL (12 CAPSULES PER 30 DAYS)

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

227

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
<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	4	PA
RELISTOR INJ 12/0.6ML	4	PA
RELISTOR TAB 150MG	3	PA
SYMPROIC TAB 0.2MG	2	PA
PHOSPHATE BINDER AGENTS		
AURYXIA TAB 210MG	2	
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	
FOSRENOL CHW 500MG	3	PA; MNPA
FOSRENOL CHW 750MG	3	PA; MNPA
FOSRENOL CHW 1000MG	3	PA; MNPA
FOSRENOL POW 750MG	3	PA; MNPA
FOSRENOL POW 1000MG	3	PA; 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	
RENVELA POW 0.8GM	3	MNPA
RENVELA POW 2.4GM	3	MNPA
RENVELA TAB 800MG	3	MNPA
<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	

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

228

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT 5MG	4	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB 250MG	3	PA, QL (90 TABLETS PER 30 DAYS)
GENITOURINARY AGENTS - MISCELLANEOUS		
ACIDIFIERS		
K-PHOS TAB NO 2	3	
ALKALINIZERS		
ORACIT SOL	3	
<i>pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	1	
<i>potassium citrate & citric acid powder pack 3300-1002 mg</i>	1	
<i>potassium citrate & citric acid soln 1100-334 mg/5ml</i>	1	
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
<i>sodium citrate & citric acid soln 500-334 mg/5ml</i>	1	
UROCIT-K 5 TAB	2	
UROCIT-K 10 TAB	2	
UROCIT-K 15 TAB	2	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG	2	PA
CYSTAGON CAP 150MG	2	PA
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP 100MG	3	PA; MNPA
PENTOSAN CAP 150MG	3	PA; MNPA
PENTOSAN CAP 200MG	3	PA; MNPA
PROSTATIC HYPERTROPHY AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	
AVODART CAP 0.5MG	3	
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		229

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
PROSCAR TAB 5MG	3	
RAPAFLO CAP 4MG	3	PA; MNPA
RAPAFLO CAP 8MG	3	PA; 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
URINARY ANALGESICS		
<i>phenazopyridine hcl tab 200 mg</i>	1	
URINARY STONE AGENTS		
LITHOSTAT TAB 250MG	3	PA; MNPA
THIOLA EC TAB 100MG	3	PA; MNPA
THIOLA EC TAB 300MG	3	PA; MNPA
<i>tiopronin tab 100 mg</i>	1	PA
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	
GOUT AGENTS		
<i>allopurinol tab 100 mg</i>	1	
<i>allopurinol tab 300 mg</i>	1	
<i>colchicine tab 0.6 mg</i>	1	QL (120 tabs per 30 days)
COLCRYS TAB 0.6MG	3	PA, 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	PA, QL (300 mL per 30 days); MNPA

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

230

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MITIGARE CAP 0.6MG	1	QL (60 caps per 30 days); Tier 1 with DAW9
ULORIC TAB 40MG	3	PA; MNPA
ULORIC TAB 80MG	3	PA; MNPA
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
URICOSURICS		
<i>probenecid tab 500 mg</i>	1	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ 30MG/ML	4	PA
HEMLIBRA INJ 60/0.4	4	PA
HEMLIBRA INJ 105/0.7	4	PA
HEMLIBRA INJ 150/ML	4	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR INJ 30MG/3ML	4	PA, QL (45 syringes every 90 days); MNPA
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	4	PA, QL (45 syringes every 90 days)
COMPLEMENT INHIBITORS		
HAEGARDA INJ 2000UNIT	4	PA, QL (20 VIALS PER 30 DAYS); MNPA
HAEGARDA INJ 3000UNIT	4	PA, QL (20 VIALS PER 30 DAYS); MNPA
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB 100MG	2	PA, QL (60 TABLETS PER 30 DAYS)
TAVALISSE TAB 150MG	2	PA, QL (60 TABLETS PER 30 DAYS)
HEMATORHEOLOGIC AGENTS		
<i>pentoxifylline tab er 400 mg</i>	1	
PLASMA KALLIKREIN INHIBITORS		
KALBITOR INJ 10MG/ML	4	PA, QL (30 CARTONS (900 MG) PER 90 DAYS)

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

231

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ORLADEYO CAP 110MG	2	QL (28 CAPSULES PER 28 DAYS)
ORLADEYO CAP 150MG	2	QL (28 CAPSULES PER 28 DAYS)
TAKHZYRO INJ 150MG/ML	4	PA, QL (2 SYRINGES PER 28 DAYS)
TAKHZYRO INJ 300/2ML	4	PA, QL (2 VIALS PER 28 DAYS)

PLATELET AGGREGATION INHIBITORS

AGRYLIN CAP 0.5MG	2	
<i>anagrelide hcl cap 0.5 mg</i>	1	
<i>anagrelide hcl cap 1 mg</i>	1	
ASA/OMEPRAZO TAB 81-40MG	3	PA; MNPA
ASP/OMEPRAZO TAB 325-40MG	3	PA; MNPA
<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	PA; MNPA
EFFIENT TAB 5MG	3	
EFFIENT TAB 10MG	3	
PLAVIX TAB 75MG	3	PA; 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	PA; MNPA
YOSPRALA TAB 325-40MG	3	PA; MNPA
ZONTIVITY TAB 2.08MG	3	PA; MNPA

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

232

Note: The coverage of prescription drugs and supplies along with the utilization management listed on this document is dependent on your benefit plan and is subject to change. For the most accurate information on your drug cost and pricing, please log in to My Account (www.carefirst.com/myaccount) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
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)
ZAVESCA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS)
AGENTS FOR SICKLE CELL DISEASE		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	
ENDARI POW 5GM	2	PA, QL (180 PACKETS PER 30 DAYS)
SIKLOS TAB 100MG	2	
SIKLOS TAB 1000MG	2	
COBALAMINS		
CYANOCOBALAM SOL 2000MCG	4	PA; MNPA
<i>cyanocobalamin inj 1000 mcg/ml</i>	4	PA
NASCOBAL SPR 500MCG	3	
FOLIC ACID/FOLATES		
<i>folic acid cap 0.8 mg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 1 mg</i>	1	
<i>folic acid tab 400 mcg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 800 mcg</i>	0	\$0 copay for women younger than 55
HEMATOPOIETIC GROWTH FACTORS		
ARANESP INJ 10MCG	4	PA
ARANESP INJ 25MCG	4	PA
ARANESP INJ 40MCG	4	PA
ARANESP INJ 60MCG	4	PA
ARANESP INJ 100MCG	4	PA
ARANESP INJ 150MCG	4	PA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ARANESP INJ 200MCG	4	PA
ARANESP INJ 300MCG	4	PA
ARANESP INJ 500MCG	4	PA
DOPTELET TAB 20MG	2	PA, QL (60 tabs every 30 days)
DOPTELET TAB 20MG	2	PA, QL (90 tabs every 30 days)
FYLNETRA INJ 6MG/0.6	4	PA, QL (2 SYRINGES PER 28 DAYS)
LEUKINE INJ 250MCG	4	PA; MNPA
MULPLETA TAB 3MG	3	PA, QL (7 TABLETS PER 14 DAYS)
NIVESTYM INJ 300/0.5	4	PA
NIVESTYM INJ 300MCG	4	PA
NIVESTYM INJ 480/0.8	4	PA
NIVESTYM INJ 480MCG	4	PA
NYVEPRIA INJ 6/0.6ML	4	PA, QL (2 SYRINGES PER 30 DAYS)
PROCRIT INJ 2000/ML	4	PA
PROCRIT INJ 3000/ML	4	PA
PROCRIT INJ 4000/ML	4	PA
PROCRIT INJ 10000/ML	4	PA
PROCRIT INJ 20000/ML	4	PA
PROCRIT INJ 40000/ML	4	PA
PROMACTA PAK 25MG	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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RETACRIT INJ 2000UNIT	4	PA
RETACRIT INJ 3000UNIT	4	PA
RETACRIT INJ 4000UNIT	4	PA
RETACRIT INJ 10000UNT	4	PA
RETACRIT INJ 20000UNI	4	PA
RETACRIT INJ 40000UNT	4	PA
ZIEXTENZO INJ 6/0.6ML	4	PA, QL (2 SYRINGES PER 28 DAYS); MNPA

HEMATOPOIETIC MIXTURES

FERIVA TAB 21/7	3	PA; MNPA
<i>folic acid-cholecalciferol tab 1 mg-3775 unit</i>	1	PA; MNPA
FOLIC D3 CAP	3	PA; MNPA
GENICIN TAB VITA-D	3	PA; MNPA
ORTHO DF CAP 1-3775IU	3	PA; MNPA
TALIVA CAP	3	PA; MNPA

HEMOSTATICS**HEMOSTATICS - SYSTEMIC**

AMICAR SOL 0.25/ML	3	PA; MNPA
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	

HEMOSTATICS - TOPICAL

ARTISS SOL 2ML	3	
ARTISS SOL 4ML	3	
ARTISS SOL 10ML	3	
TACHOSIL PAD 4.8X4.8	3	
TACHOSIL PAD 9.5X4.8	3	
TISSEEL KIT 2ML	3	
TISSEEL KIT 4ML	3	
TISSEEL KIT 10ML	3	
TISSEEL SOL 2ML	3	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TISSEEL SOL 4ML	3	
TISSEEL SOL 10ML	3	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
<i>phenobarbital elixir 20 mg/5ml</i>	1	
<i>phenobarbital tab 15 mg</i>	1	
<i>phenobarbital tab 16.2 mg</i>	1	
<i>phenobarbital tab 30 mg</i>	1	
<i>phenobarbital tab 32.4 mg</i>	1	
<i>phenobarbital tab 60 mg</i>	1	
<i>phenobarbital tab 64.8 mg</i>	1	
<i>phenobarbital tab 97.2 mg</i>	1	
<i>phenobarbital tab 100 mg</i>	1	
HYPNOTICS - TRICYCLIC AGENTS		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
SILENOR TAB 3MG	3	PA; MNPA
SILENOR TAB 6MG	3	PA; MNPA
NON-BARBITURATE HYPNOTICS		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	
EDLUAR SUB 5MG	3	PA; MNPA
EDLUAR SUB 10MG	3	PA; 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	
LUNESTA TAB 1MG	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LUNESTA TAB 2MG	3	PA; MNPA
LUNESTA TAB 3MG	3	PA; MNPA
<i>quazepam tab 15 mg</i>	1	PA; MNPA
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	
RESTORIL CAP 22.5MG	3	
RESTORIL CAP 30MG	3	
<i>temazepam cap 7.5 mg</i>	1	
<i>temazepam cap 15 mg</i>	1	
<i>temazepam cap 22.5 mg</i>	1	
<i>temazepam cap 30 mg</i>	1	
<i>triazolam tab 0.25 mg</i>	1	
<i>triazolam tab 0.125 mg</i>	1	
<i>zaleplon cap 5 mg</i>	1	
<i>zaleplon cap 10 mg</i>	1	
<i>zolpidem tartrate 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
OREXIN RECEPTOR ANTAGONISTS		
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	
SELECTIVE MELATONIN RECEPTOR AGONISTS		
HETLIOZ CAP 20MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	3	PA, QL (5 ML PER DAY)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>ramelteon tab 8 mg</i>	1	
ROZEREM TAB 8MG	3	PA; MNPA
<i>tasimelteon capsule 20 mg</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)

LAXATIVES**LAXATIVE COMBINATIONS**

<i>bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit</i>	0	\$0 copay for members age 45 through 75
CLENPIQ SOL	0	\$0 copay for members age 45 through 75
GOLYTELY SOL	3	PA; MNPA
MOVIPREP SOL	3	PA; 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	PA; MNPA; \$0 copay for members age 45 through 75
<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	PA; MNPA; \$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	3	PA; MNPA; \$0 copay for members age 45 through 75
SUTAB TAB	0	PA; MNPA; \$0 copay for members age 45 through 75

LAXATIVES - MISCELLANEOUS

KRISTALOSE PAK 10GM	3	
---------------------	---	--

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
KRISTALOSE PAK 20GM	3	
LACTULOSE PAK 10GM	3	PA; MNPA
<i>lactulose solution 10 gm/15ml</i>	1	
SALINE LAXATIVES		
OSMOPREP TAB 1.5GM	3	PA; MNPA
STIMULANT LAXATIVES		
CASCARA EXT SAGRADA	3	
MACROLIDES		
AZITHROMYCIN		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin powd pack for susp 1 gm</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
ZITHROMAX POW 1GM PAK	3	
ZITHROMAX SUS 100/5ML	3	
ZITHROMAX SUS 200/5ML	3	
ZITHROMAX TAB 250MG	3	
ZITHROMAX TAB 500MG	3	
ZITHROMAX TAB TRI-PAK	3	
ZITHROMAX TAB Z-PAK	3	
CLARITHROMYCIN		
<i>clarithromycin for susp 125 mg/5ml</i>	1	
<i>clarithromycin for susp 250 mg/5ml</i>	1	
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
ERYTHROMYCINS		
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
erythromycin ethylsuccinate for susp 400 mg/5ml	1	
erythromycin ethylsuccinate tab 400 mg	1	
erythromycin stearate tab 250 mg	1	
erythromycin tab 250 mg	1	
erythromycin tab 500 mg	1	
erythromycin tab delayed release 250 mg	1	
erythromycin tab delayed release 333 mg	1	
erythromycin tab delayed release 500 mg	1	
erythromycin w/ delayed release particles cap 250 mg	1	
FIDAXOMICIN		
DIFICID SUS	2	
DIFICID TAB 200MG	2	
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 boxes every 25 days)
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)
DIABETIC SUPPLIES		
ACCU-CHEK KIT FASTCLIX	0	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ACCU-CHEK KIT SOFTCLIX	0	
ACCU-CHEK LIQ GUIDE	0	
ACCU-CHEK LIQ SMART	0	
ACCU-CHEK MIS MLTICLIX	0	
ACCU-CHEK SOL	0	
ACCU-CHEK SOL COMPACT	0	
ACCUTREND SOL GLUCOSE	0	
ACTI-LANCE MIS 28G	0	
ACTI-LANCE MIS LITE 28G	0	
ACTI-LANCE MIS SPEC 17G	0	
ACTI-LANCE MIS UNIV 23G	0	
ADJ LANCING MIS DEVICE	0	
ADV LANCING MIS DEVICE	0	
ADV TRAVEL MIS LANC 28G	0	
ADVANCE LIQ CONTROL	0	
ADVANCE LIQ INTUITIO	0	
ADVANCE NORM LIQ CONTROL	0	
ADVCATE SAFE MIS LANC 26G	0	
ADVOCATE LIQ HIGH	0	
ADVOCATE LIQ LOW	0	
ADVOCATE MIS LANC 30G	0	
ADVOCATE MIS LANC DEV	0	
ADVOCATE MIS LANCETS	0	
ADVOCATE+ SOL REDI-COD	0	
AGAMATRIX MIS 33G	0	
AGAMATRIX SOL HIGH	0	
AGAMATRIX SOL LEVEL 2	0	
AGAMATRIX SOL LEVEL 4	0	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BD LANCET UF MIS 30G	0	
BD LANCET UF MIS 33G	0	
BD MICROTAIN MIS LANCETS	0	
CARDIOCOM MIS LANCING	0	
CAREONE ADV MIS LANCING	0	
CAREONE LANC MIS 30G	0	
CAREONE LANC MIS THIN 23G	0	
CARESENS 30G MIS LANCETS	0	
CARESENS SOL CONTROL	0	
CARETOUCH MIS EJECTOR	0	
CARETOUCH MIS LANC 26G	0	
CARETOUCH MIS LANC 28G	0	
CARETOUCH MIS LANC 30G	0	
CARETOUCH MIS TWIST 28	0	
CARETOUCH MIS TWIST 30	0	
CARETOUCH MIS TWIST 33	0	
CLEANLET 28G MIS LANCETS	0	
CLEVER CHECK MIS	0	
CLEVER CHECK MIS 30G	0	
CLEVR CHOICE LIQ HIGH	0	
CLEVR CHOICE LIQ LOW	0	
COAGUCHEK MIS LANCETS	0	
COMFORT ASSU MIS LANC 28G	0	
COMFORT ASSU MIS LANC 33G	0	
COMFORT EZ MIS 21G	0	
COMFORT EZ MIS 23G	0	
COMFORT EZ MIS 28G	0	
COMFORT MIS LANCETS	0	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CONTOUR NORM LIQ CONTROL	0	
CONTROL HIGH SOL UNISTRIP	0	
CONTROL LOW SOL UNISTRIP	0	
CONTROL NORM SOL EASY STP	0	
CONTROL SOL LIQ HI/MID/L	0	
CONTROL SOL LIQ HIGH/LOW	0	
CONTROL SOL LIQ LEVEL 2	0	
CONTROL SOL LIQ MID	0	
CONTROL SOL NORMAL	0	
COOL CONTROL SOL A	0	
COOL CONTROL SOL B	0	
CVS LANCETS MIS 21G	0	
CVS LANCETS MIS 30G	0	
CVS LANCETS MIS 33G	0	
CVS LANCETS MIS ORIGINAL	0	
CVS LANCETS MIS THIN 26G	0	
CVS LANCETS MIS THIN 30G	0	
CVS LANCETS MIS THIN 33G	0	
CVS LANCING MIS DEVICE	0	
DEXCOM 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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
ELEMENT LIQ HIGH	0	
ELEMENT LIQ LOW	0	
ELEMNT COMPA SOL LEVEL 2	0	
ELEMNT COMPA SOL LEVEL 3	0	
EMBRACE CNTR LIQ HIGH	0	
EMBRACE EVO LIQ LEVEL 1	0	
EMBRACE LANC MIS /EJECTOR	0	
EMBRACE LANC MIS THIN 30G	0	
EMBRACE PRO LIQ GLUCOSE	0	
EMBRACE SOL LOW	0	
EMBRACE TALK SOL HIGH/L2	0	
EMBRACE TALK SOL LOW/L1	0	
EQL LANCETS MIS 21G COLR	0	
EQL LANCETS MIS 33G COLR	0	
EQL LANCETS MIS THIN 26G	0	
EQL LANCETS MIS THIN 30G	0	
EVENCAR MINI SOL NORMAL	0	
EVENCARE G2 SOL LOW/HIGH	0	
EVENCARE G3 SOL LOW/HIGH	0	
EVENCARE SOL LIQ LOW/HIGH	0	
EVOLUTION SOL NORMAL	0	
EZ-LETS 21G MIS LANCETS	0	
EZ-LETS 26G MIS LANCETS	0	
EZ-LETS 28G MIS LANCETS	0	
EZ-LETS 30G MIS LANCETS	0	
FASTCLIX MIS LANCETS	0	
FIFTY50 SAFE MIS LANCETS	0	
FINE 30 MIS	0	
FINGERSTIX MIS LANCETS	0	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
FORA CONTROL SOL HIGH	0	
FORA CONTROL SOL LOW	0	
FORA CONTROL SOL NORMAL	0	
FORA LANCETS MIS 30G	0	
FORA MIS LANCETS	0	
FORA MIS LANCING	0	
FORACARE GDH SOL HIGH	0	
FORACARE GDH SOL LOW	0	
FORACARE GDH SOL NORMAL	0	
FORTISCARE SOL CNTL HI	0	
FORTISCARE SOL CNTL LOW	0	
FORTISCARE SOL CNTL NML	0	
FREESTY LIBR KIT 2 SENSOR	0	QL (2 sensors per month); MNPA
FREESTY LIBR MIS 2 READER	0	PA, QL (1 each every year); MNPA; FREESTYLE LIBRE
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS READER	0	PA, QL (1 each every year); MNPA; 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 sensors per month)
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
GENTEEL PLUS MIS PURPLE	0	
GENTEEL PLUS MIS WHITE	0	
GENTEEL TIPS MIS BLUE	0	
GENTEEL TIPS MIS CLEAR	0	
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LANCET CARRY MIS CASE	0	
LANCET DEVIC MIS 30G	0	
LANCET DEVIC MIS ADJUST	0	
LANCET MICRO MIS THIN 33G	0	
LANCET STAND MIS 21G	0	
LANCET SUPER MIS THIN 30G	0	
LANCET ULTRA MIS 28G	0	
LANCET ULTRA MIS THIN 30G	0	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LITETOUCH MIS LANCETS	0	
LONGS LANCET MIS STANDARD	0	
LONGS LANCET MIS THIN	0	
LONGS LANCET MIS ULTRA TH	0	
MEDICHOICE MIS LANCET	0	
MEDISENSE LIQ GLUC-KET	0	
MEDISENSE LIQ GLUC/KET	0	
MEDLANCE MIS 30G PLUS	0	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MPD SFTY LAN MIS 28G	0	
MPD SFTY LAN MIS 30G	0	
MULTI-LANCET KIT DEVICE	0	
MULTI-LANCET MIS DEVICE	0	
MYGLUCOHEALT MIS LANC 30G	0	
MYGLUCOHEALT SOL LO/NL/HI	0	
NEUTEK 2TEK SOL CONTROL	0	
NOVA MAX GLU LIQ /KET CON	0	
NOVA SAFETY MIS LANC 23G	0	
NOVA SAFETY MIS LANC 28G	0	
NOVA SURE MIS LANCETS	0	
NOVA SUREFLX MIS LANC DEV	0	
OMNIPOD 5 G6 KIT INTRO	0	PA, QL (1 kit per 999 days)
OMNIPOD 5 G6 MIS PODS	0	PA, QL (10 pods per month)
OMNIPOD MIS CLASSIC	0	PA, QL (10 pods per month)
OMNIPOD PDM KIT CLASSIC	0	PA, QL (1 kit per 999 days)
ON-THE-GO MIS LANC 30G	0	
ONETOUCH DEL MIS LANC DEV	0	
ONETOUCH DEL MIS PLUS 30G	0	
ONETOUCH DEL MIS PLUS 33G	0	
ONETOUCH FP MIS LANCETS	0	
ONETOUCH 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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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 LANCETS	0	
PRODIGY MIS 26G	0	
PRODIGY MIS 28G	0	
PRODIGY MIS LANC DEV	0	
PRODIGY SOL HIGH	0	
PRODIGY SOL LOW	0	
PSS SAFE LAN MIS	0	
PSS SEL LANC MIS	0	
PSS SEL PLAT MIS	0	
PX LANCETS MIS 28G	0	
PX LANCETS MIS ULT THIN	0	
QC LANCETS MIS 28G	0	
QC LANCETS MIS 30G	0	
QC LANCING MIS DEVICE	0	
QUICKTEK LIQ SOLUTION	0	
QUINTET CONT SOL HGH/NORM	0	
RA E-ZJECT MIS 28G	0	
RA E-ZJECT MIS THIN 26G	0	
RA E-ZJECT MIS THIN 28G	0	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
UNIVERSAL 1 MIS LANC 30G	0	
V-GO 20 KIT	0	PA, QL (30 pumps per month)
V-GO 30 KIT	0	QL (30 pumps per month)
V-GO 40 KIT	0	QL (30 pumps per month)
VANTAGE LANC MIS DEVICE	0	
VERASENS LIQ LEVEL 1	0	
VIVAGUARD LIQ CONTROL	0	
VIVAGUARD MIS 28G	0	
VIVAGUARD MIS 30G	0	
VIVAGUARD MIS LANCING	0	
MISC. DEVICES		
ALCOH-GLOVE PAD CONTOURE	0	
ALCOHOL PAD	0	
ALCOHOL PAD 70%	0	
ALCOHOL PAD PREP	0	
ALCOHOL PAD SWABSTIC	0	
ALCOHOL PREP PAD	0	
ALCOHOL PREP PAD 70%	0	
ALCOHOL PREP PAD MED 70%	0	
ALCOHOL PREP PAD PADS 70%	0	
ALCOHOL SWAB PAD	0	
ALCOHOL SWAB PAD 70%	0	
ALCOHOL SWAB PAD EX-THICK	0	
ALCOHOL WIPE PAD	0	
APLICARE ALC PAD SWABSTIC	0	
BD SWAB BFLY PAD SNGL USE	0	
CARETOUCH PAD ALCOHOL	0	
CURITY PREP PAD ALCOHOL	0	
CURITY SWABS PAD ALCOHOL	0	
EASY COMFORT PAD ALCOHOL	0	
FIFTY50 PREP PAD PADS	0	
GLOBAL PREP PAD PADS	0	
GNP ALCOHOL PAD SWABS	0	
HM STERILE PAD ALCHOL	0	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
PARENTERAL THERAPY SUPPLIES		
BD U-500 MIS 31GX6MM	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	PA; MNPA
BD ULTRAFINE PEN NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
CEQR SIMPL KIT PATCH 2U	0	
COMFORT EZ MIS 31GX5/16	0	PA; MNPA
HM INSULIN S MIS 0.3/31G	0	PA; MNPA
HM INSULIN S MIS 1ML/30G	0	PA; MNPA
INPEN 100EL MIS BLUE-HUM	0	
INSULIN SRYG MIS 1ML/32G	0	PA; MNPA
SYRINGE MIS 0.5/30G	0	PA; MNPA
1ML SYRINGE MIS 29G	0	PA; MNPA
1ML SYRINGE MIS 30G	0	PA; MNPA
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS FLOW-VU	3	
AERCHMBR PLS MIS LRG MASK	3	
AERCHMBR PLS MIS MED MASK	3	
AERCHMBR PLS MIS SM MASK	3	
AERCHMBR Z- MIS STAT PLS	3	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
INSPIRACHAMB MIS MOUTHPC	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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
RITEFLO MIS	3	
TRUZONE PEAK MIS FLOW MTR	3	

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

AIMOVIG INJ 70MG/ML	4	ST, PA, QL (2 pens every 25 days)
AIMOVIG INJ 140MG/ML	4	ST, PA, QL (1 pen every 25 days)
AJOVY INJ 225/1.5	4	ST, QL (3 auto-injectors every 75 days)
AJOVY INJ 225/1.5	4	ST, QL (3 syringes every 75 days)
EMGALITY INJ 100MG/ML	4	ST, QL (3 syringes every 25 days)
EMGALITY INJ 120MG/ML	4	ST, QL (2 pens every 25 days); Loading Dose: 2 injectors per month; Maintenance Dose: 1 injector per month
EMGALITY INJ 120MG/ML	4	ST, QL (2 syringes every 25 days); Loading Dose: 2 syringes per month; Maintenance Dose: 1 syringe per month
NURTEC TAB 75MG ODT	2	QL (16 tabs every 25 days)
QULIPTA TAB 10MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 30MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 60MG	2	ST, QL (30 tabs every 25 days)
UBRELVY TAB 50MG	2	PA, QL (16 ea every 25 days)
UBRELVY TAB 100MG	2	PA, QL (16 ea every 25 days)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MIGRAINE COMBINATIONS		
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
MIGRAINE PRODUCTS		
<i>dihydroergotamine mesylate nasal spray 4 mg/ml</i>	4	PA, QL (8.01 mL every 30 days); MNPA
ERGOMAR SUB 2MG	3	
MIGRANAL SPR 4MG/ML	4	QL (8.01 mL every 30 days)
TRUDHESA AER 0.725MG	3	
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POW 50MG	3	PA; MNPA
<i>diclofenac potassium (migraine) packet 50 mg</i>	1	MNPA
SEROTONIN AGONISTS		
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 30 days)
AMERGE TAB 1MG	3	QL (12 tabs every 30 days)
AMERGE TAB 2.5MG	3	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
FROVA TAB 2.5MG	3	QL (30 tabs every 30 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
IMITREX INJ 4MG/0.5	4	QL (12 injections every 30 days)
IMITREX INJ 4MG/0.5	4	QL (36 injections every 30 days)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
IMITREX INJ 6MG/0.5	4	QL (12 injections every 30 days)
IMITREX INJ 6MG/0.5	4	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	PA, QL (30 tabs every 30 days); MNPA
MAXALT-MLT TAB 10MG	3	PA, 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)
RELPAK TAB 20MG	3	QL (12 tabs every 30 days)
RELPAK TAB 40MG	3	QL (12 tabs every 30 days)
REYVOW TAB 50MG	3	ST, QL (4 tabs every 30 days)
REYVOW TAB 100MG	3	ST, QL (8 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>sumatriptan nasal spray 5 mg/act</i>	1	QL (30 inhalers every 30 days)
<i>sumatriptan nasal spray 20 mg/act</i>	1	QL (12 inhalers every 30 days)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	4	QL (12 injections every 30 days)
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml</i>	4	QL (12 injections every 30 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml</i>	4	QL (12 injections every 30 days)
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	4	QL (36 injections every 30 days)
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	4	QL (24 injections every 30 days)
<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	4	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	PA, QL (3 ea every 30 days); MNPA
ZEMBRACE SYM INJ 3/0.5ML	4	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)
<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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MINERALS & ELECTROLYTES		
FLUORIDE		
<i>sodium fluoride chew tab 0.5 mg f (from 1.1 mg naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride chew tab 0.25 mg f (from 0.55 mg naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride soln 0.5 mg/ml f (from 1.1 mg/ml naf)</i>	0	
<i>sodium fluoride soln 0.125 mg/drop f (0.275 mg/drop naf)</i>	0	
<i>sodium fluoride soln 0.125 mg/drop f (0.275 mg/drop naf)</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>sodium fluoride tab 0.5 mg f (from 1.1 mg naf)</i>	0	
POTASSIUM		
<i>K-TAB TAB 8MEQ CR</i>	3	
<i>K-TAB TAB 10MEQ CR</i>	2	
<i>K-TAB TAB 20MEQ</i>	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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
CUPRIMINE CAP 250MG	3	PA; MNPA
DEPEN TITRA TAB 250MG	3	
<i>penicillamine cap 250 mg</i>	1	
<i>penicillamine tab 250 mg</i>	1	
SYPRINE CAP 250MG	3	PA; MNPA
<i>trientine hcl cap 250 mg</i>	1	
IMMUNOMODULATORS		
<i>lenalidomide cap 5 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 10 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 15 mg</i>	0	PA, QL (28 CAPSULES PER 28 DAYS)
<i>lenalidomide cap 25 mg</i>	0	PA, QL (21 CAPSULES PER 28 DAYS)
REVLIMID CAP 2.5MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
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)
REZUROCK TAB 200MG	3	PA, QL (30 TABLETS PER 30 DAYS); MNPA
THALOMID CAP 50MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
THALOMID CAP 100MG	0	PA, QL (28 CAPSULES PER 28 DAYS)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
THALOMID CAP 150MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
THALOMID CAP 200MG	0	PA, QL (56 CAPSULES PER 28 DAYS)

IMMUNOSUPPRESSIVE AGENTS

ASTAGRAF XL CAP 0.5MG	3	PA
ASTAGRAF XL CAP 1MG	3	PA
ASTAGRAF XL CAP 5MG	3	PA
azathioprine tab 50 mg	1	
azathioprine tab 75 mg	2	
azathioprine tab 100 mg	2	
CELLCEPT CAP 250MG	3	PA
CELLCEPT IV INJ 500MG	3	PA
CELLCEPT SUS 200MG/ML	3	PA
CELLCEPT TAB 500MG	3	PA
cyclosporine cap 25 mg	1	
cyclosporine cap 100 mg	1	
cyclosporine modified cap 25 mg	1	
cyclosporine modified cap 50 mg	1	
cyclosporine modified cap 100 mg	1	
cyclosporine modified oral soln 100 mg/ml	1	
ENSPRYNG INJ	4	QL (1 PFS PER 28 DAYS); LOADING DOSE: 3 PFS PER 29 DAYS
ENVARUSUS XR TAB 0.75MG	3	PA
ENVARUSUS XR TAB 1MG	3	PA
ENVARUSUS XR TAB 4MG	3	PA
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 CAPSULES PER 30 DAYS); MNPA
mycophenolate mofetil cap 250 mg	1	
mycophenolate mofetil for oral susp 200 mg/ml	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>mycophenolate mofetil tab 500 mg</i>	1	
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	1	
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	1	
MYFORTIC TAB 180MG	3	PA
MYFORTIC TAB 360MG	3	PA
NEORAL CAP 25MG	3	
NEORAL CAP 100MG	3	
NEORAL SOL 100MG/ML	3	
PROGRAF CAP 0.5MG	3	PA
PROGRAF CAP 1MG	3	PA
PROGRAF CAP 5MG	3	PA
PROGRAF GRA 0.2MG	3	PA
PROGRAF GRA 1MG	3	PA
RAPAMUNE SOL 1MG/ML	3	PA
RAPAMUNE TAB 0.5MG	3	PA
RAPAMUNE TAB 1MG	3	PA
RAPAMUNE TAB 2MG	3	PA
SANDIMMUNE CAP 25MG	3	
SANDIMMUNE CAP 100MG	3	
SANDIMMUNE SOL 100MG/ML	3	
<i>sirolimus oral soln 1 mg/ml</i>	1	
<i>sirolimus tab 0.5 mg</i>	1	
<i>sirolimus tab 1 mg</i>	1	
<i>sirolimus tab 2 mg</i>	1	
<i>tacrolimus cap 0.5 mg</i>	1	
<i>tacrolimus cap 1 mg</i>	1	
<i>tacrolimus cap 5 mg</i>	1	
ZORTRESS TAB 0.5MG	3	PA
ZORTRESS TAB 0.25MG	3	PA
ZORTRESS TAB 0.75MG	3	PA
ZORTRESS TAB 1MG	3	PA
POTASSIUM REMOVING AGENTS		
LOKELMA PAK 5GM	2	MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
LOKELMA PAK 10GM	2	MNPA
<i>sodium polystyrene sulfonate oral susp 15 gm/60ml</i>	1	
<i>sodium polystyrene sulfonate powder</i>	1	
VELTASSA POW 8.4GM	2	
VELTASSA POW 16.8GM	2	
VELTASSA POW 25.2GM	2	
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP 50MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA INJ 200MG/ML	4	PA, QL (4 INJ PER 28 DAYS); LOADING DOSE: 8 SYR PER 28 DAYS
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
<i>lidocaine hcl laryngotracheal soln 4%</i>	1	
<i>lidocaine hcl viscous soln 2%</i>	1	
ANTI-INFECTIVES - THROAT		
<i>clotrimazole troche 10 mg</i>	1	QL (90 ea every 25 days)
<i>nystatin susp 100000 unit/ml</i>	1	
ORAVIG TAB 50MG	3	
ANTISEPTICS - MOUTH/THROAT		
<i>chlorhexidine gluconate soln 0.12%</i>	1	
PERIDEX SOL 0.12%	3	
DENTAL PRODUCTS		
NAFRINSE DLY SOL /NEUTRAL	3	
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
<i>sodium fluoride gel 1.1% (0.5% f)</i>	1	
<i>stannous fluoride conc 0.63%</i>	1	
<i>stannous fluoride gel 0.4%</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
STEROIDS - MOUTH/THROAT/DENTAL		
<i>triamcinolone acetonide dental paste 0.1%</i>	1	
THROAT PRODUCTS - MISC.		
<i>cevimeline hcl cap 30 mg</i>	1	
EVOXAC CAP 30MG	2	
NUMOISYN LOZ	3	
ORAFATE PST 10%	3	
<i>pilocarpine hcl tab 5 mg</i>	1	
<i>pilocarpine hcl tab 7.5 mg</i>	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	2	
SALAGEN TAB 7.5MG	2	
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
<i>b-complex w/ c & folic acid tab</i>	1	PA; MNPA
<i>b-complex w/ c & folic acid tab 1 mg</i>	1	PA; MNPA
<i>b-complex w/ c & folic acid tab 5 mg</i>	1	PA; MNPA
FOLIC-K CAP	3	PA; MNPA
MULTIPLE VITAMINS W/ MINERALS		
<i>multiple vitamins w/ minerals cap</i>	1	PA; MNPA
MULTIVITAMINS		
GENICIN TAB VITA-Q	3	PA; MNPA
PRENATAL VITAMINS		
ATABEX EC TAB 29-1MG	3	PA; MNPA
ATABEX OB TAB 29-1MG	3	PA; MNPA
AZESCHEW CHW 13-1MG	3	PA; MNPA
AZESCO TAB 13-1MG	3	PA; MNPA
C-NATE DHA CAP 28-1-200	3	PA; MNPA
CITRANATAL CAP HARMONY	2	PA; MNPA
CITRANATAL CAP MEDLEY	2	PA; MNPA
CITRANATAL MIS	2	PA; MNPA
CITRANATAL MIS 90 DHA	2	PA; MNPA
CITRANATAL MIS B-CALM	2	PA; MNPA
CITRANATAL PAK ASSURE	2	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CITRANATAL PAK DHA	2	PA; MNPA
CITRANATAL TAB BLOOM	2	MNPA
CITRANATAL TAB RX	2	PA; MNPA
CO-NATAL FA TAB 29-1MG	3	PA; MNPA
CONCEPT DHA CAP	3	PA; MNPA
CONCEPT OB CAP	3	PA; MNPA
DUET DHA 400 MIS 25-1-400	3	PA; MNPA
DUET DHA MIS BALANCED	3	PA; MNPA
ENBRACE HR CAP	3	PA; MNPA
JENLIVA CAP	3	PA; MNPA
KOSHR PRENAT TAB 30-1MG	3	PA; MNPA
M-NATAL PLUS TAB	3	PA; MNPA
MYNATAL CAP	3	PA; MNPA
MYNATAL PLUS TAB	3	PA; MNPA
MYNATAL-Z TAB	3	PA; MNPA
NATACHEW CHW	3	PA; MNPA
NATALVIT TAB 75-1MG	3	PA; MNPA
NEEVO DHA CAP 27-1.13	3	PA; MNPA
NEONATAL 19 TAB	3	PA; MNPA
NEONATAL FE TAB	3	PA; MNPA
NEONATAL PLS TAB 27-1MG	3	PA; MNPA
NEONATAL TAB COMPLETE	3	PA; MNPA
NEONATAL TAB COMPLTE	3	PA; MNPA
NEONATAL/DHA MIS	3	PA; MNPA
NESTABS DHA PAK	3	PA; MNPA
NESTABS ONE CAP	3	PA; MNPA
NESTABS TAB	3	PA; MNPA
NIVA-PLUS TAB	3	PA; MNPA
O-CAL TAB PRENATAL	3	PA; MNPA
OB COMPLETE CAP ONE	3	PA; MNPA
OB COMPLETE CAP PETITE	3	PA; MNPA
OB COMPLETE TAB	3	PA; MNPA
OB COMPLETE TAB PREMIER	3	PA; MNPA
OB COMPLETE/ CAP DHA	3	PA; MNPA
OBSTETRIX EC TAB	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VITAFOL FE+ CAP	3	PA; MNPA
VITAFOL STRP MIS 1MG	3	PA; MNPA
VITAFOL-NANO TAB	3	PA; MNPA
VITAFOL-OB PAK +DHA	3	PA; MNPA
VITAFOL-OB TAB 65-1MG	3	PA; MNPA
VITAFOL-ONE CAP	3	PA; MNPA
VITAMEDMD CAP ONE RX	3	PA; MNPA
VITAPEARL CAP	3	PA; MNPA
VITATHELY TAB	3	PA; MNPA
VITATRUE MIS	3	PA; MNPA
VIVA DHA CAP	3	PA; MNPA
VP-PNV-DHA CAP	3	PA; MNPA
WESTAB PLUS TAB 27-1MG	3	PA; MNPA
WESTGEL DHA CAP	3	PA; MNPA
ZALVIT TAB 13-1MG	3	PA; MNPA

VITAMIN MIXTURES

NICOMIDE TAB	3	PA; MNPA
--------------	---	----------

MUSCULOSKELETAL THERAPY AGENTS**CENTRAL MUSCLE RELAXANTS**

AMRIX CAP 15MG	3	PA; MNPA
AMRIX CAP 30MG	3	PA; MNPA
<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>carisoprodol tab 350 mg</i>	1	PA, QL (84 tabs every 25 days); MNPA
<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; 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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
OZOBAX SOL 5MG/5ML	3	PA; MNPA
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	
DIRECT MUSCLE RELAXANTS		
DANTRIUM CAP 25MG	2	
DANTRIUM CAP 50MG	2	
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
MUSCLE RELAXANT COMBINATIONS		
<i>carisoprodol w/ aspirin & codeine tab 200-325-16 mg</i>	1	QL (168 tabs every 25 days)
NORGESIC TAB FORTE	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>orphenadrine w/ aspirin & caffeine tab 50-770-60 mg</i>	1	PA; MNPA
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 package (23gm) per 25 days)
DYMISTA SPR 137-50	3	PA, QL (1 package (23gm) per 25 days); MNPA
NASAL AGENTS - MISC.		
NOZIN NASAL MIS SANITIZE	0	
NASAL ANESTHETICS		
COCAINE HCL SOL 40MG/ML	3	PA; MNPA
GOPRELTO SOL 40MG/ML	3	PA; MNPA
NUMBRINO SOL 40MG/ML	3	PA; MNPA
NASAL ANTIALLERGY		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	1	
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 package (30.5gm) per 25 days)
PATANASE SPR 0.6%	3	QL (1 package (30.5gm) per 25 days)
NASAL ANTICHOLINERGICS		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	
NASAL STEROIDS		
BECONASE AQ SUS 0.042%	3	PA, 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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA, QL (1 package (12.5gm) per 25 days); MNPA
QNASL AER 80MCG	3	PA; MNPA
QNASL CHILD SPR 40MCG	3	PA; MNPA
XHANCE MIS 93MCG	3	PA, QL (2 packages (16mL each) per 25 days)
ZETONNA AER 37MCG	3	PA, QL (1 package (6.1gm) per 25 days); MNPA
SYMPATHOMIMETIC DECONGESTANTS		
ADRENALIN SOL 1:1000	3	
NEUROMUSCULAR AGENTS		
ALS AGENTS		
EXSERVAN MIS 50MG	3	MNPA
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)
RILUTEK TAB 50MG	3	
<i>riluzole tab 50 mg</i>	1	
TIGLUTIK SUS 50/10ML	3	PA; MNPA
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOL	3	PA, QL (2 BOTTLES (120 MG) PER 24 DAYS)
NUTRIENTS		
MISC. NUTRITIONAL SUBSTANCES		
ALTEMLA EMU	3	
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT MIS 5MG OP	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BETA-BLOCKERS - OPHTHALMIC		
<i>betaxolol hcl ophth soln 0.5%</i>	1	
BETIMOL SOL 0.5%	2	PA; MNPA
BETIMOL SOL 0.25%	2	PA; 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%	2	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	
<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	PA; MNPA
TIM/DORZ/LAT SOL	3	PA; MNPA
TIMOL/BRIM SOL DORZ/LAT	3	PA; MNPA
TIMOL/LATAN SOL	3	PA; MNPA
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	
<i>timolol maleate ophth soln 0.5%</i>	1	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	
<i>timolol maleate ophth soln 0.25%</i>	1	
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	
TIMOPTIC OCU SOL 0.5% OP	3	PA; MNPA
TIMOPTIC OCU SOL 0.25% OP	3	PA; 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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
CYCLOPLEGIC MYDRIATICS		
ATROPINE SUL SOL 0.01%	3	PA; MNPA
ATROPINE SUL SOL 1% OP	3	
CYCLOGYL SOL 0.5% OP	3	
CYCLOGYL SOL 1% OP	3	
CYCLOGYL SOL 2% OP	3	
CYCLOMYDRIL SOL OP	3	
<i>cyclopentolate hcl ophth soln 0.5%</i>	1	
<i>cyclopentolate hcl ophth soln 1%</i>	1	
<i>cyclopentolate hcl ophth soln 2%</i>	1	
ISOPTO ATROP SOL 1% OP	3	
<i>phenylephrine hcl ophth soln 2.5%</i>	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
TROP-CYC-PE DRO 1-1-2.5	3	PA; MNPA
TROP-PHENYL SOL 1-2.5%	3	PA; MNPA
TROP/CYC/PE/ SOL KETO/PRO	3	PA; MNPA
TROP/CYC/PE/ SOL KETOROLA	3	PA; MNPA
TROP/CYCL/PE SOL KETOROLA	3	PA; MNPA
MIOTICS		
ISOPTO CARP SOL 1% OP	3	
ISOPTO CARP SOL 2% OP	3	
ISOPTO CARP SOL 4% OP	3	
PHOSPHOLINE SOL 0.125%OP	3	
<i>pilocarpine hcl ophth soln 1%</i>	1	
<i>pilocarpine hcl ophth soln 2%</i>	1	
<i>pilocarpine hcl ophth soln 4%</i>	1	
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
BRIMO/DORZO SOL 0.15-2%	3	PA; MNPA
<i>brimonidine tartrate ophth soln 0.2%</i>	1	
<i>brimonidine tartrate ophth soln 0.15%</i>	1	
IOPIDINE SOL 1% OP	3	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SIMBRINZA SUS 1-0.2%	2	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE SOL 1%	3	PA; 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	
CILOXAN OIN 0.3% OP	2	PA; MNPA
CILOXAN SOL 0.3% OP	3	PA; 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	PA; MNPA
<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	PA; MNPA
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	PA; MNPA
MOXIFLOXACIN SOL 0.5%	3	PA; MNPA
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	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	
TOBEX OIN 0.3% OP	3	
TOBEX SOL 0.3% OP	3	
<i>trifluridine ophth soln 1%</i>	1	
VANCOMYCIN SOL 10MG/ML	3	PA; MNPA
VIGAMOX DRO 0.5%	3	
ZIRGAN GEL 0.15%	3	PA; MNPA
ZYMAXID SOL 0.5%	3	
OPHTHALMIC IMMUNOMODULATORS		
CEQUA SOL 0.09%	3	PA; MNPA
<i>cyclosporine (ophth) emulsion 0.05%</i>	1	PA; MNPA
RESTASIS EMU 0.05% OP	1	PA; Tier 1 with DAW 9
RESTASIS MUL EMU 0.05% OP	2	PA
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5%	2	PA
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA SOL 0.02%	2	MNPA
ROCKLATAN DRO	2	MNPA
OPHTHALMIC LOCAL ANESTHETICS		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
<i>proparacaine hcl ophth soln 0.5%</i>	1	
<i>tetracaine hcl ophth soln 0.5%</i>	1	
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE SOL 20MCG/ML	3	PA, QL (16 CARTONS PER 56 DAYS - ONE TIME TREATMENT)
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA VIS SOL 0.146-20	3	PA; MNPA
PHOTREXA/PHO SOL VISC KIT	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
OPHTHALMIC STEROIDS		
ALREX SUS 0.2%	3	PA; MNPA
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
DUREZOL EMU 0.05%	3	
EYSUVIS DRO 0.25%	3	PA
FLAREX SUS 0.1% OP	3	PA; MNPA
<i>fluorometholone ophth susp 0.1%</i>	1	
FML FORTE SUS 0.25% OP	2	PA; MNPA
FML LIQUIFLM SUS 0.1% OP	3	PA; MNPA
FML OIN 0.1% OP	2	PA; MNPA
INVELTYS SUS 1%	3	PA; MNPA
KLARITY-L DRO 0.2%	3	PA; MNPA
KLARITY-L DRO 0.5%	3	PA; MNPA
LOTEMAX GEL 0.5%	3	PA; MNPA
LOTEMAX OIN 0.5%	3	PA; MNPA
LOTEMAX SM GEL 0.38%	3	PA; MNPA
LOTEMAX SUS 0.5%	3	PA; MNPA
<i>loteprednol etabonate ophth gel 0.5%</i>	1	PA; MNPA
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
MAXIDEX SUS 0.1% OP	2	PA; 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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PRED MOXIFLO SOL 1-0.5%	3	PA; MNPA
PRED MOXIFLO SUS BROMFEN	3	PA; MNPA
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; MNPA
PRED-GATIFL- SUS BROMFENA	3	PA; MNPA
PRED/NEPAFEN DRO 1-0.1%	3	PA; MNPA
PREDNI/MOXI/ DRO NEPAFENA	3	PA; MNPA
PREDNI/MOXIF DRO 1-0.5%	3	PA; MNPA
<i>prednisolone acetate ophth susp 1%</i>	1	
PREDNISOLONE SOL MOX-BROM	3	PA; MNPA
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	PA; 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	PA; MNPA
OPHTHALMIC SURGICAL AIDS		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
OPHTHALMICS - MISC.		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ACUVAIL SOL 0.45%	2	PA; 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	PA; MNPA
<i>brinzolamide ophth susp 1%</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
BROMSITE DRO 0.075%	3	PA; MNPA
CHONDROITIN SOL	3	PA; MNPA
<i>cromolyn sodium ophth soln 4%</i>	1	
CYSTADROPS SOL 0.37%	3	PA, QL (4 BOTTLES PER 28 DAYS); MNPA
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	
LASTACFT SOL 0.25%	2	PA; MNPA
NEVANAC SUS 0.1%	2	PA; MNPA
PROLENSA SOL 0.07%	2	
TRUSOPT SOL 2% OP	3	
UPNEEQ SOL 0.1%	3	PA; MNPA
ZERVIAE DRO 0.24%	3	PA; MNPA
PROSTAGLANDINS - OPHTHALMIC		
<i>bimatoprost ophth soln 0.03%</i>	1	
<i>latanoprost ophth soln 0.005%</i>	1	
LUMIGAN SOL 0.01%	2	MNPA
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	
TRAVATAN Z DRO 0.004%	3	PA; MNPA
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	
VYZULTA SOL 0.024%	3	MNPA
XALATAN SOL 0.005%	3	
XELPROS EMU 0.005%	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ZIOPTAN DRO 0.0015%	2	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln 2%	1	
OTIC ANTI-INFECTIVES		
CETRAXAL SOL 0.2%	3	
ciprofloxacin hcl otic soln 0.2% (base equivalent)	1	
ofloxacin otic soln 0.3%	1	
OTIC COMBINATIONS		
CIPRO HC SUS OTIC	3	PA; MNPA
CIPRODEX SUS 0.3-0.1%	3	PA; MNPA
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
ciprofloxacin-fluocinolone acetone (pf) otic soln 0.3-0.025%	1	PA; MNPA
CORTISPORIN SUS -TC OTIC	3	
neomycin-polymyxin-hc otic soln 1%	1	
neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%	1	
OTOVEL DRO	3	PA; MNPA
OTIC STEROIDS		
DERMOTIC OIL 0.01%	3	
fluocinolone acetonide (otic) oil 0.01%	1	
hydrocortisone w/ acetic acid otic soln 1-2%	1	
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
CERVIDIL VAG MIS 10MG INS	3	
PREPIDIL GEL 0.5MG/3G	3	
PROSTIN E2 SUP 20MG	3	
OXYTOCICS		
methylergonovine maleate tab 0.2 mg	1	PA, QL (120 tabs every 30 days)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PENICILLINS		
AMINOPENICILLINS		
<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	
NATURAL PENICILLINS		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	
PENICILLIN COMBINATIONS		
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	

PA - Prior Authorization **QL** - Quantity Limits **ST** - 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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
AUGMENTIN SUS 125/5ML	3	
AUGMENTIN SUS 250/5ML	3	
AUGMENTIN SUS ES-600	3	
AUGMENTIN TAB 500MG	3	
PENICILLINASE-RESISTANT PENICILLINS		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
PROGESTINS		
PROGESTINS		
AYGESTIN TAB 5MG	3	
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	
<i>medroxyprogesterone acetate tab 5 mg</i>	1	
<i>medroxyprogesterone acetate tab 10 mg</i>	1	
<i>megestrol acetate susp 625 mg/5ml</i>	1	
<i>norethindrone acetate tab 5 mg</i>	1	
<i>progesterone cap 100 mg</i>	1	
<i>progesterone cap 100 mg</i>	1	PA
<i>progesterone cap 200 mg</i>	1	
<i>progesterone cap 200 mg</i>	1	PA
<i>progesterone im in oil 50 mg/ml</i>	4	
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	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	
<i>disulfiram tab 250 mg</i>	1	
<i>disulfiram tab 500 mg</i>	1	
LUCEMYRA TAB 0.18MG	3	PA; MNPA
ANTI-CATAPLECTIC AGENTS		
LUMRYZ PAK 6GM	3	PA, QL (30 PACKETS PER 30 DAYS)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
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)

ANTIDEMENTIA AGENTS

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	
EXELON DIS 13.3/24	3	
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	
<i>galantamine hydrobromide tab 4 mg</i>	1	
<i>galantamine hydrobromide tab 8 mg</i>	1	
<i>galantamine hydrobromide tab 12 mg</i>	1	
<i>memantine hcl cap er 24hr 7 mg</i>	1	
<i>memantine hcl cap er 24hr 14 mg</i>	1	
<i>memantine hcl cap er 24hr 21 mg</i>	1	
<i>memantine hcl cap er 24hr 28 mg</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl tab 5 mg</i>	1	
<i>memantine hcl tab 10 mg</i>	1	
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
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	
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	
COMBINATION PSYCHOTHERAPEUTICS		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-50 mg</i>	1	
SYMBYAX CAP 3-25MG	3	
SYMBYAX CAP 6-25MG	3	
SYMBYAX CAP 6-50MG	3	
SYMBYAX CAP 12-50MG	3	
FIBROMYALGIA AGENTS		
SAVELLA MIS TITR PAK	3	
SAVELLA TAB 12.5MG	3	
SAVELLA TAB 25MG	3	
SAVELLA TAB 50MG	3	
SAVELLA TAB 100MG	3	
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
VYLEESI INJ 1.75/0.3	4	PA; MNPA
MOVEMENT DISORDER DRUG THERAPY		
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)
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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)

MULTIPLE SCLEROSIS AGENTS

AMPYRA TAB 10MG	3	PA, QL (60 TABLETS PER 30 DAYS)
AUBAGIO TAB 7MG	2	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AUBAGIO TAB 14MG	2	PA, QL (30 TABLETS PER 30 DAYS); MNPA
AVONEX PEN KIT 30MCG	4	QL (4 PENS PER 28 DAYS)
AVONEX PREFL KIT 30MCG	4	QL (4 SYRINGES PER 28 DAYS)
BAFIERTAM CAP 95MG	3	PA, QL (120 CAPSULES PER 30 DAYS); MNPA
BETASERON INJ 0.3MG	4	PA, QL (14 KITS PER 28 DAYS); MNPA
COPAXONE INJ 20MG/ML	4	PA, QL (30 SYRINGES PER 30 DAYS)
COPAXONE INJ 40MG/ML	4	PA, QL (12 SYRINGES PER 28 DAYS)
<i>dalfampridine tab er 12hr 10 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	PA, QL (14 CAPSULES PER 28 DAYS)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
GILENYA CAP 0.5MG	3	PA, QL (30 CAPSULES PER 30 DAYS); MNPA
<i>glatiramer acetate soln prefilled syringe 20 mg/ml</i>	4	PA, QL (30 SYRINGES PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 40 mg/ml</i>	4	PA, QL (12 SYRINGES PER 28 DAYS)
KESIMPTA INJ 20/.4ML	4	PA, QL (1 PENS PER 28 DAYS); LOADING DOSE: 3 PENS PER 15 DAYS
MAVENCLAD PAK 10MG(4)	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)
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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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)
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
GRALISE TAB 300MG	2	QL (150 tabs every 25 days)
GRALISE TAB 450MG	2	QL (90 tablets per 25 days)
GRALISE TAB 600MG	2	QL (90 tabs every 25 days)
GRALISE TAB 750MG	2	QL (60 tablets per 25 days)
GRALISE TAB 900MG	2	QL (60 tablets per 25 days)
LYRICA CR TAB 82.5MG	3	PA, QL (60 tabs every 30 days); MNPA
LYRICA CR TAB 165MG	3	PA, QL (60 tabs every 30 days); MNPA
LYRICA CR TAB 330MG	3	PA, QL (60 tabs every 30 days); MNPA
<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)
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
<i>fluoxetine hcl (pmdd) tab 10 mg</i>	1	PA; MNPA
<i>fluoxetine hcl (pmdd) tab 20 mg</i>	1	PA; MNPA
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUEDEXTA CAP 20-10MG	2	PA; MNPA
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
<i>ergoloid mesylates tab 1 mg</i>	1	
<i>pimozide tab 1 mg</i>	1	
<i>pimozide tab 2 mg</i>	1	
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB 300MG ER	3	PA, QL (60 tabs every 25 days); MNPA
HORIZANT TAB 600MG ER	3	PA, QL (60 tabs every 25 days); MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SMOKING DETERRENTS		
<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	OTC; \$0 limited to 2 treatment cycles/year
NICODERM CQ DIS 14MG/24H	0	OTC; \$0 limited to 2 treatment cycles/year
NICODERM CQ DIS 21MG/24H	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG CINN	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG MINT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MG ORIG	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 2MGFRUIT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG CINN	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG MINT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MG ORIG	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE GUM 4MGFRUIT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE LOZ 2MG MINT	0	OTC; \$0 limited to 2 treatment cycles/year

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
NICORETTE LOZ 4MG MINT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 2MG MINT	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 2MG ORIG	0	OTC; \$0 limited to 2 treatment cycles/year
NICORETTE ST GUM 4MG ORIG	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 7 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
NICOTROL INH	0	
NICOTROL NS SPR 10MG/ML	0	
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ 284/1.5	4	PA, QL (4 PFS PER 28 DAYS)
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP 7.5MG	3	
<i>paroxetine mesylate cap 7.5 mg (base equiv)</i>	1	PA; MNPA
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
BRONCHITOL CAP 40MG	3	PA, QL (600 CAPSULES PER 30 DAYS); MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
BRONCHITOL CAP TOL TEST	3	PA, QL (90 CAPSULES PER 30 DAYS); MNPA
KALYDECO GRA 5.8MG	3	PA, 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)
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	3	PA, QL (60 AMPULES PER 30 DAYS)
SYMDEKO TAB 50-75MG	3	PA, QL (56 TABLETS PER 28 DAYS)
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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP 267MG	2	PA, QL (270 CAPSULES PER 30 DAYS); MNPA
ESBRIET TAB 267MG	2	PA, QL (270 TABLETS PER 30 DAYS); MNPA
ESBRIET TAB 801MG	2	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	PA, QL (270 TABLETS PER 30 DAYS)
<i>pirfenidone tab 801 mg</i>	1	PA, QL (90 TABLETS PER 30 DAYS)
SULFONAMIDES		
SULFONAMIDES		
<i>sulfadiazine tab 500 mg</i>	3	
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB 150MG	3	
TETRACYCLINES		
ACTICLATE TAB 75MG	3	PA; MNPA
ACTICLATE TAB 150MG	3	PA; MNPA
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline hcl tab 300 mg</i>	1	
DORYX MPC TAB 120MG	3	PA; MNPA
DORYX TAB 50MG	3	PA; MNPA
DORYX TAB 80MG	3	PA; MNPA
DORYX TAB 200MG	3	PA; 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	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
<i>doxycycline hyclate tab delayed release 50 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 75 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 80 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 100 mg</i>	1	PA; MNPA
<i>doxycycline hyclate tab delayed release 150 mg</i>	1	PA; 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 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 75 mg</i>	1	PA; MNPA
<i>doxycycline monohydrate tab 100 mg</i>	1	
<i>doxycycline monohydrate tab 150 mg</i>	1	
<i>doxycycline monohydrate tab 150 mg</i>	1	PA; MNPA
<i>minocycline hcl cap 50 mg</i>	1	
<i>minocycline hcl cap 75 mg</i>	1	
<i>minocycline hcl cap 100 mg</i>	1	
<i>minocycline hcl 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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; MNPA
MINOLIRA TAB 135MG	3	PA; MNPA
SEYSARA TAB 60MG	3	PA; MNPA
SEYSARA TAB 100MG	3	PA; MNPA
SEYSARA TAB 150MG	3	PA; MNPA
SOLODYN TAB 55MG	3	
SOLODYN TAB 65MG	3	
SOLODYN TAB 80MG	3	
SOLODYN TAB 105MG	3	
SOLODYN TAB 115MG	3	
<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	PA; MNPA
XIMINO CAP 90MG ER	3	PA; MNPA
XIMINO CAP 135MG ER	3	PA; 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	
-----------------------	---	--

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
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	PA; MNPA
CYTOMEL TAB 25MCG	3	PA; MNPA
CYTOMEL TAB 50MCG	3	PA; MNPA
levothyroxine sodium cap 13 mcg	1	PA; MNPA
levothyroxine sodium cap 25 mcg	1	PA; MNPA
levothyroxine sodium cap 50 mcg	1	PA; MNPA
levothyroxine sodium cap 75 mcg	1	PA; MNPA
levothyroxine sodium cap 88 mcg	1	PA; MNPA
levothyroxine sodium cap 100 mcg	1	PA; MNPA
levothyroxine sodium cap 112 mcg	1	PA; MNPA
levothyroxine sodium cap 125 mcg	1	PA; MNPA
levothyroxine sodium cap 137 mcg	1	PA; MNPA
levothyroxine sodium cap 150 mcg	1	PA; MNPA
levothyroxine sodium cap 175 mcg	1	PA; MNPA
levothyroxine sodium cap 200 mcg	1	PA; MNPA
levothyroxine sodium tab 25 mcg	1	
levothyroxine sodium tab 50 mcg	1	
levothyroxine sodium tab 75 mcg	1	
levothyroxine sodium tab 88 mcg	1	
levothyroxine sodium tab 100 mcg	1	
levothyroxine sodium tab 112 mcg	1	
levothyroxine sodium tab 125 mcg	1	
levothyroxine sodium tab 137 mcg	1	
levothyroxine sodium tab 150 mcg	1	
levothyroxine sodium tab 175 mcg	1	
levothyroxine sodium tab 200 mcg	1	
levothyroxine sodium tab 300 mcg	1	
liothyronine sodium tab 5 mcg	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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>liothyronine sodium tab 25 mcg</i>	1	
<i>liothyronine sodium tab 50 mcg</i>	1	
NATURE THROI TAB 162.5MG	3	PA; MNPA
NATURE-THROI TAB 16.25MG	3	PA; MNPA
NATURE-THROI TAB 32.5MG	3	PA; MNPA
NATURE-THROI TAB 48.75MG	3	PA; MNPA
NATURE-THROI TAB 65MG	3	PA; MNPA
NATURE-THROI TAB 81.25MG	3	PA; MNPA
NATURE-THROI TAB 97.5MG	3	PA; MNPA
NATURE-THROI TAB 113.75MG	3	PA; MNPA
NATURE-THROI TAB 130MG	3	PA; MNPA
NATURE-THROI TAB 146.25MG	3	PA; MNPA
NATURE-THROI TAB 195MG	3	PA; MNPA
NATURE-THROI TAB 260MG	3	PA; MNPA
NATURE-THROI TAB 325MG	3	PA; MNPA
NP THYROID TAB 15MG	3	
NP THYROID TAB 30MG	3	
NP THYROID TAB 60MG	3	
NP THYROID TAB 90MG	3	
NP THYROID TAB 120MG	3	
SYNTHROID TAB 25MCG	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	MNPA
TIROSINT CAP 13MCG	3	PA; MNPA
TIROSINT CAP 25MCG	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
TIROSINT CAP 50MCG	3	PA; MNPA
TIROSINT CAP 75MCG	3	PA; MNPA
TIROSINT CAP 88MCG	3	PA; MNPA
TIROSINT CAP 100MCG	3	PA; MNPA
TIROSINT CAP 112MCG	3	PA; MNPA
TIROSINT CAP 125MCG	3	PA; MNPA
TIROSINT CAP 137MCG	3	PA; MNPA
TIROSINT CAP 150MCG	3	PA; MNPA
TIROSINT CAP 175MCG	3	PA; MNPA
TIROSINT CAP 200	3	PA; MNPA
TIROSINT-SOL SOL 13MCG/ML	3	PA; MNPA
TIROSINT-SOL SOL 25MCG/ML	3	PA; MNPA
TIROSINT-SOL SOL 50MCG/ML	3	PA; MNPA
TIROSINT-SOL SOL 75MCG/ML	3	PA; MNPA
TIROSINT-SOL SOL 88MCG/ML	3	PA; MNPA
TIROSINT-SOL SOL 100MCG	3	PA; MNPA
TIROSINT-SOL SOL 112MCG	3	PA; MNPA
TIROSINT-SOL SOL 125MCG	3	PA; MNPA
TIROSINT-SOL SOL 137MCG	3	PA; MNPA
TIROSINT-SOL SOL 150MCG	3	PA; MNPA
TIROSINT-SOL SOL 175MCG	3	PA; MNPA
TIROSINT-SOL SOL 200MCG	3	PA; MNPA
WESTHROID TAB 32.5MG	3	PA; MNPA
WESTHROID TAB 65MG	3	PA; MNPA
WESTHROID TAB 97.5MG	3	PA; MNPA
WESTHROID TAB 130MG	3	PA; MNPA
WESTHROID TAB 195MG	3	PA; MNPA
WP THYROID TAB 16.25MG	3	PA; MNPA
WP THYROID TAB 32.5MG	3	PA; MNPA
WP THYROID TAB 48.75MG	3	PA; MNPA
WP THYROID TAB 65MG	3	PA; MNPA
WP THYROID TAB 81.25MG	3	PA; MNPA
WP THYROID TAB 97.5MG	3	PA; MNPA
WP THYROID TAB 113.75MG	3	PA; MNPA
WP THYROID TAB 130MG	3	PA; MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		
ANASPAZ TAB 0.125MG	2	
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	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	PA; MNPA
GLYCOPYRROLA TAB 1.5MG	3	PA; MNPA
<i>glycopyrrolate inj pf soln pref syr 0.4 mg/2ml (0.2 mg/ml)</i>	4	PA; MNPA
<i>glycopyrrolate inj pf soln prefilled syringe 0.2 mg/ml</i>	4	PA; MNPA
<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	PA; MNPA
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
SYMAX DUOTAB TAB	3	
H-2 ANTAGONISTS		
<i>cimetidine hcl soln 300 mg/5ml</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>cimetidine tab 300 mg</i>	1	
<i>cimetidine tab 400 mg</i>	1	
<i>cimetidine tab 800 mg</i>	1	
<i>famotidine for susp 40 mg/5ml</i>	1	
<i>famotidine tab 40 mg</i>	1	
<i>nizatidine cap 150 mg</i>	1	
<i>nizatidine cap 300 mg</i>	1	
<i>nizatidine oral soln 15 mg/ml</i>	1	
PEPCID TAB 40MG	3	
MISC. ANTI-ULCER		
CARAFATE SUS 1GM/10ML	3	PA; MNPA
CARAFATE TAB 1GM	3	PA; MNPA
<i>sucralfate susp 1 gm/10ml</i>	1	PA; MNPA
<i>sucralfate tab 1 gm</i>	1	
PROTON PUMP INHIBITORS		
ACIPHEX SPR CAP 5MG	3	PA, QL (90 caps every year); MNPA
ACIPHEX SPR CAP 10MG	3	PA, QL (90 caps every year); MNPA
ACIPHEX TAB 20MG	3	PA, QL (90 tabs every year); MNPA
DEXILANT CAP 30MG DR	2	PA, QL (90 caps every year); MNPA
DEXILANT CAP 60MG DR	2	PA, QL (90 caps every year); MNPA
<i>dexlansoprazole cap delayed release 30 mg</i>	1	PA, QL (90 caps every year); MNPA
<i>dexlansoprazole cap delayed release 60 mg</i>	1	PA, QL (90 caps every year); MNPA
ESOMEPRAZOLE CAP 49.3MG	3	PA, QL (90 caps every year); MNPA
<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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA, QL (90 ea every year); MNPA
<i>lansoprazole tab delayed release orally disintegrating 30 mg</i>	1	PA, QL (90 ea every year); MNPA
NEXIUM CAP 20MG	3	PA, QL (90 caps every year); MNPA
NEXIUM CAP 40MG	3	PA, QL (90 caps every year); MNPA
NEXIUM GRA 2.5MG DR	3	PA, QL (90 packets every year); MNPA
NEXIUM GRA 5MG DR	3	PA, QL (90 packets every year); MNPA
NEXIUM GRA 10MG DR	3	PA, QL (90 packets every year); MNPA
NEXIUM GRA 20MG DR	3	PA, QL (90 packets every year); MNPA
NEXIUM GRA 40MG DR	3	PA, 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
PREVACID CAP 15MG DR	3	PA, QL (90 caps every year); MNPA

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
PREVACID CAP 30MG DR	3	PA, QL (90 caps every year); MNPA
PREVACID TAB 15MG STB	3	PA, QL (90 ea every year); MNPA
PREVACID TAB 30MG STB	3	PA, 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 PAK 40MG	3	PA, QL (90 packets every year); MNPA
PROTONIX TAB 20MG	3	PA, QL (90 tabs every year); MNPA
PROTONIX TAB 40MG	3	PA, 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)

ULCER DRUGS - PROSTAGLANDINS

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

ULCER THERAPY COMBINATIONS

<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
HELIDAC MIS THERAPY	3	PA; MNPA
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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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
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	PA; MNPA
DETROL LA CAP 4MG	3	PA; MNPA
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
ENABLEX TAB 7.5MG	3	PA; 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 tab 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<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	PA; 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	
<i>tolterodine tartrate tab 2 mg</i>	1	
TOVIAZ TAB 4MG	2	PA; MNPA
TOVIAZ TAB 8MG	2	PA; MNPA
<i>trospium chloride cap er 24hr 60 mg</i>	1	
<i>trospium chloride tab 20 mg</i>	1	
VESICARE LS SUS 5MG/5ML	3	
VESICARE TAB 5MG	3	
VESICARE TAB 10MG	3	
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB 75MG	2	
MYRBETRIQ SUS 8MG/ML	2	PA; MNPA
MYRBETRIQ TAB 25MG	2	PA; MNPA
MYRBETRIQ TAB 50MG	2	PA; MNPA
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
<i>flavoxate hcl tab 100 mg</i>	1	
VAGINAL AND RELATED PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
INTRAROSA SUP 6.5MG	3	PA; MNPA
SPERMICIDES		
ENCARE SUP 100MG	0	OTC
GYNOL II GEL 3%	0	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
SHUR-SEAL GEL 2%	0	
TODAY SPONGE MIS	0	
VCF VAGINAL AER CONTRACP	0	
VCF VAGINAL GEL CONTRACE	0	
VCF VAGINAL MIS CONTRACP	0	
VAGINAL ANTI-INFECTIVES		
CLEOCIN CRE 2% VAG	2	
CLEOCIN SUP 100MG	3	
<i>clindamycin phosphate vaginal cream 2%</i>	1	
CLINDESSE CRE 2%	3	
GYNAZOLE-1 CRE 2%	3	
<i>metronidazole vaginal gel 0.75%</i>	1	
<i>miconazole nitrate vaginal suppos 200 mg</i>	1	
NUVESSA GEL 1.3%	3	PA; MNPA
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
VANDAZOLE GEL 0.75%	1	
XACIATO GEL 2%	3	
VAGINAL ESTROGENS		
ESTRACE VAG CRE 0.01%	3	
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
ESTRING MIS 2MG	3	PA; MNPA
FEMRING MIS 0.1MG/24	3	PA; MNPA
FEMRING MIS 0.05/24H	3	PA; MNPA
IMVEXXY MAIN SUP 4MCG	2	
IMVEXXY MAIN SUP 10MCG	2	
IMVEXXY STRT SUP 4MCG	2	
IMVEXXY STRT SUP 10MCG	2	
PREMARIN VAG CRE 0.625MG	3	PA; MNPA
VAGIFEM TAB 10MCG	1	Tier 1 with DAW9
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG	2	
CRINONE GEL 8% VAG	2	
ENDOMETRIN SUP 100MG	2	

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
ADRENALIN INJ 1MG/ML	3	PA; MNPA
ADRENALIN INJ 30/30ML	3	PA; MNPA
AUVI-Q INJ 0.1MG	2	QL (3 pens every 300 days)
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	PA, QL (6 kits every 300 days); MNPA
<i>epinephrine inj 30 mg/30ml (1 mg/ml) (1:1000)</i>	1	
EPINEPHRINE KIT SNAP-EMS	3	PA, QL (6 kits every 300 days); MNPA
<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	PA, QL (6 kits every 300 days); MNPA
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	2	PA, QL (3 syringes every 300 days); MNPA
SYMJEPI INJ 0.15MG	2	PA, 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)

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Drug Name	Drug Tier	Requirements/Limits
<i>droxidopa cap 300 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
VASOPRESSORS		
EPINEPHRINE INJ 0.2MG	3	
EPINEPHRINE INJ 1MG/10ML	3	
EPINEPHRINE INJ 1MG/ML	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	
VITAMINS		
OIL SOLUBLE VITAMINS		
DRISDOL CAP 50000UNT	3	
ERGOCAL CAP 2500UNIT	3	PA; MNPA
<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

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) and click on Drug & Pharmacy Resources under the Coverage tab.

Index

1	
1ML SYRINGE MIS 29G	260
1ML SYRINGE MIS 30G	260
A	
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	140
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	140
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	140
<i>abacavir sulfate tab 300 mg (base equiv)</i>	140
ABILIFY MAIN INJ 300MG	139
ABILIFY MAIN INJ 400MG	139
ABILIFY MYCI TAB 10MG	139
ABILIFY MYCI TAB 15MG	139
ABILIFY MYCI TAB 20MG.....	139
ABILIFY MYCI TAB 2MG	139
ABILIFY MYCI TAB 30MG.....	139
ABILIFY MYCI TAB 5MG	139
ABILIFY TAB 10MG	139
ABILIFY TAB 15MG	139
ABILIFY TAB 20MG	139
ABILIFY TAB 2MG.....	139
ABILIFY TAB 30MG	139
ABILIFY TAB 5MG.....	139
<i>abiraterone acetate tab 250 mg</i>	117
<i>abiraterone acetate tab 500 mg</i>	117
ABSORICA CAP 10MG	172
ABSORICA CAP 20MG.....	172
ABSORICA CAP 25MG	172
ABSORICA CAP 30MG.....	172
ABSORICA CAP 35MG	172
ABSORICA CAP 40MG.....	172
ABSORICA LD CAP 16MG.....	173
ABSORICA LD CAP 24MG	173
ABSORICA LD CAP 32MG	173
ABSORICA LD CAP 8MG	173
<i>acamprosate calcium tab delayed release 333 mg</i>	288
ACANYA GEL 1.2-2.5%	173
<i>acarbose tab 100 mg</i>	82
<i>acarbose tab 25 mg</i>	82
<i>acarbose tab 50 mg</i>	82
ACCOLATE TAB 10MG	56
ACCOLATE TAB 20MG	56
ACCU-CHEK GUIDE	195
ACCU-CHEK KIT FASTCLIX	240
ACCU-CHEK KIT SOFTCLIX.....	241
ACCU-CHEK LIQ GUIDE	241
ACCU-CHEK LIQ SMART.....	241
ACCU-CHEK MIS MLTICLIX.....	241
ACCU-CHEK SOL	241
ACCU-CHEK SOL COMPACT	241
ACCU-CHEK TES AVIVA PL	195
ACCU-CHEK TES COMPACT.....	195
ACCU-CHEK TES SMART	195
ACCUPRIL TAB 10MG.....	101
ACCUPRIL TAB 20MG.....	101
ACCUPRIL TAB 40MG.....	101
ACCUPRIL TAB 5MG	101
ACCURETIC TAB 10-12.5	105
ACCURETIC TAB 20-12.5	105
ACCURETIC TAB 20-25MG	105
ACCUTREND SOL GLUCOSE.....	241
ACCUTREND TES GLUCOSE	195
<i>acebutolol hcl cap 200 mg</i>	151
<i>acebutolol hcl cap 400 mg</i>	151
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	42
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	42
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	42
<i>acetaminophen w/ codeine tab 300-15 mg</i>	42
<i>acetaminophen w/ codeine tab 300-30 mg</i>	42
<i>acetaminophen w/ codeine tab 300-60 mg</i>	42
<i>acetazolamide cap er 12hr 500 mg</i>	211
<i>acetazolamide tab 125 mg</i>	211
<i>acetazolamide tab 250 mg</i>	211
<i>acetic acid otic soln 2%</i>	286

<i>acetylcysteine inhal soln 10%</i>	172	<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	173
<i>acetylcysteine inhal soln 20%</i>	172	.....	173
ACIPHEX SPR CAP 10MG	306	<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	173
ACIPHEX SPR CAP 5MG.....	306	.....	173
ACIPHEX TAB 20MG.....	306	<i>adapalene cream 0.1%</i>	173
<i>acitretin cap 10 mg</i>	179	<i>adapalene gel 0.1%</i>	173
<i>acitretin cap 17.5 mg</i>	179	<i>adapalene gel 0.3%</i>	173
<i>acitretin cap 25 mg</i>	179	<i>adapalene pads 0.1%</i>	173
ACTHAR INJ 80UNIT	214	ADAPALENE SOL 0.1%	173
ACTICLATE TAB 150MG	299	ADASUVE INH 10MG	136
ACTICLATE TAB 75MG.....	299	ADBRY INJ 150MG/ML.....	190
ACTI-LANCE MIS 28G.....	241	ADDERALL TAB 10MG.....	1
ACTI-LANCE MIS LITE 28G.....	241	ADDERALL TAB 12.5MG.....	1
ACTI-LANCE MIS SPEC 17G.....	241	ADDERALL TAB 15MG.....	1
ACTI-LANCE MIS UNIV 23G.....	241	ADDERALL TAB 20MG.....	1
ACTIMMUNE INJ 2MU/0.5	128	ADDERALL TAB 30MG.....	1
ACTIQ LOZ 1200MCG.....	32	ADDERALL TAB 5MG	1
ACTIQ LOZ 1600MCG.....	32	ADDERALL TAB 7.5MG	1
ACTIQ LOZ 200MCG	32	ADDERALL XR CAP 10MG	1
ACTIQ LOZ 400MCG	32	ADDERALL XR CAP 15MG	1
ACTIQ LOZ 600MCG	32	ADDERALL XR CAP 20MG.....	1
ACTIQ LOZ 800MCG	32	ADDERALL XR CAP 25MG.....	1
ACTIVELLA TAB 1-0.5MG.....	221	ADDERALL XR CAP 30MG.....	1
ACTONEL TAB 150MG	213	ADDERALL XR CAP 5MG.....	1
ACTONEL TAB 35MG.....	213	<i>adefovir dipivoxil tab 10 mg</i>	148
ACTOPLUS MET TAB 15-500MG.....	82	ADEMPAS TAB 0.5MG.....	163
ACTOPLUS MET TAB 15-850MG	82	ADEMPAS TAB 1.5MG.....	163
ACTOS TAB 15MG.....	89	ADEMPAS TAB 1MG.....	163
ACTOS TAB 30MG.....	89	ADEMPAS TAB 2.5MG.....	164
ACTOS TAB 45MG.....	89	ADEMPAS TAB 2MG.....	164
ACULAR LS SOL 0.4%	284	ADHANSIA XR CAP 25MG	8
ACULAR SOL 0.5% OP.....	284	ADHANSIA XR CAP 35MG	8
ACUVAIL SOL 0.45%	284	ADHANSIA XR CAP 45MG.....	8
<i>acyclovir cap 200 mg</i>	149	ADHANSIA XR CAP 55MG.....	8
<i>acyclovir cream 5%</i>	184	ADHANSIA XR CAP 70MG.....	8
<i>acyclovir oint 5%</i>	184	ADHANSIA XR CAP 85MG.....	8
<i>acyclovir susp 200 mg/5ml</i>	149	ADIPEX-P CAP 37.5MG.....	6
<i>acyclovir tab 400 mg</i>	149	ADIPEX-P TAB 37.5MG	6
<i>acyclovir tab 800 mg</i>	149	ADJ LANCING MIS DEVICE.....	241
ACZONE GEL 5%	173	ADLYXIN INJ 10/20MCG	86
ACZONE GEL 7.5%.....	173	ADLYXIN INJ 20MCG.....	86
ADALIMU-ADAZ INJ 40/0.4ML.....	16	ADMELOG INJ 100U/ML.....	87
		ADMELOG SOLO INJ 100U/ML	87

ADRENALIN INJ 1MG/ML.....	312	AEROCHAMBER MIS PLUS.....	261
ADRENALIN INJ 30/30ML	312	AEROVENT MIS PLUS.....	261
ADRENALIN SOL 1:1000.....	278	AFINITOR DIS TAB 2MG	120
ADVAIR DISKU AER 100/50	59	AFINITOR DIS TAB 3MG	120
ADVAIR DISKU AER 250/50.....	59	AFINITOR DIS TAB 5MG.....	120
ADVAIR DISKU AER 500/50.....	59	AFINITOR TAB 10MG	120
ADVAIR HFA AER 115/21	59	AFINITOR TAB 2.5MG.....	120
ADVAIR HFA AER 230/21.....	59	AFINITOR TAB 5MG	120
ADVAIR HFA AER 45/21.....	59	AFINITOR TAB 7.5MG.....	120
ADVANCE LIQ CONTROL.....	241	AFREZZA POW 12 UNIT	87
ADVANCE LIQ INTUITIO	241	AFREZZA POW 4-8-12.....	87
ADVANCE NORM LIQ CONTROL.....	241	AFREZZA POW 4-8 UNIT	87
ADVANCE TES INTUITIO	195	AFREZZA POW 4UNIT	87
ADVANCE TES MICRO-DW	195	AFREZZA POW 8-12UNIT.....	87
ADVOCATE SAFE MIS LANC 26G.....	241	AFREZZA POW 8 UNIT	87
ADV LANCING MIS DEVICE	241	AGAMATRIX MIS 33G.....	241
ADVOCATE+ SOL REDI-COD	241	AGAMATRIX SOL HIGH	241
ADVOCATE LIQ HIGH	241	AGAMATRIX SOL LEVEL 2	241
ADVOCATE LIQ LOW.....	241	AGAMATRIX SOL LEVEL 4	241
ADVOCATE MIS LANC 30G	241	AGAMATRIX SOL NORM/HGH.....	241
ADVOCATE MIS LANC DEV	241	AGAMATRIX SOL NORMAL	241
ADVOCATE MIS LANCETS.....	241	AGAMATRIX TES AMP.....	195
ADVOCATE TES.....	195	AGAMATRIX TES JAZZ.....	195
ADVOCATE TES REDI-COD	195	AGAMATRIX TES KEYNOTE	195
ADVOCATE TES REDICODE.....	195	AGAMATRIX TES PRESTO	195
ADV TRAVEL MIS LANC 28G.....	241	AGRYLIN CAP 0.5MG.....	232
ADZENYS ER SUS 1.25MG	1	AIMOVIG INJ 140MG/ML	262
ADZENYS XR TAB 12.5MG	2	AIMOVIG INJ 70MG/ML	262
ADZENYS XR TAB 15.7 MG	2	AIMSCO TWIST MIS 32G.....	241
ADZENYS XR TAB 18.8MG	2	AIMSCO TWIST MIS 33G.....	241
ADZENYS XR TAB 3.1MG	1	AIRDUO DGHLR INH 113-14	59
ADZENYS XR TAB 6.3MG	1	AIRDUO DGHLR INH 232-14.....	60
ADZENYS XR TAB 9.4MG	1	AIRDUO DGHLR INH 55-14.....	59
AEMCOLO TAB 194MG	48	AIRDUO RESPI INH 113-14	60
AERCHMBR PLS MIS FLOW-VU.....	260	AIRDUO RESPI INH 232-14	60
AERCHMBR PLS MIS LRG MASK.....	260	AIRDUO RESPI INH 55-14	60
AERCHMBR PLS MIS MED MASK	260	AIRSUPRA AER 90-80MCG.....	60
AERCHMBR PLS MIS SM MASK.....	260	AJOVY INJ 225/1.5	262
AERCHMBR Z- MIS STAT PLS	260	AKLIEF CRE 0.005%	173
AEROCHAMBER KIT ACTION.....	261	AKTEN GEL 3.5%	282
AEROCHAMBER MIS CHAMBER	261	AKYNZEO CAP 300-0.5.....	93
AEROCHAMBER MIS FLOSIGNA.....	261	ALA-SCALP LOT 2%	185
AEROCHAMBER MIS MV	261	<i>albendazole tab 200 mg</i>	48

ALBENZA TAB 200MG	48	<i>alendronate sodium tab 10 mg</i>	213
ALBUTEROL NEB 0.5%	60	<i>alendronate sodium tab 35 mg</i>	213
<i>albuterol sulfate inhal aero 108 mcg/act</i>		<i>alendronate sodium tab 5 mg</i>	213
<i>(90mcg base equiv)</i>	60	<i>alendronate sodium tab 70 mg</i>	214
<i>albuterol sulfate soln nebu 0.083% (2.5</i>		<i>alfuzosin hcl tab er 24hr 10 mg</i>	229
<i>mg/3ml)</i>	60	ALINIA SUS 100/5ML	49
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>		ALINIA TAB 500MG	49
.....	60	<i>aliskiren fumarate tab 150 mg (base</i>	
<i>albuterol sulfate soln nebu 0.63 mg/3ml</i>		<i>equivalent)</i>	111
<i>(base equiv)</i>	60	<i>aliskiren fumarate tab 300 mg (base</i>	
<i>albuterol sulfate soln nebu 1.25 mg/3ml</i>		<i>equivalent)</i>	111
<i>(base equiv)</i>	60	ALKERAN TAB 2MG	113
<i>albuterol sulfate syrup 2 mg/5ml</i>	60	ALKINDI SPRI CAP 0.5MG	169
<i>albuterol sulfate tab 2 mg</i>	60	ALKINDI SPRI CAP 1MG	169
<i>albuterol sulfate tab 4 mg</i>	60	ALKINDI SPRI CAP 2MG	169
<i>albuterol sulfate tab er 12hr 4 mg</i>	60	ALKINDI SPRI CAP 5MG	169
<i>albuterol sulfate tab er 12hr 8 mg</i>	60	<i>allopurinol tab 100 mg</i>	230
ALCAINE SOL 0.5% OP	282	<i>allopurinol tab 300 mg</i>	230
<i>acclometasone dipropionate cream 0.05%</i>		ALLZITAL TAB 25-325MG	31
.....	185	<i>almotriptan malate tab 12.5 mg</i>	263
<i>acclometasone dipropionate oint 0.05%</i>	185	<i>almotriptan malate tab 6.25 mg</i>	263
ALCOH-GLOVE PAD CONTOURE	259	ALOCRI SOL 2%	284
ALCOHOL PAD	259	<i>alogliptin benzoate tab 12.5 mg (base equiv)</i>	
ALCOHOL PAD 70%	259	.....	85
ALCOHOL PAD PREP	259	<i>alogliptin benzoate tab 25 mg (base equiv)</i>	
ALCOHOL PAD SWABSTIC	259	.....	85
ALCOHOL PREP PAD	259	<i>alogliptin benzoate tab 6.25 mg (base</i>	
ALCOHOL PREP PAD 70%	259	<i>equiv)</i>	85
ALCOHOL PREP PAD MED 70%	259	<i>alogliptin-metformin hcl tab 12.5-1000 mg</i>	
ALCOHOL PREP PAD PADS 70%	259	.....	82
ALCOHOL SWAB PAD	259	<i>alogliptin-metformin hcl tab 12.5-500 mg</i>	82
ALCOHOL SWAB PAD 70%	259	<i>alogliptin-pioglitazone tab 12.5-15 mg</i>	82
ALCOHOL SWAB PAD EX-THICK	259	<i>alogliptin-pioglitazone tab 12.5-30 mg</i>	82
ALCOHOL WIPE PAD	259	<i>alogliptin-pioglitazone tab 12.5-45 mg</i>	82
ALDACTAZIDE TAB 25/25	211	<i>alogliptin-pioglitazone tab 25-15 mg</i>	82
ALDACTAZIDE TAB 50/50	211	<i>alogliptin-pioglitazone tab 25-30 mg</i>	82
ALDACTONE TAB 100MG	212	<i>alogliptin-pioglitazone tab 25-45 mg</i>	82
ALDACTONE TAB 25MG	212	ALOMIDE SOL 0.1% OP	284
ALDACTONE TAB 50MG	212	ALORA DIS 0.025MG	222
ALDARA CRE 5%	191	ALORA DIS 0.05MG	222
ALECENSA CAP 150MG	120	ALORA DIS 0.075MG	222
<i>alendronate sodium oral soln 70 mg/75ml</i>		ALORA DIS 0.1MG	222
.....	213	<i>alose tron hcl tab 0.5 mg (base equiv)</i>	227

<i>alose tron hcl tab 1 mg (base equiv)</i>	227	AMBIEN CR TAB 6.25MG	236
ALPHAGAN P SOL 0.1%	280	AMBIEN TAB 10MG	236
ALPHAGAN P SOL 0.15%	280	AMBIEN TAB 5MG	236
ALPRAZOLAM CON 1 MG/ML.....	52	<i>ambrisentan tab 10 mg</i>	162
<i>alprazolam orally disintegrating tab 0.25</i>		<i>ambrisentan tab 5 mg</i>	162
<i>mg</i>	52	<i>amcinonide cream 0.1%</i>	185
<i>alprazolam orally disintegrating tab 0.5 mg</i>		<i>amcinonide lotion 0.1%</i>	185
.....	52	<i>amcinonide oint 0.1%</i>	185
<i>alprazolam orally disintegrating tab 1 mg</i> .	52	AMELUZ GEL 10%.....	178
<i>alprazolam orally disintegrating tab 2 mg</i>	53	AMERGE TAB 1MG.....	263
<i>alprazolam tab 0.25 mg</i>	53	AMERGE TAB 2.5MG.....	263
<i>alprazolam tab 0.5 mg</i>	53	AMICAR SOL 0.25/ML	235
<i>alprazolam tab 1 mg</i>	53	AMICAR TAB 1000MG	235
<i>alprazolam tab 2 mg</i>	53	AMICAR TAB 500MG	235
<i>alprazolam tab er 24hr 0.5 mg</i>	53	<i>amiloride & hydrochlorothiazide tab 5-50</i>	
<i>alprazolam tab er 24hr 1 mg</i>	53	<i>mg</i>	211
<i>alprazolam tab er 24hr 2 mg</i>	53	<i>amiloride hcl tab 5 mg</i>	212
<i>alprazolam tab er 24hr 3 mg</i>	53	<i>aminocaproic acid oral soln 0.25 gm/ml</i>	235
ALREX SUS 0.2%	283	<i>aminocaproic acid tab 1000 mg</i>	235
ALTABAX OIN 1%	176	<i>aminocaproic acid tab 500 mg</i>	235
ALTACE CAP 1.25MG	101	<i>amiodarone hcl tab 100 mg</i>	55
ALTACE CAP 10MG	101	<i>amiodarone hcl tab 200 mg</i>	55
ALTACE CAP 2.5MG	101	<i>amiodarone hcl tab 400 mg</i>	55
ALTACE CAP 5MG	101	AMITIZA CAP 24MCG	225
ALTEMIA EMU	278	AMITIZA CAP 8MCG	225
ALTOPREV TAB 20MG ER	98	<i>amitriptyline hcl tab 100 mg</i>	80
ALTOPREV TAB 40MG ER	98	<i>amitriptyline hcl tab 10 mg</i>	80
ALTOPREV TAB 60MG ER	98	<i>amitriptyline hcl tab 150 mg</i>	80
ALTRENO LOT 0.05%	173	<i>amitriptyline hcl tab 25 mg</i>	80
ALUNBRIG PAK.....	120	<i>amitriptyline hcl tab 50 mg</i>	80
ALUNBRIG TAB 180MG	120	<i>amitriptyline hcl tab 75 mg</i>	80
ALUNBRIG TAB 30MG	120	AMJEVITA INJ 10/0.2ML.....	16
ALUNBRIG TAB 90MG	120	AMJEVITA INJ 20/0.4ML.....	16
ALVESCO AER 160MCG.....	57	AMJEVITA INJ 40/0.8ML.....	16
ALVESCO AER 80MCG	57	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>alvimopan cap 12 mg</i>	228	<i>tab 10-10 mg</i>	158
<i>amantadine hcl cap 100 mg</i>	129	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>amantadine hcl soln 50 mg/5ml</i>	129	<i>tab 10-20 mg</i>	158
<i>amantadine hcl tab 100 mg</i>	129	<i>amlodipine besylate-atorvastatin calcium</i>	
AMARYL TAB 1MG.....	90	<i>tab 10-40 mg</i>	158
AMARYL TAB 2MG	90	<i>amlodipine besylate-atorvastatin calcium</i>	
AMARYL TAB 4MG	90	<i>tab 10-80 mg</i>	158
AMBIEN CR TAB 12.5MG	236		

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	157	<i>amlodipine besylate-valsartan tab 10-320 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	158	<i>amlodipine besylate-valsartan tab 5-160 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	158	<i>amlodipine besylate-valsartan tab 5-320 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	158	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	158	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	158	<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	106
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	158	<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	106
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	105	<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	106
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	105	<i>amoxapine tab 100 mg</i>	80
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	105	<i>amoxapine tab 150 mg</i>	80
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	105	<i>amoxapine tab 25 mg</i>	80
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	105	<i>amoxapine tab 50 mg</i>	80
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	105	<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	308
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	106	<i>amoxicillin (trihydrate) cap 250 mg</i>	287
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	106	<i>amoxicillin (trihydrate) cap 500 mg</i>	287
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	105	<i>amoxicillin (trihydrate) chew tab 125 mg</i>	287
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	106	<i>amoxicillin (trihydrate) chew tab 250 mg</i>	287
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	154	<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	287
<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	154	<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	287
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	154	<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	287
<i>amlodipine besylate-valsartan tab 10-160 mg</i>	106	<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	287
		<i>amoxicillin (trihydrate) tab 500 mg</i>	287
		<i>amoxicillin (trihydrate) tab 875 mg</i>	287
		<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	287
		<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	287
		<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	287

<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	287	<i>ampicillin cap 500 mg</i>	287
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	287	AMPYRA TAB 10MG	292
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	287	AMRIX CAP 15MG	275
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	287	AMRIX CAP 30MG	275
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	287	AMZEEQ AER 4%	173
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	287	ANACAINE OIN	192
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	287	ANAFRANIL CAP 25MG	80
AMPHETAMI ER SUS 1.25/ML	2	ANAFRANIL CAP 50MG	80
<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	2	ANAFRANIL CAP 75MG	80
<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	2	<i>anagrelide hcl cap 0.5 mg</i>	232
<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	2	<i>anagrelide hcl cap 1 mg</i>	232
<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	2	ANALPRAM-HC CRE 1-1%	47
<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	2	ANALPRAM-HC LOT 2.5%	47
<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	2	ANASPAZ TAB 0.125MG	305
<i>amphetamine-dextroamphetamine tab 10 mg</i>	2	<i>anastrozole tab 1 mg</i>	117
<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	2	ANCOBON CAP 250MG	93
<i>amphetamine-dextroamphetamine tab 15 mg</i>	2	ANCOBON CAP 500MG	93
<i>amphetamine-dextroamphetamine tab 20 mg</i>	2	ANDRODERM DIS 2MG/24HR	46
<i>amphetamine-dextroamphetamine tab 30 mg</i>	2	ANDRODERM DIS 4MG/24HR	46
<i>amphetamine-dextroamphetamine tab 5 mg</i>	2	ANDROGEL GEL 1.62%	46
<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	2	ANDROGEL GEL 1%(25MG)	46
<i>amphetamine sulfate tab 10 mg</i>	2	ANDROGEL GEL 1%(50MG)	46
<i>amphetamine sulfate tab 5 mg</i>	2	ANGELIQ TAB 0.25-0.5	221
		ANGELIQ TAB 0.5-1MG	221
		ANNOVERA MIS	168
		ANORO ELLIPT AER 62.5-25	60
		ANTARA CAP 30MG	97
		ANTARA CAP 90MG	97
		ANUSOL-HC CRE 2.5%	48
		ANZEMET TAB 100MG	92
		ANZEMET TAB 50MG	92
		APADAZ TAB 4.08-325	42
		APADAZ TAB 6.12-325	42
		APADAZ TAB 8.16-325	42
		APEXICON E CRE 0.05%	185
		APIDRA INJ SOLOSTAR	87
		ALENZIN TAB 174MG	75
		ALENZIN TAB 348MG	75
		ALENZIN TAB 522MG	75
		APLICARE ALC PAD SWABSTIC	259
		<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	280
		<i>aprepitant capsule 125 mg</i>	93

<i>aprepitant capsule 40 mg</i>	93	<i>aripiprazole orally disintegrating tab 15 mg</i>	139
<i>aprepitant capsule 80 mg</i>	93	<i>aripiprazole oral solution 1 mg/ml</i>	139
<i>aprepitant capsule therapy pack 80 & 125</i> <i>mg</i>	93	<i>aripiprazole tab 10 mg</i>	139
APRISO CAP 0.375GM.....	226	<i>aripiprazole tab 15 mg</i>	139
APTENSIO XR CAP 10MG.....	9	<i>aripiprazole tab 20 mg</i>	139
APTENSIO XR CAP 15MG.....	9	<i>aripiprazole tab 2 mg</i>	139
APTENSIO XR CAP 20MG.....	9	<i>aripiprazole tab 30 mg</i>	139
APTENSIO XR CAP 30MG.....	9	<i>aripiprazole tab 5 mg</i>	139
APTENSIO XR CAP 40MG.....	9	ARISTADA INJ 1064MG.....	139
APTENSIO XR CAP 50MG.....	9	ARISTADA INJ 441MG/1.....	139
APTENSIO XR CAP 60MG.....	9	ARISTADA INJ 662MG/2.....	139
APTIOM TAB 200MG.....	66	ARISTADA INJ 882MG/3.....	139
APTIOM TAB 400MG.....	66	ARISTADA INJ INITIO.....	140
APTIOM TAB 600MG.....	66	ARIXTRA INJ 10/0.8ML.....	64
APTIOM TAB 800MG.....	66	ARIXTRA INJ 2.5/0.5.....	64
APTIVUS CAP 250MG.....	140	ARIXTRA INJ 5/0.4ML.....	64
APTIVUS SOL.....	140	ARIXTRA INJ 7.5/0.6.....	64
AQUALANCE MIS 30G.....	241	<i>armodafinil tab 150 mg</i>	9
ARAKODA TAB 100MG.....	112	<i>armodafinil tab 200 mg</i>	9
ARANESP INJ 100MCG.....	233	<i>armodafinil tab 250 mg</i>	9
ARANESP INJ 10MCG.....	233	<i>armodafinil tab 50 mg</i>	9
ARANESP INJ 150MCG.....	233	ARMONAIR DIG AER 113MCG.....	57
ARANESP INJ 200MCG.....	234	ARMONAIR DIG AER 232MCG.....	57
ARANESP INJ 25MCG.....	233	ARMONAIR DIG AER 55MCG.....	57
ARANESP INJ 300MCG.....	234	ARMOUR THYRO TAB 120MG.....	302
ARANESP INJ 40MCG.....	233	ARMOUR THYRO TAB 15MG.....	301
ARANESP INJ 500MCG.....	234	ARMOUR THYRO TAB 180MG.....	302
ARANESP INJ 60MCG.....	233	ARMOUR THYRO TAB 240MG.....	302
ARAVA TAB 10MG.....	29	ARMOUR THYRO TAB 300MG.....	302
ARAVA TAB 20MG.....	29	ARMOUR THYRO TAB 30MG.....	302
ARAZLO LOT 0.045%.....	173	ARMOUR THYRO TAB 60MG.....	302
ARCALYST INJ 220MG.....	24	ARMOUR THYRO TAB 90MG.....	302
<i>arformoterol tartrate soln nebu 15 mcg/2ml</i> <i>(base equiv)</i>	60	ARNUITY ELPT INH 100MCG.....	57
ARICEPT TAB 10MG.....	289	ARNUITY ELPT INH 200MCG.....	57
ARICEPT TAB 23MG.....	289	ARNUITY ELPT INH 50MCG.....	57
ARICEPT TAB 5MG.....	289	AROMASIN TAB 25MG.....	117
ARIKAYCE SUS.....	16	ARTESUNATE SOL 110MG.....	112
ARIMIDEX TAB 1MG.....	117	ARTHROTEC 50 TAB.....	26
<i>aripiprazole orally disintegrating tab 10 mg</i>	139	ARTHROTEC 75 TAB.....	26
		ARTISS SOL 10ML.....	235
		ARTISS SOL 2ML.....	235
		ARTISS SOL 4ML.....	235

ASA/OMEPRAZO TAB 81-40MG	232	ASSURE PLUS MIS PEDIATRI	242
ASACOL HD TAB 800MG	226	ASSURE PRISM SOL LEVEL1/2	242
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	136	ASSURE PRISM TES MULTI.....	196
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	136	ASSURE PRO LIQ LEVEL1/2.....	242
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	136	ASSURE PRO TES	196
ASMANEX 120 AER 220MCG	57	ASSURE TES PLATINUM	196
ASMANEX 14 AER 220MCG.....	57	ASTAGRAF XL CAP 0.5MG	268
ASMANEX 30 AER 110MCG	57	ASTAGRAF XL CAP 1MG.....	268
ASMANEX 30 AER 220MCG.....	57	ASTAGRAF XL CAP 5MG.....	268
ASMANEX 60 AER 220MCG.....	57	ASTERO GEL 4%.....	192
ASMANEX 7 AER 110MCG.....	57	ATABEX EC TAB 29-1MG.....	271
ASMANEX HFA AER 100 MCG	58	ATABEX OB TAB 29-1MG	271
ASMANEX HFA AER 200 MCG	58	ATACAND HCT TAB 16-12.5	106
ASMANEX HFA AER 50MCG.....	57	ATACAND HCT TAB 32-12.5.....	106
ASP/OMEPRAZO TAB 325-40MG.....	232	ATACAND HCT TAB 32-25MG.....	106
<i>aspirin chew tab 81 mg</i>	32	ATACAND TAB 16MG	103
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	232	ATACAND TAB 32MG.....	103
<i>aspirin tab delayed release 81 mg</i>	32	ATACAND TAB 4MG.....	103
ASSURE 3 LIQ CONTROL	241	ATACAND TAB 8MG.....	103
ASSURE 3 TES.....	195	<i>atazanavir sulfate cap 150 mg (base equiv)</i>	140
ASSURE 4 LIQ LEVEL1/2	241	<i>atazanavir sulfate cap 200 mg (base equiv)</i>	140
ASSURE 4 TES.....	195	<i>atazanavir sulfate cap 300 mg (base equiv)</i>	141
ASSURE CMFRT MIS 28G	242	ATELVIA TAB.....	214
ASSURE DOSE SOL NORM/HGH.....	242	<i>atenolol & chlorthalidone tab 100-25 mg</i> 106	
ASSURE DOSE SOL NORMAL	242	<i>atenolol & chlorthalidone tab 50-25 mg</i> .106	
ASSURE II LIQ LEVEL 1	242	<i>atenolol tab 100 mg</i>	151
ASSURE II LIQ LEVEL1/2	242	<i>atenolol tab 25 mg</i>	151
ASSURE II TES	195	<i>atenolol tab 50 mg</i>	151
ASSURE II TES CHECK.....	196	ATIVAN TAB 0.5MG.....	53
ASSURE LANCE MIS 21G	242	ATIVAN TAB 1MG.....	53
ASSURE LANCE MIS 28G.....	242	ATIVAN TAB 2MG	53
ASSURE LANCE MIS LOW FLOW	242	<i>atomoxetine hcl cap 100 mg (base equiv)</i> ..7	
ASSURE LANCE MIS MICRO	242	<i>atomoxetine hcl cap 10 mg (base equiv)</i>.....7	
ASSURE LANCE MIS SAFE 25G	242	<i>atomoxetine hcl cap 18 mg (base equiv)</i>.....7	
ASSURE LANCE MIS SAFE 30G	242	<i>atomoxetine hcl cap 25 mg (base equiv)</i> ....7	
ASSURE PLUS MIS HIGH 18G.....	242	<i>atomoxetine hcl cap 40 mg (base equiv)</i>....7	
ASSURE PLUS MIS LOW 25G.....	242	<i>atomoxetine hcl cap 60 mg (base equiv)</i>....7	
ASSURE PLUS MIS MCRO 28G.....	242	<i>atomoxetine hcl cap 80 mg (base equiv)</i>....7	
ASSURE PLUS MIS NORM 21G.....	242	<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	98

<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	98	AUTOLET PLAT MIS 1.8MM.....	242
<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	98	AUTOLET PLAT MIS 2.4MM.....	242
<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	98	AUTOLET PLAT MIS 3.0MM.....	242
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	111	AUTOLET PLUS MIS	242
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	111	AUTOLET PLUS MIS LANC DEV.....	242
<i>atovaquone susp 750 mg/5ml</i>	49	AUVI-Q INJ 0.15MG.....	312
ATRALIN GEL 0.05%.....	173	AUVI-Q INJ 0.1MG	312
ATRIPLA TAB.....	141	AUVI-Q INJ 0.3MG	312
ATROPINE SUL SOL 0.01%	280	AVALIDE TAB 150-12.5	106
ATROPINE SUL SOL 1% OP	280	AVALIDE TAB 300-12.5	106
ATROVENT HFA AER 17MCG	56	AVANDIA TAB 2MG	89
AUBAGIO TAB 14MG	292	AVANDIA TAB 4MG.....	89
AUBAGIO TAB 7MG.....	292	AVAPRO TAB 150MG.....	103
AUGMENTIN SUS 125/5ML.....	288	AVAPRO TAB 300MG.....	103
AUGMENTIN SUS 250/5ML	288	AVAPRO TAB 75MG.....	103
AUGMENTIN SUS ES-600	288	AVODART CAP 0.5MG.....	229
AUGMENTIN TAB 500MG.....	288	AVONEX PEN KIT 30MCG	292
AURORA LANCE MIS 30G	242	AVONEX PREFL KIT 30MCG	292
AURORA LANCE MIS THIN 23G	242	AYGESTIN TAB 5MG	288
AURYXIA TAB 210MG.....	228	AYVAKIT TAB 100MG.....	118
AUSTEDO TAB 12MG	291	AYVAKIT TAB 200MG	118
AUSTEDO TAB 6MG.....	291	AYVAKIT TAB 25MG.....	118
AUSTEDO TAB 9MG.....	291	AYVAKIT TAB 300MG	119
AUSTEDO XR TAB 12MG.....	291	AYVAKIT TAB 50MG.....	118
AUSTEDO XR TAB 24MG.....	291	AZASITE SOL 1%.....	281
AUSTEDO XR TAB 6MG.....	291	<i>azathioprine tab 100 mg</i>	268
AUSTEDO XR TAB TITR KIT	291	<i>azathioprine tab 50 mg</i>	268
AUTOCODE TES BLD GLUC.....	196	<i>azathioprine tab 75 mg</i>	268
AUTO LANCET MIS.....	242	<i>azelaic acid gel 15%</i>	194
AUTO-LANCET MIS.....	242	<i>azelastine hcl-fluticasone prop nasal spray</i> <i>137-50 mcg/act</i>	277
AUTO-LANCET MIS MINI.....	242	<i>azelastine hcl nasal spray 0.1% (137</i> <i>mcg/spray)</i>	277
AUTOLET II KIT CLINISAF	242	<i>azelastine hcl nasal spray 0.15% (205.5</i> <i>mcg/spray)</i>	277
AUTOLET IMPR MIS LANC DEV.....	242	<i>azelastine hcl ophth soln 0.05%</i>	284
AUTOLET LANC MIS DEVICE	242	AZELEX CRE 20%	173
AUTOLET LITE KIT	242	AZESCHEW CHW 13-1MG	271
AUTOLET LITE KIT CLINISAF	242	AZESCO TAB 13-1MG	271
AUTOLET LITE KIT STARTER	242	AZILECT TAB 0.5MG.....	132
AUTOLET MINI MIS	242	AZILECT TAB 1MG	132
		<i>azithromycin for susp 100 mg/5ml</i>	239
		<i>azithromycin for susp 200 mg/5ml</i>	239

<i>azithromycin powd pack for susp 1 gm</i>	239	BD MICROTAIN MIS LANCETS	243
<i>azithromycin tab 250 mg</i>	239	BD SWAB BFLY PAD SNGL USE	259
<i>azithromycin tab 500 mg</i>	239	BD U-500 MIS 31GX6MM	260
<i>azithromycin tab 600 mg</i>	239	BD ULTRAFINE INSULIN	
AZOPT SUS 1% OP.....	284	SYRINGES/NEEDLES	260
AZOR TAB 10-20MG	106	BD ULTRAFINE PEN NEEDLES	260
AZOR TAB 10-40MG	106	BECONASE AQ SUS 0.042%.....	277
AZOR TAB 5-20MG.....	106	BELBUCA MIS 150MCG.....	45
AZOR TAB 5-40MG.....	106	BELBUCA MIS 300MCG.....	45
AZSTARYS CAP 26.1-5.2	9	BELBUCA MIS 450MCG.....	45
AZSTARYS CAP 39.2-7.8	9	BELBUCA MIS 600MCG.....	45
AZSTARYS CAP 52.3-10.....	9	BELBUCA MIS 750MCG.....	45
AZULFIDINE TAB 500MG	226	BELBUCA MIS 75MCG	45
AZULFIDINE TAB 500MG EN	226	BELBUCA MIS 900MCG.....	45
B		BELLA/OPIUM SUP 16.2-30	305
<i>bacitracin ophth oint 500 unit/gm</i>	281	BELLA/OPIUM SUP 16.2-60	305
<i>bacitracin-polymyxin b ophth oint</i>	281	BELSOMRA TAB 10MG.....	237
<i>bacitracin-polymyxin-neomycin-hc ophth</i>		BELSOMRA TAB 15MG.....	237
<i>oint 1%</i>	283	BELSOMRA TAB 20MG.....	237
<i>baclofen tab 10 mg</i>	275	BELSOMRA TAB 5MG	237
<i>baclofen tab 20 mg</i>	275	<i>benazepril & hydrochlorothiazide tab 10-</i>	
<i>baclofen tab 5 mg</i>	275	<i>12.5 mg</i>	106
BACTRIM DS TAB 800-160	49	<i>benazepril & hydrochlorothiazide tab 20-</i>	
BACTRIM TAB 400-80MG	49	<i>12.5 mg</i>	106
BAFIERTAM CAP 95MG.....	292	<i>benazepril & hydrochlorothiazide tab 20-25</i>	
BALCOLTRA TAB 0.1-20	165	<i>mg</i>	107
<i>balsalazide disodium cap 750 mg</i>	226	<i>benazepril & hydrochlorothiazide tab 5-</i>	
BALVERSA TAB 3MG.....	120	<i>6.25 mg</i>	106
BALVERSA TAB 4MG.....	120	<i>benazepril hcl tab 10 mg</i>	101
BALVERSA TAB 5MG.....	120	<i>benazepril hcl tab 20 mg</i>	101
BANZEL SUS 40MG/ML.....	67	<i>benazepril hcl tab 40 mg</i>	101
BANZEL TAB 200MG.....	67	<i>benazepril hcl tab 5 mg</i>	101
BANZEL TAB 400MG.....	67	BENICAR HCT TAB 20-12.5.....	107
BAQSIMI ONE POW 3MG/DOSE	85	BENICAR HCT TAB 40-12.5	107
BAQSIMI TWO POW 3MG/DOSE	85	BENICAR HCT TAB 40-25MG.....	107
BARACLUDGE SOL	148	BENICAR TAB 20MG.....	103
BASAGLAR INJ 100UNIT.....	87	BENICAR TAB 40MG	103
BAXDELA TAB 450MG.....	224	BENICAR TAB 5MG.....	103
<i>b-complex w/ c & folic acid tab</i>	271	BENLYSTA INJ 200MG/ML	270
<i>b-complex w/ c & folic acid tab 1 mg</i>	271	BENZAACLIN GEL 1-5%	173
<i>b-complex w/ c & folic acid tab 5 mg</i>	271	BENZAACLIN GEL 1-5%PUMP	173
BD LANCET UF MIS 30G.....	243	BENZALKONIUM SOL NF.....	140
BD LANCET UF MIS 33G	243	BENZAMYCIN GEL 5-3%.....	173

BENZEPRO AER 5.2%	173	<i>betamethasone dipropionate oint 0.05%</i>	185
BENZEPRO AER 9.7%	173	.....	185
BENZEPRO LIQ 6.8%	173	<i>betamethasone valerate aerosol foam</i>	185
BENZEPRO MIS 5.8%.....	173	0.12%.....	185
BENZHY/ACETA TAB 4.08-325.....	42	<i>betamethasone valerate cream 0.1% (base</i>	185
BENZHY/ACETA TAB 6.12-325	42	<i>equivalent)</i>	185
BENZHY/ACETA TAB 8.16-325.....	42	<i>betamethasone valerate lotion 0.1% (base</i>	186
BENZNIDAZOLE TAB 100MG	48	<i>equivalent)</i>	186
BENZNIDAZOLE TAB 12.5MG.....	48	<i>betamethasone valerate oint 0.1% (base</i>	186
<i>benzonatate cap 100 mg</i>	171	<i>equivalent)</i>	186
<i>benzonatate cap 150 mg</i>	171	BETAPACE AF TAB 120MG	152
<i>benzonatate cap 200 mg</i>	171	BETAPACE AF TAB 160MG	152
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	174	BETAPACE AF TAB 80MG.....	152
.....	174	BETAPACE TAB 120MG	152
<i>benzoyl peroxide foam 5.3%</i>	173	BETAPACE TAB 160MG	152
<i>benzoyl peroxide foam 9.8%</i>	173	BETAPACE TAB 80MG	152
<i>benzoyl peroxide-hydrocortisone lotion 5-</i>	174	BETASERON INJ 0.3MG	292
0.5%	174	<i>betaxolol hcl ophth soln 0.5%.....</i>	279
<i>benzoyl peroxide liq 7%</i>	174	<i>betaxolol hcl tab 10 mg.....</i>	151
BENZOYL PERX LIQ 6.9%	174	<i>betaxolol hcl tab 20 mg</i>	151
BENZ PER FOR LOT HC 7.5-1.....	173	<i>bethanechol chloride tab 10 mg.....</i>	310
BENZ PEROXID GEL 6.5%	173	<i>bethanechol chloride tab 25 mg.....</i>	310
<i>benzphetamine hcl tab 25 mg</i>	6	<i>bethanechol chloride tab 50 mg</i>	310
<i>benzphetamine hcl tab 50 mg</i>	6	<i>bethanechol chloride tab 5 mg.....</i>	310
<i>benztropine mesylate tab 0.5 mg.....</i>	129	BETHKIS NEB 300/4ML.....	16
<i>benztropine mesylate tab 1 mg.....</i>	129	BETIMOL SOL 0.25%	279
<i>benztropine mesylate tab 2 mg</i>	129	BETIMOL SOL 0.5%.....	279
BEPREVE DRO 1.5%.....	284	BETOPTIC-S SUS 0.25% OP	279
BESIVANCE SUS 0.6%.....	281	BEVESPI AER 9-4.8MCG.....	60
BESREMI SOL 500MCG.....	128	<i>bexarotene cap 75 mg</i>	128
BETADINE SOL 5% OP	281	BEYAZ TAB.....	165
<i>betamethasone dipropionate augmented</i>	185	<i>bicalutamide tab 50 mg.....</i>	117
<i>cream 0.05%.....</i>	185	BIDIL TAB.....	158
<i>betamethasone dipropionate augmented</i>	185	BIJUVA CAP 1-100MG.....	221
<i>gel 0.05%</i>	185	BIKTARVY TAB	141
<i>betamethasone dipropionate augmented</i>	185	BILTRICIDE TAB 600MG.....	48
<i>lotion 0.05%</i>	185	<i>bimatoprost ophth soln 0.03%</i>	285
<i>betamethasone dipropionate augmented</i>	185	BINOSTO TAB 70MG	214
<i>ointment 0.05%</i>	185	BIOSCANNER TES GLUCOSE	196
<i>betamethasone dipropionate cream 0.05%</i>	185	BIO-STATIN CAP 1000000	94
.....	185	BIO-STATIN CAP 500000	93
<i>betamethasone dipropionate lotion 0.05%</i>	185	<i>bisacodyl tab & peg 3350-kcl-sod bicarb-</i>	238
.....	185	<i>nacl for soln kit.....</i>	238

<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	308	BRIVIACT SOL 10MG/ML.....	67
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	107	BRIVIACT TAB 100MG.....	67
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	107	BRIVIACT TAB 10MG	67
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	107	BRIVIACT TAB 25MG.....	67
<i>bisoprolol fumarate tab 10 mg</i>	151	BRIVIACT TAB 50MG	67
<i>bisoprolol fumarate tab 5 mg</i>	151	BRIVIACT TAB 75MG.....	67
BLEPH-10 SOL 10% OP	281	<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	285
BLEPHAMIDE OIN S.O.P.	283	<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	129
BLEPHAMIDE SUS OP	283	<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	129
BLOOD GLUCOS TES.....	196	BROMSITE DRO 0.075%	285
BLOOD GLUCOS TES LE1.....	196	BRONCHITOL CAP 40MG	297
BLOOD GLUCOS TES PREMIUM	196	BRONCHITOL CAP TOL TEST.....	298
BLOOD GLUCOS TES STRIPS.....	196	BROVANA NEB 15MCG.....	61
BONIVA TAB 150MG.....	214	BRUKINSA CAP 80MG	121
BONJESTA TAB 20-20MG.....	93	BRYHALI LOT 0.01%	186
BORIC ACID GRA.....	193	<i>budesonide delayed release particles cap 3 mg</i>	169
<i>bosentan tab 125 mg</i>	162	<i>budesonide inhalation susp 0.25 mg/2ml</i> 58	
<i>bosentan tab 62.5 mg</i>	162	<i>budesonide inhalation susp 0.5 mg/2ml</i> ..58	
BOSULIF TAB 100MG.....	120	<i>budesonide inhalation susp 1 mg/2ml</i>.....58	
BOSULIF TAB 400MG.....	121	<i>budesonide tab er 24hr 9 mg</i>	169
BOSULIF TAB 500MG.....	121	<i>bumetanide tab 0.5 mg</i>	212
BRAFTOVI CAP 75MG	121	<i>bumetanide tab 1 mg</i>	212
BREATHE EASE MIS LG MASK	261	<i>bumetanide tab 2 mg</i>	212
BREATHE EASE MIS MED MASK.....	261	BUMEX TAB 0.5MG	212
BREATHE EASE MIS SM MASK	261	BUNAVAIL MIS 4.2-0.7	45
BREO ELLIPTA INH 100-25.....	61	BUNAVAIL MIS 6.3-1MG	45
BREO ELLIPTA INH 200-25.....	61	<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	45
BREO ELLIPTA INH 50-25MCG	60	<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	45
BREXAFEMME TAB 150MG	93	<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	45
BREZTRI AERO AER SPHERE	61	<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	45
BRILINTA TAB 60MG	232	<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	45
BRILINTA TAB 90MG	232	<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	45
BRIMO/DORZO SOL 0.15-2%	280		
<i>brimonidine tartrate ophth soln 0.15%</i> ..280			
<i>brimonidine tartrate ophth soln 0.2%</i> ....280			
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	279		
<i>brinzolamide ophth susp 1%</i>	284		
BRISDELLE CAP 7.5MG	297		

<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	<i>butalbital-acetaminophen tab 25-325 mg.31</i>
.....45	<i>butalbital-acetaminophen tab 50-300 mg</i>
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	.....32
.....45	<i>butalbital-acetaminophen tab 50-325 mg32</i>
<i>buprenorphine td patch weekly 10 mcg/hr</i>	<i>butalbital-aspirin-caffeine cap 50-325-40</i>
.....45	<i>mg.....32</i>
<i>buprenorphine td patch weekly 15 mcg/hr</i>	<i>butalbital-aspirin-caff w/ codeine cap 50-</i>
.....45	<i>325-40-30 mg .....43</i>
<i>buprenorphine td patch weekly 20 mcg/hr</i>	<i>butorphanol tartrate nasal soln 10 mg/ml 46</i>
.....45	BUTRANS DIS 10MCG/HR.....46
<i>buprenorphine td patch weekly 5 mcg/hr45</i>	BUTRANS DIS 15MCG/HR.....46
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	BUTRANS DIS 20MCG/HR.....46
.....45	BUTRANS DIS 5MCG/HR.....46
<i>bupropion hcl (smoking deterrent) tab er</i>	BUTRANS DIS 7.5/HR .....46
<i>12hr 150 mg.....296</i>	BYDUREON BC INJ 2/0.85ML .....86
<i>bupropion hcl tab 100 mg .....75</i>	BYDUREON PEN INJ 2MG .....86
<i>bupropion hcl tab 75 mg .....75</i>	BYETTA INJ 10MCG.....86
<i>bupropion hcl tab er 12hr 100 mg.....75</i>	BYETTA INJ 5MCG .....86
<i>bupropion hcl tab er 12hr 150 mg.....75</i>	BYLVAY CAP 1200MCG.....225
<i>bupropion hcl tab er 12hr 200 mg .....75</i>	BYLVAY CAP 200MCG .....225
<i>bupropion hcl tab er 24hr 150 mg .....75</i>	BYLVAY CAP 400MCG .....225
<i>bupropion hcl tab er 24hr 300 mg .....75</i>	BYLVAY CAP 600MCG .....225
<i>bupropion hcl tab er 24hr 450 mg .....75</i>	BYSTOLIC TAB 10MG .....151
<i>bupirone hcl tab 10 mg .....52</i>	BYSTOLIC TAB 2.5MG.....151
<i>bupirone hcl tab 15 mg .....52</i>	BYSTOLIC TAB 20MG.....151
<i>bupirone hcl tab 30 mg .....52</i>	BYSTOLIC TAB 5MG.....151
<i>bupirone hcl tab 5 mg.....52</i>	C
<i>bupirone hcl tab 7.5 mg.....52</i>	<i>cabergoline tab 0.5 mg.....219</i>
BUT/ASA/CAF TAB .....31	CABOMETYX TAB 20MG .....121
<i>butalbital-acetaminophen-caffeine cap 50-</i>	CABOMETYX TAB 40MG .....121
<i>300-40 mg .....32</i>	CABOMETYX TAB 60MG .....121
<i>butalbital-acetaminophen-caffeine cap 50-</i>	CADUET TAB 10-10MG .....158
<i>325-40 mg.....32</i>	CADUET TAB 10-20MG .....158
<i>butalbital-acetaminophen-caffeine soln 50-</i>	CADUET TAB 10-40MG .....158
<i>325-40 mg/15ml.....32</i>	CADUET TAB 10-80MG .....158
<i>butalbital-acetaminophen-caffeine tab 50-</i>	CADUET TAB 5-10MG.....158
<i>325-40 mg.....32</i>	CADUET TAB 5-20MG .....158
<i>butalbital-acetaminophen-caff w/ cod cap</i>	CADUET TAB 5-40MG .....158
<i>50-300-40-30 mg.....42</i>	CADUET TAB 5-80MG .....158
<i>butalbital-acetaminophen-caff w/ cod cap</i>	CAFERGOT TAB 1-100MG .....263
<i>50-325-40-30 mg .....43</i>	<i>caffeine citrate oral soln 60 mg/3ml (10</i>
<i>butalbital-acetaminophen cap 50-300 mg</i>	<i>mg/ml base equiv) .....5</i>
.....31	CALAN SR TAB 120MG .....154

CALAN SR TAB 180MG.....	154	CAPRELSA TAB 100MG.....	121
CALAN SR TAB 240MG.....	154	CAPRELSA TAB 300MG.....	121
<i>calcipotriene-betamethasone dipropionate oint 0.005-0.064%</i>	186	<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	107
<i>calcipotriene-betamethasone dipropionate susp 0.005-0.064%</i>	186	<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	107
<i>calcipotriene cream 0.005%</i>	179	<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	107
<i>calcipotriene foam 0.005%</i>	179	<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	107
<i>calcipotriene oint 0.005%</i>	179	<i>captopril tab 100 mg</i>	101
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	179	<i>captopril tab 12.5 mg</i>	101
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	214	<i>captopril tab 25 mg</i>	101
<i>calcitriol cap 0.25 mcg</i>	217	<i>captopril tab 50 mg</i>	101
<i>calcitriol cap 0.5 mcg</i>	217	CARAC CRE 0.5%.....	178
<i>calcitriol oint 3 mcg/gm</i>	179	CARAFATE SUS 1GM/10ML.....	306
<i>calcitriol oral soln 1 mcg/ml</i>	217	CARAFATE TAB 1GM.....	306
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	228	CARBAGLU TAB 200MG.....	217
CALQUENCE CAP 100MG.....	121	<i>carbamazepine cap er 12hr 100 mg</i>	67
CAMBIA POW 50MG.....	263	<i>carbamazepine cap er 12hr 200 mg</i>	67
CAMINO PRO LIQ 15PE.....	205	<i>carbamazepine cap er 12hr 300 mg</i>	67
CAMZYOS CAP 10MG.....	157	<i>carbamazepine chew tab 100 mg</i>	67
CAMZYOS CAP 15MG.....	157	<i>carbamazepine susp 100 mg/5ml</i>	67
CAMZYOS CAP 2.5MG.....	157	<i>carbamazepine tab 200 mg</i>	67
CAMZYOS CAP 5MG.....	157	<i>carbamazepine tab er 12hr 100 mg</i>	67
CANASA SUP 1000MG.....	226	<i>carbamazepine tab er 12hr 200 mg</i>	67
<i>candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg</i>	107	<i>carbamazepine tab er 12hr 400 mg</i>	67
<i>candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg</i>	107	CARBATROL CAP 100MG.....	67
<i>candesartan cilexetil-hydrochlorothiazide tab 32-25 mg</i>	107	CARBATROL CAP 200MG.....	67
<i>candesartan cilexetil tab 16 mg</i>	103	CARBATROL CAP 300MG.....	67
<i>candesartan cilexetil tab 32 mg</i>	103	<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	129
<i>candesartan cilexetil tab 4 mg</i>	103	<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	129
<i>candesartan cilexetil tab 8 mg</i>	103	<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	130
CANTHARIDIN SOL 0.7%.....	192	<i>carbidopa & levodopa tab 10-100 mg</i>	130
<i>capecitabine tab 150 mg</i>	114	<i>carbidopa & levodopa tab 25-100 mg</i>	130
<i>capecitabine tab 500 mg</i>	114	<i>carbidopa & levodopa tab 25-250 mg</i>	130
CAPEX SHA 0.01%.....	186	<i>carbidopa & levodopa tab er 25-100 mg</i>	130
CAPLYTA CAP 10.5MG.....	133	<i>carbidopa & levodopa tab er 50-200 mg</i>	130
CAPLYTA CAP 21MG.....	133	<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	130
CAPLYTA CAP 42MG.....	133		

<i>carbidopa-levodopa-entacapone tabs</i>	CARETOUCH MIS LANC 28G.....	243
18.75-75-200 mg.....	CARETOUCH MIS LANC 30G.....	243
<i>carbidopa-levodopa-entacapone tabs 25-</i>	CARETOUCH MIS TST STRP.....	196
100-200 mg.....	CARETOUCH MIS TWIST 28.....	243
<i>carbidopa-levodopa-entacapone tabs</i>	CARETOUCH MIS TWIST 30.....	243
31.25-125-200 mg.....	CARETOUCH MIS TWIST 33.....	243
<i>carbidopa-levodopa-entacapone tabs 37.5-</i>	CARETOUCH PAD ALCOHOL.....	259
150-200 mg.....	<i>carglumic acid soluble tab 200 mg.....</i>	217
<i>carbidopa-levodopa-entacapone tabs 50-</i>	<i>carisoprodol tab 250 mg.....</i>	275
200-200 mg.....	<i>carisoprodol tab 350 mg.....</i>	275
<i>carbidopa tab 25 mg.....</i>	<i>carisoprodol w/ aspirin & codeine tab 200-</i>	
<i>carbinoxamine maleate soln 4 mg/5ml</i>	325-16 mg.....	276
95	CARNITOR SF SOL 1GM/10ML.....	217
<i>carbinoxamine maleate tab 4 mg.....</i>	CARNITOR SOL 1GM/10ML.....	217
95	CARNITOR TAB 330MG.....	217
CARBINOXAMIN TAB 6MG.....	CAROSPIR SUS 25MG/5ML.....	212
95	<i>carteolol hcl ophth soln 1%.....</i>	279
CARDIOCOM MIS LANCING.....	<i>carvedilol phosphate cap er 24hr 10 mg .150</i>	
243	<i>carvedilol phosphate cap er 24hr 20 mg 150</i>	
CARDIZEM CD CAP 120MG/24.....	<i>carvedilol phosphate cap er 24hr 40 mg 150</i>	
154	<i>carvedilol phosphate cap er 24hr 80 mg 150</i>	
CARDIZEM CD CAP 180MG/24.....	<i>carvedilol tab 12.5 mg.....</i>	150
154	<i>carvedilol tab 25 mg.....</i>	150
CARDIZEM CD CAP 240MG/24.....	<i>carvedilol tab 3.125 mg.....</i>	150
154	<i>carvedilol tab 6.25 mg.....</i>	150
CARDIZEM CD CAP 300MG/24.....	CASCARA EXT SAGRADA.....	239
154	CASODEX TAB 50MG.....	117
CARDIZEM CD CAP 360MG/24.....	CATAPRES-TTS DIS 0.1/24HR.....	104
154	CATAPRES-TTS DIS 0.2/24HR.....	104
CARDIZEM LA TAB 120MG.....	CATAPRES-TTS DIS 0.3/24HR.....	104
154	CAVERJECT IM KIT 10MCG.....	158
CARDIZEM LA TAB 180MG.....	CAVERJECT INJ 40MCG.....	159
154	CAVERJECT KIT 20MCG.....	159
CARDIZEM LA TAB 240MG.....	CAYA DPR.....	240
154	CAYSTON INH 75MG.....	50
CARDIZEM LA TAB 300MG/24.....	<i>cefaclor cap 250 mg.....</i>	164
154	<i>cefaclor cap 500 mg.....</i>	164
CARDIZEM LA TAB 360MG.....	CEFACLOR ER TAB 500MG.....	165
154	<i>cefaclor for susp 125 mg/5ml.....</i>	165
CARDIZEM LA TAB 420MG/24.....	<i>cefaclor for susp 250 mg/5ml.....</i>	165
154	<i>cefaclor for susp 375 mg/5ml.....</i>	165
CARDIZEM TAB 120MG.....	<i>cefadroxil cap 500 mg.....</i>	164
154	<i>cefadroxil for susp 250 mg/5ml.....</i>	164
CARDIZEM TAB 30MG.....		
154		
CARDIZEM TAB 60MG.....		
154		
CARDURA TAB 1MG.....		
104		
CARDURA TAB 2MG.....		
104		
CARDURA TAB 4MG.....		
104		
CARDURA TAB 8MG.....		
104		
CARDURA XL TAB 4MG.....		
230		
CARDURA XL TAB 8MG.....		
230		
CAREONE ADV MIS LANCING.....		
243		
CAREONE LANC MIS 30G.....		
243		
CAREONE LANC MIS THIN 23G.....		
243		
CARESENS 30G MIS LANCETS.....		
243		
CARESENS N TES.....		
196		
CARESENS SOL CONTROL.....		
243		
CARETOUCH MIS EJECTOR.....		
243		
CARETOUCH MIS LANC 26G.....		
243		

<i>cefadroxil for susp 500 mg/5ml</i>	164	<i>cephalexin tab 500 mg</i>	164
<i>cefadroxil tab 1 gm</i>	164	CEQUA SOL 0.09%.....	282
<i>cefdinir cap 300 mg</i>	165	CEQR SIMPL KIT PATCH 2U.....	260
<i>cefdinir for susp 125 mg/5ml</i>	165	CERDELGA CAP 84MG.....	233
<i>cefdinir for susp 250 mg/5ml</i>	165	CERVIDIL VAG MIS 10MG INS.....	286
<i>cefixime cap 400 mg</i>	165	CETRAXAL SOL 0.2%.....	286
<i>cefixime for susp 100 mg/5ml</i>	165	CETROTIDE KIT 0.25MG.....	215
<i>cefixime for susp 200 mg/5ml</i>	165	<i>cevimeline hcl cap 30 mg</i>	271
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	165	CHANTIX PAK 1MG.....	296
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	165	CHANTIX TAB 0.5& 1MG.....	296
<i>cefpodoxime proxetil tab 100 mg</i>	165	CHANTIX TAB 0.5MG.....	296
<i>cefpodoxime proxetil tab 200 mg</i>	165	CHANTIX TAB 1MG.....	296
<i>cefprozil for susp 125 mg/5ml</i>	165	CHEMET CAP 100MG.....	91
<i>cefprozil for susp 250 mg/5ml</i>	165	CHEMSTRIP K TES.....	196
<i>cefprozil tab 250 mg</i>	165	CHEMSTRIP TES UGK.....	196
<i>cefprozil tab 500 mg</i>	165	CHENODAL TAB 250MG.....	224
<i>cefuroxime axetil tab 250 mg</i>	165	<i>chlordiazepoxide-amitriptyline tab 10-25</i> <i>mg</i>	290
<i>cefuroxime axetil tab 500 mg</i>	165	<i>chlordiazepoxide-amitriptyline tab 5-12.5</i> <i>mg</i>	290
CELEBREX CAP 100MG.....	26	<i>chlordiazepoxide hcl cap 10 mg</i>	53
CELEBREX CAP 200MG.....	26	<i>chlordiazepoxide hcl cap 25 mg</i>	53
CELEBREX CAP 400MG.....	26	<i>chlordiazepoxide hcl cap 5 mg</i>	53
CELEBREX CAP 50MG.....	26	<i>chlordiazepoxide hcl-clidinium bromide</i> <i>cap 5-2.5 mg</i>	305
<i>celecoxib cap 100 mg</i>	26	<i>chlorhexidine gluconate soln 0.12%</i>	270
<i>celecoxib cap 200 mg</i>	26	<i>chloroquine phosphate tab 250 mg</i>	112
<i>celecoxib cap 400 mg</i>	26	<i>chloroquine phosphate tab 500 mg</i>	112
<i>celecoxib cap 50 mg</i>	26	<i>chlorpromazine hcl tab 100 mg</i>	138
CELEXA TAB 10MG.....	76	<i>chlorpromazine hcl tab 10 mg</i>	138
CELEXA TAB 20MG.....	76	<i>chlorpromazine hcl tab 200 mg</i>	138
CELEXA TAB 40MG.....	76	<i>chlorpromazine hcl tab 25 mg</i>	138
CELLCEPT CAP 250MG.....	268	<i>chlorpromazine hcl tab 50 mg</i>	138
CELLCEPT IV INJ 500MG.....	268	<i>chlorthalidone tab 25 mg</i>	213
CELLCEPT SUS 200MG/ML.....	268	<i>chlorthalidone tab 50 mg</i>	213
CELLCEPT TAB 500MG.....	268	<i>chlorzoxazone tab 250 mg</i>	275
CELONTIN CAP 300MG.....	74	<i>chlorzoxazone tab 375 mg</i>	275
CENTANY OIN 2%.....	176	<i>chlorzoxazone tab 500 mg</i>	275
<i>cephalexin cap 250 mg</i>	164	<i>chlorzoxazone tab 750 mg</i>	275
<i>cephalexin cap 500 mg</i>	164	CHOLBAM CAP 250MG.....	224
<i>cephalexin cap 750 mg</i>	164	CHOLBAM CAP 50MG.....	224
<i>cephalexin for susp 125 mg/5ml</i>	164	<i>cholestyramine light powder 4 gm/dose</i> ..	96
<i>cephalexin for susp 250 mg/5ml</i>	164		
<i>cephalexin tab 250 mg</i>	164		

<i>cholestyramine light powder packets 4 gm</i>	96	<i>ciprofloxacin-fluocinolone acetone (pf) otic soln 0.3-0.025%</i>	286
<i>cholestyramine powder 4 gm/dose</i>	96	<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	281
<i>cholestyramine powder packets 4 gm</i>	96	<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	286
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	97	<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	224
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	97	<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	224
CHONDROITIN SOL.....	285	<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	224
CIALIS TAB 10MG	159	<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	224
CIALIS TAB 2.5MG	159	CIPRO HC SUS OTIC	286
CIALIS TAB 20MG	159	CIPRO TAB 250MG.....	224
CIALIS TAB 5MG.....	159	CIPRO TAB 500MG	224
CIBINQO TAB 100MG	191	<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	76
CIBINQO TAB 200MG.....	191	<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	76
CIBINQO TAB 50MG	191	<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	76
<i>ciclopirox gel 0.77%</i>	176	<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	76
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	176	CITRANATAL CAP HARMONY	271
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	176	CITRANATAL CAP MEDLEY	271
<i>ciclopirox shampoo 1%</i>	176	CITRANATAL MIS.....	271
<i>ciclopirox solution 8%</i>	176	CITRANATAL MIS 90 DHA	271
<i>cilostazol tab 100 mg</i>	232	CITRANATAL MIS B-CALM.....	271
<i>cilostazol tab 50 mg</i>	232	CITRANATAL PAK ASSURE.....	271
CILOXAN OIN 0.3% OP	281	CITRANATAL PAK DHA	272
CILOXAN SOL 0.3% OP	281	CITRANATAL TAB BLOOM.....	272
CIMDUO TAB 300-300.....	141	CITRANATAL TAB RX.....	272
<i>cimetidine hcl soln 300 mg/5ml</i>	305	CLARINEX-D TAB 2.5-120	171
<i>cimetidine tab 300 mg</i>	306	CLARINEX TAB 5MG	95
<i>cimetidine tab 400 mg</i>	306	<i>clarithromycin for susp 125 mg/5ml</i>	239
<i>cimetidine tab 800 mg</i>	306	<i>clarithromycin for susp 250 mg/5ml</i>	239
CIMZIA KIT 200MG.....	226	<i>clarithromycin tab 250 mg</i>	239
CIMZIA PREFL KIT 200MG/ML.....	226	<i>clarithromycin tab 500 mg</i>	239
CIMZIA START KIT 200MG/ML	226	<i>clarithromycin tab er 24hr 500 mg</i>	239
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	217	CLEANLET 28G MIS LANCETS	243
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	217	<i>clemastine fumarate tab 2.68 mg</i>	95
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	217		
CIPRO (10%) SUS 500MG/5	224		
CIPRO (5%) SUS 250MG/5	224		
CIPRODEX SUS 0.3-0.1%.....	286		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	286		

CLENPIQ SOL	238	<i>clindamycin phosphate vaginal cream 2%</i>	
CLEOCIN CAP 150MG	50	.....	311
CLEOCIN CAP 300MG	50	<i>clindamycin phosph-benzoyl peroxide</i>	
CLEOCIN CAP 75MG.....	50	(refrig) gel 1.2 (1)-5%	174
CLEOCIN CRE 2% VAG.....	311	CLINDESSE CRE 2%	311
CLEOCIN PED SOL 75MG/5ML.....	50	<i>clobazam suspension 2.5 mg/ml</i>	65
CLEOCIN SUP 100MG.....	311	<i>clobazam tab 10 mg</i>	65
CLEOCIN-T LOT 1%.....	174	<i>clobazam tab 20 mg</i>	65
CLEVER CHECK MIS	243	<i>clobetasol propionate cream 0.05%</i>	186
CLEVER CHECK MIS 30G	243	<i>clobetasol propionate emollient base cream</i>	
CLEVER CHEK TES.....	196	0.05%	186
CLEVER CHEK TES AUTO CD	196	<i>clobetasol propionate emulsion foam</i>	
CLEVER CHEK TES TALK	196	0.05%	186
CLEVER CHEK TES VOICE	196	<i>clobetasol propionate foam 0.05%</i>	186
CLEVER CHOIC TES MICRO	196	<i>clobetasol propionate gel 0.05%</i>	186
CLEVR CHOICE LIQ HIGH.....	243	<i>clobetasol propionate lotion 0.05%</i>	186
CLEVR CHOICE LIQ LOW	243	<i>clobetasol propionate oint 0.05%</i>	186
CLEVR CHOICE TES AUTO-CD.....	197	<i>clobetasol propionate shampoo 0.05%</i> ..	186
CLEVR CHOICE TES NOCODE.....	197	<i>clobetasol propionate soln 0.05%</i>	186
CLIMARA DIS 0.025MG	222	<i>clobetasol propionate spray 0.05%</i>	186
CLIMARA DIS 0.0375MG	222	CLOBEX LOT 0.05%	186
CLIMARA DIS 0.05MG	222	CLOBEX SHA 0.05%	186
CLIMARA DIS 0.06MG	222	CLOBEX SPR 0.05%	186
CLIMARA DIS 0.075MG	222	<i>clocortolone pivalate cream 0.1%</i>	186
CLIMARA DIS 0.1MG.....	222	CLODERM CRE 0.1%.....	186
CLIMARA PRO DIS WEEKLY	221	<i>clomiphene citrate tab 50 mg</i>	215
CLINDAGEL GEL 1%	174	<i>clomipramine hcl cap 25 mg</i>	80
<i>clindamycin hcl cap 150 mg</i>	50	<i>clomipramine hcl cap 50 mg</i>	80
<i>clindamycin hcl cap 300 mg</i>	50	<i>clomipramine hcl cap 75 mg</i>	80
<i>clindamycin hcl cap 75 mg</i>	50	<i>clonazepam orally disintegrating tab 0.125</i>	
<i>clindamycin palmitate hcl for soln 75</i>		<i>mg</i>	65
<i>mg/5ml (base equiv)</i>	50	<i>clonazepam orally disintegrating tab 0.25</i>	
<i>clindamycin phosphate-benzoyl peroxide</i>		<i>mg</i>	65
<i>gel 1.2-2.5%</i>	174	<i>clonazepam orally disintegrating tab 0.5 mg</i>	
<i>clindamycin phosphate-benzoyl peroxide</i>		.....	65
<i>gel 1-5%</i>	174	<i>clonazepam orally disintegrating tab 1 mg</i>	
<i>clindamycin phosphate foam 1%</i>	174	.....	66
<i>clindamycin phosphate gel 1%</i>	174	<i>clonazepam orally disintegrating tab 2 mg</i>	
<i>clindamycin phosphate lotion 1%</i>	174	.....	66
<i>clindamycin phosphate soln 1%</i>	174	<i>clonazepam tab 0.5 mg</i>	66
<i>clindamycin phosphate swab 1%</i>	174	<i>clonazepam tab 1 mg</i>	66
<i>clindamycin phosphate-tretinoin gel 1.2-</i>		<i>clonazepam tab 2 mg</i>	66
<i>0.025%</i>	174	<i>clonidine hcl tab 0.1 mg</i>	104

<i>clonidine hcl tab 0.2 mg</i>	104	CODEINE SULF TAB 15MG.....	32
<i>clonidine hcl tab 0.3 mg</i>	104	CODEINE SULF TAB 60MG.....	32
<i>clonidine hcl tab er 12hr 0.1 mg</i>	7	COLAZAL CAP 750MG.....	226
<i>clonidine td patch weekly 0.1 mg/24hr</i> ..	104	<i>colchicine tab 0.6 mg</i>	230
<i>clonidine td patch weekly 0.2 mg/24hr</i> ..	104	<i>colchicine w/ probenecid tab 0.5-500 mg</i>	230
<i>clonidine td patch weekly 0.3 mg/24hr</i> ..	104	COLCRYS TAB 0.6MG	230
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	232	<i>colesevelam hcl packet for susp 3.75 gm</i> 96	
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	232	<i>colesevelam hcl tab 625 mg</i>	96
<i>clorazepate dipotassium tab 15 mg</i>	53	COLESTID FLA GRA 5/7.5GM	97
<i>clorazepate dipotassium tab 3.75 mg</i>	53	COLESTID FLA GRA 5GM	97
<i>clorazepate dipotassium tab 7.5 mg</i>	53	COLESTID GRA 5GM	97
<i>clotrimazole soln 1%</i>	176	COLESTID POW 5GM.....	97
<i>clotrimazole troche 10 mg</i>	270	COLESTID TAB 1GM	97
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	177	<i>colestipol hcl granule packets 5 gm</i>	97
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	177	<i>colestipol hcl granules 5 gm</i>	97
<i>clozapine orally disintegrating tab 100 mg</i>	136	<i>colestipol hcl tab 1 gm</i>	97
<i>clozapine orally disintegrating tab 12.5 mg</i>	136	COMBIGAN SOL 0.2/0.5%.....	279
<i>clozapine orally disintegrating tab 150 mg</i>	136	COMBIPATCH DIS.....	221
<i>clozapine orally disintegrating tab 200 mg</i>	136	COMBIVENT AER 20-100	61
<i>clozapine orally disintegrating tab 25 mg</i>	136	COMBIVIR TAB 150-300	141
<i>clozapine tab 100 mg</i>	136	COMETRIQ KIT 100MG.....	121
<i>clozapine tab 200 mg</i>	136	COMETRIQ KIT 140MG.....	121
<i>clozapine tab 25 mg</i>	136	COMETRIQ KIT 60MG	121
<i>clozapine tab 50 mg</i>	136	COMFORT ASSU MIS LANC 28G.....	243
CLOZARIL TAB 100MG	136	COMFORT ASSU MIS LANC 33G.....	243
CLOZARIL TAB 200MG	136	COMFORT EZ MIS 21G	243
CLOZARIL TAB 25MG	136	COMFORT EZ MIS 23G	243
CLOZARIL TAB 50MG.....	136	COMFORT EZ MIS 28G	243
C-NATE DHA CAP 28-1-200	271	COMFORT EZ MIS 31GX5/16.....	260
COAGUCHEK MIS LANCETS.....	243	COMFORT MIS LANCETS.....	243
<i>coal tar soln 20%</i>	194	COMFORTOUCH MIS LANCET	243
COARTEM TAB 20-120MG	111	COMFORT TCH MIS LANC 28G.....	243
COCAINE HCL SOL 40MG/ML	277	COMFORT TCH MIS LANC 31G	243
<i>codeine sulfate tab 30 mg</i>	33	COMPACT SPAC MIS CHAMBER	261
		COMPACT SPAC MIS LG MASK	261
		COMPACT SPAC MIS MD MASK	261
		COMPACT SPAC MIS SM MASK.....	261
		COMPLEAT LIQ CLS SYS	205
		COMPLEAT PED LIQ ORG BLND.....	205
		COMTAN TAB 200MG	129
		CO-NATAL FA TAB 29-1MG	272
		CONCEPT DHA CAP.....	272

CONCEPT OB CAP.....	272	COREG CR CAP 20MG	150
CONCERTA TAB 18MG.....	9	COREG CR CAP 40MG	151
CONCERTA TAB 27MG	9	COREG CR CAP 80MG	151
CONCERTA TAB 36MG	9	COREG TAB 12.5MG	151
CONCERTA TAB 54MG	9	COREG TAB 25MG	151
CONDYLOX GEL 0.5%.....	192	COREG TAB 3.125MG	151
CONFIRM/MICR TES GLUCOSE.....	197	COREG TAB 6.25MG.....	151
CONJUPRI TAB 2.5MG	154	CORGARD TAB 20MG	152
CONJUPRI TAB 5MG	154	CORGARD TAB 40MG	152
CONSENSI TAB 10-200MG	153	CORGARD TAB 80MG	152
CONSENSI TAB 2.5-200	153	CORLANOR SOL 5MG/5ML.....	164
CONSENSI TAB 5-200MG.....	153	CORLANOR TAB 5MG	164
CONTOUR HIGH LIQ CONTROL.....	243	CORLANOR TAB 7.5MG	164
CONTOUR LOW LIQ CONTROL.....	243	CORTEF TAB 10MG	169
CONTOUR NEXT SOL LEVEL 1	243	CORTEF TAB 20MG	169
CONTOUR NEXT SOL LEVEL 2	243	CORTEF TAB 5MG.....	169
CONTOUR NORM LIQ CONTROL.....	244	CORTENEMA ENE 100MG	47
CONTOUR TES BLD GLUC	197	CORTIFOAM AER 90MG	47
CONTOUR TES NEXT	197	CORTISPORIN SUS -TC OTIC	286
CONTROL HIGH SOL UNISTRIP	244	CORTROPHIN GEL 80UNIT	214
CONTROL LOW SOL UNISTRIP	244	COSENTYX INJ 150MG/ML	180
CONTROL NORM SOL EASY STP.....	244	COSENTYX INJ 300DOSE.....	180
CONTROL SOL LIQ HI/MID/L	244	COSENTYX INJ 75MG/0.5	179
CONTROL SOL LIQ HIGH/LOW.....	244	COSENTYX PEN INJ 150MG/ML	180
CONTROL SOL LIQ LEVEL 2.....	244	COSENTYX PEN INJ 300DOSE	181
CONTROL SOL LIQ MID.....	244	COSENTYX UNO INJ 300/2ML.....	181
CONTROL SOL NORMAL	244	COSOFT PF SOL 2%-0.5%.....	279
CONZIP CAP 100MG	33	COSOFT SOL 2-0.5%OP	279
CONZIP CAP 200MG.....	33	COTELLIC TAB 20MG.....	121
CONZIP CAP 300MG.....	33	COTEMPLA XR TAB 17.3MG	10
COOL BLOOD TES GLUCOSE	197	COTEMPLA XR TAB 25.9MG	10
COOL CONTROL SOL A.....	244	COTEMPLA XR TAB 8.6MG	9
COOL CONTROL SOL B.....	244	COZAAR TAB 100MG.....	103
COPAXONE INJ 20MG/ML	292	COZAAR TAB 25MG.....	103
COPAXONE INJ 40MG/ML	292	COZAAR TAB 50MG	103
COPIKTRA CAP 15MG	121	CREON CAP 12000UNT.....	210
COPIKTRA CAP 25MG.....	121	CREON CAP 24000UNT	210
CORDRAN 80X3 TAP 4MCG/CM	186	CREON CAP 3000UNIT	210
CORDRAN CRE 0.025%	186	CREON CAP 36000UNT	210
CORDRAN CRE 0.05%	186	CREON CAP 6000UNIT	210
CORDRAN LOT 0.05%.....	187	CRESEMBA CAP 186 MG	94
CORDRAN OIN 0.05%	187	CRESTOR TAB 10MG.....	98
COREG CR CAP 10MG.....	150	CRESTOR TAB 20MG	98

CRESTOR TAB 40MG	98	CYCLOPHOSPH TAB 50MG	113
CRESTOR TAB 5MG	98	<i>cycloserine cap 250 mg</i>	113
CRINONE GEL 4% VAG	311	CYCLOSET TAB 0.8MG.....	86
CRINONE GEL 8% VAG	311	<i>cyclosporine (ophth) emulsion 0.05%</i>	282
CRIXIVAN CAP 400MG	141	<i>cyclosporine cap 100 mg</i>	268
<i>cromolyn sodium ophth soln 4%</i>	285	<i>cyclosporine cap 25 mg</i>	268
<i>cromolyn sodium oral conc 100 mg/5ml</i>	225	<i>cyclosporine modified cap 100 mg</i>	268
<i>cromolyn sodium soln nebu 20 mg/2ml</i> ..	55	<i>cyclosporine modified cap 25 mg</i>	268
<i>crotonon lotion 10%</i>	194	<i>cyclosporine modified cap 50 mg</i>	268
CRUCIAL LIQ UNFLAVOR.....	205	<i>cyclosporine modified oral soln 100 mg/ml</i>	268
CUPRIMINE CAP 250MG.....	267	.....	268
CURITY PREP PAD ALCOHOL	259	CYMBALTA CAP 20MG.....	78
CURITY SWABS PAD ALCOHOL	259	CYMBALTA CAP 30MG	78
CUTIVATE LOT 0.05%	187	CYMBALTA CAP 60MG	79
CUVPOSA SOL 1MG/5ML.....	305	<i>cyproheptadine hcl syrup 2 mg/5ml</i>	96
CVS ADVANCED TES GLUCOSE	197	<i>cyproheptadine hcl tab 4 mg</i>	96
CVS GLUCOSE TES TEST STR	197	CYSTADANE POW.....	217
CVS KETONE TES CARE	197	CYSTADROPS SOL 0.37%.....	285
CVS LANCETS MIS 21G.....	244	CYSTAGON CAP 150MG.....	229
CVS LANCETS MIS 30G.....	244	CYSTAGON CAP 50MG	229
CVS LANCETS MIS 33G	244	CYSTARAN SOL 0.44%	285
CVS LANCETS MIS ORIGINAL	244	CYTOMEL TAB 25MCG.....	302
CVS LANCETS MIS THIN 26G.....	244	CYTOMEL TAB 50MCG	302
CVS LANCETS MIS THIN 30G.....	244	CYTOMEL TAB 5MCG.....	302
CVS LANCETS MIS THIN 33G.....	244	CYTOTEC TAB 100MCG	308
CVS LANCING MIS DEVICE.....	244	CYTOTEC TAB 200MCG	308
<i>cyanocobalamin inj 1000 mcg/ml</i>	233	D	
CYANOCOBALAM SOL 2000MCG	233	<i>dalfampridine tab er 12hr 10 mg</i>	292
<i>cyclobenzaprine hcl cap er 24hr 15 mg</i> ..	275	DALIRESP TAB 250MCG.....	57
<i>cyclobenzaprine hcl cap er 24hr 30 mg</i> ..	275	DALIRESP TAB 500MCG	57
<i>cyclobenzaprine hcl tab 10 mg</i>	276	<i>danazol cap 100 mg</i>	46
<i>cyclobenzaprine hcl tab 5 mg</i>	276	<i>danazol cap 200 mg</i>	46
<i>cyclobenzaprine hcl tab 7.5 mg</i>	276	<i>danazol cap 50 mg</i>	46
CYCLOGYL SOL 0.5% OP	280	DANTRIUM CAP 25MG	276
CYCLOGYL SOL 1% OP.....	280	DANTRIUM CAP 50MG.....	276
CYCLOGYL SOL 2% OP	280	<i>dantrolene sodium cap 100 mg</i>	276
CYCLOMYDRIL SOL OP.....	280	<i>dantrolene sodium cap 25 mg</i>	276
<i>cyclopentolate hcl ophth soln 0.5%</i>	280	<i>dantrolene sodium cap 50 mg</i>	276
<i>cyclopentolate hcl ophth soln 1%</i>	280	<i>dapsone gel 5%</i>	174
<i>cyclopentolate hcl ophth soln 2%</i>	280	<i>dapsone gel 7.5%</i>	174
<i>cyclophosphamide cap 25 mg</i>	113	<i>dapsone tab 100 mg</i>	50
<i>cyclophosphamide cap 50 mg</i>	113	<i>dapsone tab 25 mg</i>	49
CYCLOPHOSPH TAB 25MG	113	DARAPRIM TAB 25MG	112

<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	309	DERMA-SMOOTH OIL /FS BODY	187
<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	309	DERMA-SMOOTH OIL /FS SCLP	187
DAYPRO TAB 600MG	26	DERMOTIC OIL 0.01%	286
DAYTRANA DIS 10MG/9HR	10	DESCOVY TAB 120-15MG	141
DAYTRANA DIS 15MG/9HR	10	DESCOVY TAB 200/25MG	141
DAYTRANA DIS 20MG/9HR	10	<i>desipramine hcl tab 100 mg</i>	81
DAYTRANA DIS 30MG/9HR	10	<i>desipramine hcl tab 10 mg</i>	80
DAYVIGO TAB 10MG	237	<i>desipramine hcl tab 150 mg</i>	81
DAYVIGO TAB 5MG	237	<i>desipramine hcl tab 25 mg</i>	80
D-CARE BLOOD TES GLUCOSE	197	<i>desipramine hcl tab 50 mg</i>	80
DDAVP SOL 0.01%	219	<i>desipramine hcl tab 75 mg</i>	81
DDAVP TAB 0.1MG	219	<i>desloratadine tab 5 mg</i>	95
DDAVP TAB 0.2MG	219	<i>desloratadine tab orally disintegrating 2.5 mg</i>	95
<i>deferasirox granules packet 180 mg</i>	91	<i>desloratadine tab orally disintegrating 5 mg</i>	95
<i>deferasirox granules packet 360 mg</i>	91	<i>desmopressin acetate nasal spray soln 0.01%</i>	219
<i>deferasirox granules packet 90 mg</i>	91	<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	219
<i>deferasirox tab 180 mg</i>	91	<i>desmopressin acetate tab 0.1 mg</i>	219
<i>deferasirox tab 360 mg</i>	91	<i>desmopressin acetate tab 0.2 mg</i>	219
<i>deferasirox tab 90 mg</i>	91	<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	165
<i>deferasirox tab for oral susp 125 mg</i>	91	<i>desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg</i>	165
<i>deferasirox tab for oral susp 250 mg</i>	91	<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	166
<i>deferasirox tab for oral susp 500 mg</i>	91	DESONATE GEL 0.05%	187
<i>deferiprone tab 500 mg</i>	91	<i>desonide cream 0.05%</i>	187
DELESTROGEN INJ 10MG/ML	222	<i>desonide gel 0.05%</i>	187
DELESTROGEN INJ 20MG/ML	222	<i>desonide lotion 0.05%</i>	187
DELESTROGEN INJ 40MG/ML	222	<i>desonide oint 0.05%</i>	187
DELZICOL CAP 400MG	226	DESOWEN CRE 0.05%	187
<i>demeclocycline hcl tab 150 mg</i>	299	<i>desoximetasone cream 0.05%</i>	187
<i>demeclocycline hcl tab 300 mg</i>	299	<i>desoximetasone cream 0.25%</i>	187
DEMSER CAP 250MG	103	<i>desoximetasone gel 0.05%</i>	187
DENAVIR CRE 1%	184	<i>desoximetasone oint 0.05%</i>	187
DEPAKOTE ER TAB 250MG	74	<i>desoximetasone oint 0.25%</i>	187
DEPAKOTE ER TAB 500MG	74	<i>desoximetasone spray 0.25%</i>	187
DEPAKOTE SPR CAP 125MG	74	DESOPYN TAB 5MG	2
DEPAKOTE TAB 125MG DR	74	<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	79
DEPAKOTE TAB 250MG DR	74		
DEPAKOTE TAB 500MG DR	74		
DEPEN TITRA TAB 250MG	267		
DEPO-ESTRADI INJ 5MG/ML	222		
DEPO-PROVERA INJ 150MG/ML	168		
DEPO-SQ PROV INJ 104	168		

<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	79	DEXEDRINE CAP 15MG CR	3
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	79	DEXEDRINE CAP 5MG CR.....	3
DESVENLAFAX TAB 100MG ER	79	DEXILANT CAP 30MG DR	306
DESVENLAFAX TAB 50MG ER	79	DEXILANT CAP 60MG DR	306
DETROL LA CAP 2MG.....	309	<i>dexlansoprazole cap delayed release 30 mg</i>	306
DETROL LA CAP 4MG.....	309	<i>dexlansoprazole cap delayed release 60 mg</i>	306
DETROL TAB 1MG.....	309	<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	10
DETROL TAB 2MG.....	309	<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	10
DEXABLISS TAB 1.5MG	169	<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	10
DEXAMETHASON CON 1MG/ML	169	<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	10
<i>dexamethasone elixir 0.5 mg/5ml</i>	169	<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	10
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	283	<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>	11
<i>dexamethasone soln 0.5 mg/5ml</i>	169	<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>	11
<i>dexamethasone tab 0.5 mg</i>	169	<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	10
<i>dexamethasone tab 0.75 mg</i>	169	<i>dexmethylphenidate hcl tab 10 mg</i>	11
<i>dexamethasone tab 1.5 mg</i>	169	<i>dexmethylphenidate hcl tab 2.5 mg</i>	11
<i>dexamethasone tab 1 mg</i>	169	<i>dexmethylphenidate hcl tab 5 mg</i>	11
<i>dexamethasone tab 2 mg</i>	169	<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	3
<i>dexamethasone tab 4 mg</i>	169	<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	3
<i>dexamethasone tab 6 mg</i>	169	<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	3
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	169	<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	3
<i>dexamethasone tab therapy pack 1.5 mg (27)</i>	169	<i>dextroamphetamine sulfate tab 10 mg</i>	3
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	169	<i>dextroamphetamine sulfate tab 15 mg</i>	3
<i>dexamethasone tab therapy pack 1.5 mg (49)</i>	169	<i>dextroamphetamine sulfate tab 2.5 mg</i>	3
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	169	<i>dextroamphetamine sulfate tab 20 mg</i>	3
<i>dexchlorpheniramine maleate oral soln 2 mg/5ml</i>	95	<i>dextroamphetamine sulfate tab 30 mg</i>	3
DEXCOM G5 MIS RECEIVER	244	<i>dextroamphetamine sulfate tab 5 mg</i>	3
DEXCOM G5 MIS TRANSMIT	244	<i>dextroamphetamine sulfate tab 7.5 mg</i>	3
DEXCOM G6 MIS RECEIVER	244	DIABETIC TF LIQ	205
DEXCOM G6 MIS SENSOR	244		
DEXCOM G6 MIS TRANSMIT	244		
DEXCOM G7 MIS RECEIVER	244		
DEXCOM G7 MIS SENSOR	244		
DEXEDRINE CAP 10MG CR	3		

DIABETISOURC LIQ.....	205	<i>diclofenac sodium soln 1.5%</i>	176
DIACOMIT CAP 250MG.....	67	<i>diclofenac sodium soln 2%</i>	176
DIACOMIT CAP 500MG.....	67	<i>diclofenac sodium tab delayed release 25</i>	
DIACOMIT PAK 250MG.....	67	<i>mg</i>	26
DIACOMIT PAK 500MG.....	67	<i>diclofenac sodium tab delayed release 50</i>	
DIASTAT ACDL GEL 12.5-20.....	66	<i>mg</i>	26
DIASTAT ACDL GEL 5-10MG.....	66	<i>diclofenac sodium tab delayed release 75</i>	
DIASTAT PED GEL 2.5M GEL.....	66	<i>mg</i>	26
DIASTIX TES STRIPS.....	197	<i>diclofenac sodium tab er 24hr 100 mg</i>	26
DIATHRIVE+ MIS TEST STR.....	197	<i>diclofenac w/ misoprostol tab delayed</i>	
DIATHRIVE LIQ CONTROL.....	244	<i>release 50-0.2 mg</i>	26
DIATHRIVE MIS LANCETS.....	244	<i>diclofenac w/ misoprostol tab delayed</i>	
DIATHRIVE MIS LANCING.....	244	<i>release 75-0.2 mg</i>	26
DIATHRIVE MIS TEST STR.....	197	<i>dicloxacillin sodium cap 250 mg</i>	288
DIATHRIVE MIS UT 30G.....	244	<i>dicloxacillin sodium cap 500 mg</i>	288
DIATRUE CONT SOL LEVEL 1.....	244	<i>dicyclomine hcl cap 10 mg</i>	305
DIATRUE CONT SOL LEVEL 2.....	244	<i>dicyclomine hcl oral soln 10 mg/5ml</i>	305
DIATRUE CONT SOL LEVEL 3.....	244	<i>dicyclomine hcl tab 20 mg</i>	305
DIATRUE PLUS TES STRIPS.....	197	<i>diethylpropion hcl tab 25 mg</i>	6
<i>diazepam conc 5 mg/ml</i>	53	<i>diethylpropion hcl tab er 24hr 75 mg</i>	6
<i>diazepam oral soln 1 mg/ml</i>	53	DIFFERIN CRE 0.1%.....	174
<i>diazepam rectal gel delivery system 10 mg</i>		DIFFERIN GEL 0.1%.....	174
.....	66	DIFFERIN GEL 0.3%.....	174
<i>diazepam rectal gel delivery system 2.5 mg</i>		DIFFERIN LOT 0.1%.....	174
.....	66	DIFICID SUS.....	240
<i>diazepam rectal gel delivery system 20 mg</i>		DIFICID TAB 200MG.....	240
.....	66	<i>diflorasone diacetate cream 0.05%</i>	187
<i>diazepam tab 10 mg</i>	53	<i>diflorasone diacetate oint 0.05%</i>	187
<i>diazepam tab 2 mg</i>	53	DIFLUCAN SUS 10MG/ML.....	94
<i>diazepam tab 5 mg</i>	53	DIFLUCAN SUS 40MG/ML.....	94
<i>diazoxide susp 50 mg/ml</i>	85	DIFLUCAN TAB 100MG.....	94
DIBENZYLINE CAP 10MG.....	103	DIFLUCAN TAB 150MG.....	94
<i>dichlorphenamide tab 50 mg</i>	211	DIFLUCAN TAB 200MG.....	94
DICLEGIS TAB 10-10MG.....	93	DIFLUCAN TAB 50MG.....	94
DICLOFENAC CAP 35MG.....	26	<i>diflunisal tab 500 mg</i>	32
<i>diclofenac epolamine patch 1.3%</i>	176	<i>difluprednate ophth emulsion 0.05%</i>	283
<i>diclofenac potassium (migraine) packet 50</i>		<i>digoxin oral soln 0.05 mg/ml</i>	157
<i>mg</i>	263	<i>digoxin tab 125 mcg (0.125 mg)</i>	157
<i>diclofenac potassium cap 25 mg</i>	26	<i>digoxin tab 250 mcg (0.25 mg)</i>	157
<i>diclofenac potassium tab 50 mg</i>	26	<i>dihydroergotamine mesylate nasal spray 4</i>	
<i>diclofenac sodium (actinic keratoses) gel</i>		<i>mg/ml</i>	263
<i>3%</i>	178	DILANTIN-125 SUS 125/5ML.....	74
<i>diclofenac sodium ophth soln 0.1%</i>	285	DILANTIN CAP 100MG.....	74

DILANTIN CAP 30MG.....	74	<i>diltiazem hcl tab er 24hr 420 mg.....</i>	155
DILANTIN CHW 50MG.....	74	<i>dimethyl fumarate capsule delayed release</i>	
DILATRATE SR CAP 40MG.....	51	120 mg.....	292
DILAUDID LIQ 1MG/ML.....	33	<i>dimethyl fumarate capsule delayed release</i>	
DILAUDID TAB 2MG.....	33	240 mg.....	292
DILAUDID TAB 4MG.....	33	<i>dimethyl fumarate capsule dr starter pack</i>	
DILAUDID TAB 8MG.....	33	120 mg & 240 mg.....	293
<i>diltiazem hcl cap er 12hr 120 mg.....</i>	154	DIOVAN HCT TAB 160-12.5.....	107
<i>diltiazem hcl cap er 12hr 60 mg.....</i>	154	DIOVAN HCT TAB 160-25MG.....	107
<i>diltiazem hcl cap er 12hr 90 mg.....</i>	154	DIOVAN HCT TAB 320-12.5.....	107
<i>diltiazem hcl cap er 24hr 120 mg.....</i>	154	DIOVAN HCT TAB 320-25MG.....	107
<i>diltiazem hcl cap er 24hr 180 mg.....</i>	154	DIOVAN HCT TAB 80/12.5.....	107
<i>diltiazem hcl cap er 24hr 240 mg.....</i>	154	DIOVAN TAB 160MG.....	103
<i>diltiazem hcl coated beads cap er 24hr 120</i>		DIOVAN TAB 320MG.....	103
<i>mg.....</i>	154	DIOVAN TAB 40MG.....	103
<i>diltiazem hcl coated beads cap er 24hr 180</i>		DIOVAN TAB 80MG.....	103
<i>mg.....</i>	154	DIPENTUM CAP 250MG.....	226
<i>diltiazem hcl coated beads cap er 24hr 240</i>		<i>diphenoxylate w/ atropine liq 2.5-0.025</i>	
<i>mg.....</i>	154	<i>mg/5ml.....</i>	91
<i>diltiazem hcl coated beads cap er 24hr 300</i>		<i>diphenoxylate w/ atropine tab 2.5-0.025</i>	
<i>mg.....</i>	155	<i>mg.....</i>	91
<i>diltiazem hcl coated beads cap er 24hr 360</i>		DIPROLENE AF CRE 0.05%.....	187
<i>mg.....</i>	155	DIPROLENE OIN 0.05%.....	187
<i>diltiazem hcl extended release beads cap</i>		<i>dipyridamole tab 25 mg.....</i>	232
<i>er 24hr 120 mg.....</i>	155	<i>dipyridamole tab 50 mg.....</i>	232
<i>diltiazem hcl extended release beads cap</i>		<i>dipyridamole tab 75 mg.....</i>	232
<i>er 24hr 180 mg.....</i>	155	<i>disopyramide phosphate cap 100 mg.....</i>	54
<i>diltiazem hcl extended release beads cap</i>		<i>disopyramide phosphate cap 150 mg.....</i>	54
<i>er 24hr 240 mg.....</i>	155	<i>disulfiram tab 250 mg.....</i>	288
<i>diltiazem hcl extended release beads cap</i>		<i>disulfiram tab 500 mg.....</i>	288
<i>er 24hr 300 mg.....</i>	155	DITROPAN XL TAB 10MG.....	309
<i>diltiazem hcl extended release beads cap</i>		DITROPAN XL TAB 5MG.....	309
<i>er 24hr 360 mg.....</i>	155	DIURIL SUS 250/5ML.....	213
<i>diltiazem hcl extended release beads cap</i>		<i>divalproex sodium cap delayed release</i>	
<i>er 24hr 420 mg.....</i>	155	<i>sprinkle 125 mg.....</i>	74
<i>diltiazem hcl tab 120 mg.....</i>	155	<i>divalproex sodium tab delayed release 125</i>	
<i>diltiazem hcl tab 30 mg.....</i>	155	<i>mg.....</i>	74
<i>diltiazem hcl tab 60 mg.....</i>	155	<i>divalproex sodium tab delayed release 250</i>	
<i>diltiazem hcl tab 90 mg.....</i>	155	<i>mg.....</i>	74
<i>diltiazem hcl tab er 24hr 180 mg.....</i>	155	<i>divalproex sodium tab delayed release 500</i>	
<i>diltiazem hcl tab er 24hr 240 mg.....</i>	155	<i>mg.....</i>	74
<i>diltiazem hcl tab er 24hr 300 mg.....</i>	155	<i>divalproex sodium tab er 24 hr 250 mg....</i>	75
<i>diltiazem hcl tab er 24hr 360 mg.....</i>	155	<i>divalproex sodium tab er 24 hr 500 mg....</i>	75

DIVIGEL GEL 0.25MG	222	<i>doxepin hcl conc 10 mg/ml</i>	81
DIVIGEL GEL 0.5MG	222	<i>doxepin hcl cream 5%</i>	179
DIVIGEL GEL 0.75MG	222	<i>doxercalciferol cap 0.5 mcg</i>	217
DIVIGEL GEL 1.25MG	222	<i>doxercalciferol cap 1 mcg.....</i>	217
DIVIGEL GEL 1MG/GM	222	<i>doxercalciferol cap 2.5 mcg.....</i>	217
<i>dofetilide cap 125 mcg (0.125 mg)</i>	55	<i>doxycycline hyclate cap 100 mg.....</i>	299
<i>dofetilide cap 250 mcg (0.25 mg)</i>	55	<i>doxycycline hyclate cap 50 mg</i>	299
<i>dofetilide cap 500 mcg (0.5 mg)</i>	55	<i>doxycycline hyclate tab 100 mg</i>	300
<i>donepezil hydrochloride orally</i>		<i>doxycycline hyclate tab 150 mg</i>	300
<i>disintegrating tab 10 mg.....</i>	289	<i>doxycycline hyclate tab 20 mg</i>	299
<i>donepezil hydrochloride orally</i>		<i>doxycycline hyclate tab 50 mg</i>	299
<i>disintegrating tab 5 mg</i>	289	<i>doxycycline hyclate tab 75 mg</i>	300
<i>donepezil hydrochloride tab 10 mg</i>	289	<i>doxycycline hyclate tab delayed release</i>	
<i>donepezil hydrochloride tab 23 mg.....</i>	289	<i>100 mg.....</i>	300
<i>donepezil hydrochloride tab 5 mg.....</i>	289	<i>doxycycline hyclate tab delayed release</i>	
DOPTELET TAB 20MG	234	<i>150 mg.....</i>	300
DORAL TAB 15MG	236	<i>doxycycline hyclate tab delayed release</i>	
DORYX MPC TAB 120MG	299	<i>200 mg</i>	300
DORYX TAB 200MG.....	299	<i>doxycycline hyclate tab delayed release 50</i>	
DORYX TAB 50MG	299	<i>mg.....</i>	300
DORYX TAB 80MG	299	<i>doxycycline hyclate tab delayed release 75</i>	
<i>dorzolamide hcl ophth soln 2%</i>	285	<i>mg.....</i>	300
<i>dorzolamide hcl-timolol maleate ophth soln</i>		<i>doxycycline hyclate tab delayed release 80</i>	
<i>2-0.5%.....</i>	279	<i>mg.....</i>	300
<i>dorzolamide hcl-timolol maleate pf ophth</i>		<i>doxycycline monohydrate cap 100 mg ..</i>	300
<i>soln 2-0.5%.....</i>	279	<i>doxycycline monohydrate cap 150 mg...300</i>	
DORZOLAMIDE SOL 2%	285	<i>doxycycline monohydrate cap 50 mg ....300</i>	
DOVATO TAB 50-300MG	141	<i>doxycycline monohydrate cap 75 mg ....300</i>	
DOVONEX CRE 0.005%.....	181	<i>doxycycline monohydrate for susp 25</i>	
<i>doxazosin mesylate tab 1 mg.....</i>	104	<i>mg/5ml</i>	300
<i>doxazosin mesylate tab 2 mg</i>	105	<i>doxycycline monohydrate tab 100 mg ...300</i>	
<i>doxazosin mesylate tab 4 mg</i>	105	<i>doxycycline monohydrate tab 150 mg ...300</i>	
<i>doxazosin mesylate tab 8 mg</i>	105	<i>doxycycline monohydrate tab 50 mg.....300</i>	
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>		<i>doxycycline monohydrate tab 75 mg</i>	300
.....	236	<i>doxylamine-pyridoxine tab delayed release</i>	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>		<i>10-10 mg</i>	93
.....	236	DRISDOL CAP 50000UNT.....	313
<i>doxepin hcl cap 100 mg</i>	81	DRIZALMA CAP 20MG DR.....	79
<i>doxepin hcl cap 10 mg</i>	81	DRIZALMA CAP 30MG DR.....	79
<i>doxepin hcl cap 150 mg</i>	81	DRIZALMA CAP 40MG DR.....	79
<i>doxepin hcl cap 25 mg</i>	81	DRIZALMA CAP 60MG DR.....	79
<i>doxepin hcl cap 50 mg.....</i>	81	<i>dronabinol cap 10 mg</i>	93
<i>doxepin hcl cap 75 mg</i>	81	<i>dronabinol cap 2.5 mg.....</i>	93

<i>dronabinol cap 5 mg</i>	93	DUPIXENT INJ 300/2ML.....	191
DROPLET LANC MIS 30G.....	244	DURAGESIC DIS 100MCG/H	33
DROPLET LANC MIS DEVICE.....	244	DURAGESIC DIS 12MCG/HR	33
DROPLET PERS MIS LANC 30G	245	DURAGESIC DIS 25MCG/HR.....	33
<i>drospirenone-ethinyl estradiol tab 3-0.02</i>		DURAGESIC DIS 50MCG/HR	33
<i>mg</i>	166	DURAGESIC DIS 75MCG/HR.....	33
<i>drospirenone-ethinyl estradiol tab 3-0.03</i>		DUREZOL EMU 0.05%	283
<i>mg</i>	166	DURLAZA CAP 162.5MG	232
<i>drospirenone-ethinyl estrad-levomefolate</i>		<i>dutasteride cap 0.5 mg</i>	230
<i>tab 3-0.02-0.451 mg</i>	166	<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	230
<i>drospirenone-ethinyl estrad-levomefolate</i>		.....	230
<i>tab 3-0.03-0.451 mg</i>	166	DUTOPROL TAB 100-12.5.....	107
DROXIA CAP 200MG	233	DUTOPROL TAB 25-12.5	107
DROXIA CAP 300MG	233	DUTOPROL TAB 50-12.5	107
DROXIA CAP 400MG	233	DXEVO 11-DAY PAK 1.5MG.....	169
<i>droxidopa cap 100 mg</i>	312	DYANAVAL XR CHW 10MG	4
<i>droxidopa cap 200 mg</i>	312	DYANAVAL XR CHW 15MG.....	4
<i>droxidopa cap 300 mg</i>	313	DYANAVAL XR CHW 20MG.....	4
DRYSOL SOL 20%.....	193	DYANAVAL XR CHW 5MG	4
DUAKLIR AER 400/12	61	DYANAVAL XR SUS 2.5MG/ML.....	4
DUAVEE TAB 0.45-20	221	DYMISTA SPR 137-50.....	277
DUETACT TAB 30-2MG	82	DYRENIUM CAP 100MG	213
DUETACT TAB 30-4MG	82	DYRENIUM CAP 50MG.....	213
DUET DHA 400 MIS 25-1-400.....	272	E	
DUET DHA MIS BALANCED.....	272	E.E.S. GRAN SUS 200/5ML	239
DUEXIS TAB 800-26.6.....	26	EAA SUPPLEME POW TROPICAL	205
DULERA AER 100-5MCG	61	EASIVENT MIS.....	261
DULERA AER 200-5MCG.....	61	EASIVENT MIS MASK LG.....	261
DULERA AER 50-5MCG.....	61	EASIVENT MIS MASK MED	261
<i>duloxetine hcl enteric coated pellets cap 20</i>		EASIVENT MIS MASK SM.....	261
<i>mg (base eq)</i>	79	EASY COMFORT MIS 30G.....	245
<i>duloxetine hcl enteric coated pellets cap 30</i>		EASY COMFORT MIS LANC/30G.....	245
<i>mg (base eq)</i>	79	EASY COMFORT MIS TWIST.....	245
<i>duloxetine hcl enteric coated pellets cap 40</i>		EASY COMFORT PAD ALCOHOL	259
<i>mg (base eq)</i>	79	EASYGLUCO SOL PLUS.....	245
<i>duloxetine hcl enteric coated pellets cap 60</i>		EASYGLUCO TES.....	198
<i>mg (base eq)</i>	79	EASYGLUCO TES PLUS	198
DUOBRII LOT	187	EASYMAX 15 LIQ LEVEL2-3	245
DUO-CARE LIQ LEVEL1/2	245	EASYMAX 15 SOL LEVEL 2	246
DUO-CARE TES.....	197	EASYMAX 15 TES.....	198
DUPIXENT INJ 100/0.67	55	EASYMAX LIQ NORM/HIG	246
DUPIXENT INJ 200/1.14	55	EASYMAX SOL NORMAL.....	246
DUPIXENT INJ 200MG	191	EASYMAX TES	198

EASY MINI MIS.....	245	EDEX KIT 40MCG	159
EASY MINI MIS EJECT	245	EDLUAR SUB 10MG	236
EASY PLUS II SOL HIGH.....	245	EDLUAR SUB 5MG	236
EASY PLUS II SOL LOW	245	EDURANT TAB 25MG	141
EASY PLUS II TES BLD GLUC	197	<i>efavirenz cap 200 mg</i>	141
EASYPRO PLUS TES.....	198	<i>efavirenz cap 50 mg</i>	141
EASYPRO TES BLD GLUC	198	<i>efavirenz-emtricitabine-tenofovir df tab</i>	
EASystEP HGH SOL CONTROL	246	<i>600-200-300 mg</i>	141
EASystEP LOW SOL CONTROL	246	<i>efavirenz-lamivudine-tenofovir df tab 400-</i>	
EASY STEP TES.....	197	<i>300-300 mg</i>	142
EASY TALK SOL HIGH.....	245	<i>efavirenz-lamivudine-tenofovir df tab 600-</i>	
EASY TALK SOL LOW	245	<i>300-300 mg</i>	142
EASY TALK SOL NORMAL.....	245	<i>efavirenz tab 600 mg</i>	141
EASY TALK TES BLD GLUC	197	EFFEXOR XR CAP 150MG	79
EASY TOUCH MIS.....	245	EFFEXOR XR CAP 37.5MG.....	79
EASY TOUCH MIS LANC/21G	245	EFFEXOR XR CAP 75MG.....	79
EASY TOUCH MIS LANC/23G.....	245	EFFIENT TAB 10MG	232
EASY TOUCH MIS LANC/26G	245	EFFIENT TAB 5MG	232
EASY TOUCH MIS LANC/28G.....	245	EFUDEX CRE 5%.....	178
EASY TOUCH MIS LANC/30G	245	EGRIFTA SV INJ 2MG.....	216
EASY TOUCH MIS LANC/32G.....	245	ELEMENT CONT LIQ NORMAL.....	246
EASY TOUCH MIS LANC/33G.....	245	ELEMENT LIQ HIGH.....	246
EASY TOUCH SOL CONTROL	245	ELEMENT LIQ LOW	246
EASY TOUCH SOL HIGH/LOW	245	ELEMENT TES	198
EASY TOUCH TES GLUCOSE.....	197	ELEMNT COMPA SOL LEVEL 2.....	246
EASY TOUCH TES STRIPS.....	198	ELEMNT COMPA SOL LEVEL 3	246
EASY TRAK II LIQ NORMAL.....	245	ELEMNT COMPA TES STRIPS	198
EASY TRAK II TES BLD GLUC	198	ELEPSIA XR TAB 1000MG.....	67
EASY TRAK SOL HIGH	245	ELEPSIA XR TAB 1500MG.....	67
EASY TRAK SOL LOW	245	ELESTRIN GEL 0.06%	222
EASY TRAK SOL NORMAL	245	<i>eletriptan hydrobromide tab 20 mg (base</i>	
EASY TRAK TES BLD GLUC	198	<i>equivalent)</i>	263
EC-NAPROSYN TAB 375MG	26	<i>eletriptan hydrobromide tab 40 mg (base</i>	
EC-NAPROSYN TAB 500MG.....	26	<i>equivalent)</i>	263
<i>econazole nitrate cream 1%</i>	177	ELIDEL CRE 1%	192
ECOZA AER 1%.....	177	ELIMITE CRE 5%.....	194
EDARBI TAB 40MG	103	ELIQUIS TAB 2.5MG.....	63
EDARBI TAB 80MG	104	ELIQUIS TAB 5MG.....	63
EDARBYCLOR TAB 40-12.5	107	ELLA TAB 30MG	168
EDARBYCLOR TAB 40-25MG	107	ELMIRON CAP 100MG	229
EDECIN TAB 25MG	212	EMBRACE CNTR LIQ HIGH	246
EDEX KIT 10MCG.....	159	EMBRACE EVO LIQ LEVEL 1	246
EDEX KIT 20MCG	159	EMBRACE EVO TES.....	198

EMBRACE LANC MIS /EJECTOR	246	ENBREL INJ 50MG/ML.....	31
EMBRACE LANC MIS THIN 30G.....	246	ENBREL MINI INJ 50MG/ML	31
EMBRACE PRO LIQ GLUCOSE.....	246	ENBREL SRCLK INJ 50MG/ML.....	31
EMBRACE PRO TES	198	ENCARE SUP 100MG	310
EMBRACE SOL LOW	246	ENDARI POW 5GM	233
EMBRACE TALK SOL HIGH/L2.....	246	ENDOMETRIN SUP 100MG	311
EMBRACE TALK SOL LOW/L1	246	<i>enoxaparin sodium inj 300 mg/3ml</i>	64
EMBRACE TALK TES STRIPS.....	198	<i>enoxaparin sodium inj soln pref syr 100</i>	
EMBRACE TES BLD GLUC.....	198	<i>mg/ml</i>	64
EMCYT CAP 140MG.....	117	<i>enoxaparin sodium inj soln pref syr 120</i>	
EMEND CAP 80MG.....	93	<i>mg/0.8ml.....</i>	64
EMEND SUS 125MG	93	<i>enoxaparin sodium inj soln pref syr 150</i>	
EMEND TRIPAC PAK 80 & 125.....	93	<i>mg/ml</i>	64
EMGALITY INJ 100MG/ML.....	262	<i>enoxaparin sodium inj soln pref syr 30</i>	
EMGALITY INJ 120MG/ML.....	262	<i>mg/0.3ml.....</i>	64
EMSAM DIS 12MG/24H.....	76	<i>enoxaparin sodium inj soln pref syr 40</i>	
EMSAM DIS 6MG/24HR.....	76	<i>mg/0.4ml</i>	64
EMSAM DIS 9MG/24HR.....	76	<i>enoxaparin sodium inj soln pref syr 60</i>	
<i>emtricitabine caps 200 mg</i>	142	<i>mg/0.6ml</i>	64
<i>emtricitabine-tenofovir disoproxil fumarate</i>		<i>enoxaparin sodium inj soln pref syr 80</i>	
<i>tab 100-150 mg</i>	142	<i>mg/0.8ml.....</i>	64
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSPRYNG INJ	268
<i>tab 133-200 mg</i>	142	ENSTILAR AER	187
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSURE PLANT LIQ CHOCOLAT	205
<i>tab 167-250 mg</i>	142	<i>entacapone tab 200 mg</i>	129
<i>emtricitabine-tenofovir disoproxil fumarate</i>		<i>entecavir tab 0.5 mg</i>	148
<i>tab 200-300 mg.....</i>	142	<i>entecavir tab 1 mg</i>	148
EMTRIVA CAP 200MG.....	142	ENTERAGAM POW 5GM	205
EMTRIVA SOL 10MG/ML.....	142	ENTEREG CAP 12MG.....	228
EMVERM CHW 100MG	48	ENTOCORT EC CAP 3MG DR	169
ENABLEX TAB 7.5MG	309	ENTRESTO TAB 24-26MG.....	158
<i>enalapril maleate & hydrochlorothiazide tab</i>		ENTRESTO TAB 49-51MG	158
<i>10-25 mg</i>	107	ENTRESTO TAB 97-103MG.....	158
<i>enalapril maleate & hydrochlorothiazide tab</i>		ENU PRO3 POW PLUS	210
<i>5-12.5 mg</i>	107	ENVARBUS XR TAB 0.75MG	268
<i>enalapril maleate oral soln 1 mg/ml.....</i>	101	ENVARBUS XR TAB 1MG.....	268
<i>enalapril maleate tab 10 mg.....</i>	101	ENVARBUS XR TAB 4MG.....	268
<i>enalapril maleate tab 2.5 mg</i>	101	EO28 SPLASH LIQ ORANGE	205
<i>enalapril maleate tab 20 mg</i>	102	EPANED SOL 1MG/ML.....	102
<i>enalapril maleate tab 5 mg</i>	101	EPCLUSA PAK 150-37.5	148
ENBRACE HR CAP	272	EPCLUSA PAK 200-50MG	148
ENBREL INJ 25/0.5ML.....	30	EPCLUSA TAB 200-50MG	148
ENBREL INJ 25MG.....	30	EPCLUSA TAB 400-100.....	148

EPICYN SPR	193	<i>ergotamine w/ caffeine suppos 2-100 mg</i>	263
EPIDIOLEX SOL 100MG/ML	67	.....	263
EPIDUO FORTE GEL 0.3-2.5%	174	<i>ergotamine w/ caffeine tab 1-100 mg</i>	263
EPIDUO GEL 0.1-2.5%	174	ERIVEDGE CAP 150MG.....	116
EPIFOAM AER 1%	187	ERLEADA TAB 240MG.....	117
<i>epinastine hcl ophth soln 0.05%</i>	285	ERLEADA TAB 60MG.....	117
EPINEPHRINE INJ 0.2MG.....	313	<i>erlotinib hcl tab 100 mg (base equivalent)</i>	116
EPINEPHRINE INJ 1MG/10ML.....	313	.....	116
EPINEPHRINE INJ 1MG/ML	313	<i>erlotinib hcl tab 150 mg (base equivalent)</i>	116
<i>epinephrine inj 30 mg/30ml (1 mg/ml)</i>		.....	116
<i>(1:1000)</i>	312	<i>erlotinib hcl tab 25 mg (base equivalent)</i> .	116
EPINEPHRINE KIT SNAP-EMS.....	312	ERTACZO CRE 2%	177
<i>epinephrine solution auto-injector 0.15</i>		ERYGEL GEL 2%	174
<i>mg/0.15ml (1:1000)</i>	312	ERYPED SUS 200/5ML	239
<i>epinephrine solution auto-injector 0.15</i>		ERYPED SUS 400/5ML	239
<i>mg/0.3ml (1:2000)</i>	312	<i>erythromycin ethylsuccinate for susp 200</i>	
<i>epinephrine solution auto-injector 0.3</i>		<i>mg/5ml</i>	239
<i>mg/0.3ml (1:1000)</i>	312	<i>erythromycin ethylsuccinate for susp 400</i>	
EPINEPHR PRO KIT 1MG/ML	312	<i>mg/5ml</i>	240
EPINPHEPHRIN KIT SNAP-V	312	<i>erythromycin ethylsuccinate tab 400 mg</i>	240
EPIPEN 2-PAK INJ 0.3MG	312	.....	240
EPIPEN-JR INJ 0.15MG.....	312	<i>erythromycin gel 2%</i>	174
EPIVIR SOL 10MG/ML.....	142	<i>erythromycin ophth oint 5 mg/gm</i>	281
EPIVIR TAB 150MG.....	142	<i>erythromycin pads 2%</i>	174
EPIVIR TAB 300MG.....	142	<i>erythromycin soln 2%</i>	174
<i>eplerenone tab 25 mg</i>	111	<i>erythromycin stearate tab 250 mg</i>	240
<i>eplerenone tab 50 mg</i>	111	<i>erythromycin tab 250 mg</i>	240
EPZICOM TAB 600-300	142	<i>erythromycin tab 500 mg</i>	240
EQL LANCETS MIS 21G COLR.....	246	<i>erythromycin tab delayed release 250 mg</i>	
EQL LANCETS MIS 33G COLR.....	246	.....	240
EQL LANCETS MIS THIN 26G	246	<i>erythromycin tab delayed release 333 mg</i>	
EQL LANCETS MIS THIN 30G.....	246	.....	240
EQUACARE JR POW CHOCOLA	210	<i>erythromycin tab delayed release 500 mg</i>	
EQUACARE JR POW UNFLAVO	210	.....	240
EQUACARE JR POW VANILLA	210	<i>erythromycin w/ delayed release particles</i>	
EQUETRO CAP 100MG	133	<i>cap 250 mg</i>	240
EQUETRO CAP 200MG.....	133	ESBRIET CAP 267MG.....	299
EQUETRO CAP 300MG.....	133	ESBRIET TAB 267MG	299
ERGOCAL CAP 2500UNIT.....	313	ESBRIET TAB 801MG.....	299
<i>ergocalciferol cap 1.25 mg (50000 unit)</i> .	313	<i>escitalopram oxalate soln 5 mg/5ml (base</i>	
<i>ergoloid mesylates tab 1 mg</i>	295	<i>equiv)</i>	76
ERGOMAR SUB 2MG.....	263	<i>escitalopram oxalate tab 10 mg (base</i>	
		<i>equiv)</i>	76

<i>escitalopram oxalate tab 20 mg (base equiv)</i>	76	<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	223
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	76	<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	222
ESGIC TAB.....	32	<i>estradiol td patch weekly 0.025 mg/24hr</i>	223
ESKATA SOL 40%	184	<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	223
ESOMEPRAZOLE CAP 49.3MG	306	<i>estradiol td patch weekly 0.05 mg/24hr</i> 223	
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	306	<i>estradiol td patch weekly 0.06 mg/24hr</i> 223	
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	306	<i>estradiol td patch weekly 0.075 mg/24hr</i>	223
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	307	<i>estradiol td patch weekly 0.1 mg/24hr</i>	223
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	307	<i>estradiol vaginal cream 0.1 mg/gm</i>	311
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	307	<i>estradiol valerate im in oil 20 mg/ml</i>	223
ESSENTIAL POW CARE JR	210	<i>estradiol valerate im in oil 40 mg/ml</i>	223
<i>estazolam tab 1 mg</i>	236	ESTRING MIS 2MG.....	311
<i>estazolam tab 2 mg</i>	236	ESTROGEL GEL	223
ESTRACE TAB 0.5MG.....	222	ESTROSTEP FE TAB	166
ESTRACE TAB 1MG.....	222	<i>eszopiclone tab 1 mg</i>	236
ESTRACE TAB 2MG	222	<i>eszopiclone tab 2 mg</i>	236
ESTRACE VAG CRE 0.01%	311	<i>eszopiclone tab 3 mg</i>	236
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	221	<i>ethacrynic acid tab 25 mg</i>	212
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	221	<i>ethambutol hcl tab 100 mg</i>	113
<i>estradiol tab 0.5 mg</i>	222	<i>ethambutol hcl tab 400 mg</i>	113
<i>estradiol tab 1 mg</i>	222	<i>ethosuximide cap 250 mg</i>	74
<i>estradiol tab 2 mg</i>	222	<i>ethosuximide soln 250 mg/5ml</i>	74
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	222	ETHYL CHLOR AER FINE PIN.....	192
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	222	ETHYL CHLOR AER FN STRM.....	192
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	222	ETHYL CHLOR AER MED JET	192
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	222	ETHYL CHLOR AER MED STRM	192
<i>estradiol td gel 1 mg/gm (0.1%)</i>	222	ETHYL CHLOR AER MIST	192
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	222	<i>ethyl chloride aerosol spray</i>	192
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	223	<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	166
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	222	<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	166
		<i>etodolac cap 200 mg</i>	26
		<i>etodolac cap 300 mg</i>	26
		<i>etodolac tab 400 mg</i>	26
		<i>etodolac tab 500 mg</i>	26
		<i>etodolac tab er 24hr 400 mg</i>	26
		<i>etodolac tab er 24hr 500 mg</i>	26

<i>etodolac tab er 24hr 600 mg</i>	26	EXELON DIS 9.5MG/24.....	289
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	168	<i>exemestane tab 25 mg</i>	117
<i>etoposide cap 50 mg</i>	128	EXFORGE HCT TAB 10-160-12.5.....	108
<i>etravirine tab 100 mg</i>	142	EXFORGE HCT TAB 10-160-25.....	108
<i>etravirine tab 200 mg</i>	142	EXFORGE HCT TAB 10-320-25.....	108
EUCRISA OIN 2%.....	193	EXFORGE HCT TAB 5-160-12.5.....	107
EVAMIST SPR 1.53MG.....	223	EXFORGE HCT TAB 5-160-25.....	107
EVEKEO ODT TAB 10MG.....	4	EXFORGE TAB 10-160MG.....	108
EVEKEO ODT TAB 15MG.....	4	EXFORGE TAB 10-320MG.....	108
EVEKEO ODT TAB 20MG.....	4	EXFORGE TAB 5-160MG.....	108
EVEKEO ODT TAB 5MG.....	4	EXFORGE TAB 5-320MG.....	108
EVEKEO TAB 10MG.....	4	EXJADE TAB 125MG.....	91
EVEKEO TAB 5MG.....	4	EXJADE TAB 250MG.....	91
EVENCARE + TES BLD GLUC.....	198	EXJADE TAB 500MG.....	91
EVENCARE G2 SOL LOW/HIGH.....	246	EXODERM LOT 25-1%.....	177
EVENCARE G2 TES.....	198	EXSERVAN MIS 50MG.....	278
EVENCARE G3 SOL LOW/HIGH.....	246	EXTINA AER 2%.....	177
EVENCARE G3 TES.....	198	EYSUVIS DRO 0.25%.....	283
EVENCARE SOL LIQ LOW/HIGH.....	246	EZALLOR SPR CAP 10MG.....	98
EVENCARE TES BLD GLUC.....	199	EZALLOR SPR CAP 20MG.....	98
EVENCARE TES MINI.....	199	EZALLOR SPR CAP 40MG.....	98
EVENCARE TES PROVIEW.....	199	EZALLOR SPR CAP 5MG.....	98
EVENCAR MINI SOL NORMAL.....	246	<i>ezetimibe-simvastatin tab 10-10 mg</i>	96
<i>everolimus tab 0.25 mg</i>	268	<i>ezetimibe-simvastatin tab 10-20 mg</i>	96
<i>everolimus tab 0.5 mg</i>	268	<i>ezetimibe-simvastatin tab 10-40 mg</i>	96
<i>everolimus tab 0.75 mg</i>	268	<i>ezetimibe-simvastatin tab 10-80 mg</i>	96
<i>everolimus tab 2.5 mg</i>	121	<i>ezetimibe tab 10 mg</i>	100
<i>everolimus tab 5 mg</i>	121	E-ZJECT LANC MIS 33G.....	245
<i>everolimus tab 7.5 mg</i>	122	E-Z JECT MIS 21G.....	245
EVISTA TAB 60MG.....	216	E-Z JECT MIS 21G COLR.....	245
EVOCLIN AER 1%.....	174	E-Z JECT MIS 30G.....	245
EVOLUTION SOL NORMAL.....	246	E-Z JECT MIS 32G COLR.....	245
EVOLUTION TES AUTOCODE.....	199	E-Z JECT MIS LANC 21G.....	245
EVOTAZ TAB 300-150.....	142	E-Z JECT MIS THIN 26G.....	245
EVOXAC CAP 30MG.....	271	EZ-LETS 21G MIS LANCETS.....	246
EVRYSDI SOL.....	278	EZ-LETS 26G MIS LANCETS.....	246
EXACTECH TES.....	199	EZ-LETS 28G MIS LANCETS.....	246
EXACTECH TES R-S-G.....	199	EZ-LETS 30G MIS LANCETS.....	246
EXELDERM CRE 1%.....	177	F	
EXELDERM SOL 1%.....	177	F.A.A. LIQ.....	205
EXELON DIS 13.3/24.....	289	FABIOR AER 0.1%.....	175
EXELON DIS 4.6MG/24.....	289	<i>famciclovir tab 125 mg</i>	149
		<i>famciclovir tab 250 mg</i>	149

<i>famciclovir tab 500 mg</i>	149	<i>fenofibrate micronized cap 200 mg</i>	97
<i>famotidine for susp 40 mg/5ml</i>	306	<i>fenofibrate micronized cap 30 mg</i>	97
<i>famotidine tab 40 mg</i>	306	<i>fenofibrate micronized cap 43 mg</i>	97
FANAPT PAK.....	134	<i>fenofibrate micronized cap 67 mg</i>	97
FANAPT TAB 10MG.....	134	<i>fenofibrate micronized cap 90 mg</i>	97
FANAPT TAB 12MG.....	134	<i>fenofibrate tab 120 mg</i>	97
FANAPT TAB 1MG	134	<i>fenofibrate tab 145 mg</i>	97
FANAPT TAB 2MG.....	134	<i>fenofibrate tab 160 mg</i>	97
FANAPT TAB 4MG	134	<i>fenofibrate tab 40 mg</i>	97
FANAPT TAB 6MG.....	134	<i>fenofibrate tab 48 mg</i>	97
FANAPT TAB 8MG.....	134	<i>fenofibrate tab 54 mg</i>	97
FARESTON TAB 60MG.....	117	<i>fenofibric acid tab 105 mg</i>	98
FARXIGA TAB 10MG	89	<i>fenofibric acid tab 35 mg</i>	97
FARXIGA TAB 5MG.....	89	FENOGLIDE TAB 120MG.....	98
FASENRA PEN INJ 30MG/ML.....	55	FENOGLIDE TAB 40MG.....	98
FASTCLIX MIS LANCETS.....	246	<i>fenoprofen calcium cap 400 mg</i>	27
FAVIPIRAVIR TAB 200MG	150	<i>fenoprofen calcium tab 600 mg</i>	27
FC2 FEMALE MIS CONDOM	240	FENOPROFEN CAP 200MG.....	27
FC FEMALE MIS CONDOM	240	FENORTHO CAP 200MG	27
<i>febuxostat tab 40 mg</i>	230	<i>fenfentanyl citrate buccal tab 100 mcg (base</i>	
<i>febuxostat tab 80 mg</i>	230	<i>equiv)</i>	33
<i>felbamate susp 600 mg/5ml</i>	73	<i>fenfentanyl citrate buccal tab 200 mcg (base</i>	
<i>felbamate tab 400 mg</i>	73	<i>equiv)</i>	33
<i>felbamate tab 600 mg</i>	73	<i>fenfentanyl citrate buccal tab 400 mcg (base</i>	
FELBATOL SUS 600/5ML.....	73	<i>equiv)</i>	33
FELBATOL TAB 400MG	73	<i>fenfentanyl citrate buccal tab 600 mcg (base</i>	
FELBATOL TAB 600MG	73	<i>equiv)</i>	33
FELDENE CAP 10MG	26	<i>fenfentanyl citrate buccal tab 800 mcg (base</i>	
FELDENE CAP 20MG.....	26	<i>equiv)</i>	33
<i>felodipine tab er 24hr 10 mg</i>	155	<i>fenfentanyl citrate lozenge on a handle 1200</i>	
<i>felodipine tab er 24hr 2.5 mg</i>	155	<i>mcg</i>	33
<i>felodipine tab er 24hr 5 mg</i>	155	<i>fenfentanyl citrate lozenge on a handle 1600</i>	
FEMARA TAB 2.5MG.....	117	<i>mcg</i>	33
FEMCAP MIS 22MM.....	240	<i>fenfentanyl citrate lozenge on a handle 200</i>	
FEMCAP MIS 26MM.....	240	<i>mcg</i>	33
FEMCAP MIS 30MM.....	240	<i>fenfentanyl citrate lozenge on a handle 400</i>	
FEMHRT TAB 0.5-2.5	221	<i>mcg</i>	33
FEMRING MIS 0.05/24H	311	<i>fenfentanyl citrate lozenge on a handle 600</i>	
FEMRING MIS 0.1MG/24.....	311	<i>mcg</i>	33
<i>fenofibrate cap 150 mg</i>	97	<i>fenfentanyl citrate lozenge on a handle 800</i>	
<i>fenofibrate cap 50 mg</i>	97	<i>mcg</i>	33
<i>fenofibrate micronized cap 130 mg</i>	97	<i>fenfentanyl td patch 72hr 100 mcg/hr</i>	34
<i>fenofibrate micronized cap 134 mg</i>	97	<i>fenfentanyl td patch 72hr 12 mcg/hr</i>	34

<i>fentanyl td patch 72hr 25 mcg/hr</i>	34	FIRDAPSE TAB 10MG.....	112
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	34	FIRVANQ SOL 25MG/ML.....	49
<i>fentanyl td patch 72hr 50 mcg/hr</i>	34	FIRVANQ SOL 50MG/ML.....	49
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	34	FLAGYL CAP 375MG.....	48
<i>fentanyl td patch 72hr 75 mcg/hr</i>	34	FLAGYL TAB 500MG.....	48
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	34	FLAREX SUS 0.1% OP.....	283
FENTORA TAB 100MCG.....	34	<i>flavoxate hcl tab 100 mg</i>	310
FENTORA TAB 200MCG.....	34	<i>flecainide acetate tab 100 mg</i>	54
FENTORA TAB 400MCG.....	34	<i>flecainide acetate tab 150 mg</i>	54
FENTORA TAB 600MCG.....	34	<i>flecainide acetate tab 50 mg</i>	54
FENTORA TAB 800MCG.....	34	FLECTOR DIS 1.3%	176
FERIVA TAB 21/7	235	FLEXICHAMBER MIS.....	261
FERPRX 2-DAY TAB 1000MG	91	FLEXICHAMBER MIS MASK LRG	261
FERRIPROX SOL 100MG/ML	91	FLEXICHAMBER MIS MASK SM.....	261
FERRIPROX TAB 1000MG	91	FLOLIPID SUS 20MG/5ML	98
FERRIPROX TAB 500MG	91	FLOLIPID SUS 40MG/5ML	98
<i>fesoterodine fumarate tab er 24hr 4 mg</i> 309		FLOMAX CAP 0.4MG	230
<i>fesoterodine fumarate tab er 24hr 8 mg</i> 309		FLOVENT DISK AER 100MCG	58
FETZIMA CAP 120MG.....	79	FLOVENT DISK AER 250MCG.....	58
FETZIMA CAP 20MG	79	FLOVENT DISK AER 50MCG	58
FETZIMA CAP 40MG	79	FLOVENT HFA AER 110MCG	58
FETZIMA CAP 80MG	79	FLOVENT HFA AER 220MCG	58
FETZIMA CAP TITRATIO	79	FLOVENT HFA AER 44MCG	58
FIASP FLEX INJ TOUCH	87	<i>fluconazole for susp 10 mg/ml</i>	94
FIASP INJ 100/ML.....	87	<i>fluconazole for susp 40 mg/ml</i>	94
FIASP PENFIL INJ U-100	88	<i>fluconazole tab 100 mg</i>	94
FIBERSOURCE LIQ CLS SYS	206	<i>fluconazole tab 150 mg</i>	94
FIBERSOUR HN LIQ CLS SYS.....	205	<i>fluconazole tab 200 mg</i>	94
FIBRICOR TAB 105MG.....	98	<i>fluconazole tab 50 mg</i>	94
FIBRICOR TAB 35MG	98	<i>flucytosine cap 250 mg</i>	94
FIFTY50 GLUC TES 2.0	199	<i>flucytosine cap 500 mg</i>	94
FIFTY50 PREP PAD PADS	259	<i>fludrocortisone acetate tab 0.1 mg</i>	171
FIFTY50 SAFE MIS LANCETS.....	246	<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	277
FINACEA AER 15%	194	<i>fluocinolone acetonide (otic) oil 0.01%</i> ..	286
FINACEA GEL 15%.....	194	<i>fluocinolone acetonide cream 0.01%</i>	187
<i>finasteride tab 5 mg</i>	230	<i>fluocinolone acetonide cream 0.025%</i> ..	187
FINE 30 MIS	246	<i>fluocinolone acetonide oil 0.01% (body oil)</i>	187
FINGERSTIX MIS LANCETS.....	246	<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	187
<i>ingolimod hcl cap 0.5 mg (base equiv)</i> ..	293	<i>fluocinolone acetonide oint 0.025%</i>	187
FINTEPLA SOL 2.2MG/ML.....	68	<i>fluocinolone acetonide soln 0.01%</i>	188
FIORICET CAP	32		
FIORICET CAP CODEINE	43		
FIRAZYR INJ 30MG/3ML.....	231		

<i>fluocinonide cream 0.05%</i>	188	<i>fluticasone propionate hfa inhal aer 220</i>	
<i>fluocinonide cream 0.1%</i>	188	<i>mcg/act (250/valve)</i>	58
<i>fluocinonide emulsified base cream 0.05%</i>		<i>fluticasone propionate hfa inhal aero 44</i>	
.....	188	<i>mcg/act (50/valve)</i>	59
<i>fluocinonide gel 0.05%</i>	188	<i>fluticasone propionate lotion 0.05%</i>	188
<i>fluocinonide oint 0.05%</i>	188	<i>fluticasone propionate nasal susp 50</i>	
<i>fluocinonide soln 0.05%</i>	188	<i>mcg/act</i>	277
<i>fluorometholone ophth susp 0.1%</i>	283	<i>fluticasone propionate oint 0.005%</i>	188
FLUOROPLEX CRE 1%	178	<i>fluticasone-salmeterol aer powder ba 113-</i>	
<i>fluorouracil cream 0.5%</i>	178	<i>14 mcg/act</i>	61
<i>fluorouracil cream 5%</i>	178	<i>fluticasone-salmeterol aer powder ba 232-</i>	
<i>fluorouracil soln 2%</i>	178	<i>14 mcg/act</i>	61
<i>fluorouracil soln 5%</i>	178	<i>fluticasone-salmeterol aer powder ba 55-14</i>	
<i>fluoxetine hcl (pmd) tab 10 mg</i>	295	<i>mcg/act</i>	61
<i>fluoxetine hcl (pmd) tab 20 mg</i>	295	<i>fluvastatin sodium cap 20 mg (base</i>	
<i>fluoxetine hcl cap 10 mg</i>	76	<i>equivalent)</i>	99
<i>fluoxetine hcl cap 20 mg</i>	76	<i>fluvastatin sodium cap 40 mg (base</i>	
<i>fluoxetine hcl cap 40 mg</i>	77	<i>equivalent)</i>	99
<i>fluoxetine hcl cap delayed release 90 mg</i>	77	<i>fluvastatin sodium tab er 24 hr 80 mg (base</i>	
<i>fluoxetine hcl solution 20 mg/5ml</i>	77	<i>equivalent)</i>	99
<i>fluoxetine hcl tab 10 mg</i>	77	<i>fluvoxamine maleate cap er 24hr 100 mg</i> .77	
<i>fluoxetine hcl tab 20 mg</i>	77	<i>fluvoxamine maleate cap er 24hr 150 mg</i> .77	
<i>fluoxetine hcl tab 60 mg</i>	77	<i>fluvoxamine maleate tab 100 mg</i>	77
FLUOXETINE TAB 60MG.....	77	<i>fluvoxamine maleate tab 25 mg</i>	77
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	138	<i>fluvoxamine maleate tab 50 mg</i>	77
<i>fluphenazine hcl oral conc 5 mg/ml</i>	138	FML FORTE SUS 0.25% OP	283
<i>fluphenazine hcl tab 10 mg</i>	138	FML LIQUIFLM SUS 0.1% OP.....	283
<i>fluphenazine hcl tab 1 mg</i>	138	FML OIN 0.1% OP.....	283
<i>fluphenazine hcl tab 2.5 mg</i>	138	FOCALIN TAB 10MG	11
<i>fluphenazine hcl tab 5 mg</i>	138	FOCALIN TAB 2.5MG	11
<i>flurandrenolide cream 0.05%</i>	188	FOCALIN TAB 5MG	11
<i>flurandrenolide lotion 0.05%</i>	188	FOCALIN XR CAP 10MG	11
<i>flurandrenolide oint 0.05%</i>	188	FOCALIN XR CAP 15MG	11
<i>flurazepam hcl cap 15 mg</i>	236	FOCALIN XR CAP 20MG	11
<i>flurazepam hcl cap 30 mg</i>	236	FOCALIN XR CAP 25MG.....	11
<i>flurbiprofen sodium ophth soln 0.03%</i> ...	285	FOCALIN XR CAP 30MG	11
<i>flurbiprofen tab 100 mg</i>	27	FOCALIN XR CAP 35MG.....	11
<i>flurbiprofen tab 50 mg</i>	27	FOCALIN XR CAP 40MG	11
<i>flutamide cap 125 mg</i>	117	FOCALIN XR CAP 5MG.....	11
<i>fluticasone propionate cream 0.05%</i>	188	<i>folic acid cap 0.8 mg</i>	233
<i>fluticasone propionate hfa inhal aer 110</i>		<i>folic acid-cholecalciferol tab 1 mg-3775 unit</i>	
<i>mcg/act (125/valve)</i>	58	.....	235
		<i>folic acid tab 1 mg</i>	233

<i>folic acid tab 400 mcg</i>	233	<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	61
<i>folic acid tab 800 mcg</i>	233	FORTAMET TAB 1000MG.....	84
FOLIC D3 CAP	235	FORTAMET TAB 500MG.....	84
FOLIC-K CAP	271	FORTEO INJ 600/2.4	214
<i>fondaparinux sodium subcutaneous inj 10</i> <i>mg/0.8ml</i>	64	FORTESTA GEL 10MG/ACT	46
<i>fondaparinux sodium subcutaneous inj 2.5</i> <i>mg/0.5ml</i>	64	FORTISCARE SOL CNTL HI	247
<i>fondaparinux sodium subcutaneous inj 5</i> <i>mg/0.4ml</i>	64	FORTISCARE SOL CNTL LOW	247
<i>fondaparinux sodium subcutaneous inj 7.5</i> <i>mg/0.6ml</i>	64	FORTISCARE SOL CNTL NML.....	247
FORA 6 MIS CONNECT.....	199	FORTISCARE TES BLD GLUC.....	200
FORA BLOOD TES GLUCOSE	199	FOSAMAX + D TAB 70-2800	214
FORACARE GDH SOL HIGH	247	FOSAMAX + D TAB 70-5600	214
FORACARE GDH SOL LOW	247	FOSAMAX TAB 70MG.....	214
FORACARE GDH SOL NORMAL	247	<i>fosamprenavir calcium tab 700 mg (base</i> <i>equiv)</i>	142
FORACARE TES GD40	200	<i>fosfomycin tromethamine powd pack 3 gm</i> <i>(base equivalent)</i>	50
FORACARE TES PREM V10	200	<i>fosinopril sodium & hydrochlorothiazide tab</i> <i>10-12.5 mg</i>	108
FORACARE TES TST N GO	200	<i>fosinopril sodium & hydrochlorothiazide tab</i> <i>20-12.5 mg</i>	108
FORA CONTROL SOL HIGH	247	<i>fosinopril sodium tab 10 mg</i>	102
FORA CONTROL SOL LOW	247	<i>fosinopril sodium tab 20 mg</i>	102
FORA CONTROL SOL NORMAL	247	<i>fosinopril sodium tab 40 mg</i>	102
FORA D15G TES BLD GLUC.....	199	FOSRENOL CHW 1000MG	228
FORA D20 TES BLD GLUC.....	199	FOSRENOL CHW 500MG	228
FORA D40/G31 TES GLUCOSE.....	199	FOSRENOL CHW 750MG	228
FORA G20 TES BLD GLUC	199	FOSRENOL POW 1000MG.....	228
FORA G30/V10 TES BLD GLUC	199	FOSRENOL POW 750MG.....	228
FORA GD20 TES BLD GLUC.....	199	FOSTEUM CAP	206
FORA GD50 TES	199	FOSTEUM PLUS CAP	206
FORA GTEL TES BLD GLUC	199	FOTIVDA CAP 0.89MG	122
FORA GTEL TES KETONE.....	199	FOTIVDA CAP 1.34MG	122
FORA LANCETS MIS 30G	247	FRAGMIN INJ 10000/ML.....	64
FORA MIS LANCETS.....	247	FRAGMIN INJ 12500UNT	64
FORA MIS LANCING.....	247	FRAGMIN INJ 15000UNT.....	64
FORA TN'G TES TN'G VOI.....	200	FRAGMIN INJ 18000UNT.....	64
FORA V10 TES BLD GLUC	200	FRAGMIN INJ 2500/0.2.....	64
FORA V12 TES BLD GLUC.....	200	FRAGMIN INJ 5000/0.2	64
FORA V20 TES BLD GLUC.....	200	FRAGMIN INJ 7500/0.3.....	64
FORA V30A TES BLD GLUC	200	FRAGMIN INJ 95000UNT	64
FORFIVO XL TAB 450MG.....	75	FREESTYLE LIQ CONTROL.....	247
<i>formaldehyde solution 10%</i>	140	FREESTYLE MIS LANCETS	247

FREESTYLE MIS READER	247	GABITRIL TAB 4MG	73
FREESTYLE MIS UNISTICK.....	247	GALAFOLD CAP 123MG.....	217
FREESTYLE TES	200	<i>galantamine hydrobromide cap er 24hr 16</i>	
FREESTYLE TES INSULINX.....	200	<i>mg</i>	289
FREESTYLE TES LITE	200	<i>galantamine hydrobromide cap er 24hr 24</i>	
FREESTYLE TES PREC NEO	200	<i>mg</i>	289
FREESTY LIBR KIT 2 SENSOR	247	<i>galantamine hydrobromide cap er 24hr 8</i>	
FREESTY LIBR MIS 2 READER.....	247	<i>mg</i>	289
FROVA TAB 2.5MG	263	<i>galantamine hydrobromide oral soln 4</i>	
<i>frovatriptan succinate tab 2.5 mg (base</i>		<i>mg/ml</i>	289
<i>equivalent)</i>	263	<i>galantamine hydrobromide tab 12 mg ...</i>	289
FUNGIMEZ SOL	177	<i>galantamine hydrobromide tab 4 mg</i>	289
<i>furosemide oral soln 10 mg/ml</i>	212	<i>galantamine hydrobromide tab 8 mg</i>	289
<i>furosemide oral soln 8 mg/ml.....</i>	212	<i>ganirelix acetate soln prefilled syringe 250</i>	
<i>furosemide tab 20 mg.....</i>	212	<i>mcg/0.5ml</i>	215
<i>furosemide tab 40 mg.....</i>	212	GANIRELIX AC INJ 250/0.5	215
<i>furosemide tab 80 mg.....</i>	212	GASTROCROM CON 100/5ML	225
FUZEON INJ 90MG.....	142	<i>gatifloxacin ophth soln 0.5%</i>	281
FYCOMPA SUS 0.5MG/ML.....	65	GATTEX KIT 5MG.....	229
FYCOMPA TAB 10MG.....	65	GAVRETO CAP 100MG	122
FYCOMPA TAB 12MG.....	65	GE100 BLOOD TES GLUCOSE	200
FYCOMPA TAB 2MG	65	GE100 CONTRL SOL NORMAL	247
FYCOMPA TAB 4MG	65	GEAMETDRAY GEL 5-2-17%	192
FYCOMPA TAB 6MG	65	GEBAUERS SPR AER /STRETCH	192
FYCOMPA TAB 8MG	65	GELFILM MIS OP.....	284
FYLNETRA INJ 6MG/0.6	234	GELNIQUE GEL 10%	309
G		<i>gemfibrozil tab 600 mg.....</i>	98
G4 PLATINUM MIS PEDIATRC.....	247	GEMTESA TAB 75MG	310
G4 PLATINUM MIS RCV/SHAR	247	GENERESS FE CHW	166
G4 PLATINUM MIS RECEIVER	247	GENICIN TAB VITA-D	235
G4 PLATINUM MIS TRANSMIT	247	GENICIN TAB VITA-Q.....	271
G4 PLAT PED MIS RVC/SHAR	247	GENOTROPIN INJ 0.2MG.....	216
G4 SENSOR MIS.....	247	GENOTROPIN INJ 0.4MG.....	216
G5/G4 MIS SENSOR.....	247	GENOTROPIN INJ 0.6MG.....	216
<i>gabapentin cap 100 mg.....</i>	68	GENOTROPIN INJ 0.8MG.....	216
<i>gabapentin cap 300 mg.....</i>	68	GENOTROPIN INJ 1.2MG.....	216
<i>gabapentin cap 400 mg.....</i>	68	GENOTROPIN INJ 1.4MG	216
<i>gabapentin oral soln 250 mg/5ml</i>	68	GENOTROPIN INJ 1.6MG	216
<i>gabapentin tab 600 mg.....</i>	68	GENOTROPIN INJ 1.8MG.....	216
<i>gabapentin tab 800 mg.....</i>	68	GENOTROPIN INJ 12MG.....	216
GABITRIL TAB 12MG.....	73	GENOTROPIN INJ 1MG.....	216
GABITRIL TAB 16MG.....	73	GENOTROPIN INJ 2MG	216
GABITRIL TAB 2MG	73	GENOTROPIN INJ 5MG	216

<i>gentamicin sulfate cream 0.1%</i>	176	<i>glimepiride tab 1 mg</i>	90
<i>gentamicin sulfate oint 0.1%</i>	176	<i>glimepiride tab 2 mg</i>	90
<i>gentamicin sulfate ophth oint 0.3%</i>	281	<i>glimepiride tab 4 mg</i>	90
<i>gentamicin sulfate ophth soln 0.3%</i>	281	<i>glipizide-metformin hcl tab 2.5-250 mg</i> ...	82
GENTEEL LANC KIT BLUE	247	<i>glipizide-metformin hcl tab 2.5-500 mg</i> ...	82
GENTEEL MIS LANCETS	247	<i>glipizide-metformin hcl tab 5-500 mg</i>	82
GENTEEL MIS NOZZLES	247	<i>glipizide tab 10 mg</i>	90
GENTEEL PLUS MIS BLACK	247	<i>glipizide tab 5 mg</i>	90
GENTEEL PLUS MIS BLUE	247	<i>glipizide tab er 24hr 10 mg</i>	90
GENTEEL PLUS MIS PINK	247	<i>glipizide tab er 24hr 2.5 mg</i>	90
GENTEEL PLUS MIS PURPLE	248	<i>glipizide tab er 24hr 5 mg</i>	90
GENTEEL PLUS MIS WHITE	248	GLOBAL 28G MIS LANCETS	248
GENTEEL TIPS MIS BLUE	248	GLOBAL 30G MIS LANCETS	248
GENTEEL TIPS MIS CLEAR	248	GLOBAL LANC MIS DEVICE	248
GENTEEL TIPS MIS GREEN	248	GLOBAL PREP PAD PADS	259
GENTEEL TIPS MIS ORANGE	248	GLOPERBA SOL 0.6/5ML	230
GENTEEL TIPS MIS RAINBOW	248	GLUCAGEN INJ HYPOKIT	85
GENTEEL TIPS MIS VIOLET	248	<i>glucagon (rdna) for inj kit 1 mg</i>	85
GENTEEL TIPS MIS YELLOW	248	GLUCAGON EMR SOL 1MG	85
GENTLE-LET MIS 26G	248	GLUCAGON KIT 1MG	85
GENTLE-LET MIS 28G	248	GLUC CONTROL LIQ NORMAL	248
GENTLE-LET MIS LANCETS	248	GLUC CONTROL SOL	248
GENTLE-LET MIS PLATFORM	248	GLUC CONTROL SOL MID	248
GENULTIMATE TES	200	GLUC CONTROL SOL NORMAL	248
GENVOYA TAB	143	GLUCERNA 1.0 LIQ CARB VAN	206
GEODON CAP 20MG	133	GLUCERNA LIQ 1.2 CAL	206
GEODON CAP 40MG	133	GLUCERNA SEL LIQ VANILLA	206
GEODON CAP 60MG	133	GLUCOCARD 01 LIQ NORM/HGH	248
GEODON CAP 80MG	133	GLUCOCARD 01 SOL NORMAL	248
GEODON INJ 20MG	133	GLUCOCARD 01 TES PLUS	200
GHT TEST TES STRIPS	200	GLUCOCARD 01 TES SENSOR	201
GILENYA CAP 0.5MG	293	GLUCOCARD LIQ LEVEL 1	248
GILOTRIF TAB 20MG	116	GLUCOCARD SOL NORMAL	248
GILOTRIF TAB 30MG	116	GLUCOCARD SOL SHINE	248
GILOTRIF TAB 40MG	116	GLUCOCARD TES EXPRESSI	201
GIMOTI SPR 15MG	225	GLUCOCARD TES SHINE	201
<i>glatiramer acetate soln prefilled syringe 20</i> <i>mg/ml</i>	293	GLUCOCARD TES VITAL	201
<i>glatiramer acetate soln prefilled syringe 40</i> <i>mg/ml</i>	293	GLUCOCARD TES X-SENSOR	201
GLEOSTINE CAP 100MG	113	GLUCOCOM MIS 28G	248
GLEOSTINE CAP 10MG	113	GLUCOCOM MIS 30G	248
GLEOSTINE CAP 40MG	113	GLUCOCOM MIS 33G	248
		GLUCOCOM TES	201
		GLUCOCOM TES HIGH CON	248

GLUCOCOM TES NORM CON	248	GNP ALCOHOL PAD SWABS	259
GLUCONAVII TES STRIPS	201	GNP LANCETS MIS 21G	248
GLUCO PERFEC TES 3	200	GNP LANCETS MIS THIN	249
GLUCOSE CONT LIQ HIGH/LOW	248	GNP LANCETS MIS THIN 26G	249
GLUCOSE CONT SOL HIGH	248	GOCOVRI CAP 137MG	130
GLUCOSE CONT SOL NORMAL	248	GOCOVRI CAP 68.5MG	130
GLUCOSE CONT SOL PRECISIO	248	GOJJI BLOOD TES GLUCOSE.....	201
GLUCOSE TES STRIPS.....	201	GOJJI BLOOD TES KETONE	201
GLUCOTROL TAB 10MG	90	GOJJI CNTRL SOL NORMAL	249
GLUCOTROL XL TAB 10MG	90	GOJJI LANCET MIS 30G.....	249
GLUCOTROL XL TAB 2.5MG	90	GOJJI MIS LANC DEV	249
GLUCOTROL XL TAB 5MG	90	GOJJI STRIPS MIS W/LANCET	201
GLUMETZA TAB 1000MG	84	GOLYTELY SOL	238
GLUMETZA TAB 500MG.....	84	GONAL-F INJ 1050UNIT	215
GLUTARALDEHY SOL 25%.....	140	GONAL-F INJ 450UNIT	215
<i>glyburide-metformin tab 1.25-250 mg</i>	82	GONAL-F RFF INJ 300/0.5	215
<i>glyburide-metformin tab 2.5-500 mg</i>	82	GONAL-F RFF INJ 450/0.75	215
<i>glyburide-metformin tab 5-500 mg</i>	82	GONAL-F RFF INJ 75UNIT.....	215
<i>glyburide micronized tab 1.5 mg</i>	90	GONAL-F RFF INJ 900/1.5	215
<i>glyburide micronized tab 3 mg</i>	90	GONITRO POW 400MCG	51
<i>glyburide micronized tab 6 mg</i>	90	GOODSENSE MIS LANC 26G	249
<i>glyburide tab 1.25 mg</i>	90	GOODSENSE MIS LANC 30G.....	249
<i>glyburide tab 2.5 mg</i>	90	GOODSENSE MIS LANC 33G	249
<i>glyburide tab 5 mg</i>	90	GOODSENSE MIS LANC DVC	249
GLYCATE TAB 1.5MG.....	305	GOPRELTO SOL 40MG/ML.....	277
GLYCOLIC ACD SOL 70%.....	184	GORDOFILM SOL	192
GLYCOPYRROLA TAB 1.5MG	305	GRALISE TAB 300MG	295
<i>glycopyrrolate inj pf soln prefilled syringe</i>		GRALISE TAB 450MG	295
<i>0.2 mg/ml</i>	305	GRALISE TAB 600MG	295
<i>glycopyrrolate inj pf soln pref syr 0.4</i>		GRALISE TAB 750MG.....	295
<i>mg/2ml (0.2 mg/ml)</i>	305	GRALISE TAB 900MG	295
<i>glycopyrrolate oral soln 1 mg/5ml</i>	305	<i>granisetron hcl tab 1 mg</i>	92
<i>glycopyrrolate tab 1 mg</i>	305	GRASTEK SUB 2800BAU	15
<i>glycopyrrolate tab 2 mg</i>	305	<i>griseofulvin microsize susp 125 mg/5ml</i> ...94	
GLYNASE TAB 1.5MG	90	<i>griseofulvin microsize tab 500 mg</i>	94
GLYNASE TAB 3MG	90	<i>griseofulvin ultramicrosize tab 125 mg</i>	94
GLYNASE TAB 6MG	90	<i>griseofulvin ultramicrosize tab 250 mg</i>.....94	
GLYTACTIN PAK BTMK/DLT	206	<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	
GLYTACTIN POW BETMLK15	206	.....	172
GLYTACTIN POW RST LT10.....	206	<i>guanfacine hcl tab 1 mg</i>	105
GLYTROL LIQ PREBIO1	206	<i>guanfacine hcl tab 2 mg</i>	105
GLYXAMBI TAB 10-5 MG	82	<i>guanfacine hcl tab er 24hr 1 mg (base</i>	
GLYXAMBI TAB 25-5 MG.....	82	<i>equiv)</i>	7

<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>.....7	<i>haloperidol tab 20 mg</i> .....136
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>.....7	<i>haloperidol tab 2 mg</i> .....135
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>.....7	<i>haloperidol tab 5 mg</i> .....135
GUANIDINE TAB 125MG.....112	HARMONY TES BLD GLUC .....201
GVOKE HYPO 1 INJ .5/.1ML.....85	HARVONI PAK .....148
GVOKE HYPO 1 INJ 1MG/.2ML.....85	HARVONI PAK 45-200MG.....148
GVOKE HYPO 2 INJ .5/.1ML .....85	HARVONI TAB 45-200MG .....148
GVOKE HYPO 2 INJ 1MG/.2ML.....85	HARVONI TAB 90-400MG.....148
GVOKE KIT SOL 1MG/0.2M .....85	HC/PRAMOXINE CRE 1-2.35%.....188
GVOKE PFS INJ .....85	HC LANCING MIS DEVICE.....249
GYNAZOLE-1 CRE 2%.....311	HCU EXP20 PAK UNFLAVOR.....206
GYNOL II GEL 3% .....310	HCU EXPRESS PAK .....206
H	HELIDAC MIS THERAPY .....308
HAEGARDA INJ 2000UNIT .....231	HEMADY TAB 20MG.....169
HAEGARDA INJ 3000UNIT .....231	HEMANGEOL SOL 4.28/ML.....152
HAEMOLANCE MIS HIGH FLO .....249	HEMLIBRA INJ 105/0.7.....231
HAEMOLANCE MIS LOW FLOW .....249	HEMLIBRA INJ 150/ML.....231
HAEMOLANCE MIS PLUS.....249	HEMLIBRA INJ 30MG/ML.....231
HAEMOLANCE MIS PLUS LOW .....249	HEMLIBRA INJ 60/0.4.....231
HAEMOLANCE MIS PLUS MAX .....249	HEPARIN SOD INJ 5000/0.5 .....64
HAEMOLANCE MIS PLUS PED .....249	HEPARIN SOD INJ 5000/ML .....65
HAEMOLANCE MIS RETRACT .....249	<i>heparin sodium (porcine) inj 10000 unit/ml</i>.....65
<i>halcinonide cream 0.1%</i> .....188	<i>heparin sodium (porcine) inj 1000 unit/ml</i> 65
HALCION TAB 0.25MG .....236	<i>heparin sodium (porcine) inj 20000 unit/ml</i>.....65
HALDOL DECAN INJ 100MG/ML.....135	<i>heparin sodium (porcine) inj 5000 unit/ml</i>.....65
HALDOL DECAN INJ 50MG/ML .....135	<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>.....65
HALOBETASOL AER 0.05%.....188	HETLIOZ CAP 20MG.....237
<i>halobetasol propionate cream 0.05%</i>.....188	HETLIOZ LQ SUS 4MG/ML .....237
<i>halobetasol propionate oint 0.05%</i>.....188	HIPREX TAB 1GM .....50
HALOG CRE 0.1% .....188	HIXDEFRIMA SOL 8-1-1% .....177
HALOG OIN 0.1% .....188	HLTHY ACCNTS MIS LANC 30G .....249
HALOG SOL 0.1% .....188	HM INSULIN S MIS 0.3/31G .....260
<i>haloperidol decanoate im soln 100 mg/ml</i>.....135	HM INSULIN S MIS 1ML/30G .....260
<i>haloperidol decanoate im soln 50 mg/ml</i>.....135	HM STERILE PAD ALCHOL .....259
<i>haloperidol lactate oral conc 2 mg/ml</i>.....135	HOLD CHAMBER MIS ADLT LG .....261
<i>haloperidol tab 0.5 mg</i>.....135	HOLD CHAMBER MIS MEDIUM.....261
<i>haloperidol tab 10 mg</i>.....136	HOLD CHAMBER MIS SMALL .....261
<i>haloperidol tab 1 mg</i> .....135	HOMACTIN AA LIQ PLUS .....206
	HORIZANT TAB 300MG ER.....295

HORIZANT TAB 600MG ER.....	295	<i>hydrocodone-acetaminophen soln 7.5-325</i>	
HUMALOG INJ 100/ML.....	88	<i>mg/15ml.....</i>	43
HUMALOG JR INJ 100/ML.....	88	<i>hydrocodone-acetaminophen tab 10-300</i>	
HUMALOG KWIK INJ 100/ML.....	88	<i>mg.....</i>	43
HUMALOG KWIK INJ 200/ML.....	88	<i>hydrocodone-acetaminophen tab 10-325</i>	
HUMALOG MIX INJ 50/50.....	88	<i>mg.....</i>	43
HUMALOG MIX INJ 50/50KWP.....	88	<i>hydrocodone-acetaminophen tab 5-300</i>	
HUMALOG MIX INJ 75/25KWP.....	88	<i>mg.....</i>	43
HUMALOG MIX SUS 75/25.....	88	<i>hydrocodone-acetaminophen tab 5-325</i>	
HUMIRA INJ 10/0.1ML.....	17	<i>mg.....</i>	43
HUMIRA INJ 20/0.2ML.....	17	<i>hydrocodone-acetaminophen tab 7.5-300</i>	
HUMIRA INJ 40/0.4ML.....	17	<i>mg.....</i>	43
HUMIRA KIT 40MG/0.8.....	17	<i>hydrocodone-acetaminophen tab 7.5-325</i>	
HUMIRA PEDIA INJ CROHNS.....	18	<i>mg.....</i>	43
HUMIRA PEN INJ 40/0.4ML.....	18	<i>hydrocodone bitart-homatropine</i>	
HUMIRA PEN INJ 40MG/0.8.....	18	<i>methylbromide tab 5-1.5 mg.....</i>	171
HUMIRA PEN INJ 80/0.8ML.....	19	<i>hydrocodone bitart-homatropine</i>	
HUMIRA PEN INJ CD/UC/HS.....	19	<i>methylbrom soln 5-1.5 mg/5ml.....</i>	171
HUMIRA PEN INJ PS/UV.....	19	<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	34
HUMIRA PEN KIT CD/UC/HS.....	19	<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	34
HUMIRA PEN KIT PED UC.....	20	<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	
HUMIRA PEN KIT PS/UV.....	20	<i>.....</i>	34
HUMULIN INJ 70/30.....	88	<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	
HUMULIN INJ 70/30KWP.....	88	<i>.....</i>	34
HUMULIN N INJ U-100.....	88	<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	
HUMULIN N INJ U-100KWP.....	88	<i>.....</i>	34
HUMULIN R INJ U-500.....	88	<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	
HW EMBRACE TES PRO.....	201	<i>.....</i>	34
HW EMBRACE TES STRIPS.....	201	<i>hydrocodone bitartrate tab er 24hr deter</i>	
HYCAMTIN CAP 0.25MG.....	129	<i>100 mg.....</i>	35
HYCAMTIN CAP 1MG.....	129	<i>hydrocodone bitartrate tab er 24hr deter</i>	
HYCODAN SYP 5-1.5/5.....	171	<i>120 mg.....</i>	35
<i>hydralazine hcl tab 100 mg.....</i>	111	<i>hydrocodone bitartrate tab er 24hr deter 20</i>	
<i>hydralazine hcl tab 10 mg.....</i>	111	<i>mg.....</i>	34
<i>hydralazine hcl tab 25 mg.....</i>	111	<i>hydrocodone bitartrate tab er 24hr deter 30</i>	
<i>hydralazine hcl tab 50 mg.....</i>	111	<i>mg.....</i>	35
HYDREA CAP 500MG.....	128	<i>hydrocodone bitartrate tab er 24hr deter 40</i>	
<i>hydrochlorothiazide cap 12.5 mg.....</i>	213	<i>mg.....</i>	35
<i>hydrochlorothiazide tab 12.5 mg.....</i>	213	<i>hydrocodone bitartrate tab er 24hr deter 60</i>	
<i>hydrochlorothiazide tab 25 mg.....</i>	213	<i>mg.....</i>	35
<i>hydrochlorothiazide tab 50 mg.....</i>	213	<i>hydrocodone bitartrate tab er 24hr deter 80</i>	
<i>hydrocodone-acetaminophen soln 10-325</i>		<i>mg.....</i>	35
<i>mg/15ml.....</i>	43	<i>hydrocodone-ibuprofen tab 10-200 mg ...</i>	43

<i>hydrocodone-ibuprofen tab 5-200 mg</i> .....43	<i>hydroxyzine pamoate cap 100 mg</i>.....52
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i> ..43	<i>hydroxyzine pamoate cap 25 mg</i>.....52
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>.....172	<i>hydroxyzine pamoate cap 50 mg</i> .....52
<i>hydrocortisone acetate suppos 25 mg</i> .....48	<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>.....305
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>.....47	<i>hyoscyamine sulfate sl tab 0.125 mg</i> .....305
<i>hydrocortisone butyrate cream 0.1%</i> .....188	<i>hyoscyamine sulfate soln 0.125 mg/ml</i> ..305
<i>hydrocortisone butyrate hydrophilic lipo base cream 0.1%</i> .....188	<i>hyoscyamine sulfate tab 0.125 mg</i> .....305
<i>hydrocortisone butyrate lotion 0.1%</i>.....188	<i>hyoscyamine sulfate tab disint 0.125 mg</i> 305
<i>hydrocortisone butyrate oint 0.1%</i>.....188	<i>hyoscyamine sulfate tab er 12hr 0.375 mg</i>.....305
<i>hydrocortisone butyrate soln 0.1%</i> .....189	HYPERSAL NEB 3.5% .....172
<i>hydrocortisone cream 1%</i> .....189	HYPERSAL NEB 7%.....172
<i>hydrocortisone cream 2.5%</i> .....189	HYPOLANCE KIT LANCING .....249
<i>hydrocortisone enema 100 mg/60ml</i>.....47	HYRIMOZ .....20
<i>hydrocortisone lotion 2.5%</i> .....189	HYRIMOZ INJ 10/0.1ML .....20
<i>hydrocortisone oint 1%</i> .....189	HYRIMOZ INJ 20/0.2ML .....20
<i>hydrocortisone oint 2.5%</i> .....189	HYRIMOZ INJ 40/0.4ML.....20
<i>hydrocortisone perianal cream 1%</i>.....48	HYRIMOZ INJ 40/0.8ML.....20
<i>hydrocortisone perianal cream 2.5%</i>.....48	HYRIMOZ INJ 80/0.8ML.....21
<i>hydrocortisone tab 10 mg</i>.....169	HYRIMOZ-PED INJ CROHNS .....21
<i>hydrocortisone tab 20 mg</i> .....169	HYSINGLA ER TAB 100 MG .....36
<i>hydrocortisone tab 5 mg</i> .....169	HYSINGLA ER TAB 120 MG.....36
<i>hydrocortisone valerate cream 0.2%</i> .....189	HYSINGLA ER TAB 20 MG .....35
<i>hydrocortisone valerate oint 0.2%</i>.....189	HYSINGLA ER TAB 30 MG .....35
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i> .....286	HYSINGLA ER TAB 40 MG.....35
<i>hydromorphone hcl liqd 1 mg/ml</i>.....35	HYSINGLA ER TAB 60 MG .....35
<i>hydromorphone hcl tab 2 mg</i> .....35	HYSINGLA ER TAB 80 MG .....36
<i>hydromorphone hcl tab 4 mg</i>.....35	HYZAAR TAB 100-12.5 .....108
<i>hydromorphone hcl tab 8 mg</i>.....35	HYZAAR TAB 100-25 .....108
<i>hydromorphone hcl tab er 24hr 12 mg</i> .....35	HYZAAR TAB 50-12.5 .....108
<i>hydromorphone hcl tab er 24hr 16 mg</i> .....35	I
<i>hydromorphone hcl tab er 24hr 32 mg</i> .....35	<i>ibandronate sodium tab 150 mg (base equivalent)</i> .....214
<i>hydromorphone hcl tab er 24hr 8 mg</i> .....35	IBRANCE CAP 100MG.....122
HYDROMORPHON SUP 3MG.....35	IBRANCE CAP 125MG .....122
<i>hydroxychloroquine sulfate tab 200 mg</i> ..112	IBRANCE CAP 75MG.....122
<i>hydroxyurea cap 500 mg</i> .....128	IBRANCE TAB 100MG .....122
<i>hydroxyzine hcl syrup 10 mg/5ml</i>.....52	IBRANCE TAB 125MG.....122
<i>hydroxyzine hcl tab 10 mg</i> .....52	IBRANCE TAB 75MG .....122
<i>hydroxyzine hcl tab 25 mg</i>.....52	<i>ibuprofen susp 100 mg/5ml</i>.....27
<i>hydroxyzine hcl tab 50 mg</i>.....52	<i>ibuprofen tab 400 mg</i>.....27
	<i>ibuprofen tab 600 mg</i>.....27

<i>ibuprofen tab 800 mg</i>	27	IMURAN TAB 50MG	268
<i>icatibant acetate subcutaneous soln pref</i>		IMVEXXY MAIN SUP 10MCG	311
<i>syr 30 mg/3ml</i>	231	IMVEXXY MAIN SUP 4MCG	311
ICLUSIG TAB 10MG	122	IMVEXXY STRT SUP 10MCG	311
ICLUSIG TAB 15MG.....	122	IMVEXXY STRT SUP 4MCG	311
ICLUSIG TAB 30MG.....	122	INBRIJA CAP 42MG	130
ICLUSIG TAB 45MG.....	122	INCONTROL MIS LANC 28G	249
<i>icosapent ethyl cap 0.5 gm</i>	96	INCONTROL MIS LANC 30G.....	249
<i>icosapent ethyl cap 1 gm</i>	96	INCONTROL MIS LANC 33G	249
IDHIFA TAB 100MG	122	INCONTROL MIS LANC DEV	249
IDHIFA TAB 50MG.....	122	INCONTROL PAD ALCOHOL	260
IGLUCOSE TES.....	201	INCRELEX INJ 40MG/4ML.....	217
ILEVRO DRO 0.3% OP	285	INCRUSE ELPT INH 62.5MCG	56
<i>imatinib mesylate tab 100 mg (base</i>		<i>indapamide tab 1.25 mg</i>	213
<i>equivalent)</i>	122	<i>indapamide tab 2.5 mg</i>	213
<i>imatinib mesylate tab 400 mg (base</i>		INDERAL LA CAP 120MG	152
<i>equivalent)</i>	122	INDERAL LA CAP 160MG	152
IMBRUVICA CAP 140MG	123	INDERAL LA CAP 60MG.....	152
IMBRUVICA CAP 70MG.....	123	INDERAL LA CAP 80MG.....	152
IMBRUVICA SUS 70MG/ML	123	INDERAL XL CAP 120MG.....	152
IMBRUVICA TAB 140MG.....	123	INDERAL XL CAP 80MG	152
IMBRUVICA TAB 280MG	123	INDOCIN SUS 25MG/5ML	27
IMBRUVICA TAB 420MG	123	<i>indomethacin cap 20 mg</i>	27
IMBRUVICA TAB 560MG.....	123	<i>indomethacin cap 25 mg</i>	27
<i>imipramine hcl tab 10 mg</i>	81	<i>indomethacin cap 50 mg</i>	27
<i>imipramine hcl tab 25 mg</i>	81	<i>indomethacin cap er 75 mg</i>	27
<i>imipramine hcl tab 50 mg</i>	81	<i>indomethacin suppos 50 mg</i>	27
<i>imipramine pamoate cap 100 mg</i>	81	INFINITY SOL NORM CON	249
<i>imipramine pamoate cap 125 mg</i>	81	INFINITY TES BLD GLUC	201
<i>imipramine pamoate cap 150 mg</i>	81	INFINITY TES VOICE	201
<i>imipramine pamoate cap 75 mg</i>	81	INFNTY VOICE LIQ LEVEL 2	249
<i>imiquimod cream 3.75%</i>	191	INGREZZA CAP 40-80MG	292
<i>imiquimod cream 5%</i>	191	INGREZZA CAP 40MG	292
IMITREX INJ 4MG/0.5.....	263	INGREZZA CAP 60MG.....	292
IMITREX INJ 6MG/0.5.....	264	INGREZZA CAP 80MG.....	292
IMITREX SPR 20MG/ACT	264	INLYTA TAB 1MG.....	115
IMITREX SPR 5MG/ACT	264	INLYTA TAB 5MG	115
IMITREX TAB 100MG.....	264	INNOPRAN XL CAP 120MG.....	153
IMITREX TAB 25MG	264	INNOPRAN XL CAP 80MG	153
IMITREX TAB 50MG	264	INPEN 100EL MIS BLUE-HUM.....	260
IMPAVIDO CAP 50MG	48	INQOVI TAB 35-100MG	119
IMPEKLO LOT 0.05%.....	189	INS ASP PROT INJ FLEXPEN.....	88
IMPOYZ CRE 0.025%.....	189	INSPIRACHAMB MIS LARGE	261

INSPIRACHAMB MIS MEDIUM	261	INVEGA TRINZ INJ 819MG	134
INSPIRACHAMB MIS MOUTHPC	261	INVELTYS SUS 1%.....	283
INSPIRACHAMB MIS SMALL.....	261	INVIRASE TAB 500MG	143
INSPIREASE MIS DD SYST	261	INVOKAMET TAB 150-1000	83
INSPIREASE MIS RES BAG	261	INVOKAMET TAB 150-500	83
INSPIRA TAB 25MG	111	INVOKAMET TAB 50-1000	83
INSPIRA TAB 50MG.....	111	INVOKAMET TAB 50-500MG	83
INSULIN ASPA INJ 100/ML	88	INVOKAMET XR TAB 150-1000.....	83
INSULIN ASPA INJ 70/30	88	INVOKAMET XR TAB 150-500	83
INSULIN ASPA INJ FLEXPEN	88	INVOKAMET XR TAB 50-1000	83
INSULIN ASPA INJ PENFILL.....	88	INVOKAMET XR TAB 50-500MG	83
INSULIN LISP INJ 100/ML	88	INVOKANA TAB 100MG.....	90
INSULIN LISP INJ JUNIOR.....	88	INVOKANA TAB 300MG.....	90
INSULIN LISP INJ PROTAMIN.....	88	<i>iodoquinol-hc cream 1-1%</i>	177
INSULIN SRYG MIS 1ML/32G.....	260	<i>iodoquinol-hydrocortisone in aloe vehicle</i>	
INTELENCE TAB 100MG.....	143	<i>cream 1-1.9%</i>	177
INTELENCE TAB 200MG	143	IOPIDINE SOL 1% OP.....	280
INTELENCE TAB 25MG.....	143	<i>ipratropium-albuterol nebu soln 0.5-2.5(3)</i>	
IN TOUCH LAN MIS 30G.....	249	<i>mg/3ml</i>	61
IN TOUCH LAN MIS DEVICE.....	249	<i>ipratropium bromide inhal soln 0.02%</i>	56
IN TOUCH SOL GLUCOSE	249	<i>ipratropium bromide nasal soln 0.03% (21</i>	
IN TOUCH TES BLOOD	201	<i>mcg/spray)</i>	277
INTRAROSA SUP 6.5MG	310	<i>ipratropium bromide nasal soln 0.06% (42</i>	
INTRON A INJ 10MU.....	128	<i>mcg/spray)</i>	277
INTRON A INJ 18MU.....	128	<i>irbesartan-hydrochlorothiazide tab 150-12.5</i>	
INTRON A INJ 25MU.....	128	<i>mg</i>	108
INTRON A INJ 50MU.....	128	<i>irbesartan-hydrochlorothiazide tab 300-</i>	
INTUNIV TAB 1MG	7	<i>12.5 mg</i>	108
INTUNIV TAB 2MG	7	<i>irbesartan tab 150 mg</i>	104
INTUNIV TAB 3MG	7	<i>irbesartan tab 300 mg</i>	104
INTUNIV TAB 4MG	7	<i>irbesartan tab 75 mg</i>	104
INVEGA SUST INJ 117/0.75	134	IRESSA TAB 250MG.....	116
INVEGA SUST INJ 156MG/ML	134	ISENTRESS CHW 100MG	143
INVEGA SUST INJ 234/1.5.....	134	ISENTRESS CHW 25MG	143
INVEGA SUST INJ 39/0.25.....	134	ISENTRESS HD TAB 600MG.....	143
INVEGA SUST INJ 78/0.5ML	134	ISENTRESS POW 100MG	143
INVEGA TAB 1.5MG.....	134	ISENTRESS TAB 400MG	143
INVEGA TAB 3MG.....	134	<i>isoniazid syrup 50 mg/5ml</i>	113
INVEGA TAB 6MG	134	<i>isoniazid tab 100 mg</i>	113
INVEGA TAB 9MG	134	<i>isoniazid tab 300 mg</i>	113
INVEGA TRINZ INJ 273MG.....	134	ISOPTO ATROP SOL 1% OP	280
INVEGA TRINZ INJ 410MG.....	134	ISOPTO CARP SOL 1% OP.....	280
INVEGA TRINZ INJ 546MG	134	ISOPTO CARP SOL 2% OP	280

ISOPTO CARP SOL 4% OP	280	JALYN CAP	230
ISORDIL TAB 40MG.....	51	JANUMET TAB 50-1000	83
ISORDIL TAB 5MG	51	JANUMET TAB 50-500MG.....	83
<i>isosorbide dinitrate tab 10 mg</i>	51	JANUMET XR TAB 100-1000.....	83
<i>isosorbide dinitrate tab 20 mg</i>	51	JANUMET XR TAB 50-1000	83
<i>isosorbide dinitrate tab 30 mg</i>	51	JANUMET XR TAB 50-500MG.....	83
<i>isosorbide dinitrate tab 40 mg</i>	51	JANUVIA TAB 100MG	85
<i>isosorbide dinitrate tab 5 mg</i>	51	JANUVIA TAB 25MG	85
<i>isosorbide mononitrate tab 10 mg</i>	51	JANUVIA TAB 50MG	85
<i>isosorbide mononitrate tab 20 mg</i>	51	JARDIANCE TAB 10MG.....	90
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	51	JARDIANCE TAB 25MG	90
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	51	JATENZO CAP 158MG.....	47
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	51	JATENZO CAP 198MG.....	47
ISOSOURCE HN LIQ	206	JATENZO CAP 237MG	47
ISOSOURCE LIQ	206	JENLIVA CAP.....	272
<i>isotretinoin cap 10 mg</i>	175	JENTADUETO TAB 2.5-1000	83
<i>isotretinoin cap 20 mg</i>	175	JENTADUETO TAB 2.5-500	83
<i>isotretinoin cap 30 mg</i>	175	JENTADUETO TAB 2.5-850.....	83
<i>isotretinoin cap 40 mg</i>	175	JENTADUETO TAB XR.....	83
ISOVACTIN AA LIQ PLUS	206	JEVITY 1.2 LIQ CAL.....	206
<i>isradipine cap 2.5 mg</i>	155	JEVITY 1.5 LIQ CAL.....	207
<i>isradipine cap 5 mg</i>	155	JEVITY 1 CAL LIQ	206
ISTALOL SOL 0.5% OP	279	JORNAY PM CAP 100MG ER	12
ISTURISA TAB 10MG	213	JORNAY PM CAP 20MG ER.....	11
ISTURISA TAB 1MG.....	213	JORNAY PM CAP 40MG ER.....	12
ISTURISA TAB 5MG.....	213	JORNAY PM CAP 60MG ER.....	12
<i>itraconazole cap 100 mg</i>	94	JORNAY PM CAP 80MG ER	12
<i>itraconazole oral soln 10 mg/ml</i>	94	JUBLIA SOL 10%.....	177
<i>ivermectin lotion 0.5%</i>	194	JULUCA TAB 50-25MG	143
<i>ivermectin tab 3 mg</i>	48	JUXTAPID CAP 10MG.....	100
J		JUXTAPID CAP 20MG	100
JADENU SPRKL GRA 180MG	91	JUXTAPID CAP 30MG	100
JADENU SPRKL GRA 360MG	91	JUXTAPID CAP 40MG	100
JADENU SPRKL GRA 90MG.....	91	JUXTAPID CAP 5MG	100
JADENU TAB 180MG.....	91	JUXTAPID CAP 60MG	100
JADENU TAB 360MG	91	JYNARQUE PAK 15MG.....	220
JADENU TAB 90MG	91	JYNARQUE PAK 30-15MG	220
JAKAFI TAB 10MG.....	123	JYNARQUE PAK 45-15MG.....	220
JAKAFI TAB 15MG	123	JYNARQUE PAK 60-30MG.....	220
JAKAFI TAB 20MG	123	JYNARQUE PAK 90-30MG.....	220
JAKAFI TAB 25MG	123	JYNARQUE TAB 15MG	221
JAKAFI TAB 5MG.....	123	JYNARQUE TAB 30MG	221

K	
KALBITOR INJ 10MG/ML	231
KALETRA SOL	143
KALETRA TAB 100-25MG	143
KALETRA TAB 200-50MG	143
KALYDECO GRA 13.4MG	298
KALYDECO GRA 5.8MG.....	298
KALYDECO PAK 25MG	298
KALYDECO PAK 50MG.....	298
KALYDECO PAK 75MG	298
KAPSPARGO CAP 100MG	151
KAPSPARGO CAP 200MG.....	151
KAPSPARGO CAP 25MG	151
KAPSPARGO CAP 50MG	151
KAPVAY TAB 0.1 MG.....	7
KARBINAL ER SUS 4MG/5ML.....	95
KATERZIA SUS 1MG/ML.....	155
KAZANO 12.5- TAB 1000MG	83
KAZANO 12.5- TAB 500MG.....	83
KEFLEX CAP 750MG.....	164
KENALOG AER SPRAY.....	189
KEPPRA SOL 100MG/ML.....	68
KEPPRA TAB 1000MG.....	68
KEPPRA TAB 250MG.....	68
KEPPRA TAB 500MG	68
KEPPRA TAB 750MG.....	68
KEPPRA XR TAB 500MG	68
KEPPRA XR TAB 750MG.....	68
KERENDIA TAB 10MG	219
KERENDIA TAB 20MG	219
KERYDIN SOL 5%	177
KESIMPTA INJ 20/.4ML	293
<i>ketoconazole cream 2%</i>	177
<i>ketoconazole foam 2%</i>	177
<i>ketoconazole shampoo 2%</i>	177
<i>ketoconazole tab 200 mg</i>	94
KETO-DIASTIX TES	201
KETONE TES.....	202
KETONE TEST TES.....	202
<i>ketoprofen cap 25 mg</i>	27
<i>ketoprofen cap 50 mg</i>	27
<i>ketoprofen cap 75 mg</i>	27
<i>ketoprofen cap er 24hr 200 mg</i>	27
<i>ketorolac tromethamine ophth soln 0.4%</i>	285
<i>ketorolac tromethamine ophth soln 0.5%</i>	285
<i>ketorolac tromethamine tab 10 mg</i>	27
KETOR TROMET SPR 15.75MG	27
KETOSTIX TES STRIP	202
KEVEYIS TAB 50MG.....	211
KEVZARA INJ 150/1.14	25
KEVZARA INJ 200/1.14.....	25
KINNEY MIS LANCETS.....	249
KINNEY THIN MIS LANCETS.....	249
KISQALI 200 PAK FEMARA	119
KISQALI 400 PAK FEMARA	119
KISQALI 600 PAK FEMARA	119
KISQALI TAB 200DOSE	123
KISQALI TAB 400DOSE	123
KISQALI TAB 600DOSE	123
KITABIS PAK NEB 300/5ML	16
KLARITY-A DRO 1%	281
KLARITY-L DRO 0.2%	283
KLARITY-L DRO 0.5%	283
KLARON LOT 10%	175
KLISYRI OIN 1%.....	178
KLONOPIN TAB 0.5MG.....	66
KLONOPIN TAB 1MG	66
KLONOPIN TAB 2MG	66
KLOXXADO SPR 8MG	92
KOMBIGLYZ XR TAB 2.5-1000.....	83
KOMBIGLYZ XR TAB 5-1000MG.....	83
KOMBIGLYZ XR TAB 5-500MG	83
KORLYM TAB 300MG	85
KOSELUGO CAP 10MG	123
KOSELUGO CAP 25MG.....	123
KOSHR PRENAT TAB 30-1MG	272
K-PHOS TAB NO 2	229
KRAZATI TAB 200MG	123
KRINTAFEL TAB 150MG	112
KRISTALOSE PAK 10GM	238
KRISTALOSE PAK 20GM	239
KROGER BLOOD TES GLUCOSE	202
KROGER LANCE MIS.....	249
KROGER LANCE MIS 26G.....	249

KROGER LANCE MIS THIN.....	249	LAMICTAL XR TAB 100MG.....	69
KROGER LANCE MIS THIN 30G	249	LAMICTAL XR TAB 200MG	69
KROGER TES	202	LAMICTAL XR TAB 250MG	69
K-TAB TAB 10MEQ CR	266	LAMICTAL XR TAB 25MG.....	69
K-TAB TAB 20MEQ.....	266	LAMICTAL XR TAB 300MG	69
K-TAB TAB 8MEQ CR.....	266	LAMICTAL XR TAB 50MG	69
KUVAN POW 100MG.....	217	<i>lamivudine oral soln 10 mg/ml.....</i>	143
KUVAN POW 500MG	217	<i>lamivudine tab 100 mg (hbv).....</i>	148
KUVAN TAB 100MG	217	<i>lamivudine tab 150 mg</i>	143
L		<i>lamivudine tab 300 mg</i>	143
<i>labetalol hcl tab 100 mg.....</i>	151	<i>lamivudine-zidovudine tab 150-300 mg..</i>	143
<i>labetalol hcl tab 200 mg</i>	151	<i>lamotrigine orally disintegrating tab 100 mg</i>	
<i>labetalol hcl tab 300 mg.....</i>	151	.....	69
<i>lacosamide oral solution 10 mg/ml.....</i>	68	<i>lamotrigine orally disintegrating tab 200 mg</i>	
<i>lacosamide tab 100 mg</i>	68	.....	69
<i>lacosamide tab 150 mg</i>	68	<i>lamotrigine orally disintegrating tab 25 mg</i>	
<i>lacosamide tab 200 mg</i>	68	.....	69
<i>lacosamide tab 50 mg.....</i>	68	<i>lamotrigine orally disintegrating tab 50 mg</i>	
LACRISERT MIS 5MG OP	278	.....	69
<i>lactic acid (ammonium lactate) cream 12%</i>		<i>lamotrigine tab 100 mg</i>	69
.....	191	<i>lamotrigine tab 150 mg.....</i>	69
LACTIC ACID CRE E.....	191	<i>lamotrigine tab 200 mg.....</i>	69
LACTIC ACID LOT 10%.....	191	<i>lamotrigine tab 25 mg</i>	69
<i>lactulose (encephalopathy) solution 10</i>		<i>lamotrigine tab 25 mg (42) & 100 mg (7)</i>	
<i>gm/15ml.....</i>	227	<i>starter kit</i>	69
LACTULOSE PAK 10GM	239	<i>lamotrigine tab 35 x 25 mg starter kit</i>	69
<i>lactulose solution 10 gm/15ml.....</i>	239	<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg</i>	
LAGEVRIO CAP 200MG	150	<i>starter kit</i>	69
LAMICTAL CHW 25MG.....	68	<i>lamotrigine tab chewable dispersible 25 mg</i>	
LAMICTAL CHW 5MG.....	68	.....	69
LAMICTAL KIT START 35	68	<i>lamotrigine tab chewable dispersible 5 mg</i>	
LAMICTAL KIT START 49	68	.....	69
LAMICTAL KIT START 98	68	<i>lamotrigine tab disint 25 (14) & 50 mg (14) &</i>	
LAMICTAL ODT KIT	68	<i>100 mg (7) kit</i>	69
LAMICTAL ODT TAB 100MG.....	68	<i>lamotrigine tab er 24hr 100 mg</i>	69
LAMICTAL ODT TAB 200MG	69	<i>lamotrigine tab er 24hr 200 mg</i>	69
LAMICTAL ODT TAB 25MG.....	68	<i>lamotrigine tab er 24hr 250 mg</i>	69
LAMICTAL ODT TAB 50MG.....	68	<i>lamotrigine tab er 24hr 25 mg.....</i>	69
LAMICTAL TAB 100MG.....	69	<i>lamotrigine tab er 24hr 300 mg</i>	69
LAMICTAL TAB 150MG	69	<i>lamotrigine tab er 24hr 50 mg.....</i>	69
LAMICTAL TAB 200MG	69	LAMPIT TAB 120MG	49
LAMICTAL TAB 25MG.....	69	LAMPIT TAB 30MG.....	49
LAMICTAL XR KIT	69	LANAFLEX PAK.....	207

LANCET AUTO MIS INJECTOR.....	249	<i>lanthanum carbonate chew tab 500 mg</i>	
LANCET CARRY MIS CASE	250	(<i>elemental</i>)	228
LANCET DEVIC MIS 30G	250	<i>lanthanum carbonate chew tab 750 mg</i>	
LANCET DEVIC MIS ADJUST	250	(<i>elemental</i>)	228
LANCET MICRO MIS THIN 33G	250	LANTUS INJ 100/ML	88
LANCETS MICR MIS THIN 33G.....	250	LANTUS SOLOS INJ 100/ML.....	88
LANCETS MIS.....	250	LANZO MIS LANCING	250
LANCETS MIS 21G	250	<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	
LANCETS MIS 21G COLR.....	250	.....	124
LANCETS MIS 28G	250	LASIX TAB 20MG	212
LANCETS MIS 30G	250	LASIX TAB 40MG.....	212
LANCETS MIS 33G	250	LASIX TAB 80MG.....	212
LANCETS MIS ORANGE.....	250	LASTACAPT SOL 0.25%	285
LANCETS MIS ORIGINAL.....	250	<i>latanoprost ophth soln 0.005%</i>	285
LANCETS MIS THIN.....	250	LATUDA TAB 120MG.....	133
LANCETS MIS THIN 26G	250	LATUDA TAB 20MG	133
LANCETS MIS THIN 30G	250	LATUDA TAB 40MG	133
LANCETS SUPR MIS THIN 28G	250	LATUDA TAB 60MG	133
LANCET STAND MIS 21G.....	250	LATUDA TAB 80MG	133
LANCETS THIN MIS.....	250	LAZANDA SPR 100MCG	36
LANCETS THIN MIS 26G	250	LAZANDA SPR 400MCG.....	36
LANCETS ULTR MIS THIN	250	LB LANCET MIS 28G	250
LANCET SUPER MIS THIN 30G	250	LB LANCING MIS DEVICE.....	250
LANCET ULTRA MIS 28G.....	250	LDO PLUS GEL 4%	192
LANCET ULTRA MIS THIN 30G	250	<i>leflunomide tab 10 mg</i>	29
LANCET WITH MIS EJECTOR.....	250	<i>leflunomide tab 20 mg</i>	29
LANCING DEVI MIS	250	<i>lenalidomide cap 10 mg</i>	267
LANCING DEVI MIS 25G	250	<i>lenalidomide cap 15 mg</i>	267
LANCING DEVI MIS 30G.....	250	<i>lenalidomide cap 25 mg</i>	267
LANCING MIS DEVICE	250	<i>lenalidomide cap 5 mg</i>	267
LANOXIN TAB 0.0625MG	157	LENVIMA CAP 10 MG	115
LANOXIN TAB 0.125MG.....	157	LENVIMA CAP 12MG.....	115
LANOXIN TAB 0.25MG	157	LENVIMA CAP 14 MG.....	115
<i>lansoprazole cap delayed release 15 mg</i>	307	LENVIMA CAP 18 MG.....	115
<i>lansoprazole cap delayed release 30 mg</i>	307	LENVIMA CAP 20 MG.....	115
.....	307	LENVIMA CAP 24 MG.....	115
<i>lansoprazole tab delayed release orally</i>		LENVIMA CAP 4MG	115
<i>disintegrating 15 mg</i>	307	LENVIMA CAP 8 MG	115
<i>lansoprazole tab delayed release orally</i>		LESCOL XL TAB 80MG	99
<i>disintegrating 30 mg</i>	307	<i>letrozole tab 2.5 mg</i>	117
<i>lanthanum carbonate chew tab 1000 mg</i>		<i>leucovorin calcium tab 10 mg</i>	128
(<i>elemental</i>)	228	<i>leucovorin calcium tab 15 mg</i>	128
		<i>leucovorin calcium tab 25 mg</i>	128

<i>leucovorin calcium tab 5 mg</i>	128	<i>levonorgestrel & ethinyl estradiol tab 0.15</i>	
LEUKERAN TAB 2MG.....	113	<i>mg-30 mcg</i>	166
LEUKINE INJ 250MCG	234	<i>levonorgestrel & ethinyl estradiol tab 0.1</i>	
<i>leuprolide acetate inj kit 1 mg/0.2ml (5</i>		<i>mg-20 mcg</i>	166
<i>mg/ml)</i>	117	<i>levonorgestrel-eth estra tab 0.05-</i>	
<i>levabuterol hcl soln nebu 0.31 mg/3ml</i>		<i>30/0.075-40/0.125-30mg-mcg</i>	166
<i>(base equiv)</i>	61	<i>levonorgestrel-ethinyl estradiol</i>	
<i>levabuterol hcl soln nebu 0.63 mg/3ml</i>		<i>(continuous) tab 90-20 mcg</i>	166
<i>(base equiv)</i>	61	<i>levonorgestrel tab 1.5 mg</i>	168
<i>levabuterol hcl soln nebu 1.25 mg/3ml</i>		<i>levonorg-eth est tab 0.1-0.02mg(84) & eth</i>	
<i>(base equiv)</i>	61	<i>est tab 0.01mg(7)</i>	166
<i>levabuterol hcl soln nebu conc 1.25</i>		<i>levonorg-eth est tab 0.15-0.03mg(84) & eth</i>	
<i>mg/0.5ml (base equiv)</i>	61	<i>est tab 0.01mg(7)</i>	166
<i>levabuterol tartrate inhal aerosol 45</i>		<i>levorphanol tartrate tab 2 mg</i>	36
<i>mcg/act (base equiv)</i>	61	<i>levorphanol tartrate tab 3 mg</i>	36
LEVBID TAB 0.375 ER	305	<i>levothyroxine sodium cap 100 mcg</i>	302
LEVEMIR INJ.....	88	<i>levothyroxine sodium cap 112 mcg</i>	302
LEVEMIR INJ FLEXPEN	88	<i>levothyroxine sodium cap 125 mcg</i>	302
LEVEMIR INJ FLEXTouc	88	<i>levothyroxine sodium cap 137 mcg</i>	302
<i>levetiracetam oral soln 100 mg/ml</i>	70	<i>levothyroxine sodium cap 13 mcg</i>	302
<i>levetiracetam tab 1000 mg</i>	70	<i>levothyroxine sodium cap 150 mcg</i>	302
<i>levetiracetam tab 250 mg</i>	70	<i>levothyroxine sodium cap 175 mcg</i>	302
<i>levetiracetam tab 500 mg</i>	70	<i>levothyroxine sodium cap 200 mcg</i>	302
<i>levetiracetam tab 750 mg</i>	70	<i>levothyroxine sodium cap 25 mcg</i>	302
<i>levetiracetam tab er 24hr 500 mg</i>	70	<i>levothyroxine sodium cap 50 mcg</i>	302
<i>levetiracetam tab er 24hr 750 mg</i>	70	<i>levothyroxine sodium cap 75 mcg</i>	302
LEVITRA TAB 10MG	159	<i>levothyroxine sodium cap 88 mcg</i>	302
LEVITRA TAB 20MG.....	159	<i>levothyroxine sodium tab 100 mcg</i>	302
<i>levobunolol hcl ophth soln 0.5%</i>	279	<i>levothyroxine sodium tab 112 mcg</i>	302
<i>levocarnitine oral soln 1 gm/10ml (10%)</i> ..	217	<i>levothyroxine sodium tab 125 mcg</i>	302
<i>levocarnitine tab 330 mg</i>	217	<i>levothyroxine sodium tab 137 mcg</i>	302
<i>levocetirizine dihydrochloride soln 2.5</i>		<i>levothyroxine sodium tab 150 mcg</i>	302
<i>mg/5ml (0.5 mg/ml)</i>	95	<i>levothyroxine sodium tab 175 mcg</i>	302
<i>levofloxacin ophth soln 0.5%</i>	281	<i>levothyroxine sodium tab 200 mcg</i>	302
<i>levofloxacin oral soln 25 mg/ml</i>	224	<i>levothyroxine sodium tab 25 mcg</i>	302
<i>levofloxacin tab 250 mg</i>	224	<i>levothyroxine sodium tab 300 mcg</i>	302
<i>levofloxacin tab 500 mg</i>	224	<i>levothyroxine sodium tab 50 mcg</i>	302
<i>levofloxacin tab 750 mg</i>	224	<i>levothyroxine sodium tab 75 mcg</i>	302
<i>levonor-eth est tab 0.15-0.02/0.025/0.03</i>		<i>levothyroxine sodium tab 88 mcg</i>	302
<i>mg &eth est 0.01 mg</i>	166	LEVSIN/SL SUB 0.125MG	305
<i>levonorgestrel & ethinyl estradiol (91-day)</i>		LEVSIN TAB 0.125MG	305
<i>tab 0.15-0.03 mg</i>	166	LEVULAN KERA SOL 20%	178
		LEXAPRO TAB 10MG	77

LEXAPRO TAB 20MG.....	77	<i>lisinopril & hydrochlorothiazide tab 20-12.5</i>	
LEXAPRO TAB 5MG.....	77	<i>mg.....</i>	108
LEXETTE AER 0.05%	189	<i>lisinopril & hydrochlorothiazide tab 20-25</i>	
LEXIVA SUS 50MG/ML.....	143	<i>mg.....</i>	108
LEXIVA TAB 700MG.....	144	<i>lisinopril tab 10 mg.....</i>	102
LIALDA TAB 1.2GM	226	<i>lisinopril tab 2.5 mg.....</i>	102
LIBERTY NEXT TES GEN.....	202	<i>lisinopril tab 20 mg.....</i>	102
LIBERTY TES.....	202	<i>lisinopril tab 30 mg.....</i>	102
LIBRAX CAP 5-2.5MG.....	305	<i>lisinopril tab 40 mg.....</i>	102
LICART DIS 1.3%.....	176	<i>lisinopril tab 5 mg.....</i>	102
LIDOCA/TETRA CRE 7/7%	192	LITETOUCH MIS LANCETS	251
LIDOCAINE CRE TETRACAI	193	LITE TOUCH MIS LANCETS	250
<i>lidocaine hcl gel 2%</i>	193	LITE TOUCH MIS LANC PEN.....	250
<i>lidocaine hcl laryngotracheal soln 4%</i>	270	LITFULO CAP 50MG	191
<i>lidocaine hcl soln 4%</i>	193	<i>lithium carbonate cap 150 mg.....</i>	132
<i>lidocaine hcl urethral/mucosal gel 2%</i>	193	<i>lithium carbonate cap 300 mg.....</i>	133
<i>lidocaine hcl urethral/mucosal gel prefilled</i>		<i>lithium carbonate cap 600 mg.....</i>	133
<i>syringe 2%</i>	193	<i>lithium carbonate tab 300 mg</i>	133
<i>lidocaine hcl viscous soln 2%</i>	270	<i>lithium carbonate tab er 300 mg</i>	133
<i>lidocaine oint 5%</i>	193	<i>lithium carbonate tab er 450 mg</i>	133
<i>lidocaine patch 5%.....</i>	193	LITHIUM SOL 8MEQ/5ML	133
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	193	LITHOBID TAB 300MG CR	133
LIDODERM DIS 5%.....	193	LITHOSTAT TAB 250MG	230
LIFESCAN MIS UNISTIK2.....	250	LIVALO TAB 1MG	99
<i>lindane shampoo 1%</i>	194	LIVALO TAB 2MG.....	99
<i>linezolid for susp 100 mg/5ml.....</i>	50	LIVALO TAB 4MG.....	99
<i>linezolid tab 600 mg.....</i>	50	LIVTENCITY TAB 200MG	147
LINZESS CAP 145MCG	227	LOCOID LIPO CRE 0.1%	189
LINZESS CAP 290MCG	227	LOCOID LOT 0.1%	189
LINZESS CAP 72MCG.....	227	LODINE TAB 400MG	27
<i>liothyronine sodium tab 25 mcg</i>	303	LODOSYN TAB 25MG	129
<i>liothyronine sodium tab 50 mcg.....</i>	303	LOKELMA PAK 10GM.....	270
<i>liothyronine sodium tab 5 mcg</i>	302	LOKELMA PAK 5GM	269
LIPITOR TAB 10MG	99	LO LOESTRIN TAB 1-10-10	166
LIPITOR TAB 20MG	99	LOMOTIL TAB 2.5MG.....	91
LIPITOR TAB 40MG	99	LONGS LANCET MIS STANDARD	251
LIPITOR TAB 80MG	99	LONGS LANCET MIS THIN.....	251
LIPOFEN CAP 150MG.....	98	LONGS LANCET MIS ULTRA TH.....	251
LIPOFEN CAP 50MG	98	LONHALA MAGN SOL 25MCG	56
LIQUID HOPE LIQ.....	207	LONSURF TAB 15-6.14.....	119
<i>lisinopril & hydrochlorothiazide tab 10-12.5</i>		LONSURF TAB 20-8.19	120
<i>mg.....</i>	108	LOPHLEX POW	207
		LOPID TAB 600MG.....	98

<i>lopinavir-ritonavir soln 400-100 mg/5ml</i>	LOTRONEX TAB 0.5MG	227
(80-20 mg/ml)	LOTRONEX TAB 1MG	227
<i>lopinavir-ritonavir tab 100-25 mg</i>	<i>lovastatin tab 10 mg</i>	99
<i>lopinavir-ritonavir tab 200-50 mg</i>	<i>lovastatin tab 20 mg</i>	99
LOPRESSOR TAB 100MG	<i>lovastatin tab 40 mg</i>	99
LOPRESSOR TAB 50MG	LOVAZA CAP 1GM	96
LOPROX CRE 0.77%	LOVENOX INJ 100MG/ML	65
LOPROX SHA 1%	LOVENOX INJ 120/0.8	65
LOPROX SUS 0.77%	LOVENOX INJ 150MG/ML	65
<i>lorazepam conc 2 mg/ml</i>	LOVENOX INJ 30/0.3ML	65
<i>lorazepam tab 0.5 mg</i>	LOVENOX INJ 300/3ML	65
<i>lorazepam tab 1 mg</i>	LOVENOX INJ 40/0.4ML	65
<i>lorazepam tab 2 mg</i>	LOVENOX INJ 60/0.6ML	65
LORBRENA TAB 100MG	LOVENOX INJ 80/0.8ML	65
LORBRENA TAB 25MG	<i>loxapine succinate cap 10 mg</i>	136
LORMATE CAP	<i>loxapine succinate cap 25 mg</i>	136
LORTAB ELX 10-300MG	<i>loxapine succinate cap 50 mg</i>	136
<i>losartan potassium & hydrochlorothiazide</i>	<i>loxapine succinate cap 5 mg</i>	136
<i>tab 100-12.5 mg</i>	<i>lubiprostone cap 24 mcg</i>	225
<i>losartan potassium & hydrochlorothiazide</i>	<i>lubiprostone cap 8 mcg</i>	225
<i>tab 100-25 mg</i>	LUCEMYRA TAB 0.18MG	288
<i>losartan potassium & hydrochlorothiazide</i>	<i>luliconazole cream 1%</i>	177
<i>tab 50-12.5 mg</i>	LUMAKRAS TAB 120MG	124
<i>losartan potassium tab 100 mg</i>	LUMAKRAS TAB 320MG	124
<i>losartan potassium tab 25 mg</i>	LUMIGAN SOL 0.01%	285
<i>losartan potassium tab 50 mg</i>	LUMRYZ PAK 6GM	288
LOSEASONIQUE TAB	LUMRYZ PAK 7.5GM	289
LOTEMAX GEL 0.5%	LUMRYZ PAK 9GM	289
LOTEMAX OIN 0.5%	LUMRYZ PKG 4.5GM	289
LOTEMAX SM GEL 0.38%	LUNESTA TAB 1MG	236
LOTEMAX SUS 0.5%	LUNESTA TAB 2MG	237
LOTENSIN HCT TAB 10-12.5	LUNESTA TAB 3MG	237
LOTENSIN HCT TAB 20-12.5	LUPKYNIS CAP 7.9MG	268
LOTENSIN HCT TAB 20-25MG	LUPRON DEPOT INJ 11.25MG	117
LOTENSIN TAB 10MG	LUPRON DEPOT INJ 3.75MG	117
LOTENSIN TAB 20MG	<i>lurasidone hcl tab 120 mg</i>	133
LOTENSIN TAB 40MG	<i>lurasidone hcl tab 20 mg</i>	133
<i>loteprednol etabonate ophth gel 0.5%</i>	<i>lurasidone hcl tab 40 mg</i>	133
<i>loteprednol etabonate ophth susp 0.5%</i>	<i>lurasidone hcl tab 60 mg</i>	133
LOTREL CAP 10-20MG	<i>lurasidone hcl tab 80 mg</i>	133
LOTREL CAP 10-40MG	LUXIQ AER 0.12%	189
LOTREL CAP 5-10MG	LUZU CRE 1%	177
LOTREL CAP 5-20MG	LYNPARZA TAB 100MG	124

LYNPARZA TAB 150MG.....	124	MAVENCLAD PAK 10MG(8)	293
LYRICA CAP 100MG	70	MAVENCLAD PAK 10MG(9)	293
LYRICA CAP 150MG	70	MAXALT-MLT TAB 10MG	264
LYRICA CAP 200MG	70	MAXALT TAB 10MG	264
LYRICA CAP 225MG.....	70	MAXIDEX SUS 0.1% OP	283
LYRICA CAP 25MG	70	MAXITROL OIN 0.1% OP	283
LYRICA CAP 300MG	70	MAXITROL SUS 0.1% OP	283
LYRICA CAP 50MG.....	70	MAXZIDE-25 TAB	212
LYRICA CAP 75MG	70	MAXZIDE TAB 75-50.....	212
LYRICA CR TAB 165MG	295	MAYZENT PAK STARTER	293
LYRICA CR TAB 330MG.....	295	MAYZENT TAB 0.25MG	293
LYRICA CR TAB 82.5MG.....	295	MAYZENT TAB 1MG.....	293
LYRICA SOL 20MG/ML.....	70	MAYZENT TAB 2MG.....	293
LYSODREN TAB 500MG	117	MCT PRO-CAL PAK.....	207
LYSTEDA TAB 650MG	235	MECLIZINE TAB 50MG.....	92
LYUMJEV KWPN INJ 100UT/ML	88	<i>meclofenamate sodium cap 100 mg</i>	27
LYUMJEV KWPN INJ 200UT/ML	88	<i>meclofenamate sodium cap 50 mg.....</i>	27
LYVISPAH GRA 10MG	276	MEDICHOICE MIS LANCET	251
LYVISPAH GRA 20MG.....	276	MEDISENSE LIQ GLUC/KET	251
LYVISPAH GRA 5MG	276	MEDISENSE LIQ GLUC-KET	251
M		MEDLANCE MIS 30G PLUS.....	251
MACROBID CAP 100MG.....	50	MEDLANCE MIS EXTR 21G.....	251
MACRODANTIN CAP 100MG.....	50	MEDLANCE MIS LITE 25G.....	251
MACRODANTIN CAP 25MG	50	MEDLANCE MIS PLUS	251
MACRODANTIN CAP 50MG	50	MEDLANCE MIS PLUS 30G.....	251
<i>mafenide acetate packet for topical soln</i>		MEDLANCE MIS UNV 21G	251
<i>5% (50 gm).....</i>	185	MEDLANCE PLS MIS 0.8MM	251
MALARONE TAB 250-100	111	MEDLANCE PLS MIS EXTR 21G.....	251
MALARONE TAB 62.5-25	111	MEDLANCE PLS MIS LITE 25G.....	251
<i>malathion lotion 0.5%.....</i>	194	MEDLANCE PLS MIS UNIV 21G	251
<i>maprotiline hcl tab 25 mg</i>	75	MEDROL TAB 16MG.....	170
<i>maprotiline hcl tab 50 mg</i>	75	MEDROL TAB 2MG.....	169
<i>maprotiline hcl tab 75 mg</i>	75	MEDROL TAB 32MG	170
MARINOL CAP 10MG	93	MEDROL TAB 4MG	170
MARINOL CAP 2.5MG.....	93	MEDROL TAB 8MG	170
MARINOL CAP 5MG	93	<i>medroxyprogesterone acetate im susp 150</i>	
MARPLAN TAB 10MG.....	76	<i>mg/ml.....</i>	168
MATULANE CAP 50MG	128	<i>medroxyprogesterone acetate im susp</i>	
MAVENCLAD PAK 10MG(10)	293	<i>prefilled syr 150 mg/ml</i>	168
MAVENCLAD PAK 10MG(4)	293	<i>medroxyprogesterone acetate tab 10 mg</i>	
MAVENCLAD PAK 10MG(5)	293	<i>.....</i>	288
MAVENCLAD PAK 10MG(6)	293	<i>medroxyprogesterone acetate tab 2.5 mg</i>	
MAVENCLAD PAK 10MG(7)	293	<i>.....</i>	288

<i>medroxyprogesterone acetate tab 5 mg</i>	288	MEPRON SUS	49
<i>mefenamic acid cap 250 mg</i>	27	<i>mercaptapurine tab 50 mg</i>	114
<i>mefloquine hcl tab 250 mg</i>	112	<i>mesalamine cap dr 400 mg</i>	226
<i>megestrol acetate susp 40 mg/ml</i>	117	<i>mesalamine cap er 24hr 0.375 gm</i>	226
<i>megestrol acetate susp 625 mg/5ml</i>	288	<i>mesalamine cap er 500 mg</i>	226
<i>megestrol acetate tab 20 mg</i>	117	<i>mesalamine enema 4 gm</i>	226
<i>megestrol acetate tab 40 mg</i>	117	<i>mesalamine rectal enema 4 gm & cleanser</i>	
MEIJER BLOOD TES GLUCOSE	202	<i>wipe kit</i>	226
MEIJER LANCE MIS COLOR	251	<i>mesalamine suppos 1000 mg</i>	226
MEIJER LANCE MIS UNIV 21G	251	<i>mesalamine tab delayed release 1.2 gm</i> .	226
MEIJER LANCE MIS UNIV 30G	251	<i>mesalamine tab delayed release 800 mg</i>	
MEIJER LANCE MIS UNIVERSA.....	251	.....	226
MEIJER MIS LANCETS.....	251	MESNEX TAB 400MG	128
MEIJER TES TRUETEST	202	MESTINON SOL 60MG/5ML	112
MEIJER TES TRUETRAC	202	MESTINON TAB 60MG	112
MEKINIST TAB 0.5MG	124	MESTINON TAB TIMESPAN	112
MEKINIST TAB 2MG.....	124	<i>metaxalone tab 400 mg</i>	276
MEKTOVI TAB 15MG.....	124	<i>metaxalone tab 800 mg</i>	276
<i>meloxicam cap 10 mg</i>	27	<i>metformin hcl oral soln 500 mg/5ml</i>	84
<i>meloxicam cap 5 mg</i>	27	<i>metformin hcl tab 1000 mg</i>	84
<i>meloxicam tab 15 mg</i>	27	<i>metformin hcl tab 500 mg</i>	84
<i>meloxicam tab 7.5 mg</i>	27	<i>metformin hcl tab 850 mg</i>	84
<i>melphalan tab 2 mg</i>	113	<i>metformin hcl tab er 24hr 500 mg</i>	84
<i>memantine hcl cap er 24hr 14 mg</i>	289	<i>metformin hcl tab er 24hr 750 mg</i>	84
<i>memantine hcl cap er 24hr 21 mg</i>	289	<i>metformin hcl tab er 24hr modified release</i>	
<i>memantine hcl cap er 24hr 28 mg</i>	289	<i>1000 mg</i>	85
<i>memantine hcl cap er 24hr 7 mg</i>	289	<i>metformin hcl tab er 24hr modified release</i>	
<i>memantine hcl oral solution 2 mg/ml</i>	290	<i>500 mg</i>	85
<i>memantine hcl tab 10 mg</i>	290	<i>metformin hcl tab er 24hr osmotic 1000 mg</i>	
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg</i>		.....	85
<i>titration pack</i>	290	<i>metformin hcl tab er 24hr osmotic 500 mg</i>	
<i>memantine hcl tab 5 mg</i>	290	.....	85
MEMBRANEBLUE INJ 0.15%	284	<i>methadone hcl conc 10 mg/ml</i>	36
MENEST TAB 0.3MG	223	<i>methadone hcl soln 10 mg/5ml</i>	36
MENEST TAB 0.625MG.....	223	<i>methadone hcl soln 5 mg/5ml</i>	36
MENEST TAB 1.25MG.....	223	<i>methadone hcl tab 10 mg</i>	36
MENOPUR INJ 75UNIT	215	<i>methadone hcl tab 5 mg</i>	36
MENOSTAR DIS 14MCG.....	223	<i>methadone hcl tab for oral susp 40 mg</i>	36
<i>meperidine hcl oral soln 50 mg/5ml</i>	36	METHADOSE CON 10MG/ML	36
<i>meperidine hcl tab 50 mg</i>	36	METHADOSE SF CON 10MG/ML.....	36
MEPHYTON TAB 5MG	313	<i>methamphetamine hcl tab 5 mg</i>	4
<i>meprobamate tab 200 mg</i>	52	<i>methazolamide tab 25 mg</i>	211
<i>meprobamate tab 400 mg</i>	52	<i>methazolamide tab 50 mg</i>	211

<i>methenamine hippurate tab 1 gm</i>	50	<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	12
<i>methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg</i>	49	<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	12
<i>methenamine mandelate tab 0.5 gm</i>	50	<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	12
<i>methenamine mandelate tab 1 gm</i>	50	<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	12
<i>methimazole tab 10 mg</i>	301	<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	12
<i>methimazole tab 5 mg</i>	301	<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	12
METHITEST TAB 10MG	47	<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	13
<i>methocarbamol tab 500 mg</i>	276	<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	13
<i>methocarbamol tab 750 mg</i>	276	<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	13
<i>methotrexate sodium for inj 1 gm</i>	114	<i>methylphenidate hcl cap er 30 mg (cd)</i>	13
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	114	<i>methylphenidate hcl cap er 40 mg (cd)</i>	13
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	114	<i>methylphenidate hcl cap er 50 mg (cd)</i>	13
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	114	<i>methylphenidate hcl cap er 60 mg (cd)</i>	13
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	114	<i>methylphenidate hcl chew tab 10 mg</i>	13
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	114	<i>methylphenidate hcl chew tab 2.5 mg</i>	13
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	114	<i>methylphenidate hcl chew tab 5 mg</i>	13
<i>methoxsalen rapid cap 10 mg</i>	181	<i>methylphenidate hcl soln 10 mg/5ml</i>	13
<i>methscopolamine bromide tab 2.5 mg</i> ..	305	<i>methylphenidate hcl soln 5 mg/5ml</i>	13
<i>methscopolamine bromide tab 5 mg</i>	305	<i>methylphenidate hcl tab 10 mg</i>	13
<i>methyl dopa & hydrochlorothiazide tab 250-15 mg</i>	108	<i>methylphenidate hcl tab 20 mg</i>	13
<i>methyl dopa & hydrochlorothiazide tab 250-25 mg</i>	109	<i>methylphenidate hcl tab 5 mg</i>	13
<i>methyl dopa tab 250 mg</i>	105	<i>methylphenidate hcl tab er 10 mg</i>	13
<i>methyl dopa tab 500 mg</i>	105	<i>methylphenidate hcl tab er 20 mg</i>	13
<i>methylergonovine maleate tab 0.2 mg</i> ...	286	<i>methylphenidate hcl tab er 24hr 18 mg</i>	13
METHYLIN SOL 10MG/5ML	12	<i>methylphenidate hcl tab er 24hr 27 mg</i>	13
METHYLIN SOL 5MG/5ML	12	<i>methylphenidate hcl tab er 24hr 36 mg</i>	14
<i>methylphenidate hcl cap er 10 mg (cd)</i>	12	<i>methylphenidate hcl tab er 24hr 54 mg</i>	14
<i>methylphenidate hcl cap er 20 mg (cd)</i>	12	<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	14
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	12	<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	14
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	12	<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	14
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	12		

<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	14	METROLOTION LOT 0.75%	194
METHYLPHENID TAB 72MG ER	12	<i>metronidazole cap 375 mg</i>	48
<i>methylprednisolone tab 16 mg</i>	170	<i>metronidazole cream 0.75%</i>	194
<i>methylprednisolone tab 32 mg</i>	170	<i>metronidazole gel 0.75%</i>	194
<i>methylprednisolone tab 4 mg</i>	170	<i>metronidazole gel 1%</i>	194
<i>methylprednisolone tab 8 mg</i>	170	<i>metronidazole lotion 0.75%</i>	194
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	170	<i>metronidazole tab 250 mg</i>	48
<i>methyltestosterone cap 10 mg</i>	47	<i>metronidazole tab 500 mg</i>	48
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	225	<i>metronidazole vaginal gel 0.75%</i>	311
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	225	<i>metyrosine cap 250 mg</i>	103
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	225	<i>mexiletine hcl cap 150 mg</i>	54
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	225	<i>mexiletine hcl cap 200 mg</i>	54
METOCLOPRAMI TAB 10MG ODT	225	<i>mexiletine hcl cap 250 mg</i>	54
<i>metolazone tab 10 mg</i>	213	MIACALCIN INJ 200/ML	214
<i>metolazone tab 2.5 mg</i>	213	MICARDIS HCT TAB 40/12.5	109
<i>metolazone tab 5 mg</i>	213	MICARDIS HCT TAB 80/12.5	109
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	109	MICARDIS HCT TAB 80-25MG	109
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	109	MICARDIS TAB 20MG	104
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	109	MICARDIS TAB 40MG	104
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	151	MICARDIS TAB 80MG	104
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	152	<i>miconazole nitrate vaginal suppos 200 mg</i>	311
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	151	<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%</i>	177
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	151	MICROCHAMBER MIS	261
<i>metoprolol tartrate tab 100 mg</i>	152	MICRODOT CON SOL HIGH/LOW	251
<i>metoprolol tartrate tab 25 mg</i>	152	MICRODOT TES	202
<i>metoprolol tartrate tab 37.5 mg</i>	152	MICRODOT TES XTRA	202
<i>metoprolol tartrate tab 50 mg</i>	152	MICROLET MIS LANCETS	251
<i>metoprolol tartrate tab 75 mg</i>	152	MICROLET MIS NEXT	251
METROCREAM CRE 0.75%	194	MICRO THIN MIS LANC 33G	251
METROGEL GEL 1%	194	<i>midodrine hcl tab 10 mg</i>	313
		<i>midodrine hcl tab 2.5 mg</i>	313
		<i>midodrine hcl tab 5 mg</i>	313
		MIFEPREX TAB 200MG	219
		<i>mifepristone tab 200 mg</i>	219
		<i>miglitol tab 100 mg</i>	82
		<i>miglitol tab 25 mg</i>	82
		<i>miglitol tab 50 mg</i>	82
		<i>miglustat cap 100 mg</i>	233
		MIGRANAL SPR 4MG/ML	263
		MILLIPRED TAB 5MG	170
		MINASTRIN 24 CHW FE	166

MINI LANCING MIS DEVICE.....	251	MIRAPEX TAB 1MG	130
MINIPRESS CAP 1MG	105	MIRCETTE TAB 28 DAY	166
MINIPRESS CAP 2MG.....	105	<i>mirtazapine orally disintegrating tab 15 mg</i>	
MINIPRESS CAP 5MG.....	105	.....	75
MINIVELLE DIS 0.025MG.....	223	<i>mirtazapine orally disintegrating tab 30 mg</i>	
MINIVELLE DIS 0.0375MG	223	.....	75
MINIVELLE DIS 0.05MG.....	223	<i>mirtazapine orally disintegrating tab 45 mg</i>	
MINIVELLE DIS 0.075MG.....	223	.....	75
MINIVELLE DIS 0.1MG.....	223	<i>mirtazapine tab 15 mg</i>	75
<i>minocycline hcl cap 100 mg.....</i>	300	<i>mirtazapine tab 30 mg</i>	75
<i>minocycline hcl cap 50 mg</i>	300	<i>mirtazapine tab 45 mg.....</i>	75
<i>minocycline hcl cap 75 mg.....</i>	300	<i>mirtazapine tab 7.5 mg.....</i>	75
<i>minocycline hcl cap er 24hr 135 mg (base</i>		MIRVASO GEL 0.33%	194
<i>equivalent)</i>	300	<i>misoprostol tab 100 mcg</i>	308
<i>minocycline hcl cap er 24hr 45 mg (base</i>		<i>misoprostol tab 200 mcg</i>	308
<i>equivalent)</i>	300	MITIGARE CAP 0.6MG.....	231
<i>minocycline hcl cap er 24hr 90 mg (base</i>		MITOSOL KIT 0.2MG.....	281
<i>equivalent)</i>	300	MM LANCING MIS DEVICE	251
<i>minocycline hcl tab 100 mg</i>	300	MM TWIST MIS LANCETS.....	251
<i>minocycline hcl tab 50 mg</i>	300	M-NATAL PLUS TAB	272
<i>minocycline hcl tab 75 mg</i>	300	MOBIC TAB 15MG	27
<i>minocycline hcl tab er 24hr 105 mg</i>	301	MOBIC TAB 7.5MG	27
<i>minocycline hcl tab er 24hr 115 mg</i>	301	MOBILE LANCE MIS 30G	251
<i>minocycline hcl tab er 24hr 135 mg</i>	301	<i>modafinil tab 100 mg</i>	14
<i>minocycline hcl tab er 24hr 45 mg.....</i>	300	<i>modafinil tab 200 mg</i>	14
<i>minocycline hcl tab er 24hr 55 mg.....</i>	300	<i>moexipril hcl tab 15 mg</i>	102
<i>minocycline hcl tab er 24hr 65 mg.....</i>	301	<i>moexipril hcl tab 7.5 mg</i>	102
<i>minocycline hcl tab er 24hr 80 mg.....</i>	301	<i>molindone hcl tab 10 mg.....</i>	138
<i>minocycline hcl tab er 24hr 90 mg</i>	301	<i>molindone hcl tab 25 mg</i>	138
MINOLIRA TAB 105MG.....	301	<i>molindone hcl tab 5 mg</i>	138
MINOLIRA TAB 135MG	301	<i>mometasone furoate cream 0.1%.....</i>	189
<i>minoxidil tab 10 mg</i>	111	<i>mometasone furoate nasal susp 50</i>	
<i>minoxidil tab 2.5 mg.....</i>	111	<i>mcg/act.....</i>	278
MIRAPEX ER TAB 0.375MG	130	<i>mometasone furoate oint 0.1%</i>	189
MIRAPEX ER TAB 0.75MG	130	<i>mometasone furoate solution 0.1% (lotion)</i>	
MIRAPEX ER TAB 1.5MG	130	.....	189
MIRAPEX ER TAB 2.25MG.....	130	MONOLET MIS LANCETS.....	251
MIRAPEX ER TAB 3.75MG	130	MONOLET OPD MIS LANCETS.....	251
MIRAPEX ER TAB 3MG.....	130	MONOLETTOR MIS LANCETS.....	251
MIRAPEX ER TAB 4.5MG.....	130	<i>montelukast sodium chew tab 4 mg (base</i>	
MIRAPEX TAB 0.125MG	130	<i>equiv)</i>	56
MIRAPEX TAB 0.5MG.....	130	<i>montelukast sodium chew tab 5 mg (base</i>	
MIRAPEX TAB 0.75MG.....	130	<i>equiv)</i>	56

<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	56	MOUNJARO INJ 10MG/0.5	86
<i>montelukast sodium tab 10 mg (base equiv)</i>	56	MOUNJARO INJ 12.5/0.5	86
MONUROL PAK GRANULES.....	50	MOUNJARO INJ 15MG/0.5	86
<i>morphine sulfate beads cap er 24hr 120 mg</i>	36	MOUNJARO INJ 2.5/0.5.....	86
<i>morphine sulfate beads cap er 24hr 30 mg</i>	36	MOUNJARO INJ 5MG/0.5.....	86
<i>morphine sulfate beads cap er 24hr 45 mg</i>	36	MOUNJARO INJ 7.5/0.5.....	86
<i>morphine sulfate beads cap er 24hr 60 mg</i>	36	MOVANTIK TAB 12.5MG.....	228
<i>morphine sulfate beads cap er 24hr 75 mg</i>	36	MOVANTIK TAB 25MG	228
<i>morphine sulfate beads cap er 24hr 90 mg</i>	36	MOVIPREP SOL.....	238
<i>morphine sulfate cap er 24hr 100 mg</i>	37	MOXEZA SOL 0.5%.....	281
<i>morphine sulfate cap er 24hr 10 mg</i>	37	<i>moxifloxacin hcl ophth soln 0.5% (base eq)</i> <i>(2 times daily)</i>	281
<i>morphine sulfate cap er 24hr 20 mg</i>	37	<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	281
<i>morphine sulfate cap er 24hr 30 mg</i>	37	<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	224
<i>morphine sulfate cap er 24hr 40 mg</i>	37	MOXIFLOXACIN SOL 0.5%.....	281
<i>morphine sulfate cap er 24hr 50 mg</i>	37	MPD SFTY LAN MIS 21G.....	251
<i>morphine sulfate cap er 24hr 60 mg</i>	37	MPD SFTY LAN MIS 23G	251
<i>morphine sulfate cap er 24hr 80 mg</i>	37	MPD SFTY LAN MIS 28G	252
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	37	MPD SFTY LAN MIS 30G	252
<i>morphine sulfate oral soln 10 mg/5ml</i>	37	MS CONTIN TAB 100MG ER.....	38
<i>morphine sulfate oral soln 20 mg/5ml</i>	37	MS CONTIN TAB 15MG ER	38
<i>morphine sulfate suppos 10 mg</i>	37	MS CONTIN TAB 200MG ER	38
<i>morphine sulfate suppos 20 mg</i>	37	MS CONTIN TAB 30MG ER.....	38
<i>morphine sulfate suppos 30 mg</i>	37	MS CONTIN TAB 60MG ER	38
<i>morphine sulfate suppos 5 mg</i>	37	MULPLETA TAB 3MG.....	234
<i>morphine sulfate tab 15 mg</i>	37	MULTAQ TAB 400MG	55
<i>morphine sulfate tab 30 mg</i>	37	MULTI-LANCET KIT DEVICE	252
<i>morphine sulfate tab er 100 mg</i>	38	MULTI-LANCET MIS DEVICE	252
<i>morphine sulfate tab er 15 mg</i>	37	<i>multiple vitamins w/ minerals cap</i>	271
<i>morphine sulfate tab er 200 mg</i>	38	<i>mupirocin calcium cream 2%</i>	176
<i>morphine sulfate tab er 30 mg</i>	38	<i>mupirocin oint 2%</i>	176
<i>morphine sulfate tab er 60 mg</i>	38	MUSE SUP 1000MCG	160
MOTEGRITY TAB 1MG.....	224	MUSE SUP 125MCG.....	159
MOTEGRITY TAB 2MG	224	MUSE SUP 250MCG	160
MOTOFEN TAB 1-0.025	91	MUSE SUP 500MCG.....	160
		MYALEPT INJ 11.3MG.....	217
		MYAMBUTOL TAB 400MG.....	113
		MYCAPSSA CAP 20MG.....	220
		MYCOBUTIN CAP 150MG	113
		<i>mycophenolate mofetil cap 250 mg</i>	268

<i>mycophenolate mofetil for oral susp 200 mg/ml</i>	268	NALOCET TAB 2.5-300.....	43
<i>mycophenolate mofetil tab 500 mg</i>	269	<i>naloxone hcl inj 0.4 mg/ml</i>	92
<i>mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)</i>	269	<i>naloxone hcl inj 4 mg/10ml</i>	92
<i>mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)</i>	269	<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	92
MYDAYIS CAP 12.5MG.....	4	<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	92
MYDAYIS CAP 25MG.....	4	<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	92
MYDAYIS CAP 37.5MG.....	4	<i>naltrexone hcl tab 50 mg</i>	92
MYDAYIS CAP 50MG.....	4	NAMENDA TAB 10MG.....	290
MYFEMBREE TAB.....	221	NAMENDA TAB 5-10MG.....	290
MYFORTIC TAB 180MG.....	269	NAMENDA TAB 5MG.....	290
MYFORTIC TAB 360MG.....	269	NAMENDA XR CAP 14MG.....	290
MYGLUCOHEALT MIS LANC 30G.....	252	NAMENDA XR CAP 21MG.....	290
MYGLUCOHEALT SOL LO/NL/HI.....	252	NAMENDA XR CAP 28MG.....	290
MYGLUCOHEALT TES BLD GLUC.....	202	NAMENDA XR CAP 7MG.....	290
MYLERAN TAB 2MG.....	113	NAMENDA XR CAP TITRATIO.....	290
MYNATAL CAP.....	272	NAMZARIC CAP.....	290
MYNATAL PLUS TAB.....	272	NAMZARIC CAP 14-10MG.....	290
MYNATAL-Z TAB.....	272	NAMZARIC CAP 21-10MG.....	290
MYRBETRIQ SUS 8MG/ML.....	310	NAMZARIC CAP 28-10MG.....	290
MYRBETRIQ TAB 25MG.....	310	NAMZARIC CAP 7-10MG.....	290
MYRBETRIQ TAB 50MG.....	310	NAPRELAN TAB 375MG CR.....	28
MYSOLINE TAB 250MG.....	70	NAPRELAN TAB 500MG CR.....	28
MYSOLINE TAB 50MG.....	70	NAPRELAN TAB 750MG CR.....	28
MYTESI TAB 125MG.....	90	NAPROSYN SUS 125/5ML.....	28
N		NAPROSYN TAB 500MG.....	28
<i>nabumetone tab 500 mg</i>	27	<i>naproxen-esomeprazole magnesium tab dr 375-20 mg</i>	28
<i>nabumetone tab 750 mg</i>	28	<i>naproxen-esomeprazole magnesium tab dr 500-20 mg</i>	28
<i>nadolol tab 20 mg</i>	153	<i>naproxen sodium tab 275 mg</i>	28
<i>nadolol tab 40 mg</i>	153	<i>naproxen sodium tab 550 mg</i>	28
<i>nadolol tab 80 mg</i>	153	<i>naproxen sodium tab er 24hr 375 mg (base equiv)</i>	28
NAFRINSE DLY SOL /NEUTRAL.....	270	<i>naproxen sodium tab er 24hr 500 mg (base equiv)</i>	28
NAFRINSE SOL DAILY.....	270	<i>naproxen sodium tab er 24hr 750 mg (base equiv)</i>	28
NAFRINSE WK SOL 0.2%.....	270	<i>naproxen susp 125 mg/5ml</i>	28
<i>naftifine hcl cream 1%</i>	177	<i>naproxen tab 250 mg</i>	28
<i>naftifine hcl cream 2%</i>	177	<i>naproxen tab 375 mg</i>	28
<i>naftifine hcl gel 1%</i>	177	<i>naproxen tab 500 mg</i>	28
NAFTIN GEL 1%.....	178	<i>naproxen tab ec 375 mg</i>	28
NAFTIN GEL 2%.....	178		
NALFON CAP 400MG.....	28		
NALFON TAB 600MG.....	28		

<i>naproxen tab ec 500 mg</i>	28	<i>nefazodone hcl tab 200 mg</i>	78
<i>naratriptan hcl tab 1 mg (base equiv)</i>	264	<i>nefazodone hcl tab 250 mg</i>	78
<i>naratriptan hcl tab 2.5 mg (base equiv)</i> ..	264	<i>nefazodone hcl tab 50 mg</i>	78
NARCAN SPR 4MG.....	92	NEOCATE LIQ SPLASH.....	207
NARDIL TAB 15MG.....	76	NEOKE MCT70 POW.....	207
NASCOBAL SPR 500MCG.....	233	<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i>	
NASONEX SPR 50MCG/AC.....	278	<i>400unt-10000unt op oin</i>	281
NATACHEW CHW.....	272	<i>neomycin-polymy-gramicid op sol 1.75-</i>	
NATACYN SUS 5% OP.....	281	<i>10000-0.025mg-unt-mg/ml</i>	281
NATALVIT TAB 75-1MG.....	272	<i>neomycin-polymyxin-dexamethasone</i>	
NATAZIA TAB.....	166	<i>ophth oint 0.1%</i>	283
<i>nateglinide tab 120 mg</i>	89	<i>neomycin-polymyxin-dexamethasone</i>	
<i>nateglinide tab 60 mg</i>	89	<i>ophth susp 0.1%</i>	283
NATESTO GEL 5.5MG.....	47	<i>neomycin-polymyxin-hc ophth susp</i>	283
NATPARA INJ 100MCG.....	214	<i>neomycin-polymyxin-hc otic soln 1%</i>	286
NATPARA INJ 25MCG.....	214	<i>neomycin-polymyxin-hc otic susp 3.5</i>	
NATPARA INJ 50MCG.....	214	<i>mg/ml-10000 unit/ml-1%</i>	286
NATPARA INJ 75MCG.....	214	<i>neomycin sulfate tab 500 mg</i>	16
NATROBA SUS 0.9%.....	194	NEONATAL/DHA MIS.....	272
NATURE-THROI TAB 113.75MG.....	303	NEONATAL 19 TAB.....	272
NATURE-THROI TAB 130MG.....	303	NEONATAL FE TAB.....	272
NATURE-THROI TAB 146.25MG.....	303	NEONATAL PLS TAB 27-1MG.....	272
NATURE-THROI TAB 16.25MG.....	303	NEONATAL TAB COMPLETE.....	272
NATURE THROI TAB 162.5MG.....	303	NEONATAL TAB COMPLTE.....	272
NATURE-THROI TAB 195MG.....	303	NEORAL CAP 100MG.....	269
NATURE-THROI TAB 260MG.....	303	NEORAL CAP 25MG.....	269
NATURE-THROI TAB 32.5MG.....	303	NEORAL SOL 100MG/ML.....	269
NATURE-THROI TAB 325MG.....	303	NEO-SYNALAR CRE.....	176
NATURE-THROI TAB 48.75MG.....	303	NEOTUSS PLUS LIQ.....	172
NATURE-THROI TAB 65MG.....	303	NEPRO LIQ VANILLA.....	207
NATURE-THROI TAB 81.25MG.....	303	NERLYNX TAB 40MG.....	124
NATURE-THROI TAB 97.5MG.....	303	NESINA TAB 12.5MG.....	85
NAYZILAM SPR 5MG.....	66	NESINA TAB 25MG.....	85
<i>nebivolol hcl tab 10 mg (base equivalent)</i>		NESINA TAB 6.25MG.....	85
.....	152	NESTABS DHA PAK.....	272
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>		NESTABS ONE CAP.....	272
.....	152	NESTABS TAB.....	272
<i>nebivolol hcl tab 20 mg (base equivalent)</i>		NEUPRO DIS 1MG/24HR.....	130
.....	152	NEUPRO DIS 2MG/24HR.....	131
<i>nebivolol hcl tab 5 mg (base equivalent)</i> .152		NEUPRO DIS 3MG/24HR.....	131
NEEVO DHA CAP 27-1.13.....	272	NEUPRO DIS 4MG/24HR.....	131
<i>nefazodone hcl tab 100 mg</i>	78	NEUPRO DIS 6MG/24HR.....	131
<i>nefazodone hcl tab 150 mg</i>	78	NEUPRO DIS 8MG/24HR.....	131

NEURONTIN CAP 100MG	70	NICORETTE GUM 2MG ORIG	296
NEURONTIN CAP 300MG	70	NICORETTE GUM 4MG	296
NEURONTIN CAP 400MG	70	NICORETTE GUM 4MG CINN	296
NEURONTIN SOL 250/5ML	70	NICORETTE GUM 4MGFRUIT	296
NEURONTIN TAB 600MG	71	NICORETTE GUM 4MG MINT	296
NEURONTIN TAB 800MG	71	NICORETTE GUM 4MG ORIG	296
NEUTEK 2TEK SOL CONTROL	252	NICORETTE LOZ 2MG MINT	296
NEUTEK 2TEK TES STRIPS	202	NICORETTE LOZ 4MG MINT	297
NEVANAC SUS 0.1%	285	NICORETTE ST GUM 2MG MINT	297
<i>nevirapine susp 50 mg/5ml</i>	144	NICORETTE ST GUM 2MG ORIG	297
<i>nevirapine tab 200 mg</i>	144	NICORETTE ST GUM 4MG ORIG	297
<i>nevirapine tab er 24hr 100 mg</i>	144	<i>nicotine polacrilex gum 2 mg</i>	297
<i>nevirapine tab er 24hr 400 mg</i>	144	<i>nicotine polacrilex gum 4 mg</i>	297
NEXAVAR TAB 200MG	124	<i>nicotine polacrilex lozenge 2 mg</i>	297
NEXIUM CAP 20MG	307	<i>nicotine polacrilex lozenge 4 mg</i>	297
NEXIUM CAP 40MG	307	<i>nicotine td patch 24hr 14 mg/24hr</i>	297
NEXIUM GRA 10MG DR	307	<i>nicotine td patch 24hr 21 mg/24hr</i>	297
NEXIUM GRA 2.5MG DR	307	<i>nicotine td patch 24hr 7 mg/24hr</i>	297
NEXIUM GRA 20MG DR	307	NICOTROL INH	297
NEXIUM GRA 40MG DR	307	NICOTROL NS SPR 10MG/ML	297
NEXIUM GRA 5MG DR	307	<i>nifedipine cap 10 mg</i>	155
NEXLETOL TAB 180MG	96	<i>nifedipine cap 20 mg</i>	155
NEXLIZET TAB 180/10MG	96	<i>nifedipine tab er 24hr 30 mg</i>	155
<i>niacin (antihyperlipidemic) tab 500 mg</i> ..	100	<i>nifedipine tab er 24hr 60 mg</i>	155
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	100	<i>nifedipine tab er 24hr 90 mg</i>	156
.....	100	<i>nifedipine tab er 24hr osmotic release 30</i>	
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	100	<i>mg</i>	156
.....	100	<i>nifedipine tab er 24hr osmotic release 60</i>	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	100	<i>mg</i>	156
.....	100	<i>nifedipine tab er 24hr osmotic release 90</i>	
NIASPAN TAB 1000 ER	101	<i>mg</i>	156
NIASPAN TAB 500MG ER	100	NILANDRON TAB 150MG	117
NIASPAN TAB 750MG ER	101	<i>nilutamide tab 150 mg</i>	117
<i>nicardipine hcl cap 20 mg</i>	155	<i>nimodipine cap 30 mg</i>	156
<i>nicardipine hcl cap 30 mg</i>	155	NINLARO CAP 2.3MG	124
NICODERM CQ DIS 14MG/24H	296	NINLARO CAP 3MG	124
NICODERM CQ DIS 21MG/24H	296	NINLARO CAP 4MG	124
NICODERM CQ DIS 7MG/24HR	296	<i>nisoldipine tab er 24hr 17 mg</i>	156
NICOMIDE TAB	275	<i>nisoldipine tab er 24hr 20 mg</i>	156
NICORETTE GUM 2MG	296	<i>nisoldipine tab er 24hr 25.5 mg</i>	156
NICORETTE GUM 2MG CINN	296	<i>nisoldipine tab er 24hr 30 mg</i>	156
NICORETTE GUM 2MGFRUIT	296	<i>nisoldipine tab er 24hr 34 mg</i>	156
NICORETTE GUM 2MG MINT	296	<i>nisoldipine tab er 24hr 40 mg</i>	156

<i>nisoldipine tab er 24hr 8.5 mg</i>	156	<i>nizatidine cap 150 mg</i>	306
<i>nitazoxanide tab 500 mg</i>	49	<i>nizatidine cap 300 mg</i>	306
<i>nitisinone cap 10 mg</i>	218	<i>nizatidine oral soln 15 mg/ml</i>	306
<i>nitisinone cap 2 mg</i>	217	NOC DURNA SUB 27.7MCG.....	219
<i>nitisinone cap 5 mg</i>	217	NOC DURNA SUB 55.3MCG	219
NITRO-BID OIN 2%.....	51	NO CODING TES BLD GLUC	202
NITRO-DUR DIS 0.1MG/HR	51	NORDITROPIN INJ 10/1.5ML	216
NITRO-DUR DIS 0.2MG/HR	51	NORDITROPIN INJ 15/1.5ML	216
NITRO-DUR DIS 0.3MG/HR	51	NORDITROPIN INJ 30/3ML	216
NITRO-DUR DIS 0.4MG/HR	51	NORDITROPIN INJ 5/1.5ML.....	216
NITRO-DUR DIS 0.6MG/HR	51	<i>norelgestromin-ethinyl estradiol td ptwk</i>	
NITRO-DUR DIS 0.8MG/HR	51	<i>150-35 mcg/24hr</i>	168
<i>nitrofurantoin macrocrystalline cap 100 mg</i>		<i>norethindrone & ethinyl estradiol-fe chew</i>	
.....	51	<i>tab 0.4 mg-35 mcg</i>	167
<i>nitrofurantoin macrocrystalline cap 25 mg</i>		<i>norethindrone & ethinyl estradiol-fe chew</i>	
.....	50	<i>tab 0.8 mg-25 mcg</i>	167
<i>nitrofurantoin macrocrystalline cap 50 mg</i>		<i>norethindrone & ethinyl estradiol tab 0.4</i>	
.....	51	<i>mg-35 mcg</i>	167
<i>nitrofurantoin monohydrate</i>		<i>norethindrone & ethinyl estradiol tab 0.5</i>	
<i>macrocrystalline cap 100 mg</i>	51	<i>mg-35 mcg</i>	167
<i>nitrofurantoin susp 25 mg/5ml</i>	51	<i>norethindrone & ethinyl estradiol tab 1 mg-</i>	
<i>nitroglycerin sl tab 0.3 mg</i>	51	<i>35 mcg</i>	167
<i>nitroglycerin sl tab 0.4 mg</i>	51	<i>norethindrone ace & ethinyl estradiol-fe tab</i>	
<i>nitroglycerin sl tab 0.6 mg</i>	52	<i>1.5 mg-30 mcg</i>	167
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	52	<i>norethindrone ace & ethinyl estradiol-fe tab</i>	
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	52	<i>1 mg-20 mcg</i>	167
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	52	<i>norethindrone ace & ethinyl estradiol tab 1.5</i>	
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	52	<i>mg-30 mcg</i>	167
<i>nitroglycerin tl soln 0.4 mg/spray (400</i>		<i>norethindrone ace & ethinyl estradiol tab 1</i>	
<i>mcg/spray)</i>	52	<i>mg-20 mcg</i>	167
NITROLINGUAL SPR PUMPSRA.....	52	<i>norethindrone ace-eth estradiol-fe chew</i>	
NITROMIST AER 400MCG.....	52	<i>tab 1 mg-20 mcg (24)</i>	167
NITROSTAT SUB 0.3MG.....	52	<i>norethindrone ace-ethinyl estradiol-fe cap 1</i>	
NITROSTAT SUB 0.4MG	52	<i>mg-20 mcg (24)</i>	167
NITROSTAT SUB 0.6MG	52	<i>norethindrone ace-ethinyl estradiol-fe tab 1</i>	
NITYR TAB 10MG.....	218	<i>mg-20 mcg (24)</i>	167
NITYR TAB 2MG.....	218	<i>norethindrone acetate-ethinyl estradiol tab</i>	
NITYR TAB 5MG	218	<i>0.5 mg-2.5 mcg</i>	221
NIVA-PLUS TAB	272	<i>norethindrone acetate-ethinyl estradiol tab</i>	
NIVESTYM INJ 300/0.5	234	<i>1 mg-5 mcg</i>	221
NIVESTYM INJ 300MCG	234	<i>norethindrone acetate tab 5 mg</i>	288
NIVESTYM INJ 480/0.8	234	<i>norethindrone ac-ethinyl estrad-fe tab 1-</i>	
NIVESTYM INJ 480MCG	234	<i>20/1-30/1-35 mg-mcg</i>	167

<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	167	NOVOLIN INJ 70/30 FP	88
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	167	NOVOLIN N INJ 100 UNIT	88
<i>norethindrone tab 0.35 mg</i>	168	NOVOLIN N INJ U-100	88
NORGESIC TAB FORTE	276	NOVOLOG INJ 100/ML	89
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	167	NOVOLOG INJ FLEXPEN	89
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	167	NOVOLOG INJ FLEX REL	89
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	167	NOVOLOG INJ PENFILL.....	89
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	168	NOVOLOG INJ RELION	89
NORITATE CRE 1%	194	NOVOLOG MIX INJ 70/30	89
NORPACE CAP 100MG	54	NOVOLOG MIX INJ FLEXPEN	89
NORPACE CAP 100MG CR	54	NOVOLOG MIX INJ FLEX REL	89
NORPACE CAP 150MG	54	NOVOLOG RELI INJ 70/30	89
NORPACE CAP 150MG CR	54	NOXAFIL SUS 40MG/ML	94
NORPRAMIN TAB 10MG	81	NOXAFIL TAB 100MG.....	94
NORPRAMIN TAB 25MG	81	NOZIN NASAL MIS SANITIZE	277
<i>nortriptyline hcl cap 10 mg</i>	81	NP THYROID TAB 120MG.....	303
<i>nortriptyline hcl cap 25 mg</i>	81	NP THYROID TAB 15MG	303
<i>nortriptyline hcl cap 50 mg</i>	81	NP THYROID TAB 30MG	303
<i>nortriptyline hcl cap 75 mg</i>	81	NP THYROID TAB 60MG	303
<i>nortriptyline hcl soln 10 mg/5ml</i>	81	NP THYROID TAB 90MG	303
NORVASC TAB 10MG	156	NUBEQA TAB 300MG.....	117
NORVASC TAB 2.5MG.....	156	NUCALA INJ 100MG.....	55
NORVASC TAB 5MG	156	NUCALA INJ 100MG/ML	55
NORVIR POW 100MG	144	NUCALA INJ 40MG/0.4.....	55
NORVIR SOL 80MG/ML	144	NUCYNTA ER TAB 100MG.....	38
NORVIR TAB 100MG.....	144	NUCYNTA ER TAB 150MG	38
NOURIANZ TAB 20MG.....	129	NUCYNTA ER TAB 200MG	38
NOURIANZ TAB 40MG	129	NUCYNTA ER TAB 250MG	38
NOVA MAX GLU LIQ /KET CON.....	252	NUCYNTA ER TAB 50MG	38
NOVA MAX PLS TES KETONE	202	NUCYNTA TAB 100MG.....	38
NOVA MAX TES GLUCOSE.....	202	NUCYNTA TAB 50MG	38
NOVA SAFETY MIS LANC 23G.....	252	NUCYNTA TAB 75MG	38
NOVA SAFETY MIS LANC 28G.....	252	NUEDEXTA CAP 20-10MG	295
NOVASOURCE LIQ RENAL	207	NULYTELY SOL LMN/LIME	238
NOVA SUREFLX MIS LANC DEV	252	NUMBRINO SOL 40MG/ML	277
NOVA SURE MIS LANCETS	252	NUMOISYN LOZ.....	271
NOVOLIN INJ 70/30.....	88	NUPLAZID CAP 34MG	133
		NUPLAZID TAB 10MG	133
		NURTEC TAB 75MG ODT.....	262
		NUTRAMINE PAK	207
		NUTREN 1.0 LIQ UNFLAVOR.....	207
		NUTREN 1.5 LIQ FIBER	207
		NUTREN 2.0 LIQ VANILLA.....	207

NUTREN JR LIQ.....	207	<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml)</i>	220
NUTREN LIQ JUNIOR	207	OCUFLOX DRO 0.3% OP	281
NUTREN RENAL LIQ	207	ODEFSEY TAB	144
NUTRIRENAL LIQ	207	ODOMZO CAP 200MG	116
NUVARING MIS.....	168	OFEV CAP 100MG.....	299
NUVESSA GEL 1.3%	311	OFEV CAP 150MG.....	299
NUVIGIL TAB 150MG.....	14	<i>ofloxacin ophth soln 0.3%</i>	281
NUVIGIL TAB 200MG	14	<i>ofloxacin otic soln 0.3%</i>	286
NUVIGIL TAB 250MG	14	<i>ofloxacin tab 300 mg</i>	224
NUVIGIL TAB 50MG	14	<i>ofloxacin tab 400 mg</i>	224
NUZYRA TAB 150MG.....	299	<i>olanzapine-fluoxetine hcl cap 12-25 mg</i> ..	291
NYMALIZE SOL	156	<i>olanzapine-fluoxetine hcl cap 12-50 mg</i> ..	291
<i>nystatin cream 100000 unit/gm</i>	178	<i>olanzapine-fluoxetine hcl cap 3-25 mg</i> ..	290
<i>nystatin oint 100000 unit/gm</i>	178	<i>olanzapine-fluoxetine hcl cap 6-25 mg</i> ..	290
<i>nystatin oral powder</i>	94	<i>olanzapine-fluoxetine hcl cap 6-50 mg</i> ...	291
<i>nystatin susp 100000 unit/ml</i>	270	<i>olanzapine for im inj 10 mg</i>	136
<i>nystatin tab 500000 unit</i>	94	<i>olanzapine orally disintegrating tab 10 mg</i>	136
<i>nystatin topical powder 100000 unit/gm</i>	178	<i>olanzapine orally disintegrating tab 15 mg</i>	136
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	178	<i>olanzapine orally disintegrating tab 20 mg</i>	136
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	178	<i>olanzapine orally disintegrating tab 5 mg</i>	136
NYVEPRIA INJ 6/0.6ML.....	234	<i>olanzapine tab 10 mg</i>	136
o		<i>olanzapine tab 15 mg</i>	136
OB COMPLETE/ CAP DHA	272	<i>olanzapine tab 2.5 mg</i>	136
OB COMPLETE CAP ONE	272	<i>olanzapine tab 20 mg</i>	136
OB COMPLETE CAP PETITE.....	272	<i>olanzapine tab 5 mg</i>	136
OB COMPLETE TAB.....	272	<i>olanzapine tab 7.5 mg</i>	136
OB COMPLETE TAB PREMIER	272	OLINVYK SOL 1MG/ML	38
OBSTETRIX EC TAB	272	OLINVYK SOL 2MG/2ML	38
OBSTETRIX MIS DHA	273	OLINVYK SOL 30MG/30	38
OBSTETRIX ONE CAP 38-1-225	273	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 20-5-12.5 mg</i>	109
OALIVA TAB 10MG.....	224	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-12.5 mg</i>	109
OALIVA TAB 5MG	224	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-25 mg</i> .	109
O-CAL TAB PRENATAL.....	272	<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-5-12.5 mg</i>	109
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	220		
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml)</i>	220		
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	220		
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml)</i>	220		

<i>olmesartan-amlodipine-</i>	ONETOUCH DEL MIS PLUS 30G.....	252
<i>hydrochlorothiazide tab 40-5-25 mg...</i>	ONETOUCH DEL MIS PLUS 33G.....	252
<i>olmesartan medoxomil-</i>	ONETOUCH FP MIS LANCETS.....	252
<i>hydrochlorothiazide tab 20-12.5 mg</i>	ONETOUCH KIT ULTRA 2	252
<i>olmesartan medoxomil-</i>	ONETOUCH KIT VERIO FL	252
<i>hydrochlorothiazide tab 40-12.5 mg</i>	ONETOUCH KIT VERIO RE.....	252
<i>olmesartan medoxomil-</i>	ONETOUCH LIQ ULT CONT.....	252
<i>hydrochlorothiazide tab 40-25 mg</i>	ONETOUCH LIQ VERIO	252
<i>olmesartan medoxomil tab 20 mg</i>	ONETOUCH LIQ VERIO 4.....	252
<i>olmesartan medoxomil tab 40 mg</i>	ONETOUCH MIS 30G	252
<i>olmesartan medoxomil tab 5 mg</i>	ONETOUCH MIS LANC DEV	252
<i>olopatadine hcl nasal soln 0.6%</i>	ONETOUCH MIS LANCETS	252
OLUX AER 0.05%	ONETOUCH SOL KIT COMPLETE.....	252
OLUX-E AER 0.05%	ONETOUCH SOL KIT FIT	252
OMECLAMOX- MIS PAK.....	ONETOUCH SOL KIT REFILL.....	252
<i>omega-3-acid ethyl esters cap 1 gm</i>	ONETOUCH TES ULTRA	202
<i>omeprazole cap delayed release 10 mg .</i>	ONETOUCH TES VERIO	202
<i>omeprazole cap delayed release 20 mg .</i>	ONETOUCH US MIS LANCETS	253
<i>omeprazole cap delayed release 40 mg .</i>	ONE VITE TAB 1MG PLUS	273
<i>omeprazole-sodium bicarbonate cap 20-</i>	ONEXTON GEL 1.2-3.75	175
<i>1100 mg</i>	ONFI SUS 2.5MG/ML.....	66
<i>omeprazole-sodium bicarbonate cap 40-</i>	ONFI TAB 10MG	66
<i>1100 mg</i>	ONFI TAB 20MG.....	66
<i>omeprazole-sodium bicarbonate powd</i>	ONGENTYS CAP 25MG	129
<i>pack for susp 20-1680 mg</i>	ONGENTYS CAP 50MG	129
<i>omeprazole-sodium bicarbonate powd</i>	ONGLYZA TAB 2.5MG.....	86
<i>pack for susp 40-1680 mg.....</i>	ONGLYZA TAB 5MG	86
OMNARIS SPR.....	ON-THE-GO MIS LANC 30G	252
OMNIFLEX DPR.....	ONUREG TAB 200MG.....	114
OMNIPOD 5 G6 KIT INTRO.....	ONUREG TAB 300MG.....	114
OMNIPOD 5 G6 MIS PODS	ONZETRA XSAI MIS 11MG.....	264
OMNIPOD MIS CLASSIC.....	OPSUMIT TAB 10MG.....	162
OMNIPOD PDM KIT CLASSIC	OPTICHAMBER MIS DIA MD	261
<i>ondansetron hcl oral soln 4 mg/5ml.....</i>	OPTICHAMBER MIS DIAMOND.....	261
<i>ondansetron hcl tab 24 mg</i>	OPTICHAMBER MIS DIA SM	261
<i>ondansetron hcl tab 4 mg</i>	OPTIMENTAL LIQ	208
<i>ondansetron hcl tab 8 mg</i>	OPTIUMEZ TES.....	203
<i>ondansetron orally disintegrating tab 4 mg</i>	OPTIUM TES.....	203
.....	OPZELURA CRE 1.5%.....	191
<i>ondansetron orally disintegrating tab 8 mg</i>	ORACEA CAP 40MG	194
.....	ORACIT SOL	229
ONE DROP TES BLD GLUC.....	ORAFATE PST 10%.....	271
ONETOUCH DEL MIS LANC DEV	ORALAIR SUB 300 IR	15

ORAPRED ODT TAB 10MG.....	170	<i>oseltamivir phosphate cap 45 mg (base equiv).....</i>	150
ORAPRED ODT TAB 15MG.....	170	<i>oseltamivir phosphate cap 75 mg (base equiv).....</i>	150
ORAPRED ODT TAB 30MG.....	170	<i>oseltamivir phosphate for susp 6 mg/ml (base equiv).....</i>	150
ORAVIG TAB 50MG.....	270	OSENI TAB 12.5-15.....	83
ORENCIA CLCK INJ 125MG/ML.....	30	OSENI TAB 12.5-30.....	83
ORENCIA INJ 125MG/ML.....	30	OSENI TAB 12.5-45.....	83
ORENCIA INJ 50/0.4ML.....	30	OSENI TAB 25-15MG.....	83
ORENCIA INJ 87.5/0.7.....	30	OSENI TAB 25-30MG.....	83
ORENITRAM TAB 0.125MG.....	161	OSENI TAB 25-45MG.....	83
ORENITRAM TAB 0.25MG.....	161	OSMOLEX ER TAB.....	131
ORENITRAM TAB 1MG.....	161	OSMOLEX ER TAB 129MG.....	131
ORENITRAM TAB 2.5MG.....	161	OSMOLEX ER TAB 193MG.....	131
ORENITRAM TAB 5MG.....	161	OSMOLEX ER TAB 258MG.....	131
ORENITRAM TAB MONTH 1.....	161	OSMOLITE 1.2 LIQ CAL.....	208
ORENITRAM TAB MONTH 2.....	161	OSMOLITE 1.5 LIQ CAL.....	208
ORENITRAM TAB MONTH 3.....	161	OSMOLITE 1 LIQ CAL.....	208
ORFADIN CAP 10MG.....	218	OSMOLITE HN LIQ.....	208
ORFADIN CAP 20MG.....	218	OSMOLITE LIQ.....	208
ORFADIN CAP 2MG.....	218	OSMOPREP TAB 1.5GM.....	239
ORFADIN CAP 5MG.....	218	OSPHENA TAB 60MG.....	216
ORFADIN SUS 4MG/ML.....	218	OTEZLA TAB 10/20/30.....	29
ORGOVYX TAB 120MG.....	117	OTEZLA TAB 30MG.....	29
ORIAHNN CAP.....	221	OTOVEL DRO.....	286
ORLISSA TAB 150MG.....	216	OVIDE LOT 0.5%.....	194
ORLISSA TAB 200MG.....	216	OVIDREL INJ.....	215
ORKAMBI GRA 100-125.....	298	<i>oxandrolone tab 10 mg.....</i>	46
ORKAMBI GRA 150-188.....	298	<i>oxandrolone tab 2.5 mg.....</i>	46
ORKAMBI GRA 75-94MG.....	298	<i>oxaprozin tab 600 mg.....</i>	28
ORKAMBI TAB 100-125.....	298	OXAYDO TAB 5MG.....	38
ORKAMBI TAB 200-125.....	298	OXAYDO TAB 7.5MG.....	38
ORLADEYO CAP 110MG.....	232	<i>oxazepam cap 10 mg.....</i>	53
ORLADEYO CAP 150MG.....	232	<i>oxazepam cap 15 mg.....</i>	53
<i>orlistat cap 120 mg.....</i>	6	<i>oxazepam cap 30 mg.....</i>	53
<i>orphenadrine citrate tab er 12hr 100 mg.....</i>	276	<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml).....</i>	71
<i>orphenadrine w/ aspirin & caffeine tab 50-770-60 mg.....</i>	277	<i>oxcarbazepine tab 150 mg.....</i>	71
ORTHO DF CAP 1-3775IU.....	235	<i>oxcarbazepine tab 300 mg.....</i>	71
ORTHO MICRON TAB 0.35MG.....	168	<i>oxcarbazepine tab 600 mg.....</i>	71
ORTIKOS CAP 6MG ER.....	170	OXEPA 1.5 LIQ.....	208
ORTIKOS CAP 9MG ER.....	170	OXEPA LIQ.....	208
<i>oseltamivir phosphate cap 30 mg (base equiv).....</i>	150		

OXERVATE SOL 20MCG/ML.....	282	<i>oxycodone w/ acetaminophen tab 7.5-325</i>	
OXIANUJO CRE 4-0.1%	192	<i>mg</i>	44
OXIAZAR CRE 4-0.1%	175	OXYCONTIN TAB 10MG ER	39
<i>oxiconazole nitrate cream 1%</i>	178	OXYCONTIN TAB 15MG ER	39
OXISTAT CRE 1%	178	OXYCONTIN TAB 20MG ER	40
OXISTAT LOT 1%	178	OXYCONTIN TAB 30MG ER	40
OXSORALEN-UL CAP 10MG.....	181	OXYCONTIN TAB 40MG ER.....	40
OXTELLAR XR TAB 150MG.....	71	OXYCONTIN TAB 60MG ER.....	40
OXTELLAR XR TAB 300MG.....	71	OXYCONTIN TAB 80MG ER.....	40
OXTELLAR XR TAB 600MG.....	71	<i>oxymorphone hcl tab 10 mg</i>	40
<i>oxybutynin chloride solution 5 mg/5ml</i> ..	309	<i>oxymorphone hcl tab 5 mg</i>	40
<i>oxybutynin chloride tab 5 mg</i>	309	<i>oxymorphone hcl tab er 12hr 10 mg</i>	40
<i>oxybutynin chloride tab er 24hr 10 mg</i>	310	<i>oxymorphone hcl tab er 12hr 15 mg</i>	40
<i>oxybutynin chloride tab er 24hr 15 mg</i>	310	<i>oxymorphone hcl tab er 12hr 20 mg</i>	40
<i>oxybutynin chloride tab er 24hr 5 mg</i>	309	<i>oxymorphone hcl tab er 12hr 30 mg</i>	40
OXYCOD/ACETA SOL 10/300MG.....	43	<i>oxymorphone hcl tab er 12hr 40 mg</i>	40
OXYCOD/APAP TAB 10-300MG	44	<i>oxymorphone hcl tab er 12hr 5 mg</i>	40
OXYCOD/APAP TAB 5-300MG	44	<i>oxymorphone hcl tab er 12hr 7.5 mg</i>	40
OXYCOD-APAP TAB 2.5-300	43	OXYTROL DIS 3.9MG/24	310
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	44	OZEMPIC INJ 2/1.5ML.....	87
<i>oxycodone hcl cap 5 mg</i>	38	OZEMPIC INJ 2MG/3ML.....	86
<i>oxycodone hcl conc 100 mg/5ml (20</i>		OZEMPIC INJ 4MG/3ML.....	87
<i>mg/ml)</i>	38	OZEMPIC INJ 8MG/3ML.....	87
<i>oxycodone hcl soln 5 mg/5ml</i>	39	OZOBAX SOL 5MG/5ML.....	276
<i>oxycodone hcl tab 10 mg</i>	39	P	
<i>oxycodone hcl tab 15 mg</i>	39	PAIN EASE AER MD STRM	193
<i>oxycodone hcl tab 20 mg</i>	39	PAIN EASE AER MIST	193
<i>oxycodone hcl tab 30 mg</i>	39	PALFORZIA CAP ESCALAT	15
<i>oxycodone hcl tab 5 mg</i>	39	PALFORZIA CAP LEVEL 1.....	15
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	39	PALFORZIA CAP LEVEL 10	15
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	39	PALFORZIA CAP LEVEL 2	15
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	39	PALFORZIA CAP LEVEL 3.....	15
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	39	PALFORZIA CAP LEVEL 4.....	15
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	39	PALFORZIA CAP LEVEL 5.....	15
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	39	PALFORZIA CAP LEVEL 6.....	15
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	39	PALFORZIA CAP LEVEL 7	15
<i>oxycodone w/ acetaminophen tab 10-325</i>		PALFORZIA CAP LEVEL 8.....	15
<i>mg</i>	44	PALFORZIA CAP LEVEL 9.....	15
<i>oxycodone w/ acetaminophen tab 2.5-325</i>		PALFORZIA POW LEVEL 11.....	15
<i>mg</i>	44	<i>paliperidone tab er 24hr 1.5 mg</i>	134
<i>oxycodone w/ acetaminophen tab 5-325</i>		<i>paliperidone tab er 24hr 3 mg</i>	134
<i>mg</i>	44	<i>paliperidone tab er 24hr 6 mg</i>	134
		<i>paliperidone tab er 24hr 9 mg</i>	134

PAMELOR CAP 10MG	81	PAXIL TAB 20MG	77
PAMELOR CAP 25MG.....	81	PAXIL TAB 30MG	77
PAMELOR CAP 50MG.....	81	PAXIL TAB 40MG	77
PAMELOR CAP 75MG.....	81	PAXLOVID TAB 150-100	147
PANCREAZE CAP 10500UNT	211	PAXLOVID TAB 300-100	147
PANCREAZE CAP 16800UNT	211	PC LANCETS MIS 30G	253
PANCREAZE CAP 21000UNT	211	PEDIAPRED SOL 5MG/5ML.....	170
PANCREAZE CAP 2600UNIT	211	PEDIASURE EN LIQ /FIBER	208
PANCREAZE CAP 37000	211	PEDIASURE LIQ PEPTIDE	208
PANCREAZE CAP 4200UNIT.....	211	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>	
PANDEL CRE 0.1%	189	<i>soln 236 gm</i>	238
PANRETIN GEL 0.1%.....	179	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>	
<i>pantoprazole sodium ec tab 20 mg (base</i>		<i>soln 240 gm</i>	238
<i>equiv)</i>	307	<i>peg 3350-kcl-nacl-na sulfate-na ascorbate-</i>	
<i>pantoprazole sodium ec tab 40 mg (base</i>		<i>c for soln 100 gm</i>	238
<i>equiv)</i>	307	<i>peg 3350-kcl-sod bicarb-nacl for soln 420</i>	
<i>pantoprazole sodium for delayed release</i>		<i>gm</i>	238
<i>susp packet 40 mg</i>	307	PEGINTRON KIT 50MCG.....	149
<i>paricalcitol cap 1 mcg.....</i>	218	PEG-PREP KIT	238
<i>paricalcitol cap 2 mcg.....</i>	218	PEMAZYRE TAB 13.5MG.....	124
<i>paricalcitol cap 4 mcg.....</i>	218	PEMAZYRE TAB 4.5MG	124
PARLODEL CAP 5MG	131	PEMAZYRE TAB 9MG	124
PARLODEL TAB 2.5MG	131	<i> penciclovir cream 1%.....</i>	184
PARNATE TAB 10MG.....	76	<i> penicillamine cap 250 mg.....</i>	267
<i> paromomycin sulfate cap 250 mg.....</i>	16	<i> penicillamine tab 250 mg</i>	267
<i> paroxetine hcl oral susp 10 mg/5ml (base</i>		<i> penicillin v potassium for soln 125 mg/5ml</i>	
<i>equiv)</i>	77	<i></i>	287
<i> paroxetine hcl tab 10 mg</i>	77	<i> penicillin v potassium for soln 250 mg/5ml</i>	
<i> paroxetine hcl tab 20 mg</i>	77	<i></i>	287
<i> paroxetine hcl tab 30 mg</i>	77	<i> penicillin v potassium tab 250 mg</i>	287
<i> paroxetine hcl tab 40 mg</i>	77	<i> penicillin v potassium tab 500 mg</i>	287
<i> paroxetine hcl tab er 24hr 12.5 mg.....</i>	77	PENLET II KIT BLOOD.....	253
<i> paroxetine hcl tab er 24hr 25 mg</i>	77	PENLET II MIS REPL CAP.....	253
<i> paroxetine hcl tab er 24hr 37.5 mg</i>	77	PENNSAID SOL 2%	176
<i> paroxetine mesylate cap 7.5 mg (base</i>		PENTASA CAP 250MG CR	226
<i>equiv)</i>	297	PENTASA CAP 500MG CR.....	226
PASER GRA 4GM.....	113	<i> pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	
PATANASE SPR 0.6%	277	<i></i>	46
PAXIL CR TAB 12.5MG.....	77	PENTETATE CA SOL 200MG/ML.....	91
PAXIL CR TAB 25MG	77	PENTETATE ZI SOL 200MG/ML.....	91
PAXIL CR TAB 37.5MG.....	77	PENTOSAN CAP 150MG	229
PAXIL SUS 10MG/5ML	77	PENTOSAN CAP 200MG	229
PAXIL TAB 10MG.....	77	<i> pentoxifylline tab er 400 mg</i>	231

PEPCID TAB 40MG	306	<i>phenelzine sulfate tab 15 mg</i>	76
PEPTAMEN LIQ PREBIO1.....	208	<i>phenobarbital elixir 20 mg/5ml.....</i>	236
PEPTAMEN LIQ UNFLAVOR	208	<i>phenobarbital tab 100 mg.....</i>	236
PEPTINEX DT LIQ	208	<i>phenobarbital tab 15 mg</i>	236
PEPTINEX DT LIQ VANILLA	208	<i>phenobarbital tab 16.2 mg</i>	236
PERATIVE LIQ.....	208	<i>phenobarbital tab 30 mg</i>	236
PERCOCET TAB 10-325MG.....	44	<i>phenobarbital tab 32.4 mg</i>	236
PERCOCET TAB 2.5-325.....	44	<i>phenobarbital tab 60 mg</i>	236
PERCOCET TAB 5-325MG.....	44	<i>phenobarbital tab 64.8 mg</i>	236
PERCOCET TAB 7.5-325.....	44	<i>phenobarbital tab 97.2 mg</i>	236
PERFECT 28G MIS LANCETS	253	<i>phenoxybenzamine hcl cap 10 mg.....</i>	103
PERFECT 30G MIS LANCETS.....	253	<i>phentermine hcl cap 15 mg.....</i>	6
PERFOROMIST NEB 20MCG.....	62	<i>phentermine hcl cap 30 mg.....</i>	6
PERIDEX SOL 0.12%	270	<i>phentermine hcl cap 37.5 mg.....</i>	6
<i>perindopril erbumine tab 2 mg</i>	102	<i>phentermine hcl tab 37.5 mg.....</i>	6
<i>perindopril erbumine tab 4 mg</i>	102	<i>phenylephrine hcl ophth soln 10%</i>	280
<i>perindopril erbumine tab 8 mg</i>	102	<i>phenylephrine hcl ophth soln 2.5%.....</i>	280
<i>permethrin cream 5%.....</i>	194	<i>phenytoin chew tab 50 mg</i>	74
<i>perphenazine-amitriptyline tab 2-10 mg .</i>	291	<i>phenytoin sodium extended cap 100 mg .</i>	74
<i>perphenazine-amitriptyline tab 2-25 mg .</i>	291	<i>phenytoin sodium extended cap 200 mg .</i>	74
<i>perphenazine-amitriptyline tab 4-10 mg .</i>	291	<i>phenytoin sodium extended cap 300 mg .</i>	74
<i>perphenazine-amitriptyline tab 4-25 mg .</i>	291	<i>phenytoin susp 125 mg/5ml</i>	74
<i>perphenazine-amitriptyline tab 4-50 mg</i>	291	PHLEXY-10 POW	208
<i>perphenazine tab 16 mg</i>	138	PHOSLYRA SOL	228
<i>perphenazine tab 2 mg</i>	138	PHOSPHOLINE SOL 0.125%OP.....	280
<i>perphenazine tab 4 mg</i>	138	PHOTREXA/PHO SOL VISC KIT.....	282
<i>perphenazine tab 8 mg</i>	138	PHOTREXA VIS SOL 0.146-20.....	282
PERSERIS INJ 120MG	135	<i>phytonadione tab 5 mg</i>	313
PERSERIS INJ 90MG.....	135	PICATO GEL 0.015%	179
PERTZYE CAP 16000U	211	PICATO GEL 0.05%.....	179
PERTZYE CAP 24000U.....	211	<i>pilocarpine hcl ophth soln 1%</i>	280
PERTZYE CAP 4000UNIT.....	211	<i>pilocarpine hcl ophth soln 2%.....</i>	280
PERTZYE CAP 8000UNIT.....	211	<i>pilocarpine hcl ophth soln 4%</i>	280
PEXEVA TAB 10MG	77	<i>pilocarpine hcl tab 5 mg</i>	271
PEXEVA TAB 20MG	77	<i>pilocarpine hcl tab 7.5 mg</i>	271
PEXEVA TAB 30MG	77	<i>pimecrolimus cream 1%</i>	192
PEXEVA TAB 40MG	77	<i>pimozide tab 1 mg</i>	295
PHARMACY COU MIS LANCETS.....	253	<i>pimozide tab 2 mg</i>	295
PHEBURANE MIS 483/GM	218	<i>pindolol tab 10 mg</i>	153
PHENACTIN AA LIQ PLUS.....	208	<i>pindolol tab 5 mg</i>	153
<i>phenazopyridine hcl tab 200 mg</i>	230	<i>pioglitazone hcl-glimepiride tab 30-2 mg .</i>	83
PHENDIMETRAZ CAP 105MG ER.....	6	<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	83
<i>phendimetrazine tartrate tab 35 mg.....</i>	6		

<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	83	PONVORY TAB STARTER.....	294
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	83	<i>posaconazole susp 40 mg/ml</i>	94
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	89	<i>posaconazole tab delayed release 100 mg</i>	94
<i>pioglitazone hcl tab 30 mg (base equiv)</i> ...	89	<i>pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	229
<i>pioglitazone hcl tab 45 mg (base equiv)</i> ...	89	<i>potassium chloride cap er 10 meq</i>	266
PIP LANCETS MIS 28G.....	253	<i>potassium chloride cap er 8 meq</i>	266
PIP LANCETS MIS 30G	253	<i>potassium chloride microencapsulated crys er tab 10 meq</i>	266
PIQRAY 200MG TAB DOSE.....	125	<i>potassium chloride microencapsulated crys er tab 15 meq</i>	266
PIQRAY 250MG TAB DOSE.....	125	<i>potassium chloride microencapsulated crys er tab 20 meq</i>	266
PIQRAY 300MG TAB DOSE.....	125	<i>potassium chloride oral soln 10% (20 meq/15ml)</i>	266
<i>pirfenidone tab 267 mg</i>	299	<i>potassium chloride oral soln 20% (40 meq/15ml)</i>	266
<i>pirfenidone tab 801 mg</i>	299	<i>potassium chloride powder packet 20 meq</i>	266
<i>piroxicam cap 10 mg</i>	28	<i>potassium chloride tab er 10 meq</i>	266
<i>piroxicam cap 20 mg</i>	28	<i>potassium chloride tab er 20 meq (1500 mg)</i>	266
PIVOT LIQ 1.5 CAL	208	<i>potassium chloride tab er 8 meq (600 mg)</i>	266
PKU EXPLORE5 POW UNFLAVOR	209	<i>potassium citrate & citric acid powder pack 3300-1002 mg</i>	229
PLAQUENIL TAB 200MG.....	112	<i>potassium citrate & citric acid soln 1100-334 mg/5ml</i>	229
PLAVIX TAB 75MG.....	232	<i>potassium citrate tab er 10 meq (1080 mg)</i>	229
PLEGRIDY INJ	294	<i>potassium citrate tab er 15 meq (1620 mg)</i>	229
PLEGRIDY INJ PEN.....	294	<i>potassium citrate tab er 5 meq (540 mg)</i>	229
PLEGRIDY INJ STARTER	294	POVIDONE IOD SOL 5%	282
PLEGRIDY PEN INJ STARTER.....	294	PPA/MMA POW EXPRESS	209
PLENVU SOL.....	238	PRADAXA CAP 110MG	65
PLIAGLIS CRE 7-7%.....	193	PRADAXA CAP 150MG.....	65
PNV-DHA CAP DOCUSATE	273	PRADAXA CAP 75MG	65
PNV-OMEGA CAP.....	273	PRALUENT INJ 150MG/ML	101
PNV TAB 20-1 TAB.....	273	PRALUENT INJ 75MG/ML	101
PNV TABS TAB 29-1MG	273		
POCKET CHAMB MIS	261		
POCKETCHEM SOL EZ.....	253		
POCKETCHEM TES EZ.....	203		
POCKET SPACE MIS	261		
<i>podofilox soln 0.5%</i>	192		
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	281		
POLYTRIM SOL OP.....	281		
POMALYST CAP 1MG	118		
POMALYST CAP 2MG	118		
POMALYST CAP 3MG	118		
POMALYST CAP 4MG	118		
PONVORY TAB 20MG.....	294		

<i>pramipexole dihydrochloride tab 0.125 mg</i>	131	PRECISION TES PCX PLUS	203
<i>pramipexole dihydrochloride tab 0.25 mg</i>	131	PRECISION TES QID	203
<i>pramipexole dihydrochloride tab 0.5 mg</i>	131	PRECISION TES SOF-TACT	203
<i>pramipexole dihydrochloride tab 0.75 mg</i>	131	PRECISION TES XTRA.....	203
<i>pramipexole dihydrochloride tab 1.5 mg</i>	131	PRECISN XTRA TES KETONE.....	203
<i>pramipexole dihydrochloride tab 1 mg</i>	131	PRECOSE TAB 100MG.....	82
<i>pramipexole dihydrochloride tab er 24hr</i> <i>0.375 mg</i>	131	PRECOSE TAB 25MG.....	82
<i>pramipexole dihydrochloride tab er 24hr</i> <i>0.75 mg</i>	131	PRECOSE TAB 50MG	82
<i>pramipexole dihydrochloride tab er 24hr 1.5</i> <i>mg</i>	131	PRED/NEPAFEN DRO 1-0.1%.....	284
<i>pramipexole dihydrochloride tab er 24hr</i> <i>2.25 mg</i>	131	PRED FORTE SUS 1% OP	283
<i>pramipexole dihydrochloride tab er 24hr</i> <i>3.75 mg</i>	131	PRED-GATIFL- SUS BROMFENA	284
<i>pramipexole dihydrochloride tab er 24hr 3</i> <i>mg</i>	131	PRED-GATI SUS 1-0.5%.....	284
<i>pramipexole dihydrochloride tab er 24hr</i> <i>4.5 mg</i>	131	PRED-G S.O.P OIN OP	284
PRAMOSONE CRE 1-1%	189	PRED-G SUS OP	284
PRAMOSONE LOT 1%.....	189	PRED MILD SUS 0.12% OP	283
PRAMOSONE LOT 2.5%.....	189	PRED MOXIFLO SOL 1-0.5%	284
PRAMOX GEL 1%.....	193	PRED MOXIFLO SUS BROMFEN	284
<i>prasugrel hcl tab 10 mg (base equiv)</i>	232	PREDNI/MOXI/ DRO NEPAFENA	284
<i>prasugrel hcl tab 5 mg (base equiv)</i>	232	PREDNI/MOXIF DRO 1-0.5%	284
<i>pravastatin sodium tab 10 mg</i>	99	<i>prednicarbate cream 0.1%</i>	189
<i>pravastatin sodium tab 20 mg</i>	99	<i>prednicarbate oint 0.1%</i>	189
<i>pravastatin sodium tab 40 mg</i>	99	<i>prednisolone acetate ophth susp 1%</i>	284
<i>pravastatin sodium tab 80 mg</i>	99	<i>prednisolone sodium phosphate oral soln</i> <i>25 mg/5ml (base eq)</i>	170
<i>praziquantel tab 600 mg</i>	48	<i>prednisolone sod phos orally disintegr tab</i> <i>10 mg (base eq)</i>	170
<i>prazosin hcl cap 1 mg</i>	105	<i>prednisolone sod phos orally disintegr tab</i> <i>15 mg (base eq)</i>	170
<i>prazosin hcl cap 2 mg</i>	105	<i>prednisolone sod phos orally disintegr tab</i> <i>30 mg (base eq)</i>	170
<i>prazosin hcl cap 5 mg</i>	105	<i>prednisolone sod phosphate oral soln 10</i> <i>mg/5ml (base equiv)</i>	170
PR BENZOYL LIQ 7% WASH	175	<i>prednisolone sod phosphate oral soln 15</i> <i>mg/5ml (base equiv)</i>	170
PRECISION LIQ CONTROL	253	<i>prednisolone sod phosphate oral soln 20</i> <i>mg/5ml (base equiv)</i>	170
PRECISION LIQ GLUC/KET	253	<i>prednisolone sod phosph oral soln 6.7</i> <i>mg/5ml (5 mg/5ml base)</i>	170
PRECISION LIQ NRML/MID	253	PREDNISOLONE SOL MOX-BROM	284
PRECISION PT TES OF CARE	203	<i>prednisolone soln 15 mg/5ml</i>	170
PRECISION TES PCX.....	203	PREDNISOLONE SUS 1%	284
		PREDNISON CON 5MG/ML.....	170
		<i>prednisone oral soln 5 mg/5ml</i>	170

<i>prednisone tab 10 mg</i>	171	PRENAISSANCE CAP PLUS.....	273
<i>prednisone tab 1 mg</i>	171	PRENARA CAP PRENATAL	273
<i>prednisone tab 2.5 mg</i>	171	PRENATABS FA TAB 29-1MG.....	273
<i>prednisone tab 20 mg</i>	171	PRENATAL+FE TAB 29-1MG	273
<i>prednisone tab 50 mg</i>	171	PRENATAL 19 CHW 29-1MG	273
<i>prednisone tab 5 mg</i>	171	PRENATAL 19 TAB 29-1MG	273
<i>prednisone tab therapy pack 10 mg (21)</i> ..	171	PRENATAL TAB 27-1MG.....	273
<i>prednisone tab therapy pack 10 mg (48)</i> .	171	PRENATAL-U CAP 106.5-1.....	273
<i>prednisone tab therapy pack 5 mg (21)</i>	171	PRENATAL VIT TAB LOW IRON.....	273
<i>prednisone tab therapy pack 5 mg (48)</i> ...	171	<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1</i>	
PRED SOD PHO SOL 1% OP	284	<i>mg</i>	273
PREFEST TAB	221	<i>prenatal vit w/ fe fumarate-fa chew tab 29-1</i>	
<i>pregabalin cap 100 mg</i>	71	<i>mg</i>	273
<i>pregabalin cap 150 mg</i>	71	<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>	
<i>pregabalin cap 200 mg</i>	71	.....	273
<i>pregabalin cap 225 mg</i>	71	<i>prenatal vit w/ fe fum-methylfolate-fa tab</i>	
<i>pregabalin cap 25 mg</i>	71	<i>27-0.6-0.4 mg</i>	273
<i>pregabalin cap 300 mg</i>	71	<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	
<i>pregabalin cap 50 mg</i>	71	.....	273
<i>pregabalin cap 75 mg</i>	71	PRENATE AM TAB 1MG.....	273
<i>pregabalin soln 20 mg/ml</i>	71	PRENATE CAP ENHANCE	273
<i>pregabalin tab er 24hr 165 mg</i>	295	PRENATE CAP ESSENT	273
<i>pregabalin tab er 24hr 330 mg</i>	295	PRENATE CAP PIXIE.....	273
<i>pregabalin tab er 24hr 82.5 mg</i>	295	PRENATE CAP RESTORE.....	273
PREGENNA TAB.....	273	PRENATE CHW 0.6-0.4	274
PREMARIN INJ 25MG	223	PRENATE DHA CAP.....	274
PREMARIN TAB 0.3MG.....	223	PRENATE MINI CAP	274
PREMARIN TAB 0.45MG	223	PRENATE TAB ELITE	274
PREMARIN TAB 0.625MG	223	PRENATRIX TAB	274
PREMARIN TAB 0.9MG.....	223	PRENATRYL TAB	274
PREMARIN TAB 1.25MG.....	223	PRENATVITE TAB COMPLETE.....	274
PREMARIN VAG CRE 0.625MG.....	311	PRENATVITE TAB PLUS.....	274
PREMESISRX TAB.....	273	PRENATVITE TAB RX	274
PREMIUM BLOO MIS GLUCOSE.....	203	<i>prenat w/o a w/feum-methfol-fa-dha cap</i>	
PREMPHASE TAB	221	<i>27-0.6-0.4-300 mg</i>	273
PREMPRO TAB.....	221	PREPIDIL GEL 0.5MG/3G	286
PREMPRO TAB 0.3-1.5.....	221	PREPLUS TAB 27-1MG.....	274
PREMPRO TAB 0.45-1.5	221	PREP PADS PAD	260
PREMPRO TAB 0.625-5.....	221	PRESSURE ACT MIS LANCET	253
PRENA1 CHW	273	PRESSURE ACT MIS LANCETS.....	253
PRENA1 PEARL CAP	273	PRESTALIA TAB 14-10MG.....	109
PRENA 1 TRUE MIS	273	PRESTALIA TAB 3.5-2.5	109
PRENAISSANCE CAP	273	PRESTALIA TAB 7-5MG	109

PRETAB TAB 29-1MG	274	PRO COMFORT PAD ALCOHOL.....	260
PRETOMANID TAB 200MG	113	PROCORT CRE	48
PREVACID CAP 15MG DR.....	307	PROCRIT INJ 10000/ML.....	234
PREVACID CAP 30MG DR.....	308	PROCRIT INJ 2000/ML	234
PREVACID TAB 15MG STB	308	PROCRIT INJ 20000/ML.....	234
PREVACID TAB 30MG STB	308	PROCRIT INJ 3000/ML	234
PREVYMIS TAB 240MG.....	147	PROCRIT INJ 4000/ML	234
PREVYMIS TAB 480MG.....	147	PROCRIT INJ 40000/ML.....	234
PREZCOBIX TAB 800-150.....	144	PROCTOCORT CRE 1%.....	48
PREZISTA SUS 100MG/ML	144	PROCTOCORT SUP 30MG	48
PREZISTA TAB 150MG.....	144	PROCTOFOAM AER HC 1%.....	48
PREZISTA TAB 600MG.....	144	PRODIGY MIS 26G.....	253
PREZISTA TAB 75MG.....	144	PRODIGY MIS 28G.....	253
PREZISTA TAB 800MG.....	144	PRODIGY MIS LANC DEV	253
PRIFTIN TAB 150MG	113	PRODIGY NO TES CODING.....	203
PRILOSEC POW 10MG.....	308	PRODIGY SOL HIGH	253
PRILOSEC POW 2.5MG	308	PRODIGY SOL LOW	253
PRIMACARE CAP	274	<i>progesterone cap 100 mg</i>	288
<i>primaquine phosphate tab 26.3 mg (15 mg</i> <i>base)</i>	112	<i>progesterone cap 200 mg</i>	288
PRIMAQUINE TAB 26.3MG	112	<i>progesterone im in oil 50 mg/ml</i>	288
<i>primidone tab 250 mg</i>	71	PROGLYCEM SUS 50MG/ML.....	85
<i>primidone tab 50 mg</i>	71	PROGRAF CAP 0.5MG	269
PRIMSOL SOL 50MG/5ML	48	PROGRAF CAP 1MG	269
PRINIVIL TAB 20MG	102	PROGRAF CAP 5MG	269
PRISTIQ TAB 100MG	79	PROGRAF GRA 0.2MG.....	269
PRISTIQ TAB 25MG	79	PROGRAF GRA 1MG	269
PRISTIQ TAB 50MG	79	PROLATE SOL 10/300MG	44
PROAIR DIGIH AER	62	PROLATE TAB 10-300MG	44
PROAIR HFA AER	62	PROLATE TAB 5-300MG.....	44
PROAIR RESPI AER	62	PROLATE TAB 7.5-300	44
<i>probenecid tab 500 mg</i>	231	PROLEEVA CAP	209
PROCARDIA CAP 10MG	156	PROLENSA SOL 0.07%.....	285
PROCARDIA XL TAB 30MG CR	156	PROMACTA PAK 25MG.....	234
PROCARDIA XL TAB 60MG CR	156	PROMACTA POW 12.5MG.....	234
PROCARDIA XL TAB 90MG CR.....	156	PROMACTA TAB 12.5MG.....	234
<i>prochlorperazine maleate tab 10 mg (base</i> <i>equivalent)</i>	138	PROMACTA TAB 25MG.....	234
<i>prochlorperazine maleate tab 5 mg (base</i> <i>equivalent)</i>	138	PROMACTA TAB 50MG.....	234
<i>prochlorperazine suppos 25 mg</i>	138	PROMACTA TAB 75MG.....	234
PRO COMFORT MIS 31G.....	253	PROMACTIN AA SUS PLUS.....	209
PRO COMFORT MIS LANCETS.....	253	<i>promethazine & phenylephrine syrup 6.25-</i> <i>5 mg/5ml</i>	172
		<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	172

<i>promethazine hcl suppos 12.5 mg</i>	95	PROSOURCE LIQ TF	209
<i>promethazine hcl suppos 25 mg</i>	95	PROSTIN E2 SUP 20MG	286
<i>promethazine hcl suppos 50 mg</i>	95	PROTHELIAL PST 10%	271
<i>promethazine hcl syrup 6.25 mg/5ml</i>	95	PROTONIX PAK 40MG	308
<i>promethazine hcl tab 12.5 mg</i>	95	PROTONIX TAB 20MG	308
<i>promethazine hcl tab 25 mg</i>	95	PROTONIX TAB 40MG	308
<i>promethazine hcl tab 50 mg</i>	95	PROTOPIC OIN 0.03%	192
<i>promethazine-phenylephrine-codeine</i>		PROTOPIC OIN 0.1%	192
<i>syrup 6.25-5-10 mg/5ml</i>	172	<i>protriptyline hcl tab 10 mg</i>	81
<i>promethazine w/ codeine syrup 6.25-10</i>		<i>protriptyline hcl tab 5 mg</i>	81
<i>mg/5ml</i>	172	PROVENTIL AER HFA	62
PROMETRIUM CAP 100MG	288	PROVERA TAB 10MG	288
PROMETRIUM CAP 200MG	288	PROVERA TAB 2.5MG	288
PROMOTE/ LIQ FIBER	209	PROVERA TAB 5MG	288
PROMOTE 1.0 LIQ W/ FIBER	209	PROVIDA OB CAP	274
PROMOTE LIQ VANILLA	209	PROVIGIL TAB 100MG	14
PROMOTE W/FB LIQ VANILLA	209	PROVIGIL TAB 200MG	14
PROMOTE W/ LIQ FIBER	209	PRO VOICE TES V8/V9	203
<i>propafenone hcl cap er 12hr 225 mg</i>	54	PROZAC CAP 10MG	78
<i>propafenone hcl cap er 12hr 325 mg</i>	54	PROZAC CAP 20MG	78
<i>propafenone hcl cap er 12hr 425 mg</i>	54	PROZAC CAP 40MG	78
<i>propafenone hcl tab 150 mg</i>	54	PRUDOXIN CRE 5%	179
<i>propafenone hcl tab 225 mg</i>	54	<i>pseudoephed-bromphen-dm syrup 30-2-10</i>	
<i>propafenone hcl tab 300 mg</i>	54	<i>mg/5ml</i>	172
<i>proparacaine hcl ophth soln 0.5%</i>	282	PSORCON CRE 0.05%	189
PRO-PHREE POW	209	PSS SAFE LAN MIS	253
<i>propranolol & hydrochlorothiazide tab 40-</i>		PSS SEL LANC MIS	253
<i>25 mg</i>	109	PSS SEL PLAT MIS	253
<i>propranolol & hydrochlorothiazide tab 80-</i>		PTS PANELS TES GLUCOSE	203
<i>25 mg</i>	109	PTS PANELS TES KETONE	203
<i>propranolol hcl cap er 24hr 120 mg</i>	153	PULMICORT INH 180MCG	59
<i>propranolol hcl cap er 24hr 160 mg</i>	153	PULMICORT INH 90MCG	59
<i>propranolol hcl cap er 24hr 60 mg</i>	153	PULMICORT SUS 0.25MG/2	59
<i>propranolol hcl cap er 24hr 80 mg</i>	153	PULMICORT SUS 0.5MG/2	59
<i>propranolol hcl oral soln 20 mg/5ml</i>	153	PULMICORT SUS 1MG/2ML	59
<i>propranolol hcl oral soln 40 mg/5ml</i>	153	PULMOZYME SOL 1MG/ML	298
<i>propranolol hcl tab 10 mg</i>	153	PURE COMFORT PAD	260
<i>propranolol hcl tab 20 mg</i>	153	PURIXAN SUS 20MG/ML	114
<i>propranolol hcl tab 40 mg</i>	153	PX LANCETS MIS 28G	253
<i>propranolol hcl tab 60 mg</i>	153	PX LANCETS MIS ULT THIN	253
<i>propranolol hcl tab 80 mg</i>	153	PYLERA CAP	309
<i>propylthiouracil tab 50 mg</i>	301	<i>pyrazinamide tab 500 mg</i>	113
PROSCAR TAB 5MG	230		

<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	112	QUDEXY XR CAP 50/24HR	71
<i>pyridostigmine bromide tab 30 mg</i>	112	QUESTRAN POW 4GM	97
<i>pyridostigmine bromide tab 60 mg</i>	112	QUESTRAN POW 4GM LITE	97
<i>pyridostigmine bromide tab er 180 mg</i>	112	<i>quetiapine fumarate tab 100 mg</i>	137
PYRIME/LEUCO CAP 12.5/2.5	111	<i>quetiapine fumarate tab 200 mg</i>	137
PYRIME/LEUCO CAP 25/10MG	112	<i>quetiapine fumarate tab 25 mg</i>	137
PYRIME/LEUCO CAP 25/5MG	111	<i>quetiapine fumarate tab 300 mg</i>	137
PYRIME/LEUCO CAP 50/10MG	112	<i>quetiapine fumarate tab 400 mg</i>	137
PYRIME/LEUCO CAP 50/20MG.....	112	<i>quetiapine fumarate tab 50 mg</i>	137
PYRIME/LEUCO CAP 50/25MG.....	112	<i>quetiapine fumarate tab er 24hr 150 mg</i> .	137
PYRIME/LEUCO CAP 75/25MG.....	112	<i>quetiapine fumarate tab er 24hr 200 mg</i>	137
<i>pyrimethamine tab 25 mg</i>	112	<i>quetiapine fumarate tab er 24hr 300 mg</i>	137
PYROGALL ACD OIN.....	192	<i>quetiapine fumarate tab er 24hr 400 mg</i>	137
Q		<i>quetiapine fumarate tab er 24hr 50 mg</i> ...	137
QBRELIS SOL 1MG/ML	102	QUICKTEK LIQ SOLUTION.....	253
QBREXZA PAD 2.4%	193	QUICKTEK TES	203
QC ALCOHOL PAD SWABS	260	QUILLICHEW CHW 20MG ER	14
QC LANCETS MIS 28G	253	QUILLICHEW CHW 30MG ER	14
QC LANCETS MIS 30G.....	253	QUILLICHEW CHW 40MG ER.....	14
QC LANCING MIS DEVICE.....	253	QUILLIVANT SUS 25MG/5ML.....	14
QDOLO SOL 5MG/ML.....	40	<i>quinapril hcl tab 10 mg</i>	102
QELBREE CAP 100MG ER	7	<i>quinapril hcl tab 20 mg</i>	102
QELBREE CAP 150MG ER.....	7	<i>quinapril hcl tab 40 mg</i>	102
QELBREE CAP 200MG ER.....	7	<i>quinapril hcl tab 5 mg</i>	102
QINLOCK TAB 50MG	125	<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	109
QMIIZ ODT TAB 15 MG	28	<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	109
QMIIZ ODT TAB 7.5MG	28	<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	109
QNASL AER 80MCG	278	<i>quinidine gluconate tab er 324 mg</i>	54
QNASL CHILD SPR 40MCG	278	<i>quinidine sulfate tab 200 mg</i>	54
QSYMIA CAP 11.25-69	6	<i>quinidine sulfate tab 300 mg</i>	54
QSYMIA CAP 15-92MG.....	6	<i>quinine sulfate cap 324 mg</i>	112
QSYMIA CAP 3.75-23	6	QUINTET AC TES BLD GLUC.....	203
QSYMIA CAP 7.5-46MG.....	6	QUINTET CONT SOL HGH/NORM	253
QTERN TAB 10-5MG.....	83	QUINTET TES BLD GLUC	203
QTERN TAB 5-5MG	83	QULIPTA TAB 10MG	262
QUALAQUIN CAP 324MG	112	QULIPTA TAB 30MG	262
QUARTETTE TAB.....	168	QULIPTA TAB 60MG	262
<i>quazepam tab 15 mg</i>	237	QUVIVIQ TAB 25MG	237
QUDEXY XR CAP 100/24HR.....	71	QUVIVIQ TAB 50MG.....	237
QUDEXY XR CAP 150/24HR.....	71	QVAR REDIIHA AER 80MCG	59
QUDEXY XR CAP 200/24HR.....	71		
QUDEXY XR CAP 25/24HR.....	71		

QVAR REDIHAL AER 40MCG	59	RAYOS TAB 2MG.....	171
R		RAYOS TAB 5MG.....	171
RABEPRAZOLE CAP 10MG DR	308	RAZADYNE ER CAP 16MG.....	290
<i>rabeprazole sodium ec tab 20 mg</i>	308	RAZADYNE ER CAP 24MG	290
RADICAVA ORS SUS 105/5ML.....	278	RAZADYNE ER CAP 8MG	290
RADICAVA ORS SUS STARTER.....	278	READYLANCE MIS 21G	254
RADIOGARDASE CAP 0.5GM	92	READYLANCE MIS 23G.....	254
RA E-ZJECT MIS 28G	253	READYLANCE MIS 26G	254
RA E-ZJECT MIS THIN 26G	253	READYLANCE MIS 28G	254
RA E-ZJECT MIS THIN 28G	253	READYLANCE MIS 30G	254
RA E-ZJECT MIS ULT THIN	254	REALITY MIS LANCETS	254
RAGWITEK SUB	15	REALITY SWAB PAD	260
<i>raloxifene hcl tab 60 mg</i>	217	REALITY TRIG MIS LANCETS.....	254
<i>ramelteon tab 8 mg</i>	238	REBIF INJ 22/0.5.....	294
<i>ramipril cap 1.25 mg</i>	102	REBIF INJ 44/0.5	294
<i>ramipril cap 10 mg</i>	102	REBIF REBIDO INJ 22/0.5.....	294
<i>ramipril cap 2.5 mg</i>	102	REBIF REBIDO INJ 44/0.5	294
<i>ramipril cap 5 mg</i>	102	REBIF REBIDO INJ TITRATN	294
RANEXA TAB 1000MG.....	51	REBIF TITRTN INJ PACK.....	294
RANEXA TAB 500MG.....	51	RECTIV OIN 0.4%	48
<i>ranolazine tab er 12hr 1000 mg</i>	51	RECURA CRE.....	178
<i>ranolazine tab er 12hr 500 mg</i>	51	REDICHEW RX CHW	274
RAPAFLO CAP 4MG.....	230	REDITREX INJ 10/.4ML	24
RAPAFLO CAP 8MG.....	230	REDITREX INJ 12.5/0.5	24
RAPAMUNE SOL 1MG/ML.....	269	REDITREX INJ 15/.6ML	24
RAPAMUNE TAB 0.5MG.....	269	REDITREX INJ 17.5/0.7.....	24
RAPAMUNE TAB 1MG	269	REDITREX INJ 20/.8ML.....	24
RAPAMUNE TAB 2MG	269	REDITREX INJ 22.5/0.9.....	24
RAPID-SAFE MIS LANCING	254	REDITREX INJ 25MG/ML.....	24
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>		REDITREX INJ 7.5/.3ML.....	24
.....	132	REFUAH PLUS SOL CONTROL	254
<i>rasagiline mesylate tab 1 mg (base equiv)</i>		REFUAH PLUS TES BLD GLUC.....	203
.....	132	REGIMEX TAB 25MG	7
RASUVO INJ 10MG	23	REGLAN TAB 10MG	225
RASUVO INJ 12.5MG	24	REGLAN TAB 5MG.....	225
RASUVO INJ 15MG	24	REGRANEX GEL 0.01%	194
RASUVO INJ 17.5MG	24	RELAFEN DS TAB 1000MG.....	28
RASUVO INJ 20MG.....	24	RELENZA MIS DISKHALE	150
RASUVO INJ 22.5MG.....	24	RELEXXII TAB 72MG.....	15
RASUVO INJ 25MG.....	24	RELION BLOOD TES GLUCOSE	204
RASUVO INJ 30MG.....	24	RELION KIT LANCING	254
RASUVO INJ 7.5MG.....	23	RELION LANCE MIS THIN 26G	254
RAYOS TAB 1MG	171	RELION LANCE MIS THIN 30G	254

RELION LANCI MIS DEVICE	254	RETACRIT INJ 20000UNI	235
RELION MICRO MIS THIN 33G	254	RETACRIT INJ 2000UNIT	235
RELION PREMI TES GLUCOSE	204	RETACRIT INJ 3000UNIT	235
RELION PRIME TES	204	RETACRIT INJ 40000UNT	235
RELION PRIME TES GLUCOSE	204	RETACRIT INJ 4000UNIT	235
RELION TES KETONE	204	RETEVMO CAP 40MG	125
RELION TES ULTIMA	204	RETEVMO CAP 80MG	125
RELION TRUE TES METRIX	204	RETIN-A CRE 0.025%	175
RELION ULTRA MIS THIN 30G	254	RETIN-A CRE 0.05%	175
RELION ULTRA MIS THIN PLS	254	RETIN-A CRE 0.1%	175
RELISTOR INJ 12/0.6ML	228	RETIN-A GEL 0.01%	175
RELISTOR INJ 8/0.4ML	228	RETIN-A GEL 0.025%	175
RELISTOR TAB 150MG	228	RETIN-A MICR GEL 0.04%	175
RELNATE DHA CAP	274	RETIN-A MICR GEL 0.04%PMP	175
RELPAK TAB 20MG	264	RETIN-A MICR GEL 0.06%	175
RELPAK TAB 40MG	264	RETIN-A MICR GEL 0.08%	175
REMERON SLTB TAB 15MG	75	RETIN-A MICR GEL 0.1%	175
REMERON SLTB TAB 30MG	75	RETIN-A MICR GEL 0.1%PUMP	175
REMERON SLTB TAB 45MG	75	RETROVIR CAP 100MG	144
REMERON TAB 15MG	75	RETROVIR SYP 50MG/5ML	145
REMERON TAB 30MG	75	REVCovi INJ 1.6MG/ML	218
RENAGEL TAB 800MG	228	REVLIMID CAP 10MG	267
REVELA POW 0.8GM	228	REVLIMID CAP 15MG	267
REVELA POW 2.4GM	228	REVLIMID CAP 2.5MG	267
REVELA TAB 800MG	228	REVLIMID CAP 20MG	267
<i>repaglinide tab 0.5 mg</i>	89	REVLIMID CAP 25MG	267
<i>repaglinide tab 1 mg</i>	89	REVLIMID CAP 5MG	267
<i>repaglinide tab 2 mg</i>	89	REXULTI TAB 0.25MG	140
REPATHA INJ 140MG/ML	101	REXULTI TAB 0.5MG	140
REPATHA PUSH INJ 420/3.5	101	REXULTI TAB 1MG	140
REPATHA SURE INJ 140MG/ML	101	REXULTI TAB 2MG	140
REPLETE FIBE LIQ 1 CAL	209	REXULTI TAB 3MG	140
REPLETE LIQ ULTRAPAK	209	REXULTI TAB 4MG	140
<i>resorcinol-sulfur lotion 2-5%</i>	175	REYATAZ CAP 150MG	145
RESOURCE DIA LIQ TF	209	REYATAZ CAP 200MG	145
RESTASIS EMU 0.05% OP	282	REYATAZ CAP 300MG	145
RESTASIS MUL EMU 0.05% OP	282	REYATAZ POW 50MG	145
RESTORA RX CAP 60-1.25	91	REYVOW TAB 100MG	264
RESTORIL CAP 15MG	237	REYVOW TAB 50MG	264
RESTORIL CAP 22.5MG	237	REZUROCK TAB 200MG	267
RESTORIL CAP 30MG	237	RHEUMATE CAP	209
RESTORIL CAP 7.5MG	237	RHOFADE CRE 1%	194
RETACRIT INJ 10000UNT	235	RHOPRESSA SOL 0.02%	282

RIAX AER 5.5%	175	<i>risperidone orally disintegrating tab 0.5 mg</i>	135
RIAX AER 9.5%	175	<i>risperidone orally disintegrating tab 1 mg</i>	135
<i>ribavirin cap 200 mg</i>	149	<i>risperidone orally disintegrating tab 2 mg</i>	135
<i>ribavirin tab 200 mg</i>	149	<i>risperidone orally disintegrating tab 3 mg</i>	135
RIBOZEL CAP	209	<i>risperidone orally disintegrating tab 4 mg</i>	135
RIDAURA CAP 3MG	24	<i>risperidone soln 1 mg/ml</i>	135
<i>rifabutin cap 150 mg</i>	113	<i>risperidone tab 0.25 mg</i>	135
<i>rifampin cap 150 mg</i>	113	<i>risperidone tab 0.5 mg</i>	135
<i>rifampin cap 300 mg</i>	113	<i>risperidone tab 1 mg</i>	135
RIGHTEST ALT MIS ADAPTOR	254	<i>risperidone tab 2 mg</i>	135
RIGHTEST LIQ HIGH CON	254	<i>risperidone tab 3 mg</i>	135
RIGHTEST LIQ NORM CON	254	<i>risperidone tab 4 mg</i>	135
RIGHTEST MIS GD500	254	RITALIN LA CAP 10MG.....	15
RIGHTEST MIS GL300.....	254	RITALIN LA CAP 20MG.....	15
RIGHTEST TES GS100.....	204	RITALIN LA CAP 30MG.....	15
RIGHTEST TES GS300	204	RITALIN LA CAP 40MG.....	15
RIGHTEST TES GS550	204	RITALIN TAB 10MG.....	15
RILUTEK TAB 50MG	278	RITALIN TAB 20MG.....	15
<i>riluzole tab 50 mg</i>	278	RITALIN TAB 5MG	15
<i>rimantadine hydrochloride tab 100 mg</i> ...150		RITEFLO MIS.....	262
RINVOQ TAB 15MG ER	21	<i>ritonavir tab 100 mg</i>	145
RINVOQ TAB 30MG ER	21	<i>rivastigmine tartrate cap 1.5 mg (base</i>	
RINVOQ TAB 45MG ER	22	<i>equivalent)</i>	290
RIOMET SOL 500/5ML	85	<i>rivastigmine tartrate cap 3 mg (base</i>	
<i>risedronate sodium tab 150 mg</i>	214	<i>equivalent)</i>	290
<i>risedronate sodium tab 30 mg</i>	214	<i>rivastigmine tartrate cap 4.5 mg (base</i>	
<i>risedronate sodium tab 35 mg</i>	214	<i>equivalent)</i>	290
<i>risedronate sodium tab 5 mg</i>	214	<i>rivastigmine tartrate cap 6 mg (base</i>	
<i>risedronate sodium tab delayed release 35</i>		<i>equivalent)</i>	290
<i>mg</i>	214	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	
RISPERDAL INJ 12.5MG.....	135	.....	290
RISPERDAL INJ 25MG	135	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i> .290	
RISPERDAL INJ 37.5MG.....	135	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i> .290	
RISPERDAL INJ 50MG	135	<i>rizatriptan benzoate oral disintegrating tab</i>	
RISPERDAL SOL 1MG/ML	135	<i>10 mg (base eq)</i>	264
RISPERDAL TAB 0.5MG	135	<i>rizatriptan benzoate oral disintegrating tab</i>	
RISPERDAL TAB 1MG.....	135	<i>5 mg (base eq)</i>	264
RISPERDAL TAB 2MG	135		
RISPERDAL TAB 3MG	135		
RISPERDAL TAB 4MG.....	135		
<i>risperidone orally disintegrating tab 0.25</i>			
<i>mg</i>	135		

<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	264	RUBRACA TAB 300MG.....	125
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	264	<i>rufinamide susp 40 mg/ml</i>	72
ROAOXIA GEL 3-4%.....	179	RUKOBIA TAB 600MG ER	145
ROCALTROL CAP 0.25MCG	218	RUZURGI TAB 10MG	112
ROCALTROL CAP 0.5MCG	218	RYBELSUS TAB 14MG	87
ROCALTROL SOL 1MCG/ML	218	RYBELSUS TAB 3MG	87
ROCKLATAN DRO	282	RYBELSUS TAB 7MG	87
<i>ropinirole hydrochloride tab 0.25 mg</i>	131	RYDAPT CAP 25MG	125
<i>ropinirole hydrochloride tab 0.5 mg</i>	131	RYTARY CAP 145MG.....	132
<i>ropinirole hydrochloride tab 1 mg</i>	131	RYTARY CAP 195MG.....	132
<i>ropinirole hydrochloride tab 2 mg</i>	131	RYTARY CAP 245MG	132
<i>ropinirole hydrochloride tab 3 mg</i>	131	RYTARY CAP 95MG	132
<i>ropinirole hydrochloride tab 4 mg</i>	131	RYTHMOL SR CAP 225MG.....	54
<i>ropinirole hydrochloride tab 5 mg</i>	131	RYTHMOL SR CAP 325MG.....	54
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	132	RYTHMOL SR CAP 425MG.....	54
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	132	RYVENT TAB 6MG	95
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	132	S	
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	132	S.O.S. 20 POW	209
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	132	S.O.S. 25 POW.....	209
<i>rosuvastatin calcium tab 10 mg</i>	99	SAFE-T-LANCE MIS 21G	254
<i>rosuvastatin calcium tab 20 mg</i>	99	SAFE-T-LANCE MIS 25G	254
<i>rosuvastatin calcium tab 40 mg</i>	99	SAFE-T-LANCE MIS HI FLOW.....	254
<i>rosuvastatin calcium tab 5 mg</i>	99	SAFE-T-LANCE MIS LOW FLOW.....	254
ROSZET TAB 10-10MG	96	SAFE-T-LANCE MIS NOR FLOW	254
ROSZET TAB 20-10MG.....	96	SAFE-T-PRO MIS LANCETS.....	254
ROSZET TAB 40-10MG	96	SAFE-T-PRO MIS PLUS.....	254
ROSZET TAB 5-10MG	96	SAFETY 21G MIS LANCETS	254
ROWASA KIT 4GM.....	226	SAFETY 23G MIS LANCETS	254
ROXICODONE TAB 15MG.....	40	SAFETY 28G MIS LANCETS	254
ROXICODONE TAB 30MG	40	SAFETY 30G MIS LANCETS	254
ROXICODONE TAB 5MG	40	SAFETY MIS LANCETS.....	254
ROZEREM TAB 8MG.....	238	SAFYRAL TAB	168
ROZLYTREK CAP 100MG	125	SALAGEN TAB 5MG	271
ROZLYTREK CAP 200MG.....	125	SALAGEN TAB 7.5MG.....	271
RUBRACA TAB 200MG.....	125	SALIMEZ CRE 6%	192
RUBRACA TAB 250MG.....	125	SALIMEZ FORT CRE 10%.....	192
		<i>salsalate tab 500 mg</i>	32
		<i>salsalate tab 750 mg</i>	32
		SAMSCA TAB 15MG	221
		SAMSCA TAB 30MG	221
		SANCUSO DIS 3.1MG.....	92
		SANDIMMUNE CAP 100MG	269
		SANDIMMUNE CAP 25MG.....	269

SANDIMMUNE SOL 100MG/ML.....	269	SELECT-OB CHW	274
SANDOSTATIN INJ 100MCG	220	<i>selegiline hcl cap 5 mg</i>	132
SANDOSTATIN INJ 500MCG.....	220	<i>selegiline hcl tab 5 mg</i>	132
SANDOSTATIN INJ 50MCG/ML.....	220	<i>selenium sulfide lotion 2.5%</i>	184
SANTYL OIN 250/GM.....	191	SELZENTRY SOL 20MG/ML	145
SAPHRIS SUB 10MG.....	137	SELZENTRY TAB 150MG	145
SAPHRIS SUB 2.5MG	137	SELZENTRY TAB 25MG	145
SAPHRIS SUB 5MG.....	137	SELZENTRY TAB 300MG	145
<i>sapropterin dihydrochloride powder packet</i>		SELZENTRY TAB 75MG	145
<i>100 mg</i>	218	SEMGLEE INJ 100U/ML	89
<i>sapropterin dihydrochloride powder packet</i>		SEMGLEE SOL 100U/ML.....	89
<i>500 mg</i>	218	SE-NATAL 19 CHW	274
<i>sapropterin dihydrochloride tab 100 mg</i> ..	218	SE-NATAL 19 TAB	274
SAPSCARE MIS TWIST	255	SENSIPAR TAB 30MG.....	218
SAPS CARE PAD ALCOHOL.....	260	SENSIPAR TAB 60MG.....	218
SAPS HEALTH MIS TWIST	254	SENSIPAR TAB 90MG.....	218
SAPS HEALTH PAD ALCOHOL.....	260	SEREVENT DIS AER 50MCG.....	62
SAPS TWIST MIS 30G	255	SERNIVO SPR.....	189
SAVAYSA TAB 15MG	63	SERNIVO SPR 0.05%	189
SAVAYSA TAB 30MG	63	SEROQUEL TAB 100MG.....	137
SAVAYSA TAB 60MG	63	SEROQUEL TAB 200MG	137
SAVELLA MIS TITR PAK	291	SEROQUEL TAB 25MG.....	137
SAVELLA TAB 100MG.....	291	SEROQUEL TAB 300MG	137
SAVELLA TAB 12.5MG	291	SEROQUEL TAB 400MG.....	137
SAVELLA TAB 25MG.....	291	SEROQUEL TAB 50MG	137
SAVELLA TAB 50MG.....	291	SEROQUEL XR TAB 150MG.....	137
SAXENDA INJ 18MG/3ML.....	5	SEROQUEL XR TAB 200MG	137
SB ALCOHOL PAD PREP	260	SEROQUEL XR TAB 300MG	137
SB LANCETS MIS THIN	255	SEROQUEL XR TAB 400MG.....	137
SB LANCETS MIS ULTR THN	255	SEROQUEL XR TAB 50MG	137
<i>scopolamine td patch 72hr 1 mg/3days</i>	93	SEROSTIM INJ 4MG.....	216
SEASONIQUE TAB.....	168	SEROSTIM INJ 5MG	216
SECUADO DIS 3.8MG.....	137	SEROSTIM INJ 6MG	216
SECUADO DIS 5.7MG.....	137	<i>sertraline hcl oral concentrate for solution</i>	
SECUADO DIS 7.6MG.....	137	<i>20 mg/ml</i>	78
SEEBRI NEOHA CAP 15.6MCG.....	56	<i>sertraline hcl tab 100 mg</i>	78
SEGLUROMET TAB 2.5-1000	84	<i>sertraline hcl tab 25 mg</i>	78
SEGLUROMET TAB 2.5-500	83	<i>sertraline hcl tab 50 mg</i>	78
SEGLUROMET TAB 7.5-1000	84	<i>sevelamer carbonate packet 0.8 gm</i>	228
SEGLUROMET TAB 7.5-500.....	84	<i>sevelamer carbonate packet 2.4 gm</i>	228
SELECT-LITE KIT DEV/LANC.....	255	<i>sevelamer carbonate tab 800 mg</i>	228
SELECT-LITE MIS LANC DEV	255	<i>sevelamer hcl tab 400 mg</i>	228
SELECT-OB+ PAK DHA.....	274	<i>sevelamer hcl tab 800 mg</i>	228

SEYSARA TAB 100MG	301	SIRTURO TAB 20MG.....	113
SEYSARA TAB 150MG	301	SITAVIG TAB 50MG	149
SEYSARA TAB 60MG.....	301	SIVEXTRO TAB 200MG.....	50
SFROWASA ENE 4GM.....	226	SKELAXIN TAB 800MG.....	276
SHOPKO LANC MIS DEVICE	255	SKYRIZI INJ 150DOSE.....	181
SHUR-SEAL GEL 2%	311	SKYRIZI INJ 150MG/ML	182
SIDE BUTTON MIS SAFETY	255	SKYRIZI INJ 180/1.2	227
SIGNIFOR INJ 0.3MG/ML.....	220	SKYRIZI INJ 360/2.4.....	227
SIGNIFOR INJ 0.6MG/ML.....	220	SKYRIZI PEN INJ 150MG/ML	182
SIGNIFOR INJ 0.9MG/ML.....	220	SLYND TAB 4MG.....	168
SIKLOS TAB 1000MG	233	SM ALCOHOL PAD PREP	260
SIKLOS TAB 100MG.....	233	SMARTEST MIS LANCETS.....	255
<i>sildenafil citrate for suspension 10 mg/ml</i>		SMARTEST SOL CONTROL.....	255
.....	162	SMARTEST TES BLD GLUC.....	204
<i>sildenafil citrate tab 100 mg</i>	160	SMART SENSE MIS LANC 21G	255
<i>sildenafil citrate tab 20 mg</i>	163	SMART SENSE MIS LANC 26G	255
<i>sildenafil citrate tab 25 mg</i>	160	SMART SENSE MIS LANC 30G	255
<i>sildenafil citrate tab 50 mg</i>	160	SMART SENSE MIS LANC 33G	255
SILENOR TAB 3MG.....	236	SMART SENSE TES TEST	204
SILENOR TAB 6MG.....	236	SM LANCETS MIS 33G.....	255
<i>silodosin cap 4 mg</i>	230	SM TRUEDRAW MIS LANC DEV	255
<i>silodosin cap 8 mg</i>	230	<i>sodium chloride soln nebu 0.9%</i>	172
SILVADENE CRE 1%	185	<i>sodium chloride soln nebu 10%</i>	172
<i>silver sulfadiazine cream 1%</i>	185	<i>sodium chloride soln nebu 3%</i>	172
SIMBRINZA SUS 1-0.2%	281	<i>sodium chloride soln nebu 7%</i>	172
SIMPLE DIAG MIS LANCING.....	255	<i>sodium citrate & citric acid soln 500-334</i>	
<i>simvastatin tab 10 mg</i>	100	<i>mg/5ml</i>	229
<i>simvastatin tab 20 mg</i>	100	<i>sodium fluoride chew tab 0.25 mg f (from</i>	
<i>simvastatin tab 40 mg</i>	100	<i>0.55 mg naf)</i>	266
<i>simvastatin tab 5 mg</i>	99	<i>sodium fluoride chew tab 0.5 mg f (from 1.1</i>	
<i>simvastatin tab 80 mg</i>	100	<i>mg naf)</i>	266
SINEMET TAB 10-100MG.....	132	<i>sodium fluoride gel 1.1% (0.5% f)</i>	270
SINEMET TAB 25-100MG	132	<i>sodium fluoride soln 0.125 mg/drop f (0.275</i>	
SINGLE-LET MIS 23G	255	<i>mg/drop naf)</i>	266
SINGULAIR CHW 4MG	56	<i>sodium fluoride soln 0.5 mg/ml f (from 1.1</i>	
SINGULAIR CHW 5MG	56	<i>mg/ml naf)</i>	266
SINGULAIR GRA 4MG	56	<i>sodium fluoride tab 0.5 mg f (from 1.1 mg</i>	
SINGULAIR TAB 10MG	56	<i>naf)</i>	266
<i>sirolimus oral soln 1 mg/ml</i>	269	<i>sodium phenylbutyrate oral powder 3</i>	
<i>sirolimus tab 0.5 mg</i>	269	<i>gm/teaspoonful</i>	218
<i>sirolimus tab 1 mg</i>	269	<i>sodium phenylbutyrate tab 500 mg</i>	218
<i>sirolimus tab 2 mg</i>	269	<i>sodium polystyrene sulfonate oral susp 15</i>	
SIRTURO TAB 100MG.....	113	<i>gm/60ml</i>	270

<i>sodium polystyrene sulfonate powder</i> ...270	SOTYKTU TAB 6MG .....182
SODIUM SULFA LIQ 10% WASH .....184	SOTYLIZE SOL 5MG/ML.....153
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5- 3.13-1.6 gm/177ml</i> .....238	SOVALDI PAK 150MG .....149
SOFTCLIX MIS LANCETS.....255	SOVALDI PAK 200MG .....149
SOGROYA INJ 10MG/1.5 .....216	SOVALDI TAB 200MG .....149
SOGROYA INJ 15MG/1.5 .....216	SOVALDI TAB 400MG .....149
SOGROYA INJ 5MG/1.5 .....216	<i>spinosad susp 0.9%</i> .....194
<i>solifenacin succinate tab 10 mg</i> .....310	SPIRIVA AER 1.25MCG .....56
<i>solifenacin succinate tab 5 mg</i> .....310	SPIRIVA CAP HANDIHLR.....56
SOLIQUA INJ 100/33.....84	SPIRIVA SPR 2.5MCG.....56
SOLODYN TAB 105MG .....301	<i>spironolactone & hydrochlorothiazide tab 25-25 mg</i> .....212
SOLODYN TAB 115MG .....301	<i>spironolactone tab 100 mg</i> .....213
SOLODYN TAB 55MG.....301	<i>spironolactone tab 25 mg</i> .....213
SOLODYN TAB 65MG.....301	<i>spironolactone tab 50 mg</i> .....213
SOLODYN TAB 80MG.....301	SPORANOX CAP 100MG .....94
SOLOSEC GRA 2GM.....16	SPORANOX CAP PULSEPAK .....94
SOLTAMOX SOL 10MG/5ML.....118	SPORANOX SOL 10MG/ML.....94
SOLU-CORTEF INJ 1000MG.....171	SPRAVATO SOL 56MG DOS.....76
SOLU-CORTEF INJ 100MG .....171	SPRAVATO SOL 84MG DOS.....76
SOLU-CORTEF INJ 250MG.....171	SPRITAM TAB 1000MG .....72
SOLU-CORTEF INJ 500MG .....171	SPRITAM TAB 250MG .....72
SOLUS V2 MIS LANC 28G.....255	SPRITAM TAB 500MG.....72
SOLUS V2 MIS LANC 30G .....255	SPRITAM TAB 750MG .....72
SOLUS V2 MIS LANC DEV .....255	SPRIX SPR 15.75MG .....28
SOLUS V2 SOL HIGH .....255	SPRYCEL TAB 100MG.....125
SOLUS V2 SOL LOW .....255	SPRYCEL TAB 140MG.....126
SOLUS V2 TES AUDIBLE .....204	SPRYCEL TAB 20MG .....125
SOMA TAB 250MG .....276	SPRYCEL TAB 50MG .....125
SOMA TAB 350MG .....276	SPRYCEL TAB 70MG .....125
SOOLANTRA CRE 1%.....194	SPRYCEL TAB 80MG .....125
<i>sorafenib tosylate tab 200 mg (base equivalent)</i> .....125	STALEVO 100 TAB .....132
SORIATANE CAP 10MG .....182	STALEVO 125 TAB .....132
SORIATANE CAP 25MG.....182	STALEVO 150 TAB .....132
SORILUX AER 0.005% .....182	STALEVO 200 TAB .....132
<i>sotalol hcl (afib/afl) tab 120 mg</i> .....153	STALEVO 50 TAB.....132
<i>sotalol hcl (afib/afl) tab 160 mg</i> .....153	STALEVO 75 TAB.....132
<i>sotalol hcl (afib/afl) tab 80 mg</i>.....153	<i>stannous fluoride conc 0.63%</i> .....270
<i>sotalol hcl tab 120 mg</i> .....153	<i>stannous fluoride gel 0.4%</i> .....270
<i>sotalol hcl tab 160 mg</i> .....153	STARLIX TAB 120MG.....89
<i>sotalol hcl tab 240 mg</i>.....153	<i>stavudine cap 15 mg</i>.....145
<i>sotalol hcl tab 80 mg</i>.....153	<i>stavudine cap 20 mg</i>.....145
	<i>stavudine cap 30 mg</i>.....145

<i>stavudine cap 40 mg</i>	145	<i>sucralfate susp 1 gm/10ml</i>	306
STAXYN TAB 10MG.....	160	<i>sucralfate tab 1 gm</i>	306
STEGLATRO TAB 15MG	90	SULAR TAB 17MG.....	156
STEGLATRO TAB 5MG.....	90	SULAR TAB 34MG	156
STEGLUJAN TAB 15-100MG	84	SULAR TAB 8.5MG	156
STEGLUJAN TAB 5-100MG.....	84	<i>sulconazole nitrate cream 1%</i>	178
STELARA INJ 45MG/0.5	182, 183	<i>sulconazole nitrate solution 1%</i>	178
STELARA INJ 90MG/ML	183	<i>sulfacetamide sodium lotion 10% (acne)</i> 175	
STENDRA TAB 100MG.....	160	<i>sulfacetamide sodium ophth oint 10%</i> ...282	
STENDRA TAB 200MG.....	160	<i>sulfacetamide sodium ophth soln 10%</i> ...282	
STENDRA TAB 50MG	160	<i>sulfacetamide sodium-prednisolone ophth</i>	
STERILANCE MIS 1.8MM	255	<i>soln 10-0.23(0.25)%</i>	284
STERILANCE MIS TL 28G	255	<i>sulfacetamide sodium w/ sulfur cleansing</i>	
STERILANCE MIS TL 30G	255	<i>pad 10-4%</i>	175
STERILANCE MIS TL 32G	255	<i>sulfacetamide sodium w/ sulfur emulsion</i>	
STIMATE SOL 1.5MG/ML	219	<i>10-1%</i>	175
STIOLTO AER 2.5-2.5	62	<i>sulfadiazine tab 500 mg</i>	299
STIVARGA TAB 40MG	126	<i>sulfamethoxazole-trimethoprim susp 200-</i>	
STRATTERA CAP 100MG.....	8	<i>40 mg/5ml</i>	49
STRATTERA CAP 10MG	8	<i>sulfamethoxazole-trimethoprim tab 400-80</i>	
STRATTERA CAP 18MG.....	8	<i>mg</i>	49
STRATTERA CAP 25MG.....	8	<i>sulfamethoxazole-trimethoprim tab 800-</i>	
STRATTERA CAP 40MG.....	8	<i>160 mg</i>	49
STRATTERA CAP 60MG.....	8	SULFAMYLON CRE 85MG/GM	185
STRATTERA CAP 80MG.....	8	SULFAMYLON PAK 5%	185
STRENSIQ INJ 18/0.45	218	<i>sulfasalazine tab 500 mg</i>	227
STRENSIQ INJ 28/0.7ML.....	218	<i>sulfasalazine tab delayed release 500 mg</i>	
STRENSIQ INJ 40MG/ML.....	219	.....	227
STRENSIQ INJ 80/0.8ML	219	SULF LIME SOL	194
STRIVERDI AER 2.5MCG	62	<i>sulindac tab 150 mg</i>	28
STROMECTOL TAB 3MG	48	<i>sulindac tab 200 mg</i>	29
SUBOXONE MIS 12-3MG	46	<i>sumatriptan-naproxen sodium tab 85-500</i>	
SUBOXONE MIS 2-0.5MG	46	<i>mg</i>	263
SUBOXONE MIS 4-1MG.....	46	<i>sumatriptan nasal spray 20 mg/act</i>	264
SUBOXONE MIS 8-2MG	46	<i>sumatriptan nasal spray 5 mg/act</i>	264
SUBSYS SPR 100MCG.....	40	<i>sumatriptan succinate inj 6 mg/0.5ml</i>	265
SUBSYS SPR 1200MCG	41	<i>sumatriptan succinate solution auto-</i>	
SUBSYS SPR 1600MCG	41	<i>injector 4 mg/0.5ml</i>	265
SUBSYS SPR 200MCG	40	<i>sumatriptan succinate solution auto-</i>	
SUBSYS SPR 400MCG.....	40	<i>injector 6 mg/0.5ml</i>	265
SUBSYS SPR 600MCG.....	40	<i>sumatriptan succinate solution cartridge 4</i>	
SUBSYS SPR 800MCG.....	41	<i>mg/0.5ml</i>	265
SUCRAID SOL 8500/ML.....	211		

<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	265	SURESTEP PRO TES LOW CON	256
<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	265	SURESTEP PRO TES NORM CON	256
<i>sumatriptan succinate tab 100 mg</i>	265	SURESTEP SOL CONTROL	256
<i>sumatriptan succinate tab 25 mg</i>	265	SURE-TEST TES EASYPLUS	204
<i>sumatriptan succinate tab 50 mg</i>	265	SURE-TOUCH MIS UNV LANC	256
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	126	SUSTIVA CAP 200MG	145
<i>sunitinib malate cap 25 mg (base equivalent)</i>	126	SUSTIVA CAP 50MG	145
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	126	SUSTIVA TAB 600MG	146
<i>sunitinib malate cap 50 mg (base equivalent)</i>	126	SUSTOL INJ 10/0.4ML	92
SUNOSI TAB 150MG	8	SUTAB TAB	238
SUNOSI TAB 75MG	8	SUTENT CAP 12.5MG	126
SUPER THIN MIS LANC 28G	255	SUTENT CAP 25MG	126
SUPER THIN MIS LANCETS	255	SUTENT CAP 37.5MG	126
SUPLENA LIQ VANILLA	210	SUTENT CAP 50MG	126
SUPRAX CAP 400MG	165	SYMAX DUOTAB TAB	305
SUPRAX CHW 100MG	165	SYMBICORT AER 160-4.5	62
SUPRAX CHW 200MG	165	SYMBICORT AER 80-4.5	62
SUPRAX SUS 100/5ML	165	SYMBYAX CAP 12-50MG	291
SUPRAX SUS 200/5ML	165	SYMBYAX CAP 3-25MG	291
SUPRAX SUS 500/5ML	165	SYMBYAX CAP 6-25MG	291
SUPREME II LIQ HIGH/LOW	255	SYMBYAX CAP 6-50MG	291
SUPREME TES	204	SYMDEKO TAB 100-150	298
SUPREP BOWEL SOL PREP KIT	238	SYMDEKO TAB 50-75MG	298
SURE COMFORT MIS LANC 18G	255	SYMFI LO TAB	146
SURE COMFORT MIS LANC 21G	255	SYMFI TAB	146
SURE COMFORT MIS LANC 23G	255	SYMJEPI INJ 0.15MG	312
SURE COMFORT MIS LANC 30G	255	SYMJEPI INJ 0.3MG	312
SURE COMFORT MIS LANCETS	256	SYMLINPEN 60 INJ 1000MCG	82
SURE COMFORT MIS LANC PEN	256	SYMLNPEN 120 INJ 1000MCG	82
SUREFLEX MIS LANCETS	256	SYMPAZAN MIS 10MG	66
SURE-LANCE MIS 26G	256	SYMPAZAN MIS 20MG	66
SURE-LANCE MIS LANCETS	256	SYMPAZAN MIS 5MG	66
SURELITE MIS LANCETS	256	SYMPROIC TAB 0.2MG	228
SURE-PEN MIS	256	SYMTUZA TAB	146
SURESTEP GLU SOL	256	SYNALAR CRE 0.025%	189
SURESTEP GLU SOL HIGH/LOW	256	SYNALAR OIN 0.025%	190
SURESTEP PRO TES HIGH CON	256	SYNALAR SOL 0.01%	190
		SYNAREL SOL 2MG/ML	217
		SYNDROS SOL 5MG/ML	93
		SYNERA DIS 70-70MG	193
		SYNJARDY TAB	84
		SYNJARDY TAB 12.5-500	84
		SYNJARDY TAB 5-1000MG	84

SYNJARDY TAB 5-500MG	84	TAKHZYRO INJ 150MG/ML.....	232
SYNJARDY XR TAB	84	TAKHZYRO INJ 300/2ML.....	232
SYNJARDY XR TAB 10-1000	84	TALICIA CAP	309
SYNJARDY XR TAB 25-1000.....	84	TALIVA CAP.....	235
SYNJARDY XR TAB 5-1000MG	84	TALTZ INJ 80MG/ML.....	183
SYNTHROID TAB 100MCG.....	303	TAMIFLU CAP 30MG	150
SYNTHROID TAB 112MCG	303	TAMIFLU CAP 45MG	150
SYNTHROID TAB 125MCG	303	TAMIFLU CAP 75MG	150
SYNTHROID TAB 137MCG	303	TAMIFLU SUS 6MG/ML.....	150
SYNTHROID TAB 150MCG.....	303	<i>tamoxifen citrate tab 10 mg (base</i>	
SYNTHROID TAB 175MCG	303	<i>equivalent)</i>	118
SYNTHROID TAB 200MCG	303	<i>tamoxifen citrate tab 20 mg (base</i>	
SYNTHROID TAB 25MCG.....	303	<i>equivalent)</i>	118
SYNTHROID TAB 300MCG	303	<i>tamsulosin hcl cap 0.4 mg</i>	230
SYNTHROID TAB 50MCG	303	TAPAZOLE TAB 10MG	301
SYNTHROID TAB 75MCG.....	303	TAPAZOLE TAB 5MG.....	301
SYNTHROID TAB 88MCG.....	303	TARCEVA TAB 100MG.....	116
SYPRINE CAP 250MG	267	TARCEVA TAB 150MG.....	116
SYRINGE MIS 0.5/30G.....	260	TARCEVA TAB 25MG.....	116
T		TARGRETIN CAP 75MG.....	128
TABLOID TAB 40MG	114	TARGRETIN GEL 1%	179
TACHOSIL PAD 4.8X4.8	235	TARKA TAB 2-180 CR.....	110
TACHOSIL PAD 9.5X4.8	235	TARKA TAB 2-240 CR	110
TACLONEX OIN	190	TARKA TAB 4-240 CR	110
TACLONEX SUS.....	190	TARON-PREX CAP	274
<i>tacrolimus cap 0.5 mg</i>	269	<i>tasimelteon capsule 20 mg</i>	238
<i>tacrolimus cap 1 mg</i>	269	TASMAR TAB 100MG.....	129
<i>tacrolimus cap 5 mg</i>	269	<i>tavorole soln 5%</i>	178
<i>tacrolimus oint 0.03%</i>	192	TAVALISSE TAB 100MG	231
<i>tacrolimus oint 0.1%</i>	192	TAVALISSE TAB 150MG.....	231
<i>tadalafil tab 10 mg</i>	160	TAYTULLA CAP 1MG/20MC	168
<i>tadalafil tab 2.5 mg</i>	160	TAZAROTENE AER 0.1%.....	175
<i>tadalafil tab 20 mg</i>	161	<i>tazarotene cream 0.1%</i>	183
<i>tadalafil tab 20 mg (pah)</i>	163	TAZORAC CRE 0.05%	183
<i>tadalafil tab 5 mg</i>	160	TAZORAC CRE 0.1%.....	183
TADLIQ SUS 20MG/5ML	163	TAZORAC GEL 0.05%.....	183
TAFINLAR CAP 50MG.....	126	TAZORAC GEL 0.1%	183
TAFINLAR CAP 75MG.....	126	TAZVERIK TAB 200MG.....	126
<i>tafluprost preservative free (pf) ophth soln</i>		TECHLITE AST MIS LANCETS.....	256
<i>0.0015%</i>	285	TECHLITE MIS LANC 30G	256
TAGRISSO TAB 40MG	116	TECHLITE MIS LANCETS.....	256
TAGRISSO TAB 80MG	116	TEGRETOL SUS 100/5ML	72
TAI DOC SOL NORM CON	256	TEGRETOL TAB 200MG.....	72

TEGRETOL-XR TAB 100MG	72	<i>tenofovir disoproxil fumarate tab 300 mg</i>	
TEGRETOL-XR TAB 200MG	72	.....	146
TEGRETOL-XR TAB 400MG	72	TENORETIC TAB 100	110
TEGSEDI INJ 284/1.5	297	TENORETIC TAB 50.....	110
TEKTURNA HCT TAB 150-12.5	110	TENORMIN TAB 100MG	152
TEKTURNA HCT TAB 150-25MG	110	TENORMIN TAB 25MG	152
TEKTURNA HCT TAB 300-12.5	110	TENORMIN TAB 50MG.....	152
TEKTURNA HCT TAB 300-25MG	110	TEPMETKO TAB 225MG.....	126
TEKTURNA TAB 150MG	111	<i>terazosin hcl cap 10 mg (base equivalent)</i>	
TEKTURNA TAB 300MG	111	.....	105
<i>telmisartan-amlodipine tab 40-10 mg</i>	110	<i>terazosin hcl cap 1 mg (base equivalent)</i>	105
<i>telmisartan-amlodipine tab 40-5 mg</i>	110	<i>terazosin hcl cap 2 mg (base equivalent)</i>	105
<i>telmisartan-amlodipine tab 80-10 mg</i>	110	<i>terazosin hcl cap 5 mg (base equivalent)</i>	105
<i>telmisartan-amlodipine tab 80-5 mg</i>	110	<i>terbinafine hcl tab 250 mg</i>	94
<i>telmisartan-hydrochlorothiazide tab 40-</i>		<i>terbutaline sulfate tab 2.5 mg</i>	62
<i>12.5 mg</i>	110	<i>terbutaline sulfate tab 5 mg</i>	62
<i>telmisartan-hydrochlorothiazide tab 80-12.5</i>		<i>terconazole vaginal cream 0.4%</i>	311
<i>mg</i>	110	<i>terconazole vaginal cream 0.8%</i>	311
<i>telmisartan-hydrochlorothiazide tab 80-25</i>		<i>terconazole vaginal suppos 80 mg</i>	311
<i>mg</i>	110	<i>teriflunomide tab 14 mg</i>	294
<i>telmisartan tab 20 mg</i>	104	<i>teriflunomide tab 7 mg</i>	294
<i>telmisartan tab 40 mg</i>	104	TESSALON PER CAP 100MG	171
<i>telmisartan tab 80 mg</i>	104	TESTIM GEL 1%(50MG).....	47
<i>temazepam cap 15 mg</i>	237	TESTOST CYP INJ 200MG/ML.....	47
<i>temazepam cap 22.5 mg</i>	237	<i>testosterone cypionate im inj in oil 100</i>	
<i>temazepam cap 30 mg</i>	237	<i>mg/ml</i>	47
<i>temazepam cap 7.5 mg</i>	237	<i>testosterone cypionate im inj in oil 200</i>	
TEMBEXA SUS 10MG/ML.....	150	<i>mg/ml</i>	47
TEMBEXA TAB 100MG	150	<i>testosterone enanthate im inj in oil 200</i>	
TEMIXYS TAB 300-300	146	<i>mg/ml</i>	47
TEMODAR CAP 100MG	113	<i>testosterone td gel 10mg/act (2%)</i>	47
TEMODAR CAP 140MG	113	<i>testosterone td gel 12.5 mg/act (1%)</i>	47
TEMODAR CAP 180MG	114	<i>testosterone td gel 20.25 mg/1.25gm</i>	
TEMODAR CAP 250MG	114	<i>(1.62%)</i>	47
TEMOVATE CRE 0.05%	190	<i>testosterone td gel 20.25 mg/act (1.62%)</i>	47
TEMOVATE OIN 0.05%	190	<i>testosterone td gel 25 mg/2.5gm (1%)</i>	47
<i>temozolomide cap 100 mg</i>	114	<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	
<i>temozolomide cap 140 mg</i>	114	.....	47
<i>temozolomide cap 180 mg</i>	114	<i>testosterone td gel 50 mg/5gm (1%)</i>	47
<i>temozolomide cap 20 mg</i>	114	<i>testosterone td soln 30 mg/act</i>	47
<i>temozolomide cap 250 mg</i>	114	<i>tetrabenazine tab 12.5 mg</i>	292
<i>temozolomide cap 5 mg</i>	114	<i>tetrabenazine tab 25 mg</i>	292
		<i>tetracaine hcl ophth soln 0.5%</i>	282

<i>tetracycline hcl cap 250 mg</i>	301	TIAZAC CAP 240MG/24.....	156
<i>tetracycline hcl cap 500 mg</i>	301	TIAZAC CAP 300MG/24	156
TEXACORT SOL 2.5%.....	190	TIAZAC CAP 360MG/24.....	156
TEZSPIRE INJ 210MG	55	TIAZAC CAP 420MG/24.....	156
TGT LANCET MIS 26G	256	TIBSOVO TAB 250MG	126
TGT LANCET MIS 30G	256	TIGAN CAP 300MG	93
TGT LANCET MIS 33G.....	256	TIGLUTIK SUS 50/10ML.....	278
TGT LANCING MIS DEVICE	256	TIKOSYN CAP 125MCG.....	55
THALOMID CAP 100MG	267	TIKOSYN CAP 250MCG.....	55
THALOMID CAP 150MG	268	TIKOSYN CAP 500MCG.....	55
THALOMID CAP 200MG.....	268	TIM/BRIM/DOR SOL	279
THALOMID CAP 50MG	267	TIM/DORZ/LAT SOL.....	279
THEO-24 CAP 100MG CR	63	TIMOL/BRIM SOL DORZ/LAT	279
THEO-24 CAP 200MG CR	63	TIMOL/LATAN SOL	279
THEO-24 CAP 300MG CR	63	<i>timolol maleate ophth gel forming soln</i>	
THEO-24 CAP 400MG ER.....	63	0.25%	279
<i>theophylline elixir 80 mg/15ml</i>	63	<i>timolol maleate ophth gel forming soln</i>	
<i>theophylline tab er 12hr 300 mg</i>	63	0.5%.....	279
<i>theophylline tab er 12hr 450 mg</i>	63	<i>timolol maleate ophth soln 0.25%</i>	279
<i>theophylline tab er 24hr 400 mg</i>	63	<i>timolol maleate ophth soln 0.5%</i>	279
<i>theophylline tab er 24hr 600 mg</i>	63	<i>timolol maleate ophth soln 0.5% (once-</i>	
THIN LANCETS MIS.....	256	<i>daily)</i>	279
THIN LANCETS MIS 26G	256	<i>timolol maleate preservative free ophth soln</i>	
THIN LANCETS MIS 30G	256	0.5%.....	279
THINLETS GP MIS 26G	256	<i>timolol maleate tab 10 mg</i>	153
THIOLA EC TAB 100MG.....	230	<i>timolol maleate tab 20 mg</i>	153
THIOLA EC TAB 300MG	230	<i>timolol maleate tab 5 mg</i>	153
<i>thioridazine hcl tab 100 mg</i>	139	TIMOPTIC OCU SOL 0.25% OP	279
<i>thioridazine hcl tab 10 mg</i>	138	TIMOPTIC OCU SOL 0.5% OP	279
<i>thioridazine hcl tab 25 mg</i>	138	TIMOPTIC SOL 0.25% OP	279
<i>thioridazine hcl tab 50 mg</i>	139	TIMOPTIC SOL 0.5% OP.....	279
<i>thiothixene cap 10 mg</i>	140	TIMOPTIC-XE SOL 0.25% OP	279
<i>thiothixene cap 1 mg</i>	140	TIMOPTIC-XE SOL 0.5% OP	279
<i>thiothixene cap 2 mg</i>	140	<i>tinidazole tab 250 mg</i>	48
<i>thiothixene cap 5 mg</i>	140	<i>tinidazole tab 500 mg</i>	49
THRIVITE RX TAB 29-1MG.....	274	<i>tiopronin tab 100 mg</i>	230
THYQUIDITY SOL 100MCG	303	TIROSINT CAP 100MCG	304
<i>tiagabine hcl tab 12 mg</i>	73	TIROSINT CAP 112MCG	304
<i>tiagabine hcl tab 16 mg</i>	74	TIROSINT CAP 125MCG	304
<i>tiagabine hcl tab 2 mg</i>	73	TIROSINT CAP 137MCG.....	304
<i>tiagabine hcl tab 4 mg</i>	73	TIROSINT CAP 13MCG.....	303
TIAZAC CAP 120MG/24	156	TIROSINT CAP 150MCG	304
TIAZAC CAP 180MG/24	156	TIROSINT CAP 175MCG	304

TIROSINT CAP 200	304	<i>tobramycin-dexamethasone ophth susp</i>	
TIROSINT CAP 25MCG	303	0.3-0.1%	284
TIROSINT CAP 50MCG	304	<i>tobramycin nebu soln 300 mg/4ml</i>	16
TIROSINT CAP 75MCG	304	<i>tobramycin nebu soln 300 mg/5ml</i>	16
TIROSINT CAP 88MCG	304	<i>tobramycin ophth soln 0.3%</i>	282
TIROSINT-SOL SOL 100MCG	304	TOBEX OIN 0.3% OP	282
TIROSINT-SOL SOL 112MCG	304	TOBEX SOL 0.3% OP	282
TIROSINT-SOL SOL 125MCG	304	TODAY SPONGE MIS	311
TIROSINT-SOL SOL 137MCG	304	<i>tolbutamide tab 500 mg</i>	90
TIROSINT-SOL SOL 13MCG/ML	304	<i>tolcapone tab 100 mg</i>	129
TIROSINT-SOL SOL 150MCG	304	TOLEREX POW	210
TIROSINT-SOL SOL 175MCG	304	<i>tolmetin sodium cap 400 mg</i>	29
TIROSINT-SOL SOL 200MCG	304	<i>tolmetin sodium tab 600 mg</i>	29
TIROSINT-SOL SOL 25MCG/ML	304	TOLSURA CAP 65MG	94
TIROSINT-SOL SOL 50MCG/ML	304	<i>tolterodine tartrate cap er 24hr 2 mg</i>	310
TIROSINT-SOL SOL 75MCG/ML	304	<i>tolterodine tartrate cap er 24hr 4 mg</i>	310
TIROSINT-SOL SOL 88MCG/ML	304	<i>tolterodine tartrate tab 1 mg</i>	310
TISSEEL KIT 10ML	235	<i>tolterodine tartrate tab 2 mg</i>	310
TISSEEL KIT 2ML	235	<i>tolvaptan tab 30 mg</i>	221
TISSEEL KIT 4ML	235	TOPAMAX SPR CAP 15MG	72
TISSEEL SOL 10ML	236	TOPAMAX SPR CAP 25MG	72
TISSEEL SOL 2ML	235	TOPAMAX TAB 100MG	72
TISSEEL SOL 4ML	236	TOPAMAX TAB 200MG	72
TIVICAY PD TAB 5MG	146	TOPAMAX TAB 25MG	72
TIVICAY TAB 10MG	146	TOPAMAX TAB 50MG	72
TIVICAY TAB 25MG	146	TOPCARE MIS LANC 33G	256
TIVICAY TAB 50MG	146	TOPICORT CRE 0.05%	190
TIVORBEX CAP 20MG	29	TOPICORT CRE 0.25%	190
<i>tizanidine hcl cap 2 mg (base equivalent)</i>		TOPICORT GEL 0.05%	190
.....	276	TOPICORT OIN 0.05%	190
<i>tizanidine hcl cap 4 mg (base equivalent)</i>		TOPICORT OIN 0.25%	190
.....	276	TOPICORT SPR 0.25%	190
<i>tizanidine hcl cap 6 mg (base equivalent)</i>		<i>topiramate cap er 24hr 200 mg</i>	72
.....	276	<i>topiramate cap er 24hr sprinkle 100 mg</i> ...	72
<i>tizanidine hcl tab 2 mg (base equivalent)</i>		<i>topiramate cap er 24hr sprinkle 150 mg</i> ...	72
.....	276	<i>topiramate cap er 24hr sprinkle 200 mg</i> ...	72
<i>tizanidine hcl tab 4 mg (base equivalent)</i>		<i>topiramate cap er 24hr sprinkle 25 mg</i>	72
.....	276	<i>topiramate cap er 24hr sprinkle 50 mg</i>	72
TOBAIKIENT CAP	210	<i>topiramate sprinkle cap 15 mg</i>	72
TOBRADEX OIN 0.3-0.1%	284	<i>topiramate sprinkle cap 25 mg</i>	72
TOBRADEX ST SUS 0.3-0.05	284	<i>topiramate tab 100 mg</i>	72
TOBRADEX SUS 0.3-0.1%	284	<i>topiramate tab 200 mg</i>	72
		<i>topiramate tab 25 mg</i>	72

<i>topiramate tab 50 mg</i>	72	<i>tranexamic acid tab 650 mg</i>	235
TOPROL XL TAB 100MG.....	152	TRANSDERM SC DIS 1MG/3DAY.....	93
TOPROL XL TAB 200MG	152	TRANSDERM-SC DIS 1MG/3DAY	93
TOPROL XL TAB 25MG.....	152	TRANXENE T TAB 7.5MG.....	53
TOPROL XL TAB 50MG	152	<i>tranylcypromine sulfate tab 10 mg</i>	76
<i>toremifene citrate tab 60 mg (base</i>		TRAVATAN Z DRO 0.004%.....	285
<i>equivalent)</i>	118	TRAVEL LANCE MIS 30G.....	256
<i>toremide tab 100 mg</i>	212	TRAVEL LANCE MIS ADV 28G	256
<i>toremide tab 10 mg</i>	212	<i>travoprost ophth soln 0.004%</i>	
<i>toremide tab 20 mg</i>	212	<i>(benzalkonium free) (bak free)</i>	285
<i>toremide tab 5 mg</i>	212	<i>trazodone hcl tab 100 mg</i>	78
TOSYMRA SOL 10MG.....	265	<i>trazodone hcl tab 150 mg</i>	78
TOUJEO MAX INJ 300IU/ML	89	<i>trazodone hcl tab 300 mg</i>	78
TOUJEO SOLO INJ 300IU/ML	89	<i>trazodone hcl tab 50 mg</i>	78
TOVIAZ TAB 4MG.....	310	TRECTOR TAB 250MG.....	113
TOVIAZ TAB 8MG.....	310	TRELEGY AER 100MCG.....	62
TPOXX CAP 200MG.....	150	TRELEGY AER 200MCG	62
TPOXX INJ.....	150	TREMFYA INJ 100MG/ML.....	184
TRADJENTA TAB 5MG.....	86	TRESIBA FLEX INJ 100UNIT	89
<i>tramadol-acetaminophen tab 37.5-325 mg</i>		TRESIBA FLEX INJ 200UNIT.....	89
.....	44	TRESIBA INJ 100UNIT	89
<i>tramadol hcl tab 100 mg</i>	41	<i>tretinoin cap 10 mg</i>	128
<i>tramadol hcl tab 50 mg</i>	41	<i>tretinoin cream 0.025%</i>	175
<i>tramadol hcl tab er 24hr 100 mg</i>	41	<i>tretinoin cream 0.05%</i>	175
<i>tramadol hcl tab er 24hr 200 mg</i>	41	<i>tretinoin cream 0.1%</i>	175
<i>tramadol hcl tab er 24hr 300 mg</i>	41	<i>tretinoin gel 0.01%</i>	175
<i>tramadol hcl tab er 24hr biphasic release</i>		<i>tretinoin gel 0.025%</i>	175
<i>100 mg</i>	41	<i>tretinoin gel 0.05%</i>	175
<i>tramadol hcl tab er 24hr biphasic release</i>		<i>tretinoin microsphere gel 0.04%</i>	176
<i>200 mg</i>	41	<i>tretinoin microsphere gel 0.1%</i>	175
<i>tramadol hcl tab er 24hr biphasic release</i>		TREXALL TAB 10MG	114
<i>300 mg</i>	41	TREXALL TAB 15MG	115
<i>trandolapril tab 1 mg</i>	102	TREXALL TAB 5MG.....	114
<i>trandolapril tab 2 mg</i>	102	TREXALL TAB 7.5MG.....	114
<i>trandolapril tab 4 mg</i>	102	TREXIMET TAB 85-500MG	263
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>		<i>triamcinolone acetoneide aerosol soln 0.147</i>	
.....	110	<i>mg/gm</i>	190
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>		<i>triamcinolone acetoneide cream 0.025%</i>	190
.....	110	<i>triamcinolone acetoneide cream 0.1%</i>	190
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>		<i>triamcinolone acetoneide cream 0.5%</i>	190
.....	110	<i>triamcinolone acetoneide dental paste 0.1%</i>	
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>		.....	271
.....	110	<i>triamcinolone acetoneide lotion 0.025%</i> ..	190

<i>triamcinolone acetonide lotion 0.1%</i> .....190	TRILEPTAL TAB 150MG .....72
<i>triamcinolone acetonide oint 0.025%</i> .....190	TRILEPTAL TAB 300MG.....72
<i>triamcinolone acetonide oint 0.05%</i> .....190	TRILEPTAL TAB 600MG.....72
<i>triamcinolone acetonide oint 0.1%</i> .....190	TRILIPIX CAP 135MG.....98
<i>triamcinolone acetonide oint 0.5%</i>.....190	TRILIPIX CAP 45MG .....98
<i>triamterene & hydrochlorothiazide cap</i>	<i>trimethobenzamide hcl cap 300 mg</i> .....93
<i>37.5-25 mg</i>.....212	<i>trimethoprim tab 100 mg</i> .....49
<i>triamterene & hydrochlorothiazide tab 37.5-</i>	<i>trimipramine maleate cap 100 mg</i>.....81
<i>25 mg</i>.....212	<i>trimipramine maleate cap 25 mg</i>.....81
<i>triamterene & hydrochlorothiazide tab 75-</i>	<i>trimipramine maleate cap 50 mg</i> .....81
<i>50 mg</i>.....212	TRINAZ TAB 12-1MG.....274
<i>triamterene cap 100 mg</i>.....213	TRINTELLIX TAB 10MG .....78
<i>triamterene cap 50 mg</i> .....213	TRINTELLIX TAB 20MG.....78
<i>triazolam tab 0.125 mg</i> .....237	TRINTELLIX TAB 5MG .....78
<i>triazolam tab 0.25 mg</i>.....237	TRISTART DHA CAP .....274
TRIBENZOR20- TAB 5-12.5MG .....110	TRISTART ONE CAP 35-1-215 .....274
TRIBENZOR40- TAB 10-12.5.....110	TRIUMEQ PD TAB.....146
TRIBENZOR40- TAB 10-25MG .....110	TRIUMEQ TAB.....146
TRIBENZOR40- TAB 5-12.5MG .....110	TRIZIVIR TAB.....146
TRIBENZOR40- TAB 5-25MG.....110	TROKENDI XR CAP 100MG.....72
TRICARE PRE CAP 27-1-500.....274	TROKENDI XR CAP 200MG.....73
TRICARE TAB PRENATAL.....274	TROKENDI XR CAP 25MG.....72
TRICOR TAB 145MG .....98	TROKENDI XR CAP 50MG .....72
TRICOR TAB 48MG.....98	TROP/CYC/PE/ SOL KETO/PRO .....280
TRIDESILON CRE 0.05% .....190	TROP/CYC/PE/ SOL KETOROLA.....280
<i>trientine hcl cap 250 mg</i> .....267	TROP/CYCL/PE SOL KETOROLA .....280
<i>trifluoperazine hcl tab 10 mg (base</i>	TROP-CYC-PE DRO 1-1-2.5.....280
<i>equivalent)</i> .....139	TROP-PHENYL SOL 1-2.5% .....280
<i>trifluoperazine hcl tab 1 mg (base</i>	<i>tropium chloride cap er 24hr 60 mg</i> .....310
<i>equivalent)</i> .....139	<i>tropium chloride tab 20 mg</i>.....310
<i>trifluoperazine hcl tab 2 mg (base</i>	TRUDHESA AER 0.725MG.....263
<i>equivalent)</i> .....139	TRUECONTROL LIQ LEVEL 0 .....256
<i>trifluoperazine hcl tab 5 mg (base</i>	TRUECONTROL LIQ LEVEL 1.....256
<i>equivalent)</i> .....139	TRUEDRAW MIS LANC DEV.....256
<i>trifluridine ophth soln 1%</i> .....282	TRUE FOCUS MIS BLOOD .....204
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i> ..129	TRUE METRIX SOL LEVEL 1.....256
<i>trihexyphenidyl hcl tab 2 mg</i> .....129	TRUE METRIX SOL LEVEL 2 .....256
<i>trihexyphenidyl hcl tab 5 mg</i>.....129	TRUE METRIX SOL LEVEL 3 .....256
TRIJARDY XR TAB .....84	TRUE METRIX TES GLUCOSE .....204
TRIKAFTA PAK 59.5MG.....298	TRUETEST TES.....204
TRIKAFTA PAK 75MG .....298	TRUETRACK TES .....205
TRIKAFTA TAB .....298	TRUETRACK TES BLD GLUC.....205
TRILEPTAL SUS 300MG/5M .....72	TRULANCE TAB 3MG.....224

TRULICITY INJ 0.75/0.5.....	87	TYVASO DPI POW 32MCG.....	162
TRULICITY INJ 1.5/0.5.....	87	TYVASO DPI POW 48MCG	162
TRULICITY INJ 3/0.5	87	TYVASO DPI POW 64MCG	162
TRULICITY INJ 4.5/0.5.....	87	TYVASO REFIL SOL 0.6MG/ML.....	162
TRUPLUS LANC MIS 26G.....	257	TYVASO SOL 0.6MG/ML.....	162
TRUPLUS LANC MIS 28G.....	257	TYVASO START SOL 0.6MG/ML.....	162
TRUPLUS LANC MIS 30G	257	U	
TRUPLUS LANC MIS 33G.....	257	UBRELVY TAB 100MG.....	262
TRUSELTIQ CAP 100MG.....	126	UBRELVY TAB 50MG.....	262
TRUSELTIQ CAP 125MG	127	UCERIS AER 2MG/ACT	47
TRUSELTIQ CAP 50MG	126	UCERIS TAB 9MG.....	171
TRUSELTIQ CAP 75MG.....	126	ULORIC TAB 40MG	231
TRUSOPT SOL 2% OP	285	ULORIC TAB 80MG	231
TRUVADA TAB 100-150.....	146	ULTICARE PAD ALCOHOL	260
TRUVADA TAB 133-200.....	146	ULTI-LANCE MIS CLR TIP.....	257
TRUVADA TAB 167-250.....	146	ULTILET MIS 26G	257
TRUVADA TAB 200-300	146	ULTILET MIS 28G	257
TRUZONE PEAK MIS FLOW MTR	262	ULTILET MIS 30G.....	257
TUDORZA PRES AER 400/ACT	56	ULTILET MIS 33G	257
TUKYSA TAB 150MG.....	115	ULTILET MIS LANCETS	257
TUKYSA TAB 50MG.....	115	ULTILET MIS SAFETY	257
TURALIO CAP 200MG	127	ULTILET PAD ALCOHOL.....	260
TURPENTINE SOL SPIRITS.....	192	ULTILET SAFE MIS 21G.....	257
TUSSICAPS CAP 10-8MG	172	ULTRACAL HN LIQ PLUS	210
TUXARIN ER TAB 54.3-8MG	172	ULTRACAL LIQ.....	210
TUZISTRA XR SUS.....	172	ULTRACET TAB 37.5-325	44
TWIRLA DIS 120-30.....	168	ULTRAM TAB 50MG.....	41
TWIST LANCET MIS 30G MULT.....	257	ULTRA THIN MIS 28G.....	257
TWOCAL HN LIQ	210	ULTRA THIN MIS 30G	257
TWYNEO CRE 0.1-3%	176	ULTRA THIN MIS 31G	257
TWYNSTA TAB 40-10MG	110	ULTRA THIN MIS 33G.....	257
TWYNSTA TAB 40-5MG	110	ULTRA THIN MIS LAN 31G.....	257
TWYNSTA TAB 80-10MG.....	110	ULTRA THIN MIS LANC 28G	257
TWYNSTA TAB 80-5MG	110	ULTRA THIN MIS LANC 30G	257
TYBLUME CHW 0.1-0.02.....	168	ULTRA THIN MIS LANCETS.....	257
TYBOST TAB 150MG.....	146	ULTRAVATE LOT 0.05%	190
TYKERB TAB 250MG.....	127	ULTRIENT 1.5 LIQ SAFE-T	210
TYLACTIN POW BLD 20PE	210	UNILET CMFR MIS TCH 28G	257
TYMLOS INJ.....	214	UNILET CMFR MIS TCH 30G.....	257
TYVASO DPI POW 16-32-48.....	161	UNILET EXCEL MIS 23G.....	257
TYVASO DPI POW 16-32MCG	162	UNILET EX II MIS 28G.....	257
TYVASO DPI POW 16MCG	162	UNILET G.P. MIS 21G	257
TYVASO DPI POW 32-48MCG	162	UNILET G.P MIS SUPR 23G.....	257

UNILET GP 28 MIS ULT THIN	257	UNIVERSAL 1 MIS LANC 26G	258
UNILET LANCE MIS 21G	257	UNIVERSAL 1 MIS LANC 30G	259
UNILET LANCE MIS 28G	257	UPNEEQ SOL 0.1%	285
UNILET LANCE MIS 33G	257	UPTRAVI PACK TAB 200/800	163
UNILET LANC MIS 33G	257	UPTRAVI TAB 1000MCG	163
UNILET LANCT MIS 28G	257	UPTRAVI TAB 1200MCG	163
UNILET LANCT MIS 30G	257	UPTRAVI TAB 1400MCG	163
UNILET LANCT MIS 33G	257	UPTRAVI TAB 1600MCG	163
UNILET MICRO MIS 33G	258	UPTRAVI TAB 200MCG	163
UNILET MIS 21G	258	UPTRAVI TAB 400MCG	163
UNILET SUPER MIS 23G	258	UPTRAVI TAB 600MCG	163
UNILET SUPER MIS G.P. 23G	258	UPTRAVI TAB 800MCG	163
UNISTIK 1 MIS 2.4MM	258	<i>urea cream 39%</i>	191
UNISTIK 1 MIS 3.0MM	258	<i>urea lotion 40%</i>	191
UNISTIK 2 MIS	258	UROCIT-K 10 TAB	229
UNISTIK 2 MIS 1.8MM	258	UROCIT-K 15 TAB	229
UNISTIK 2 MIS 2.4MM	258	UROCIT-K 5 TAB	229
UNISTIK 2 MIS COMFORT	258	UROXATRAL TAB 10MG	230
UNISTIK 2 MIS EXTRA	258	URSO 250 TAB 250MG	225
UNISTIK 2 MIS NEONATAL	258	<i>ursodiol cap 300 mg</i>	225
UNISTIK 2 MIS NORMAL	258	<i>ursodiol tab 250 mg</i>	225
UNISTIK 2 MIS SUPER	258	<i>ursodiol tab 500 mg</i>	225
UNISTIK 3 MIS 1.8MM	258	URSO FORTE TAB 500MG	225
UNISTIK 3 MIS COMFORT	258	UTIBRON CAP NEOHALER	62
UNISTIK 3 MIS EXTRA	258	V	
UNISTIK 3 MIS GENT 30G	258	VAGIFEM TAB 10MCG	311
UNISTIK 3 MIS NEONATAL	258	<i>valacyclovir hcl tab 1 gm</i>	149
UNISTIK 3 MIS NORMAL	258	<i>valacyclovir hcl tab 500 mg</i>	149
UNISTIK 3 MIS XTR 21G	258	VALCHLOR GEL 0.016%	179
UNISTIK CZT MIS COMFORT	258	VALCYTE SOL 50MG/ML	147
UNISTIK CZT MIS NORMAL	258	VALCYTE TAB 450MG	148
UNISTIK II MIS LANCETS	258	<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	148
UNISTIK PRO MIS LANC 21G	258	<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	148
UNISTIK PRO MIS LANC 28G	258	VALIUM TAB 10MG	53
UNISTIK SAFE MIS LANC 28G	258	VALIUM TAB 2MG	53
UNISTIK SAFE MIS LANC 30G	258	VALIUM TAB 5MG	53
UNISTIK TOUC MIS LANC 21G	258	<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	75
UNISTIK TOUC MIS LANC 23G	258	<i>valproic acid cap 250 mg</i>	75
UNISTIK TOUC MIS LANC 28G	258	<i>valsartan-hydrochlorothiazide tab 160-12.5 mg</i>	110
UNISTIK TOUC MIS LANC 30G	258		
UNISTRIP1 TES GENERIC	205		
UNITSTIK PRO MIS LANC 25G	258		
UNIVERSAL 1 MIS 33G	258		

<i>valsartan-hydrochlorothiazide tab 160-25 mg</i>	110	VASOTEC TAB 5MG.....	102
<i>valsartan-hydrochlorothiazide tab 320-12.5 mg</i>	110	VCF VAGINAL AER CONTRACP.....	311
<i>valsartan-hydrochlorothiazide tab 320-25 mg</i>	110	VCF VAGINAL GEL CONTRACE.....	311
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i>	110	VCF VAGINAL MIS CONTRACP.....	311
<i>valsartan tab 160 mg</i>	104	VECAMYL TAB 2.5MG.....	111
<i>valsartan tab 320 mg</i>	104	VECTICAL OIN 3MCG/GM.....	184
<i>valsartan tab 40 mg</i>	104	VELPHORO CHW 500MG.....	228
<i>valsartan tab 80 mg</i>	104	VELTASSA POW 16.8GM.....	270
VALTOCO SPR 10MG.....	66	VELTASSA POW 25.2GM.....	270
VALTOCO SPR 15MG.....	66	VELTASSA POW 8.4GM.....	270
VALTOCO SPR 20MG.....	66	VELTIN GEL.....	176
VALTOCO SPR 5MG.....	66	VEMLIDY TAB 25MG.....	149
VALTRESX TAB 1GM.....	149	VENCLEXTA TAB 100MG.....	116
VALTRESX TAB 500MG.....	149	VENCLEXTA TAB 10MG.....	115
VANCOCIN CAP 125MG.....	49	VENCLEXTA TAB 50MG.....	116
VANCOCIN CAP 250MG.....	49	VENCLEXTA TAB START PK.....	116
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	49	<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	80
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	49	<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	79
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	49	<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	79
VANCOMYCIN SOL 10MG/ML.....	282	<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	80
VANDAZOLE GEL 0.75%.....	311	<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	80
VANOS CRE 0.1%.....	190	<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	80
VANTAGE LANC MIS DEVICE.....	259	<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	80
<i>varidenafil hcl orally disintegrating tab 10 mg</i>	161	<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	80
<i>varidenafil hcl tab 10 mg</i>	161	<i>venlafaxine hcl tab er 24hr 150 mg (base equivalent)</i>	80
<i>varidenafil hcl tab 2.5 mg</i>	161	<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	80
<i>varidenafil hcl tab 20 mg</i>	161	<i>venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)</i>	80
<i>varidenafil hcl tab 5 mg</i>	161	<i>venlafaxine hcl tab er 24hr 75 mg (base equivalent)</i>	80
VARUBI TAB 90MG.....	93	VENTAVIS SOL 10MCG/ML.....	162
VASCEPA CAP 0.5GM.....	96	VENTAVIS SOL 20MCG/ML.....	162
VASCEPA CAP 1GM.....	96	VENTOLIN HFA AER.....	62
VASERETIC TAB 10-25MG.....	110		
VASOTEC TAB 10MG.....	102		
VASOTEC TAB 2.5MG.....	102		
VASOTEC TAB 20MG.....	103		

<i>verapamil hcl cap er 24hr 100 mg</i>	156	VIAGRA TAB 50MG.....	161
<i>verapamil hcl cap er 24hr 120 mg</i>	156	VIBERZI TAB 100MG.....	227
<i>verapamil hcl cap er 24hr 180 mg</i>	156	VIBERZI TAB 75MG.....	227
<i>verapamil hcl cap er 24hr 200 mg</i>	156	VIBRAMYCIN CAP 100MG	301
<i>verapamil hcl cap er 24hr 240 mg</i>	156	VIBRAMYCIN SUS 25MG/5ML.....	301
<i>verapamil hcl cap er 24hr 300 mg</i>	156	VIBRAMYCIN SYP 50MG/5ML.....	301
<i>verapamil hcl cap er 24hr 360 mg</i>	157	VICTOZA INJ 18MG/3ML	87
<i>verapamil hcl tab 120 mg</i>	157	<i>vigabatrin powd pack 500 mg</i>	74
<i>verapamil hcl tab 40 mg</i>	157	<i>vigabatrin tab 500 mg</i>	74
<i>verapamil hcl tab 80 mg</i>	157	VIGAMOX DRO 0.5%.....	282
<i>verapamil hcl tab er 120 mg</i>	157	VIIBRYD KIT STARTER	78
<i>verapamil hcl tab er 180 mg</i>	157	VIIBRYD TAB 10MG.....	78
<i>verapamil hcl tab er 240 mg</i>	157	VIIBRYD TAB 20MG	78
VERASENS LIQ LEVEL 1	259	VIIBRYD TAB 40MG.....	78
VERASENS TES	205	VILACTIN AA LIQ PLUS	210
VERDESO AER 0.05%.....	190	<i>vilazodone hcl tab 10 mg</i>	78
VEREGEN OIN 15%	176	<i>vilazodone hcl tab 20 mg</i>	78
VERELAN CAP 120MG SR	157	<i>vilazodone hcl tab 40 mg</i>	78
VERELAN CAP 180MG SR	157	VIMOVO TAB 375-20MG	29
VERELAN CAP 240MG SR.....	157	VIMOVO TAB 500-20MG.....	29
VERELAN CAP 360MG SR.....	157	VIMPAT SOL 10MG/ML.....	73
VERELAN PM CAP 100MG ER	157	VIMPAT TAB 100MG.....	73
VERELAN PM CAP 200MG ER.....	157	VIMPAT TAB 150MG.....	73
VERELAN PM CAP 300MG ER.....	157	VIMPAT TAB 200MG.....	73
VERQUVO TAB 10MG.....	164	VIMPAT TAB 50MG	73
VERQUVO TAB 2.5MG	164	VINATE DHA CAP 27-1.13	274
VERQUVO TAB 5MG	164	VINATE II TAB.....	274
VERSACLOZ SUS 50MG/ML.....	137	VINATE ONE TAB.....	274
VERZENIO TAB 100MG	127	VIOKACE TAB 10440	211
VERZENIO TAB 150MG	127	VIOKACE TAB 20880.....	211
VERZENIO TAB 200MG	127	VIRACEPT TAB 250MG.....	147
VERZENIO TAB 50MG.....	127	VIRACEPT TAB 625MG.....	147
VESICARE LS SUS 5MG/5ML	310	VIRAMUNE SUS 50MG/5ML.....	147
VESICARE TAB 10MG.....	310	VIRAMUNE XR TAB 400MG.....	147
VESICARE TAB 5MG	310	VIREAD POW 40MG/GM.....	147
VFEND SUS 40MG/ML.....	95	VIREAD TAB 150MG	147
VFEND TAB 200MG.....	95	VIREAD TAB 200MG	147
VFEND TAB 50MG	95	VIREAD TAB 250MG	147
V-GO 20 KIT.....	259	VIREAD TAB 300MG	147
V-GO 30 KIT.....	259	VIRT-C DHA CAP	274
V-GO 40 KIT	259	VIRT-NATE CAP DHA.....	274
VIAGRA TAB 100MG	161	VIRT-PN DHA CAP.....	274
VIAGRA TAB 25MG.....	161	VIRT-PN PLUS CAP	274

VISIONBLUE INJ 0.06%.....	284	VOSEVI TAB	149
VISTARIL CAP 25MG	52	VOTRIENT TAB 200MG	127
VISTARIL CAP 50MG.....	52	VOWST CAP	227
VISTOGARD PAK 10GM	92	VOXZOGO INJ 0.4MG.....	219
VITAFOL CAP ULTRA	274	VOXZOGO INJ 0.56MG	219
VITAFOL CHW GUMMIES.....	274	VOXZOGO INJ 1.2MG.....	219
VITAFOL FE+ CAP.....	275	VP-PNV-DHA CAP	275
VITAFOL-NANO TAB.....	275	VRAYLAR CAP 1.5-3MG.....	133
VITAFOL-OB PAK +DHA	275	VRAYLAR CAP 1.5MG	133
VITAFOL-OB TAB 65-1MG.....	275	VRAYLAR CAP 3MG.....	134
VITAFOL-ONE CAP.....	275	VRAYLAR CAP 4.5MG	134
VITAFOL STRP MIS 1MG	275	VRAYLAR CAP 6MG.....	134
VITAL HN POW	210	VTAMA CRE 1%	184
VITAMEDMD CAP ONE RX.....	275	VUMERITY CAP 231MG.....	294
VITAPEARL CAP.....	275	VUSION OIN	178
VITATHELY TAB.....	275	VYLEESI INJ 1.75/0.3	291
VITATRUE MIS.....	275	VYNDAMAX CAP 61MG.....	164
VITRAKVI CAP 100MG	127	VYTORIN TAB 10-10MG	96
VITRAKVI CAP 25MG	127	VYTORIN TAB 10-20MG.....	96
VITRAKVI SOL 20MG/ML.....	127	VYTORIN TAB 10-40MG	96
VIVA DHA CAP	275	VYTORIN TAB 10-80MG	96
VIVAGUARD LIQ CONTROL	259	VYVANSE CAP 10MG.....	4
VIVAGUARD MIS 28G.....	259	VYVANSE CAP 20MG.....	4
VIVAGUARD MIS 30G	259	VYVANSE CAP 30MG.....	5
VIVAGUARD MIS LANCING.....	259	VYVANSE CAP 40MG.....	5
VIVAGUARD TES INO.....	205	VYVANSE CAP 50MG.....	5
VIVELLE-DOT DIS 0.025MG.....	223	VYVANSE CAP 60MG.....	5
VIVELLE-DOT DIS 0.0375MG.....	223	VYVANSE CAP 70MG	5
VIVELLE-DOT DIS 0.05MG	223	VYVANSE CHW 10MG	5
VIVELLE-DOT DIS 0.075MG.....	223	VYVANSE CHW 20MG	5
VIVELLE-DOT DIS 0.1MG	223	VYVANSE CHW 30MG	5
VIVJOA CAP 150MG	95	VYVANSE CHW 40MG	5
VIVLODEX CAP 10MG	29	VYVANSE CHW 50MG	5
VIVLODEX CAP 5MG	29	VYVANSE CHW 60MG	5
VIVONEX RTF LIQ.....	210	VYZULTA SOL 0.024%.....	285
VOGELXO GEL 1%(50MG)	47	W	
VOGELXO GEL PUMP 1%.....	47	WAKIX TAB 17.8MG	8
VONJO CAP 100MG.....	127	WAKIX TAB 4.45MG	8
VOQUEZNA PAK DUAL PAK	309	<i>warfarin sodium tab 10 mg</i>	63
VOQUEZNA PAK TRIP PK.....	309	<i>warfarin sodium tab 1 mg</i>	63
<i>voriconazole for susp 40 mg/ml</i>	95	<i>warfarin sodium tab 2.5 mg</i>	63
<i>voriconazole tab 200 mg</i>	95	<i>warfarin sodium tab 2 mg</i>	63
<i>voriconazole tab 50 mg</i>	95	<i>warfarin sodium tab 3 mg</i>	63

<i>warfarin sodium tab 4 mg</i>	63	X	
<i>warfarin sodium tab 5 mg</i>	63	XACIATO GEL 2%.....	311
<i>warfarin sodium tab 6 mg</i>	63	XADAGO TAB 100MG	132
<i>warfarin sodium tab 7.5 mg</i>	63	XADAGO TAB 50MG	132
WEBCOL PREP PAD LARGE	260	XALATAN SOL 0.005%.....	285
WEBCOL PREP PAD MEDIUM	260	XALKORI CAP 200MG	127
WEGOVY INJ 0.25MG	5	XALKORI CAP 250MG	127
WEGOVY INJ 0.5MG.....	5	XANAX TAB 0.25MG	54
WEGOVY INJ 1.7MG.....	5	XANAX TAB 0.5MG.....	53
WEGOVY INJ 1MG.....	5	XANAX TAB 1MG.....	54
WEGOVY INJ 2.4MG.....	5	XANAX TAB 2MG	54
WELCHOL PAK 3.75GM.....	97	XANAX XR TAB 0.5MG	54
WELCHOL TAB 625MG.....	97	XANAX XR TAB 1MG.....	54
WELLBUTRIN TAB 100MG SR.....	76	XANAX XR TAB 2MG	54
WELLBUTRIN TAB 150MG SR	76	XANAX XR TAB 3MG	54
WELLBUTRIN TAB 200MG SR	76	XARELTO STAR TAB 15/20MG	63
WELLBUTRIN TAB XL 150MG	76	XARELTO TAB 10MG	63
WELLBUTRIN TAB XL 300MG	76	XARELTO TAB 15MG	63
WESTAB PLUS TAB 27-1MG.....	275	XARELTO TAB 2.5MG.....	63
WESTGEL DHA CAP	275	XARELTO TAB 20MG	63
WESTHROID TAB 130MG	304	XATMEP SOL 2.5MG/ML	115
WESTHROID TAB 195MG	304	XCOPRI PAK 100-150	73
WESTHROID TAB 32.5MG	304	XCOPRI PAK 12.5-25	73
WESTHROID TAB 65MG.....	304	XCOPRI PAK 150-200.....	73
WESTHROID TAB 97.5MG	304	XCOPRI PAK 50-100MG	73
WIDE-SEAL DPR KIT 60.....	240	XCOPRI PAK 50-200MG.....	73
WIDE-SEAL DPR KIT 65.....	240	XCOPRI TAB 100MG.....	73
WIDE-SEAL DPR KIT 70.....	240	XCOPRI TAB 150MG	73
WIDE-SEAL DPR KIT 75.....	240	XCOPRI TAB 200MG	73
WIDE-SEAL DPR KIT 80.....	240	XCOPRI TAB 50MG.....	73
WIDE-SEAL DPR KIT 85.....	240	XELJANZ SOL 1MG/ML	22
WIDE-SEAL DPR KIT 90.....	240	XELJANZ TAB 10MG.....	23
WIDE-SEAL DPR KIT 95.....	240	XELJANZ TAB 5MG.....	22
WINLEVI CRE 1%	176	XELJANZ XR TAB 11MG	23
WP THYROID TAB 113.75MG	304	XELJANZ XR TAB 22MG	23
WP THYROID TAB 130MG.....	304	XELODA TAB 150MG	115
WP THYROID TAB 16.25MG.....	304	XELODA TAB 500MG	115
WP THYROID TAB 32.5MG	304	XELPROS EMU 0.005%	285
WP THYROID TAB 48.75MG.....	304	XENICAL CAP 120MG	7
WP THYROID TAB 65MG	304	XENLETA TAB 600MG	50
WP THYROID TAB 81.25MG.....	304	XEPI CRE 1%.....	176
WP THYROID TAB 97.5MG	304	XERAC-AC SOL 6.25%	193
WYNZORA CRE	190	XERESE CRE 5-1%.....	184

XERMELO TAB 250MG	229
XHANCE MIS 93MCG	278
XIFAXAN TAB 200MG	49
XIFAXAN TAB 550MG	49
XIGDUO XR TAB 10-1000	84
XIGDUO XR TAB 10-500MG	84
XIGDUO XR TAB 2.5-1000	84
XIGDUO XR TAB 5-1000MG	84
XIGDUO XR TAB 5-500MG	84
XIIDRA DRO 5%	282
XIMINO CAP 135MG ER	301
XIMINO CAP 45MG ER	301
XIMINO CAP 90MG ER	301
XOFLUZA TAB 20MG	150
XOFLUZA TAB 40MG	150
XOLEGEL GEL 2%	178
XOPENEX CONC NEB 1.25/0.5	62
XOPENEX HFA AER	62
XOPENEX NEB 0.31MG	62
XOPENEX NEB 0.63MG	62
XOPENEX NEB 1.25/3ML	63
XOSPATA TAB 40MG	127
XPOVIO PAK 100MG	119
XPOVIO PAK 40MG	119
XPOVIO PAK 50MG	119
XPOVIO PAK 60MG	119
XPOVIO PAK 80MG	119
XTAMPZA ER CAP 13.5MG	41
XTAMPZA ER CAP 18MG	41
XTAMPZA ER CAP 27MG	41
XTAMPZA ER CAP 36MG	41
XTAMPZA ER CAP 9MG	41
XTANDI CAP 40MG	118
XTANDI TAB 40MG	118
XTANDI TAB 80MG	118
XULTOPHY INJ 100/3.6	84
XURIDEN POW 2GM	219
XYOSTED INJ 100/0.5	47
XYOSTED INJ 50/0.5	47
XYOSTED INJ 75/0.5	47
XYREM SOL 500MG/ML	289
XYWAV SOL 0.5GM/ML	289

Y

YASMIN 28 TAB 3-0.03MG	168
YAZ TAB 3-0.02MG	168
YONSA TAB 125MG	118
YOSPRALA TAB 325-40MG	232
YOSPRALA TAB 81-40MG	232
YUPELRI SOL	56

Z

ZACLIR LOT 8%	176
<i>zafirlukast tab 10 mg</i>	56
<i>zafirlukast tab 20 mg</i>	57
<i>zaleplon cap 10 mg</i>	237
<i>zaleplon cap 5 mg</i>	237
ZALVIT TAB 13-1MG	275
ZANAFLEX CAP 2MG	276
ZANAFLEX CAP 4MG	276
ZANAFLEX CAP 6MG	276
ZANAFLEX TAB 4MG	276
ZARONTIN CAP 250MG	74
ZARONTIN SOL 250/5ML	74
ZAVESCA CAP 100MG	233
ZCORT 7-DAY TAB 1.5MG	171
ZEGALOGUE INJ 0.6/0.6	85
ZEGERID CAP 20-1100	309
ZEGERID CAP 40-1100	309
ZEGERID POW 20-1680	309
ZEGERID POW 40-1680	309
ZEJULA CAP 100MG	127
ZEJULA TAB 100MG	127
ZEJULA TAB 200MG	127
ZEJULA TAB 300MG	128
ZELAPAR TAB 1.25MG	132
ZELBORAF TAB 240MG	128
ZELNORM TAB 6MG	227
ZEMBRACE SYM INJ 3/0.5ML	265
ZEMPLAR CAP 1MCG	219
ZEMPLAR CAP 2MCG	219
ZENPEP CAP 10000UNT	211
ZENPEP CAP 15000UNT	211
ZENPEP CAP 20000UNT	211
ZENPEP CAP 25000UNT	211
ZENPEP CAP 3000UNIT	211
ZENPEP CAP 40000UNT	211

ZENPEP CAP 5000UNIT.....	211	ZITHROMAX TAB Z-PAK.....	239
ZEPOSIA 7DAY CAP STR PACK.....	294	ZOCOR TAB 10MG	100
ZEPOSIA CAP .92MG	294	ZOCOR TAB 20MG.....	100
ZEPOSIA CAP STR KIT	295	ZOCOR TAB 40MG	100
ZERVIA TE DRO 0.24%	285	ZOCOR TAB 80MG.....	100
ZESTORETIC TAB 10-12.5	111	ZOFRAN TAB 4MG.....	92
ZESTORETIC TAB 20-12.5.....	111	ZOHYDRO ER CAP 10MG	41
ZESTORETIC TAB 20-25MG.....	111	ZOHYDRO ER CAP 15MG.....	41
ZESTRIL TAB 10MG.....	103	ZOHYDRO ER CAP 20MG	42
ZESTRIL TAB 2.5MG	103	ZOHYDRO ER CAP 30MG	42
ZESTRIL TAB 20MG	103	ZOHYDRO ER CAP 40MG	42
ZESTRIL TAB 30MG	103	ZOHYDRO ER CAP 50MG	42
ZESTRIL TAB 40MG	103	ZOKINVY CAP 50MG	270
ZESTRIL TAB 5MG.....	103	ZOKINVY CAP 75MG.....	270
ZETIA TAB 10MG	100	ZOLINZA CAP 100MG	128
ZETONNA AER 37MCG	278	<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	
ZIAC TAB 10/6.25.....	111	.....	265
ZIAC TAB 2.5/6.25	111	<i>zolmitriptan nasal spray 5 mg/spray unit</i>	
ZIAC TAB 5-6.25MG	111	.....	265
ZIAGEN SOL 20MG/ML	147	<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	
ZIAGEN TAB 300MG	147	.....	265
ZIANA GEL	176	<i>zolmitriptan orally disintegrating tab 5 mg</i>	
<i>zidovudine cap 100 mg</i>	147	.....	265
<i>zidovudine syrup 10 mg/ml</i>	147	<i>zolmitriptan tab 2.5 mg</i>	265
<i>zidovudine tab 300 mg</i>	147	<i>zolmitriptan tab 5 mg</i>	265
ZIEXTENZO INJ 6/0.6ML.....	235	ZOLOFT CON 20MG/ML.....	78
<i>zileuton tab er 12hr 600 mg</i>	57	ZOLOFT TAB 100MG	78
ZILXI AER 1.5%.....	194	ZOLOFT TAB 25MG	78
ZIOPTAN DRO 0.0015%	286	ZOLOFT TAB 50MG	78
<i>ziprasidone hcl cap 20 mg</i>	134	<i>zolpidem tartrate sl tab 1.75 mg</i>	237
<i>ziprasidone hcl cap 40 mg</i>	134	<i>zolpidem tartrate sl tab 3.5 mg</i>	237
<i>ziprasidone hcl cap 60 mg</i>	134	<i>zolpidem tartrate tab 10 mg</i>	237
<i>ziprasidone hcl cap 80 mg</i>	134	<i>zolpidem tartrate tab 5 mg</i>	237
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	134	<i>zolpidem tartrate tab er 12.5 mg</i>	237
ZIPSOR CAP 25MG	29	<i>zolpidem tartrate tab er 6.25 mg</i>	237
ZIRGAN GEL 0.15%.....	282	ZOLPIMIST SPR 5MG	237
ZITHROMAX POW 1GM PAK.....	239	ZOMIG SPR 2.5MG	265
ZITHROMAX SUS 100/5ML	239	ZOMIG SPR 5MG.....	265
ZITHROMAX SUS 200/5ML	239	ZOMIG TAB 2.5MG	265
ZITHROMAX TAB 250MG.....	239	ZOMIG TAB 5MG	265
ZITHROMAX TAB 500MG.....	239	ZOMIG ZMT TAB 2.5 MG	265
ZITHROMAX TAB TRI-PAK.....	239	ZOMIG ZMT TAB 5MG ODT.....	265
		ZONALON CRE 5%.....	179

ZONEGRAN CAP 100MG.....	73	ZYCLARA PUMP CRE 3.75%	191
ZONEGRAN CAP 25MG.....	73	ZYDELIG TAB 100MG	128
<i>zonisamide cap 100 mg</i>	73	ZYDELIG TAB 150MG	128
<i>zonisamide cap 25 mg</i>	73	ZYFLO TAB 600MG	57
<i>zonisamide cap 50 mg</i>	73	ZYKADIA TAB 150MG	128
ZONTIVITY TAB 2.08MG.....	232	ZYLET SUS 0.5-0.3%.....	284
ZORBTIVE INJ 8.8MG	216	ZYLOPRIM TAB 100MG	231
ZORTRESS TAB 0.25MG.....	269	ZYLOPRIM TAB 300MG.....	231
ZORTRESS TAB 0.5MG	269	ZYMAXID SOL 0.5%	282
ZORTRESS TAB 0.75MG.....	269	ZYPITAMAG TAB 2MG	100
ZORTRESS TAB 1MG	269	ZYPITAMAG TAB 4MG	100
ZORVOLEX CAP 18MG	29	ZYPREXA INJ 10MG	137
ZORVOLEX CAP 35MG.....	29	ZYPREXA RELP INJ 210MG.....	137
ZORYVE CRE 0.3%.....	184	ZYPREXA RELP INJ 300MG.....	137
ZOVIRAX CRE 5%.....	184	ZYPREXA RELP INJ 405MG.....	137
ZOVIRAX OIN 5%	184	ZYPREXA TAB 10MG	138
ZOVIRAX SUS 200/5ML	149	ZYPREXA TAB 15MG	138
ZTLIDO PAD 1.8%	193	ZYPREXA TAB 2.5MG.....	137
ZUBSOLV SUB 0.7-0.18.....	46	ZYPREXA TAB 20MG	138
ZUBSOLV SUB 1.4-0.36	46	ZYPREXA TAB 5MG.....	137
ZUBSOLV SUB 11.4-2.9	46	ZYPREXA TAB 7.5MG	138
ZUBSOLV SUB 2.9-0.71	46	ZYPREXA ZYDI TAB 10MG.....	138
ZUBSOLV SUB 5.7-1.4	46	ZYPREXA ZYDI TAB 15MG.....	138
ZUBSOLV SUB 8.6-2.1	46	ZYPREXA ZYDI TAB 20MG.....	138
ZUPLENZ MIS 4MG.....	92	ZYPREXA ZYDI TAB 5MG	138
ZUPLENZ MIS 8MG.....	92	ZYVOX SUS 100MG/5M.....	50
ZYCLARA CRE 3.75%	191	ZYVOX TAB 600MG	50
ZYCLARA PUMP CRE 2.5%	191		

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **[carefirst.com/rx](https://www.carefirst.com/rx)**.



10455 Mill Run Circle
Owings Mills, MD 21117

[carefirst.com/rx](https://www.carefirst.com/rx)

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.

SUM5471-1S (12/23)—For Fully-Insured Plans Only

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

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

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address P.O. Box 8894
 Baltimore, Maryland 21224

Email Address civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820

Fax Number 410-505-2011

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

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

Foreign Language Assistance

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

አማርኛ (Amharic) ማሳሰቢያ:- ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀን-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። 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 adójú tòfò rẹ. Ó le ní àwọn déètì pátó o sì le ní láti gbé ìgbésé ní àwọn ojú gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèfè. Àwọn omọ-egbé gbòdò pe nóm̄bà fòdùn tò wà lẹyìn káàdì idánimò wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tí títí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì sọ ọ pò mọ̀ 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 Cáó! Bǎ nìà kè bá nyo bǎ kè m̄ gbo kpá bó nì fùà-fúá-tiîn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bǎ bǎ m̄ kè dε wa m̄ kè nyuεε nyu hwè bǎ wé bǎa kè zi. ɔ mò nì kpé bǎ m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ m̄ dyé dε nì bídí-wùdù mú bǎ m̄ kè se wídí dò péè. Kpooò nyo bǎ m̄ dá fúùn-nòbà nìà dε waa I.D. káàò dεín nyε. Nyo tòò séín m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ fò tee bǎ wa kèε m̄ gbo cǎ bǎ m̄ kè nòbà m̄à 0 kèε dyi pàdàn hwè. ɔ jǔ kè nyo dò dyi m̄ gǎ jùîn, po wuqu m̄ m̄ poε dyie, kè nyo dò mu bó nìin bǎ ɔ kè nì wuquò mú zà.

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

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

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

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

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

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozu niile nwere ike ikpo 855-258-6518 wee chere ububu ahuru roo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

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

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

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

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náána'á' éi kójj' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį áádóo éi bikéé'dóo naasbaas bił adidiilchil. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowól.