



Effective Date 7/1/2024

Pharmacy Comprehensive Drug List Change Notice Posted 06/01/2024

We want to tell you about some upcoming changes to the Comprehensive Drug List. The Comprehensive Drug List is a list of drugs covered by Healthy Blue. Please see the table below:

EFFECTIVE FOR ALL MEMBERS ON 7/1/2024			
Therapeutic class	Drug	Revised status	Potential alternatives
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL CAP 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL TAB 1GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR ER TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFPODOXIME TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFPODOXIME TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CLARITHROMYCIN	CLARITHROMYC TAB 500MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO CAP 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 50MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 200MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	LEVOFLOXACIN SOL 25MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMINOGLYCOSIDES	NEOMYCIN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

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AMINOGLYCOSIDES	TOBRAMYCIN NEB 300/4ML	Non-Covered/PA	Refer to Comprehensive
	•	Required	Drug List **
ANTIFUNGALS	NYSTATIN TAB 500000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED	VORICONAZOLE TAB 50MG	Non-Covered/PA	Refer to Comprehensive
ANTIFUNGALS	VOINCONAZOLL TAB 30MG	Required	Drug List **
IMIDAZOLE-RELATED	VORICONAZOLE TAB 200MG	Non-Covered/PA	Refer to Comprehensive
ANTIFUNGALS	VOINCONAZOLL TAB 2001VIG	Required	Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 125MG	Non-Covered/PA	Refer to Comprehensive
TIENT ES AGENTS	TAMERICOVIII TAB 1251010	Required	Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 250MG	Non-Covered/PA	Refer to Comprehensive
TIERFES AGENTS	TAIVICICEOVIK TAB 250IVIG	Required	Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 500MG	Non-Covered/PA	Refer to Comprehensive
HERFES AGENTS	PAIVICICLOVIK TAB 3001VIG	Required	Drug List **
CLUCOCOPTICOSTEROIDS	DEVANAETHASON CON 1NAC /NAI	Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	DEXAMETHASON CON 1MG/ML	Required	Drug List **
CLUCOCOPTICOSTEROIDS	DDEDNICONE CON ENAC /NAI	Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	PREDNISONE CON 5MG/ML	Required	Drug List **
ANDROCENC	TECTOCTERONE CEL 40//25N4C)	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	TESTOSTERONE GEL 1%(25MG)	Required	Drug List **
ANDROGENS	TECTOCTED ONE OF 10//50140)	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	TESTOSTERONE GEL 1%(50MG)	Required	Drug List **
ANDROCENIC	TECTOCTEDONE CEL DUNAD 40/	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	TESTOSTERONE GEL PUMP 1%	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	ADMELOG INJ 100U/ML	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	NOVOLIN R INJ RELION	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	NOVOLIN R INJ U-100	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	NOVOLIN R INJ 100 UNIT	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	HUMULIN N INJ U-100	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	NOVOLIN N INJ RELION	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
INSULIN	NOVOLIN N INJ U-100	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
BIGUANIDES	METFORMIN TAB 500MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 0.5MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 1MG	Required	Drug List **
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MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 2MG	Non-Covered/PA	Refer to Comprehensive
WILGETTINIDE ANALOGOES	NEFAGEINIDE TAB ZIVIO	Required	Drug List **
ANTIDIABETIC	JANUMET XR TAB 50-500MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	37 (VOIVE) 7(C 17) 20 300 (VI	Required	Drug List **
ANTIDIABETIC	JANUMET XR TAB 50-1000	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	3,11011121 7.11 17.12 20 2000	Required	Drug List **
ANTIDIABETIC	JANUMET XR TAB 100-1000	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	37.11.01.12.17.11.17.12.13.0 1000	Required	Drug List **
ANTIDIABETIC	SYNJARDY TAB 5-500MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY TAB 5-1000MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY TAB 12.5-500	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY TAB	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY XR TAB 5-1000MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY XR TAB 10-1000	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY XR TAB	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	SYNJARDY XR TAB 25-1000	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC	GLIP/METFORM TAB 2.5-250M	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	- ,	Required	Drug List **
ANTIDIABETIC	GLIP/METFORM TAB 2.5-500M	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	,	Required	Drug List **
ANTIDIABETIC	GLIP/METFORM TAB 5-500MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	,	Required	Drug List **
BONE DENSITY	ALENDRONATE SOL 70/75ML	Non-Covered/PA	Refer to Comprehensive
REGULATORS	,	Required	Drug List **
HORMONE RECEPTOR	RALOXIFENE TAB 60MG	Non-Covered/PA	Refer to Comprehensive
MODULATORS		Required	Drug List **
BETA BLOCKERS NON-	PINDOLOL TAB 5MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **
BETA BLOCKERS NON-	PINDOLOL TAB 10MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **
BETA BLOCKERS NON-	TIMOLOL MAL TAB 5MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **
BETA BLOCKERS NON-	TIMOLOL MAL TAB 10MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **
BETA BLOCKERS NON-	TIMOLOL MAL TAB 20MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **

NIFEDIPINE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NIFEDIPINE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MOEXIPRIL TAB 7.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MOEXIPRIL TAB 15MG	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESARTAN TAB 4MG	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESARTAN TAB 8MG	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESARTAN TAB 16MG	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESARTAN TAB 32MG	Non-Covered/PA	Refer to Comprehensive Drug List **
VALSARTAN TAB 40MG	Non-Covered/PA	Refer to Comprehensive Drug List **
VALSARTAN TAB 80MG	Non-Covered/PA	Refer to Comprehensive Drug List **
VALSARTAN TAB 160MG	Non-Covered/PA	Refer to Comprehensive Drug List **
VALSARTAN TAB 320MG	Non-Covered/PA	Refer to Comprehensive Drug List **
METOPRL/HCTZ TAB 50-25MG	Non-Covered/PA	Refer to Comprehensive Drug List **
METOPRL/HCTZ TAB 100-25MG	Non-Covered/PA	Refer to Comprehensive Drug List **
METOPRL/HCTZ TAB 100-50MG	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESA/HCTZ TAB 16-12.5	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESA/HCTZ TAB 32-12.5	Non-Covered/PA	Refer to Comprehensive Drug List **
CANDESA/HCTZ TAB 32-25MG	Non-Covered/PA	Refer to Comprehensive Drug List **
PREVALITE POW 4GM PK	Non-Covered/PA	Refer to Comprehensive Drug List **
FENOFIBRIC CAP 45MG DR	Non-Covered/PA	Refer to Comprehensive Drug List **
FENOFIBRATE TAB 54MG	Non-Covered/PA	Refer to Comprehensive Drug List **
FENOFIBRATE TAB 160MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
	NIFEDIPINE CAP 20MG MOEXIPRIL TAB 7.5MG MOEXIPRIL TAB 15MG CANDESARTAN TAB 4MG CANDESARTAN TAB 8MG CANDESARTAN TAB 16MG CANDESARTAN TAB 32MG VALSARTAN TAB 40MG VALSARTAN TAB 80MG VALSARTAN TAB 160MG VALSARTAN TAB 320MG METOPRL/HCTZ TAB 50-25MG METOPRL/HCTZ TAB 100-25MG METOPRL/HCTZ TAB 100-50MG CANDESA/HCTZ TAB 16-12.5 CANDESA/HCTZ TAB 32-12.5 CANDESA/HCTZ TAB 32-25MG PREVALITE POW 4GM PK FENOFIBRIC CAP 45MG DR	NIFEDIPINE CAP 20MG Non-Covered/PA Required CANDESARTAN TAB 4MG CANDESARTAN TAB 16MG CANDESARTAN TAB 16MG CANDESARTAN TAB 32MG VALSARTAN TAB 40MG VALSARTAN TAB 40MG VALSARTAN TAB 80MG VALSARTAN TAB 160MG VALSARTAN TAB 160MG VALSARTAN TAB 320MG Non-Covered/PA Required Non-Covered/PA Required

PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS	ALYQ TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	IPRATROPIUM SOL 0.02%INH	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	SPIRIVA AER 1.25MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	SPIRIVA SPR 2.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	ALBUTEROL AER HFA	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	TERBUTALINE TAB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	TERBUTALINE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	IPRATROPIUM/ SOL ALBUTER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BUDES/FORMOT AER 80-4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BREYNA AER 80/4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BUDES/FORMOT AER 160-4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BREYNA AER 160/4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 55/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 113/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 100/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 100/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 232/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 250/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 250/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 500/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 500/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLOVENT DISK AER 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROID INHALANTS	FLOVENT DISK AER 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLOVENT DISK AER 250MCG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
H-2 ANTAGONISTS	NIZATIDINE CAP 150MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
H-2 ANTAGONISTS	NIZATIDINE CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIEMETICS -		Non-Covered/PA	Refer to Comprehensive
ANTICHOLINERGIC	MECLIZINE TAB 12.5MG	Required	Drug List **
INICLILINI		Non-Covered/PA	Refer to Comprehensive
INSULIN	HUMULIN N INJ U-100KWP	Required	Drug List **
INSULIN	NOVOLIN N INJ 100 UNIT	Non-Covered/PA	Refer to Comprehensive
IINSULIIN	NOVOLIN N INJ 100 ONII	Required	Drug List **
INSULIN	NOVOLIN INJ 70/30	Non-Covered/PA	Refer to Comprehensive
IINSOLIIN	NOVOLIN INJ 70/30	Required	Drug List **
INSULIN	NOVOLIN70/30 INJ RELION	Non-Covered/PA	Refer to Comprehensive
INSOLIN	NOVOLIN70/30 INJ KLLION	Required	Drug List **
INSULIN	NOVOLIN INJ 70/30 FP	Non-Covered/PA	Refer to Comprehensive
INSOLIN	100 VOLIN 1103 70/30 11	Required	Drug List **
ANTIEMETICS -	MECLIZINE TAB 25MG	Non-Covered/PA	Refer to Comprehensive
ANTICHOLINERGIC	WECEIZINE TAD 25WG	Required	Drug List **
ANTIHISTAMINES - NON-	ALL DAY ALLG CAP 10MG	Non-Covered/PA	Refer to Comprehensive
SEDATING	ALL BATTALLES GAT TOTALS	Required	Drug List **
ANTIHISTAMINES - NON-	ALLERGY REL CAP 10MG	Non-Covered/PA	Refer to Comprehensive
SEDATING		Required	Drug List **
GASTROINTESTINAL		Non-Covered/PA	Refer to Comprehensive
CHLORIDE CHANNEL	LUBIPROSTONE CAP 8MCG	Required	Drug List **
ACTIVATORS		•	
GASTROINTESTINAL	LUDIDDOCTONE CAD 24N4CC	Non-Covered/PA	Refer to Comprehensive
CHLORIDE CHANNEL	LUBIPROSTONE CAP 24MCG	Required	Drug List **
ACTIVATORS		Non Covered /DA	Defer to Comprehensive
INFLAMMATORY BOWEL AGENTS	MESALAMINE CAP 0.375GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER		Non-Covered/PA	Refer to Comprehensive
AGENTS	LANTHANUM CHW 500MG	Required	Drug List **
PHOSPHATE BINDER		Non-Covered/PA	Refer to Comprehensive
AGENTS	LANTHANUM CHW 750MG	Required	Drug List **
PHOSPHATE BINDER		Non-Covered/PA	Refer to Comprehensive
AGENTS	LANTHANUM CHW 1000MG	Required	Drug List **
PHOSPHATE BINDER		Non-Covered/PA	Refer to Comprehensive
AGENTS	SEVELAMER TAB 800MG	Required	Drug List **
PHOSPHATE BINDER		Non-Covered/PA	Refer to Comprehensive
AGENTS	SEVELAMER POW 0.8GM	Required	Drug List **
PHOSPHATE BINDER	CEVELANCE CONTRACTOR	Non-Covered/PA	Refer to Comprehensive
AGENTS	SEVELAMER POW 2.4GM	Required	Drug List **
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URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE CAP 2MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE CAP 4MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TROSPIUM CL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TROSPIUM CHL CAP 60MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS	FLAVOXATE TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MONOAMINE OXIDASE INHIBITORS (MAOIS)	TRANYLCYPROM TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUVOXAMINE CAP 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUVOXAMINE CAP 150MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 1.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 9MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 210MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 405MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHENOTHIAZINES	COMPRO SUP 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NON-BARBITURATE	ESTAZOLAM TAB 1MG	Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	ESTAZOLANI TAB ING	Required	Drug List **
NON-BARBITURATE HYPNOTICS	ESTAZOLAM TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	TRIAZOLAM TAB 0.125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE		Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	TRIAZOLAM TAB 0.25MG	Required	Drug List **
NON-BARBITURATE		Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	ZALEPLON CAP 5MG	Required	Drug List **
NON-BARBITURATE		Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	ZALEPLON CAP 10MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 5MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 10MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 15MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 20MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 25MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
AMPHETAMINES	AMPHET/DEXTR CAP 30MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID CAP 40MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID TAB 27MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID TAB 36MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID TAB 54MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID CAP 10MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID CAP 20MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHYLPHENID CAP 30MG ER	Required	Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
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ANTIDEMENTIA AGENTS	GALANTAMINE SOL 4MG/ML	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ANTIDEMENTIA AGENTS	MEMANT TITRA PAK 5-10MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **

		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	VARENICLINE TAB 0.5MG	Required	Drug List **
SMOKING DETERRENTS	VARENICLINE TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	EXTAVIA INJ 0.3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	TERIFLUNOMID TAB 7MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	TERIFLUNOMID TAB 14MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SALICYLATES	DIFLUNISAL TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 400MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 600MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 800MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 1200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 1600MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 2-0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 4-1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 8-2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 12-3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUTORPHANOL SOL 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	PENTAZ/NALOX TAB 50-0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID COMBINATIONS	APAP/CODEINE SOL 120-12/5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	DICLOFEN POT TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

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FLURBIPROFEN TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
KETOPROFEN CAP 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MECLOFEN SOD CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MECLOFEN SOD CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OXAPROZIN TAB 600MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NARATRIPTAN TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NARATRIPTAN TAB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SUMATRIPTAN SPR 5MG/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SUMATRIPTAN SPR 20MG/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COLCHICINE CAP 0.6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TIAGABINE TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TIAGABINE TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TIAGABINE TAB 12MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TIAGABINE TAB 16MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHENYTEK CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHENYTEK CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CARBAMAZEPIN SUS 100/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CARBAMAZEPIN CAP 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CARBAMAZEPIN TAB 100MGER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CARBAMAZEPIN TAB 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
	KETOPROFEN CAP 200MG ER MECLOFEN SOD CAP 50MG MECLOFEN SOD CAP 100MG OXAPROZIN TAB 600MG NARATRIPTAN TAB 1MG NARATRIPTAN TAB 2.5MG SUMATRIPTAN SPR 5MG/ACT SUMATRIPTAN SPR 20MG/ACT COLCHICINE CAP 0.6MG TIAGABINE TAB 2MG TIAGABINE TAB 4MG TIAGABINE TAB 12MG TIAGABINE TAB 16MG PHENYTEK CAP 200MG PHENYTEK CAP 300MG CARBAMAZEPIN SUS 100/5ML CARBAMAZEPIN CAP 200MG ER CARBAMAZEPIN TAB 100MGER	REQUIRED KETOPROFEN CAP 200MG ER MECLOFEN SOD CAP 50MG MECLOFEN SOD CAP 50MG MECLOFEN SOD CAP 100MG MECLOFEN SOD CAP 100MG Non-Covered/PA Required Non-Covered/PA

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ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 400MG ER	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ANTICONVULSANTS - MISC.	OXCARBAZEPIN SUS 300MG/5M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE	CARICORRODOL TAR 350MC	Non-Covered/PA	Refer to Comprehensive
RELAXANTS	CARISOPRODOL TAB 350MG	Required	Drug List **
PLATELET AGGREGATION	DIDVDID ANAQUE TAR SENAC	Non-Covered/PA	Refer to Comprehensive
INHIBITORS	DIPYRIDAMOLE TAB 25MG	Required	Drug List **
PLATELET AGGREGATION		Non-Covered/PA	Refer to Comprehensive
INHIBITORS	DIPYRIDAMOLE TAB 50MG	Required	Drug List **
PLATELET AGGREGATION		Non-Covered/PA	Refer to Comprehensive
INHIBITORS	DIPYRIDAMOLE TAB 75MG	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	MOXIFLOXACIN SOL HCL 0.5%	Required	Drug List **
OPHTHALMIC		Non-Covered/PA	Refer to Comprehensive
IMMUNOMODULATORS	CYCLOSPORINE EMU 0.05% OP	Required	Drug List **
IVIIVIOIVODOLATORS		Non-Covered/PA	Refer to Comprehensive
ACNE PRODUCTS	TRETINOIN CRE 0.025%	Required	Drug List **
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ACNE PRODUCTS	TRETINOIN CRE 0.05%	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ACNE PRODUCTS	TRETINOIN CRE 0.1%	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.01%	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.025%	Non-Covered/PA	Refer to Comprehensive
7 CHET HODGETS	THE THE SEE 0.02370	Required	Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.1%	Non-Covered/PA	Refer to Comprehensive
ACIVET HODGETS	TRETHVOHV GEE 0.170	Required	Drug List **
ACNE PRODUCTS	CLINDAMYCIN GEL 1%	Non-Covered/PA	Refer to Comprehensive
ACNE PRODUCTS	CLINDAWITCIN GEL 1/6	Required	Drug List **
ACNIE BRODLICTS	EDV/DENZOVI CEL 2 F0/	Non-Covered/PA	Refer to Comprehensive
ACNE PRODUCTS	ERY/BENZOYL GEL 3-5%	Required	Drug List **
DOCACEA ACENTO	METRONURAZOL CEL 40/	Non-Covered/PA	Refer to Comprehensive
ROSACEA AGENTS	METRONIDAZOL GEL 1%	Required	Drug List **
	10/0/0/0//5	Non-Covered/PA	Refer to Comprehensive
ANTIVIRALS - TOPICAL	ACYCLOVIR CRE 5%	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
ANTIVIRALS - TOPICAL	ACYCLOVIR OIN 5%	Required	Drug List **
CORTICOSTEROIDS -		Non-Covered/PA	Refer to Comprehensive
TOPICAL	BETAMETH VAL OIN 0.1%	Required	Drug List **
CORTICOSTEROIDS -		Non-Covered/PA	Refer to Comprehensive
TOPICAL	FLUOCINONIDE OIN 0.05%	Required	Drug List **
CORTICOSTEROIDS -		Non-Covered/PA	•
	FLUTICASONE CRE 0.05%	·	Refer to Comprehensive
TOPICAL		Required	Drug List **

CORTICOSTEROIDS - TOPICAL	FLUTICASONE OIN 0.005%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
KERATOLYTIC/ANTIMITOTIC	PODOFILOX SOL 0.5%	Non-Covered/PA	Refer to Comprehensive
AGENTS	1 0001120% 302 0.3%	Required	Drug List **
IMMUNOSUPPRESSIVE AGENTS - TOPICAL	PIMECROLIMUS CRE 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE		Non-Covered/PA	Refer to Comprehensive
AGENTS - TOPICAL	TACROLIMUS OIN 0.03%	Required	Drug List **
IMMUNOSUPPRESSIVE		Non-Covered/PA	Refer to Comprehensive
AGENTS - TOPICAL	TACROLIMUS OIN 0.1%	Required	Drug List **
OPIOID ANTAGONISTS	NALOXONE SPR 4MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
OPIOID ANTAGONISTS	NALOXONE HCL SPR 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
GROWTH HORMONES	HUMATROPE INJ 6MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
GROWTH HORMONES	HUMATROPE INJ 12MG	Required	Drug List **
CROWTHUNDRAGNIES	LILINAATRORE INLIGANAC	Non-Covered/PA	Refer to Comprehensive
GROWTH HORMONES	HUMATROPE INJ 24MG	Required	Drug List **
INICLILINI	ADMATI OC SOLO INLI 100LI /NAL	Non-Covered/PA	Refer to Comprehensive
INSULIN	ADMELOG SOLO INJ 100U/ML	Required	Drug List **
ANTIHISTAMINES - NON-	QC ALL DAY CAP 10MG	Non-Covered/PA	Refer to Comprehensive
SEDATING	QC ALL DAT CAT TOWIG	Required	Drug List **
ANTIHISTAMINES - NON-	WAL-ZYR CAP 10MG	Non-Covered/PA	Refer to Comprehensive
SEDATING	W/12 2111 G/11 101116	Required	Drug List **
ANTIHISTAMINES - NON-	CETIRIZINE TAB 5MG	Non-Covered/PA	Refer to Comprehensive
SEDATING		Required	Drug List **
ANAPHYLAXIS THERAPY	EPINEPHRINE INJ 0.15MG	Non-Covered/PA	Refer to Comprehensive
AGENTS		Required	Drug List **
ANAPHYLAXIS THERAPY	EPINEPHRINE INJ 0.3MG	Non-Covered/PA	Refer to Comprehensive
AGENTS		Required Non-Covered/PA	Drug List **
SMOKING DETERRENTS	VARENICLINE TAB 0.5& 1MG	Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS	CLATODA INLIZONAC/NAI	Non-Covered/PA	Refer to Comprehensive
AGENTS	GLATOPA INJ 20MG/ML	Required	Drug List **
MULTIPLE SCLEROSIS	GLATIRAMER INJ 20MG/ML	Non-Covered/PA	Refer to Comprehensive
AGENTS	GLATINAIVIER INJ ZUIVIG/IVIL	Required	Drug List **
MULTIPLE SCLEROSIS	GLATIRAMER INJ 40MG/ML	Non-Covered/PA	Refer to Comprehensive
AGENTS	GEATING WIELE THE HOLDING WIE	Required	Drug List **
MULTIPLE SCLEROSIS	GLATOPA INJ 40MG/ML	Non-Covered/PA	Refer to Comprehensive
AGENTS	222.7 13.13113/1112	Required	Drug List **
CALCITONIN GENE-	514041JTV 10014075	Non-Covered/PA	Refer to Comprehensive
RELATED PEPTIDE (CGRP)	EMGALITY INJ 100MG/ML	Required	Drug List **
RECEPTOR ANTAG			_

CEPHALOSPORINS - 3RD		Non-Covered/PA	Refer to Comprehensive
GENERATION	CEFPODO PROX SUS 100/5ML	Required	Drug List **
CEPHALOSPORINS - 3RD	CEFTRIAXONE INJ 250MG	Non-Covered/PA	Refer to Comprehensive
GENERATION	CEFTRIAXONE INJ 250IVIG	Required	Drug List **
CEPHALOSPORINS - 3RD	CEFTRIAXONE INJ 500MG	Non-Covered/PA	Refer to Comprehensive
GENERATION	CEL TRIAXONE IN SOUND	Required	Drug List **
CEPHALOSPORINS - 3RD	CEFTRIAXONE INJ 1GM	Non-Covered/PA	Refer to Comprehensive
GENERATION	CELTIMONOTAL ING TOTAL	Required	Drug List **
CEPHALOSPORINS - 3RD	CEFTRIAXONE INJ 2GM	Non-Covered/PA	Refer to Comprehensive
GENERATION		Required	Drug List **
CEPHALOSPORINS - 3RD	CEFTRIAXONE INJ 10GM	Non-Covered/PA	Refer to Comprehensive
GENERATION		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG BS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG BS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERY-TAB TAB 250MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERY-TAB TAB 333MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 333MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERY-TAB TAB 500MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROMYCIN CAP 250MG EC	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	ERYTHROM ETH TAB 400MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ERYTHROMYCINS	E.E.S. 400 TAB 400MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
TETRACYCLINES	DEMECLOCYCL TAB 150MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
TETRACYCLINES	DEMECLOCYCL TAB 300MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
TETRACYCLINES	MONDOXYNE NL CAP 100MG	Non-Covered/PA	Refer to Comprehensive Drug List **
		Required	
TETRACYCLINES	DOXYCYC MONO CAP 150MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 75MG	Non-Covered/PA	Refer to Comprehensive
İ		Required	Drug List **

TETRACYCLINES	AVIDOXY TAB 100MG	Non-Covered/PA	Refer to Comprehensive
TETTO TO LINES	AND EAST THE ESTATE	Required	Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 150MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCLINE SUS 25MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	TARGADOX TAB 50MG	Non-Covered/PA	Refer to Comprehensive
TETRACYCLINES	LYMEPAK TAB 100MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
TETRACTCLINES	LIMILFAR TAB 100MG	Required	Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 75MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 80MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 100MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 150MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXY 100 INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	OFLOXACIN TAB 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	OFLOXACIN TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS	FLUCYTOSINE CAP 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS	FLUCYTOSINE CAP 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	FLUCONAZOLE SUS 10MG/ML	Non-Covered/PA	Refer to Comprehensive
IMIDAZOLE-RELATED	FLUCONAZOLE SUS 40MG/ML	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
ANTIFUNGALS IMIDAZOLE-RELATED	ITRACONAZOLE CAP 100MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
ANTIFUNGALS IMIDAZOLE-RELATED	VORICONAZOLE SUS 40MG/ML	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
ANTIFUNGALS IMIDAZOLE-RELATED	VORICONAZOLE INJ 200MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
ANTIFUNGALS		Required Non-Covered/PA	Drug List ** Refer to Comprehensive
HEPATITIS AGENTS	ADEFOV DIPIV TAB 10MG	Required	Drug List **
HEPATITIS AGENTS	EPIVIR HBV SOL 5MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

HEPATITIS AGENTS	PEGASYS INJ 180MCG/M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	RIBAVIRIN CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	RIBAVIRIN TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	METRONIDAZOL CAP 375MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TINIDAZOLE TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TINIDAZOLE TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TRIMETHOPRIM TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	HYDROXY CAPR INJ 1.25/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	MEGESTROL AC TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	MEGESTROL AC TAB 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 0.75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 4MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 20MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 120MG/30	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 400/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 200/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

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GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 80MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 400/5ML	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 40MG	Required	Drug List **
CLUCOCONTICOCTENCING	145TUNU DD 66 UNU 425146	Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 125MG	Required	Drug List **
CLUCOCODTICOCTEDOIDS	MATTINI DD CC INII FOOMAC	Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 500MG	Required	Drug List **
CLUCOCORTICOSTEROIDS	METHYLDD SS INII 1000MC	Non-Covered/PA	Refer to Comprehensive
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 1000MG	Required	Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 40MG/ML	Non-Covered/PA	Refer to Comprehensive
GLOCOCOKTICOSTEROIDS	TRIAIVICIN ACE INJ 401VIG/IVIE	Required	Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 200/5ML	Non-Covered/PA	Refer to Comprehensive
GEOCOCONTICOSTENOIDS	TRIAINCIN ACE IN 200/ SIVIL	Required	Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 400/10ML	Non-Covered/PA	Refer to Comprehensive
GEOCOCONTICOSTENOIDS	TRIAIVICITY ACE INJ 400/ 101VIE	Required	Drug List **
GLUCOCORTICOSTEROIDS	BETA-PHOS/AC INJ 3-3MG/ML	Non-Covered/PA	Refer to Comprehensive
GLOCOCONTICOSTENOIDS	BETA-THOS/ACTIVIS 5-SIVIG/TVIE	Required	Drug List **
ANDROGENS	TESTOST CYP INJ 100MG/ML	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	TESTOST CIT THIS TOOMING/INTE	Required	Drug List **
ANDROGENS	DEPO-TESTOST INJ 100MG/ML	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	DELO TESTOST IN TOOMIG/INE	Required	Drug List **
ANDROGENS	TESTOST CYP INJ 200MG/ML	Non-Covered/PA	Refer to Comprehensive
ANDROGENS	1231031 011 110 2001010/1012	Required	Drug List **
ANDROGENS	DEPO-TESTOST INJ 200MG/ML	Non-Covered/PA	Refer to Comprehensive
, 5 5		Required	Drug List **
ANDROGENS	TESTOSTERONE INJ CYPIONAT	Non-Covered/PA	Refer to Comprehensive
7.11.2.11.0.02.11.0		Required	Drug List **
ANDROGENS	TESTOST ENAN INJ 200MG/ML	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
INSULIN	SEMGLEE SOL 100U/ML	Non-Covered/PA	Refer to Comprehensive
	·	Required	Drug List **
INSULIN	GLARGIN YFGN SOL 100U/ML	Non-Covered/PA	Refer to Comprehensive
ANTIDIARETIC	·	Required	Drug List **
ANTIDIABETIC	GLIP/METFORM TAB 2.5-250	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 2.5-500	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
ANTIDIABETIC COMBINATIONS	PIOGLIT/GLIM TAB 30-2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC		Non-Covered/PA	•
COMBINATIONS	PIOGLIT/GLIM TAB 30-4MG	•	Refer to Comprehensive Drug List **
COIVIBIINATIONS		Required	DI UB FISE

ANTIDIABETIC	PIOGLITA/MET TAB 15-500MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	110 de 117 y 111 e 117 de 117	Required	Drug List **
ANTIDIABETIC	PIOGLITA/MET TAB 15-850MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	,	Required	Drug List **
BONE DENSITY	ALENDRONATE TAB 5MG	Non-Covered/PA	Refer to Comprehensive
REGULATORS		Required	Drug List **
GROWTH HORMONES	ZOMACTON INJ 5MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
GROWTH HORMONES	ZOMACTON INJ 10MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
BETA BLOCKERS CARDIO-	BETAXOLOL TAB 10MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE		Required	Drug List **
BETA BLOCKERS CARDIO-	BETAXOLOL TAB 20MG	Non-Covered/PA	Refer to Comprehensive
SELECTIVE	DETAINGEDE TABLETA	Required	Drug List **
CALCIUM CHANNEL	VERAPAMIL CAP 100MG ER	Non-Covered/PA	Refer to Comprehensive
BLOCKERS	VERALAMIL CALIBORISER	Required	Drug List **
CALCIUM CHANNEL	VERAPAMIL CAP 200MG ER	Non-Covered/PA	Refer to Comprehensive
BLOCKERS	VENAFAIVIIE CAF 2001VIG EN	Required	Drug List **
CALCIUM CHANNEL	VERAPAMIL CAP 300MG ER	Non-Covered/PA	Refer to Comprehensive
BLOCKERS	VERAFAIVIIL CAP 300IVIG ER	Required	Drug List **
ACE INHIBITORS	FOSINOPRIL TAB 10MG	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	FOSINOPRIL TAB 10IVIG	Required	Drug List **
ACE INITIDITORS	FOCINIODDII TAD 20MC	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	FOSINOPRIL TAB 20MG	Required	Drug List **
ACE INITIDITORS	FOSINODDII TAD 40MC	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	FOSINOPRIL TAB 40MG	Required	Drug List **
ACE INITIDITORS	DEDINIDORDII TAR 2MC	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	PERINDOPRIL TAB 2MG	Required	Drug List **
ACE INITIDITORS	DEDINIDORDII TAR ANAC	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	PERINDOPRIL TAB 4MG	Required	Drug List **
4.05 1411 11517-0.56	DEDINID ORDIN TAR STAG	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	PERINDOPRIL TAB 8MG	Required	Drug List **
4.05 1411 11517-0.56	CUINARRU TAR ASSAS	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	QUINAPRIL TAB 10MG	Required	Drug List **
A CE INILUDITORS	OLUMADRU TAR COMAC	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	QUINAPRIL TAB 20MG	Required	Drug List **
A CE 11111111111111111111111111111111111	OURIADDII TAR 10110	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	QUINAPRIL TAB 40MG	Required	Drug List **
	2.1.020	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	RAMIPRIL CAP 1.25MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	RAMIPRIL CAP 2.5MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	RAMIPRIL CAP 5MG	Required	Drug List **
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ACE INHIBITORS	RAMIPRIL CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	TRANDOLAPRIL TAB 1MG	Required	Drug List **
A CE INILIIDITORO	TRANSCOLARDUL TAR 284C	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	TRANDOLAPRIL TAB 2MG	Required	Drug List **
ACE INHIBITORS	TRANDOLAPRIL TAB 4MG	Non-Covered/PA	Refer to Comprehensive
ACE INHIBITORS	TRAINDOLAPRIL TAB 4IVIG	Required	Drug List **
ANTIADRENERGIC	METHYLDOPA TAB 250MG	Non-Covered/PA	Refer to Comprehensive
ANTIHYPERTENSIVES	WILTITEDOFA TAB 230WG	Required	Drug List **
ANTIADRENERGIC	METHYLDOPA TAB 500MG	Non-Covered/PA	Refer to Comprehensive
ANTIHYPERTENSIVES	WETTTEDOTA TAD 300MG	Required	Drug List **
ANTIADRENERGIC	PRAZOSIN HCL CAP 1MG	Non-Covered/PA	Refer to Comprehensive
ANTIHYPERTENSIVES		Required	Drug List **
ANTIADRENERGIC	PRAZOSIN HCL CAP 2MG	Non-Covered/PA	Refer to Comprehensive
ANTIHYPERTENSIVES		Required	Drug List **
ANTIADRENERGIC	PRAZOSIN HCL CAP 5MG	Non-Covered/PA	Refer to Comprehensive
ANTIHYPERTENSIVES		Required	Drug List **
ANTIHYPERTENSIVE	CAPTOPR/HCTZ TAB 25-25MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	·	Required	Drug List **
ANTIHYPERTENSIVE	CAPTOPR/HCTZ TAB 50-15MG	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS		Required	Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CAPTOPR/HCTZ TAB 50-25MG	Non-Covered/PA	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE		Required Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	FOSINOP/HCTZ TAB 10/12.5	Required	Drug List **
ANTIHYPERTENSIVE		Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	FOSINOP/HCTZ TAB 20/12.5	Required	Drug List **
ANTIHYPERTENSIVE		Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	QNAPRIL/HCTZ TAB 10-12.5	Required	Drug List **
ANTIHYPERTENSIVE		Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	QNAPRIL/HCTZ TAB 20-12.5	Required	Drug List **
ANTIHYPERTENSIVE	0114 DDU /UCTT TAD 20 25140	Non-Covered/PA	Refer to Comprehensive
COMBINATIONS	QNAPRIL/HCTZ TAB 20-25MG	Required	Drug List **
FIRRIC ACID DEDIVATIVES	FENIOSIDDATE CAD 42N4C	Non-Covered/PA	Refer to Comprehensive
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 43MG	Required	Drug List **
FIBRIC ACID DERIVATIVES	EENIOEIRRATE CAR 67MC	Non-Covered/PA	Refer to Comprehensive
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 67MG	Required	Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 134MG	Non-Covered/PA	Refer to Comprehensive
LIDING ACID DEMINATIVES	LEMOTIDIATE CAL 134MA	Required	Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 200MG	Non-Covered/PA	Refer to Comprehensive
	TENOTION TE CAI ZOOMIO	Required	Drug List **
PULMONARY			
HYPERTENSION -	TADALAFIL TAB 20MG	Non-Covered/PA	Refer to Comprehensive
PHOSPHODIESTERASE		Required	Drug List **
INHIBITORS			

ANTIHISTAMINES -	PROMETHAZINE SYP 6.25/5ML	Non-Covered/PA	Refer to Comprehensive
PHENOTHIAZINES		Required	Drug List **
ANTIHISTAMINES - NON- SEDATING	ALL DAY ALLG TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY 24HR TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-	ALLERGY REL TAB 10MG	Non-Covered/PA	Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-	ALLERGY RELI TAB 10MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-		Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-	ALLERGY RLF TAB 10MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING	ALLER-TEC TAB 10MG	Required	Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLGY RELIEF TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	CETIRIZINE TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	CVS ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	EQL ALL DAY TAB ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	GNP ALL DAY TAB ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	QC ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	SB ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-	SM ALL DAY TAB 10MG	Non-Covered/PA	Refer to Comprehensive Drug List **
SEDATING ANTIHISTAMINES - NON-	SM ALL DAY TAB ALLERGY	Required Non-Covered/PA	Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-	WAL-ZYR TAB 10MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-	CETIRIZINE CHW 5MG	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-		Required Non-Covered/PA	Drug List ** Refer to Comprehensive
SEDATING	WAL-ZYR CHW 5MG	Required	Drug List **
ANTIHISTAMINES - NON- SEDATING	CETIRIZINE CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	WAL-ZYR CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ZYRTEC CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ZYRTEC CHILD CHW ALG 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ALL DAY ALLG SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ALL DAY ALLG SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALL-DAY ALLG SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY CHLD SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY REL SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY RELF SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY RELF SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLER-TEC SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
CETIRIZINE SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
CHILD ALLRGY SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
CHILD ALLRGY SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
WAL-ZYR SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
WAL-ZYR SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
WAL-ZYR CHLD SOL 1MG/ML	Non-Covered/PA	Refer to Comprehensive Drug List **
WAL-ZYR CHLD SOL 5MG/5ML	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY RELI CHW CETIRIZI	Non-Covered/PA Required	Refer to Comprehensive Drug List **
12HR ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ALLER-EASE TAB 60MG	Non-Covered/PA	Refer to Comprehensive Drug List **
ALLERGY RELF TAB 60MG	Non-Covered/PA	Refer to Comprehensive Drug List **
FEXOFENADINE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
	ZYRTEC CHILD CHW ALG 10MG ALL DAY ALLG SOL 1MG/ML ALL DAY ALLG SOL 5MG/5ML ALLERGY CHLD SOL 1MG/ML ALLERGY REL SOL 1MG/ML ALLERGY RELF SOL 1MG/ML ALLERGY RELF SOL 5MG/5ML ALLERGY RELF SOL 5MG/5ML CHILD ALLERGY SOL 5MG/5ML CHILD ALLRGY SOL 1MG/ML CHILD ALLRGY SOL 1MG/ML WAL-ZYR SOL 1MG/ML WAL-ZYR SOL 1MG/ML WAL-ZYR CHLD SOL 1MG/ML WAL-ZYR CHLD SOL 1MG/ML ALLERGY RELI CHW CETIRIZI 12HR ALLERGY TAB 60MG ALLERGY RELF TAB 60MG ALLERGY RELF TAB 60MG	ZYRTEC CHILD CHW ALG 10MG ALL DAY ALLG SOL 1MG/ML ALL DAY ALLG SOL 5MG/5ML ALL-DAY ALLG SOL 5MG/5ML ALLERGY CHLD SOL 1MG/ML ALLERGY RELF SOL 5MG/5ML ALLERGY RELF SOL 1MG/ML ALLERGY RELF SOL 1MG/ML ALLERGY RELF SOL 5MG/5ML CETIRIZINE SOL 5MG/5ML CHILD ALLRGY SOL 1MG/ML CHILD ALLRGY SOL 5MG/5ML WAL-ZYR SOL 1MG/ML WAL-ZYR SOL 1MG/ML WAL-ZYR SOL 5MG/5ML WAL-ZYR CHLD SOL 1MG/ML WAL-ZYR CHLD SOL 1MG/ML WAL-ZYR CHLD SOL 5MG/5ML ALLERGY RELI CHW CETIRIZI 12HR ALLERGY TAB 60MG ALLERGY RELF TAB 60MG PEXOFENADINE TAB 60MG FEXOFENADINE TAB 60MG Non-Covered/PA Required

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ANTIHISTAMINES - NON- SEDATING	FT ALLR RLF TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	HM ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	SM ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	WAL-FEX ALRG TAB 60MG 12H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	24HR ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLEGRA HIVE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLER-EASE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLER-FEX TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY 24HR TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY RELF TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	CVS ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	FEXOFENADINE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	FT ALRGY RLF TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	HM ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	MM FEXOFENAD TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	WAL-FEX TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	WAL-FEX ALLR TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY CHLD SUS 30MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLERGY RLF SUS 30/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	ALLEGRA ALRG TAB 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON- SEDATING	XYZAL TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

SEDATING ANTIHISTAMINES - NON- SEDATING CLARITIN SOL 5MG/5ML ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDATING CVS ALLERGY SOL 5MG/5ML ANTIHISTAMINES - NON- SEDATING ANTIHIST	ANTIHISTAMINES - NON-		Non-Covered/PA	Refer to Comprehensive
SEDATING ANTIHISTAMINES - NON-	SEDATING	ALLERGY RELF CAP 10MG	<u> </u>	•
SEDATING ANTIHISTAMINES - NON- SEDATING CLARITIN SOL 5MG/SML ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON-	LOPATADINE CAR 10MG	Non-Covered/PA	Refer to Comprehensive	
SEDATING ANTHISTAMINES - NON- SEDATI	SEDATING	LONATADINE CAF IONIO	Required	Drug List **
SEDATING ANTIHISTAMINES - NON- SEDATING ALLERGY CHLD SOL 5MG/SML ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDA	ANTIHISTAMINES - NON-	OCALLERGY CAP RELIEF	Non-Covered/PA	•
ANTHISTAMINES - NON- SEDATING ANTHIS		QC/ILLENGT C/II (ILLE)		-
SEDATING ANTIHISTAMINES - NON-		ALLERCLEAR TAB 10MG	<u> </u>	•
ANTIHISTAMINES - NON- SEDATING ALLERGY CHLD SOL 5MG/5ML ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDATING ALLERGY REFE LIQ CHILDREN ANTIHISTAMINES - NON- SEDATING ANTIHISTA			· ·	
ANTIHISTAMINES - NON- SEDATING	LORADAMED TAB 10MG	<u> </u>	•	
ANTIHISTAMINES - NON- SEDATING		•		
ANTIHISTAMINES - NON- SEDATING	QC LORATADIN TAB 10MG			
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON			•	•
ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDATING ALLERGY CHLD SOL 5MG/5ML ANTIHISTAMINES - NON- SEDATING ANTI		WAL-ITIN TAB 10MG	<u> </u>	•
SEDATING ANTIHISTAMINES - NON-			-	•
ANTIHISTAMINES - NON- SEDATING		WAL-ITIN CHW 5MG	<u> </u>	•
ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANON-Covered/PA Refer to Comprehensive Drug List ** ANON-Covered/PA Refer to Comprehens			•	
ANTIHISTAMINES - NON- SEDATING	ALLERGY CHLD SOL 5MG/5ML			
ANTIHISTAMINES - NON- SEDATING	· · · · · · · · · · · · · · · · · · ·	•	•	
ANTIHISTAMINES - NON- SEDATING	ALLERGY RLF LIQ CHILDREN	·	•	
SEDATING ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG ANTIHISTAMINES - NON- SEDATING AN			· ·	•
ANTIHISTAMINES - NON- SEDATING	CLARITIN SOL 5MG/5ML	<u> </u>	•	
SEDATING ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG ANON-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDATIN			· ·	
ANTIHISTAMINES - NON- SEDATING	CVS ALLERGY SOL 5MG/5ML		•	
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON			· ·	
ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG ANTIHISTAMINES - NON- SEDATING ANTIHISTAMI		EQ ALLERGY SOL 5MG/5ML		•
ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG ANTIHISTAMINES - NON- SEDATING ANTIHISTAMI			•	•
ANTIHISTAMINES - NON- SEDATING	LORATADINE SOL 10/10ML	<u> </u>	•	
ANTIHISTAMINES - NON- SEDATING		· ·		
ANTIHISTAMINES - NON- SEDATING	LORATADINE SOL 5MG/5ML			
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON			•	•
ANTIHISTAMINES - NON- SEDATING	SM ALLERGY SOL 5MG/5ML	<u> </u>	•	
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON				
ANTIHISTAMINES - NON- SEDATING	WAL-ITIN SOL 5MG/5ML		•	
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON			· ·	
ANTIHISTAMINES - NON- SEDATING	WAL-ITIN CHL SOL 5MG/5ML	· ·		
SEDATING ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Required Non-Covered/PA Refer to Comprehensive Non-Covered/PA Refer to Comprehensive			•	,
ANTIHISTAMINES - NON- SEDATING ALAVERT TAB 10MG Required Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Non-Covered/PA Refer to Comprehensive Drug List **		CVS ALLERGY TAB 5MG		•
SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- SEDATING ANTIHISTAMINES - NON- ANTIHISTAMINES - NON- ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Required Non-Covered/PA Refer to Comprehensive Non-Covered/PA Refer to Comprehensive				,
ANTIHISTAMINES - NON- SEDATING EQ LORATADIN TAB 10MG Required Drug List ** ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Non-Covered/PA Refer to Comprehensive Non-Covered/PA Refer to Comprehensive		ALAVERT TAB 10MG		•
SEDATING SEDATING Required Drug List ** ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Non-Covered/PA Refer to Comprehensive	ANTIHISTAMINES - NON-	50.100.1710	· ·	
ANTIHISTAMINES - NON- TRIAMINIC TAB 10MG Non-Covered/PA Refer to Comprehensive		EQ LORATADIN TAB 10MG	<u> </u>	•
I IRIAN/INIC LAR ININIC	ANTIHISTAMINES - NON-	TRIANAINIC TAR 4004C	· ·	•
	SEDATING	TRIAMINIC TAB 10MG	Required	•

ANTIHISTAMINES - NON- SEDATING	WAL-VERT TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	BUDESONIDE SUS 32MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	BUDESONIDE SUS NASAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLER-FLO SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY NASA SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY RELF SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLGY RELIEF SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	CLARISPRAY SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	FLUTICASONE SUS 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	24 HR NASAL SPR ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLER-CORT SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY NASA SPR 24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	NASAL ALLRGY SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	RA NASAL SPR ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	TRIAMCINOLON AER 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	TRIAMCINOLON SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	ASTEPRO SPR 205.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	ASTEPRO CHLD SPR 205.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	CROMOLYN SOD SPR 5.2/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	AZELASTINE SPR 0.15%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLUTICASONE AER 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLUTICASONE AER 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROID INHALANTS	FLUTICASONE AER 250MCG	Non-Covered/PA	Refer to Comprehensive
0.2.0.2		Required	Drug List **
LAXATIVE COMBINATIONS	PEG-3350/KCL SOL /SODIUM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	FAMOTIDINE INJ 20MG/2ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	FAMOTIDINE INJ 10MG/ML	Non-Covered/PA	Refer to Comprehensive
H-2 ANTAGONISTS	NIZATIDINE SOL 15MG/ML	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
H-2 ANTAGONISTS	NIZATIDINE SOL ISINIG/IVIL	Required	Drug List **
PROTON PUMP INHIBITORS	PANTOPRAZOLE PAK 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIEMETICS - ANTICHOLINERGIC	TRIMETHOBENZ CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
5-HT3 RECEPTOR ANTAGONISTS	ONDANSETRON TAB 24MG	Non-Covered/PA	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	CALPHRON TAB 667MG	Required Non-Covered/PA	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	OXYTROL/WOMN DIS 3.9MG/24	Required Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 2600UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 4000UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 4200UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 8000UNIT	Non-Covered/PA	Refer to Comprehensive
DIGESTIVE ENZYMES	PANCREAZE CAP 10500UNT	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
DIGESTIVE ENZYMES	PERTZYE CAP 16000U	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
DIGESTIVE ENZYMES	PANCREAZE CAP 16800UNT	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
DIGESTIVE ENZIVIES	PAINCREAZE CAP 10800UNI	Required	Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 21000UNT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 24000U	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 37000	Non-Covered/PA Required	Refer to Comprehensive Drug List **

INFLAMMATORY BOWEL AGENTS	MESALAMINE KIT 4GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INFLAMMATORY BOWEL AGENTS	AVSOLA INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	DARIFENACIN TAB 7.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	DARIFENACIN TAB 15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	ESCITALOPRAM SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	ESCITALOP OX SOL 10/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUOXETINE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUOXETINE CAP 90MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETINE SUS 10MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETIN ER TAB 12.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETINE TAB 25MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETIN ER TAB 37.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	SERTRALINE CON 20MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

		Non-Covered/PA	Pofor to Comprehensive
DIBENZAPINES	LOXAPINE CAP 25MG	Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 50MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIBENZAPINES	ASENAPINE SUB 2.5MG	Non-Covered/PA	Refer to Comprehensive
	7.02.0.0.0.0	Required	Drug List **
DIBENZAPINES	ASENAPINE SUB 5MG	Non-Covered/PA	Refer to Comprehensive
21321127111123	7.02.17.11.11.12 303.51.110	Required	Drug List **
DIBENZAPINES	ASENAPINE SUB 10MG	Non-Covered/PA	Refer to Comprehensive
51521127 11 11125	7.0217.11.112 333 131716	Required	Drug List **
DIBENZAPINES	OLANZAPINE INJ 10MG	Non-Covered/PA	Refer to Comprehensive
DIBEIVE/ II IIVES	OD/11/2/11 11/2 11/3 101/10	Required	Drug List **
NON-BARBITURATE	FLURAZEPAM CAP 15MG	Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	TEOTIAZET AIVI CAT 151VIG	Required	Drug List **
NON-BARBITURATE	FLURAZEPAM CAP 30MG	Non-Covered/PA	Refer to Comprehensive
HYPNOTICS	FLURAZEPAIVI CAP SUIVIG	Required	Drug List **
STIMULANTS - MISC.	METHYLPHENID TAB 18MG ER	Non-Covered/PA	Refer to Comprehensive
STIMULANTS - MISC.	METHTEPHENID TAB 18MG EK	Required	Drug List **
ANTIDENAENITIA ACENITS	DONEPEZIL TAB 23MG	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS	DONEPEZIL TAB 23MG	Required	Drug List **
ANITIDEN ACRITIA A CENTE	GALANTAMINE TAB 8MG	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS		Required	Drug List **
ANITIDEN ACRITIA A CENTE	GALANTAMINE TAB 12MG	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS		Required	Drug List **
ANTIDEN AFAITIA A CENITO	CALANITANAINE CARONACER	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 8MG ER	Required	Drug List **
441718544541714 4 654176	CALANTANANIS CARACAG ER	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 16MG ER	Required	Drug List **
441718544541714 4 654176	CALANITANAINIS CAR 2414C 52	Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 24MG ER	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
ANTIDEMENTIA AGENTS	MEMANTINE SOL 10MG/5ML	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE DIS 14MG/24H	Required	Drug List **
CA AOMAN O DETERORISME	NICOTINE DIG 4 (1 1 2 /2 1 1	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE DIS 14MG/24H	Required	Drug List **
CA AOMANO DETERMINA	OCAUCOTINE DISABLE (S	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	QC NICOTINE DIS 14MG/24H	Required	Drug List **
CA 40 ((N) 0 P ==================================	DA NUCCTINIS DISCONDING	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	RA NICOTINE DIS 14MG/24H	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	CVS NICOTINE DIS 21MG/24H	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE DIS 21MG/24H	Required	Drug List **
	<u>l</u>		

		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	HABITROL DIS 21MG/24H	Required	Drug List **
SMOKING DETERRENTS	NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE DIS STEP 1	Required	Drug List **
SMOKING DETERRENTS	QC NICOTINE DIS 21MG/24H	Non-Covered/PA	Refer to Comprehensive
SWOKING DETERMENTS	QC NICOTINE DIS 21IVIG/24H	Required	Drug List **
SMOKING DETERRENTS	RA NICOTINE DIS 21MG/24H	Non-Covered/PA	Refer to Comprehensive
Sittorinto De l'entre l'incertio	100011112 310 221016,2111	Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG CINN	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG ORIG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MGFRUIT	Non-Covered/PA	Refer to Comprehensive Drug List **
		Required Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE GUM 2MG CINN	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE GUM 2MG MINT	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE GUM 2MGFRUIT	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	HM NICOTINE GUM 2MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	KLS QUIT2 GUM 2MG	Required	Drug List **
CAAOVING DETERDENTS	NUCCTINE CHARACEPULT	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE GUM 2MGFRUIT	Required	Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 2MG REF	Non-Covered/PA	Refer to Comprehensive
SIVIUNING DETERMENTS	NICOTINE POL GOIVI ZIVIG REF	Required	Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 2MG STRT	Non-Covered/PA	Refer to Comprehensive
SWOKING DETERMENTS	MICOTINE FOE GOIN ZING STAT	Required	Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 2MG	Non-Covered/PA	Refer to Comprehensive
S.MOKING DETERMENTS	TOTAL GOINT ZING	Required	Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 2MG ORIG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	THRIVE GUM 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **

		Non Covered/DA	Defeate Communication
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG MINT	Non-Covered/PA	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVC NUCCTINE CLINA ANAC ODIC	Required Non-Covered/PA	Refer to Comprehensive
SIVIORING DETERMENTS	CVS NICOTINE GUM 4MG ORIG	Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG ORIG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE GUM 4MG FRT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	KLS QUIT4 GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 4MG REF	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 4MG STRT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		1	
SMOKING DETERRENTS	CVS NICOTINE LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS SMOKING DETERRENTS	CVS NICOTINE LOZ 2MG MINT EQ NICOTINE LOZ 2MG CINN	-	•
		Required Non-Covered/PA Required Non-Covered/PA	Drug List ** Refer to Comprehensive Drug List ** Refer to Comprehensive
SMOKING DETERRENTS	EQ NICOTINE LOZ 2MG CINN	Required Non-Covered/PA Required	Drug List ** Refer to Comprehensive Drug List **

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SMOKING DETERRENTS	KLS QUIT2 LOZ 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 2MG CHRY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 2MG CINN	Non-Covered/PA	Refer to Comprehensive
	<u> </u>	Required	Drug List **
SMOKING DETERRENTS	RA NICOTINE LOZ 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	STOP SMOKING LOZ 2MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 4MG CINN	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 4MG MINT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 4MG CINN	Non-Covered/PA	Refer to Comprehensive
SWIGHT DETERMENTS	24 11100 11112 202 11110 011111	Required	Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 4MG MINT	Non-Covered/PA	Refer to Comprehensive
SIVIORING DETERMENTS	EQ MICOTINE EDZ 4MIG MINT	Required	Drug List **
SMOKING DETERRENTS	EQL NICOTINE LOZ 4MG MINT	Non-Covered/PA	Refer to Comprehensive
SWOKING DETERMENTS	EQLINICOTINE LOZ 4IVIG IVIIIVI	Required	Drug List **
SMOVING DETERDENTS	HM NICOTINE LOZ 4MG CINN	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS		Required	Drug List **
CNAONING DETERDENTS	KIC OLUTA I OZ ANAC	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	KLS QUIT4 LOZ 4MG	Required	Drug List **
CA ACIVINIC DETERDENTS	NUCCTINE LOZ ANAC CININ	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE LOZ 4MG CINN	Required	Drug List **
CA ACIVINIC DETERDENTS	NUCCEINE DOLLOZ MAG GUDV	Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE POL LOZ 4MG CHRY	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	NICOTINE POL LOZ 4MG CINN	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	RA NICOTINE LOZ 4MG MINT	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	STOP SMOKING LOZ 4MG MINT	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	APO-VARENICL TAB 0.5MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
SMOKING DETERRENTS	APO-VARENICL TAB 1MG	Required	Drug List **
AGENTS FOR CHEMICAL		Non-Covered/PA	Refer to Comprehensive
DEPENDENCY	ACAMPRO CAL TAB 333MG	Required	Drug List **
AGENTS FOR CHEMICAL		Non-Covered/PA	Refer to Comprehensive
DEPENDENCY	DISULFIRAM TAB 250MG	Required	Drug List **
AGENTS FOR CHEMICAL		Non-Covered/PA	Refer to Comprehensive
DEPENDENCY	DISULFIRAM TAB 500MG	Required	Drug List **
		Nequired	Di ug List

COMBINATION		Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS	CDP/AMITRIP TAB 5-12.5MG	Required	Drug List **
COMBINATION	CDD/ANAITRID TAD 40 25N4C	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS	CDP/AMITRIP TAB 10-25MG	Required	Drug List **
COMBINATION	PERPHEN/AMIT TAB 2-10MG	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS	PERPHENI/AIVIII TAB 2-10IVIG	Required	Drug List **
COMBINATION	PERPHEN/AMIT TAB 2-25MG	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS	T ENT TIETY/WITT TAB 2 25WIG	Required	Drug List **
COMBINATION	PERPHEN/AMIT TAB 4-10MG	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS		Required	Drug List **
COMBINATION	PERPHEN/AMIT TAB 4-25MG	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS	·	Required	Drug List **
COMBINATION	PERPHEN/AMIT TAB 4-50MG	Non-Covered/PA	Refer to Comprehensive
PSYCHOTHERAPEUTICS		Required Non-Covered/PA	Drug List **
SALICYLATES	SALSALATE TAB 500MG	Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
SALICYLATES	SALSALATE TAB 750MG	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
OPIOID AGONISTS	MORPHINE SUL SOL 10/0.5ML	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
OPIOID COMBINATIONS	ENDOCET TAB 2.5-325	Required	Drug List **
ODIOID COMPINIATIONS	ADAD/CODEINE COL 200 20MC	Non-Covered/PA	Refer to Comprehensive
OPIOID COMBINATIONS	APAP/CODEINE SOL 300-30MG	Required	Drug List **
OPIOID COMBINATIONS	BUT/ASA/CAF/ CAP COD 30MG	Non-Covered/PA	Refer to Comprehensive
OF IOID COMBINATIONS	BOT/ASA/CAT/ CAT COD SOIVIG	Required	Drug List **
NONSTEROIDAL ANTI-		Non-Covered/PA	Refer to Comprehensive
INFLAMMATORY AGENTS	CATAFLAM TAB 50MG	Required	Drug List **
(NSAIDS)		•	<u> </u>
NONSTEROIDAL ANTI-	ETODOLAC CAR 200AC	Non-Covered/PA	Refer to Comprehensive
INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC CAP 300MG	Required	Drug List **
NONSTEROIDAL ANTI-			
INFLAMMATORY AGENTS	ETODOLAC TAB 500MG	Non-Covered/PA	Refer to Comprehensive
(NSAIDS)	ETODOLINE TRIB SCORE	Required	Drug List **
NONSTEROIDAL ANTI-			
INFLAMMATORY AGENTS	ETODOLAC ER TAB 400MG	Non-Covered/PA	Refer to Comprehensive
(NSAIDS)		Required	Drug List **
NONSTEROIDAL ANTI-		Non-Covered/PA	Pafar to Comprehensive
INFLAMMATORY AGENTS	ETODOLAC ER TAB 500MG	Required	Refer to Comprehensive Drug List **
(NSAIDS)		Nequireu	Diug List
NONSTEROIDAL ANTI-		Non-Covered/PA	Refer to Comprehensive
INFLAMMATORY AGENTS	ETODOLAC ER TAB 600MG	Required	Drug List **
(NSAIDS)		- 4	3 =====

NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	FENOPROFEN CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	FLURBIPROFEN TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	INDOMETHACIN CAP 75MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	KETOPROFEN CAP 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	KETOPROFEN CAP 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	RELAFEN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	RELAFEN TAB 750MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS ALLERGY DRO 0.035%OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS OLOPATAD SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL ITCH/RED	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	NAPROXEN SOD TAB 275MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	NAPROXEN SOD TAB 550MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	TOLMETIN SOD CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	TOLMETIN SOD TAB 600MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI- INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE- RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	NURTEC TAB 75MG ODT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIGRAINE COMBINATIONS	ERGOT/CAFFEN TAB 1-100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIGRAINE COMBINATIONS	MIGERGOT SUP 2/100	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN CAP 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN CAP 300MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 35	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTICONVULSANTS - MISC.	SUBVENITE KIT START 35	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 49	Required	Drug List **
ANTICONVULSANTS - MISC.	SUBVENITE KIT START 49	Non-Covered/PA	Refer to Comprehensive
ANTICONVOLSANTS - WISC.	SOBVENITE KIT START 49	Required	Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 98	Non-Covered/PA	Refer to Comprehensive
ANTICONVOLSANTS WISC.	LAWOTHIGHTE KIT START 30	Required	Drug List **
ANTICONVULSANTS - MISC.	SUBVENITE KIT START 98	Non-Covered/PA	Refer to Comprehensive
7.1111661116611176	305751115 111 317111 30	Required	Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIG ODT KIT 25/50MG	Non-Covered/PA	Refer to Comprehensive
7.1111661116611176	LAWIOTHIG ODT KIT 23/30WIG	Required	Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIG ODT KIT 50/100MG	Non-Covered/PA	Refer to Comprehensive
7.1111661116611176	E 11/10 11/10 051 KH 30/1001/10	Required	Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT ODT	Non-Covered/PA	Refer to Comprehensive
ANTICONVOLSANTS WISC.	EAMOTHIGHTE KIT OUT	Required	Drug List **
ANTICONVULSANTS - MISC.	PREGABALIN SOL 20MG/ML	Non-Covered/PA	Refer to Comprehensive
ANTICONVOLSANTS WISC.	TREGADALIN 30L ZUNIG/IVIL	Required	Drug List **
ANTIPARKINSON COMT	ENTACAPONE TAB 200MG	Non-Covered/PA	Refer to Comprehensive
INHIBITORS	ENTACAPONE TAB 2001VIG	Required	Drug List **
ANTIPARKINSON	ANAANTADINE CAD 100MC	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	AMANTADINE CAP 100MG	Required	Drug List **
ANTIPARKINSON	ANAANTADINE TAD 100NAC	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	AMANTADINE TAB 100MG	Required	Drug List **
ANTIPARKINSON	ANAANTA DINE COL FONAC (FNAL	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	AMANTADINE SOL 50MG/5ML	Required	Drug List **
ANTIPARKINSON	DDOMAGCDIDTINI CAD FAAC	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	BROMOCRIPTIN CAP 5MG	Required	Drug List **
ANTIPARKINSON	DD 0440 0D IDTIN TAB 2 5440	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	BROMOCRIPTIN TAB 2.5MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO TAB 10-100MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO TAB 25-100MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO TAB 25-250MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO ER TAB 25-100MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO ER TAB 50-200MG	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO 50 TAB /ENTACAP	Required	Drug List **
ANTIPARKINSON		Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS	CARB/LEVO 75 TAB /ENTACAP	Required	Drug List **
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ANTIPARKINSON DOPAMINERGICS	CARB/LEVO100 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO125 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON	CARB/LEVO150 TAB /ENTACAP	Non-Covered/PA	Refer to Comprehensive
DOPAMINERGICS		Required	Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO200 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	SELEGILINE CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	SELEGILINE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE RELAXANTS	CARISOPRODOL TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE RELAXANTS	VANADOM TAB 350MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MUSCLE RELAXANT COMBINATIONS	CARISOPRODOL TAB ASA/COD	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 25MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 40MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 60MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 1000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 5000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 5000/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 10000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 20000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	CILOSTAZOL TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	CILOSTAZOL TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	ANAGRELIDE CAP 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

PLATELET AGGREGATION	ANAGRELIDE CAP 1MG	Non-Covered/PA	Refer to Comprehensive
INHIBITORS		Required	Drug List **
OPHTHALMIC ANTI- INFECTIVES	BACITRACIN OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI- INFECTIVES	ERYTHROMYCIN OIN 5MG/GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	GATIFLOXACIN SOL 0.5%	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	GENTAMICIN SOL 0.3% OP	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	GENTAK OIN 0.3% OP	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	LEVOFLOXACIN SOL 0.5%	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	LEVOFLOXACIN SOL 1.5%	Required	Drug List **
OPHTHALMIC ANTI-		Non-Covered/PA	Refer to Comprehensive
INFECTIVES	MOXIFLOXACIN SOL 0.5%	•	Drug List **
		Required	•
OPHTHALMIC ANTI-	OFLOXACIN DRO 0.3% OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES		Required	Drug List **
OPHTHALMIC ANTI-	TOBRAMYCIN SOL 0.3% OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES		Required	Drug List **
OPHTHALMIC ANTI-	SULFACET SOD SOL 10% OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES		Required	Drug List **
OPHTHALMIC ANTI-	SULFACET SOD OIN 10% OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES		Required	Drug List **
OPHTHALMIC ANTI-	TRIFLURIDINE SOL 1% OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	71(11 EG1(15)11 E 30E 170 G1	Required	Drug List **
OPHTHALMIC ANTI-	AK-POLY-BAC OIN OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	ARTOLI BAC OIN OI	Required	Drug List **
OPHTHALMIC ANTI-	BACIT/POLYMY OIN OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	BACIT/FOLTIVIT OIN OF	Required	Drug List **
OPHTHALMIC ANTI-	POLYCIN OIN OP	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	POLICIN OIN OF	Required	Drug List **
OPHTHALMIC ANTI-	DOLVMAYVIN B / COL TRIMETUR	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	POLYMYXIN B/ SOL TRIMETHP	Required	Drug List **
OPHTHALMIC ANTI-	TDINAETHODDINA COL DOLVA AVVA	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	TRIMETHOPRIM SOL POLYMYXN	Required	Drug List **
OPHTHALMIC ANTI-	NEO/DAC/DOLY CIN OD	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	NEO/BAC/POLY OIN OP	Required	Drug List **
OPHTHALMIC ANTI-	NEO BOLVONI ON CO	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	NEO-POLYCIN OIN OP	Required	Drug List **
OPHTHALMIC ANTI-	NEO IRONAIDA O CITA	Non-Covered/PA	Refer to Comprehensive
INFECTIVES	NEO/POLY/BAC OIN OP	Required	Drug List **
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OPHTHALMIC ANTI- INFECTIVES	NEO/POLY/GRA SOL OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 1% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 2% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 4% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ADRENERGIC AGENTS	APRACLONIDIN SOL 0.5% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ADRENERGIC AGENTS	BRIMONIDINE SOL 0.15%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	AZELASTINE DRO 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EPINASTINE DRO 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	OLOPATADINE DRO 0.1% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS OLOPATAD SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL ITCH REL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	GNP OLOPATAD SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	SM OLOPATADI SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.7%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OTIC ANTI-INFECTIVES	CIPROFLOXACN SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OTIC COMBINATIONS	NEO/POLY/HC SUS 1% OTIC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	TRIAMCINOLON PST DEN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	ORALONE DENT PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	KOURZEQ PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROIDS - MOUTH/THROAT/DENTAL	TRIAMCINOLON PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INTRARECTAL STEROIDS	HYDROCORT ENE 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AMNESTEEM CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AMNESTEEM CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ACNE PRODUCTS	AMNESTEEM CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AVITA GEL 0.025%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDAMYCIN MIS 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDACIN-P PAD 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDACIN MIS ETZ 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ROSACEA AGENTS	ROSADAN CRE 0.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ROSACEA AGENTS	ROSADAN GEL 0.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIBIOTICS - TOPICAL	GENTAMICIN CRE 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIBIOTICS - TOPICAL	GENTAMICIN OIN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS - TOPICAL	MYCOZYL AL SOL 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFLAMMATORY AGENTS - TOPICAL	DICLOFENAC SOL 1.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	DOCOSANOL CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	FT DOCOSAN CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	CALCITRENE OIN 0.005%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	HM DOCOSAN CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	DESONIDE GEL 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	DESRX GEL 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	ALA-CORT CRE 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOMODULATING AGENTS - TOPICAL	IMIQUIMOD CRE 3.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SCABICIDES & PEDICULICIDES	SPINOSAD SUS 0.9%	Non-Covered/PA Required	Refer to Comprehensive Drug List **

		Non-Covered/PA	Refer to Comprehensive
OPIOID ANTAGONISTS	NALMEFENE INJ 1MG/ML	Required	Drug List **
OPIOID ANTAGONISTS	OPVEE SPR 2.7/0.1	Non-Covered/PA	Refer to Comprehensive
OF IOID AIVIAGONISTS	01 VEL 31 N 2.77 0.1	Required	Drug List **
OPIOID ANTAGONISTS	KLOXXADO SPR 8MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
OPIOID ANTAGONISTS	NALTREXONE TAB 50MG	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIAGNOSTIC TESTS	TRUE METRIX TES GLUCOSE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIAGNOSTIC TESTS	RELION TRUE TES METRIX	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIAGNOSTIC TESTS	TRU METRIX TES STRIPS	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIAGNOSTIC TESTS	GNP TRU METR TES STRIPS	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	OMNIPOD MIS CLASSIC	Required	Drug List **
DIADETIC CUIDDUIC	OMMUDOD DDM VIT CLASSIC	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	OMNIPOD PDM KIT CLASSIC	Required	Drug List **
DIABETIC SUPPLIES	ONANIBOD DASH VIT DDNA	Non-Covered/PA	Refer to Comprehensive
DIADETIC SUPPLIES	OMNIPOD DASH KIT PDM	Required	Drug List **
DIABETIC SUPPLIES	FREESTYLE MIS READER	Non-Covered/PA	Refer to Comprehensive
DIADETIC SOLT LIES	TREESTILE WIS READER	Required	Drug List **
DIABETIC SUPPLIES	DEXCOM G7 MIS RECEIVER	Non-Covered/PA	Refer to Comprehensive
517.1521116 5011 2125	DEAGON OF THIS RECEIVER	Required	Drug List **
DIABETIC SUPPLIES	DEXCOM G7 MIS SENSOR	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 33G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 30G	Non-Covered/PA	Refer to Comprehensive
		Required Non-Covered/PA	Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN	Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LANCETS MIS ORIGINAL	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	RELION LANCE MIS THIN 26G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	RELION LANCE MIS THIN 30G	Required	Drug List **
DIADETIC CLIESTIES	DELIGNA MICRO A MIC THUN 22 C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	RELION MICRO MIS THIN 33G	Required	Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
DIADETIC SUPPLIES	JUNE COIVIFORT IVIIS LAINCETS	Required	Drug List **

DIABETIC SUPPLIES	SURE COMFORT MIS LANC 18G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FIFTY50 SAFE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURELITE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CLEANLET 28G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FORA MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PSS SEL LANC MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PSS SAFE LAN MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS HI FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS NOR FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS LOW FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THINLETS GP MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	TRUPLUS LANC MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS ORIGINAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MYGLUCOHEALT MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AUTO LANCET MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS LITE 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS UNIV 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ACTI-LANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS 30G PLUS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	IN TOUCH LAN MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SUPER THIN MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THIN LANCETS MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THIN LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET STAND MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MICRO THIN MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	EQL LANCETS MIS 33G COLR	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	TGT LANCET MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION ULTRA MIS THIN PLS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TOPCARE MIS LANC 33G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	SM LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 33G	Non-Covered/PA	Refer to Comprehensive
DI// (BETTE 3011 E1E3	CV3 E/ ((VCE 13 1VII 3 3 3 C	Required	Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LANCETS THIN MIS 26G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LANCET SUPER MIS THIN 30G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LONGS LANCET MIS STANDARD	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LONGS LANCET MIS THIN	Required	Drug List **
DIA DETIC CUIDDUIEC	LONGS LANGET ANG LUTDA TU	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LONGS LANCET MIS ULTRA TH	Required	Drug List **
DIADETIC CUIDDUIC	CND LANCETC AUG 24.6	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GNP LANCETS MIS 21G	Required	Drug List **
DIADETIC CUIDDUIC	CAID LANCETC MAIS THIN 250	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GNP LANCETS MIS THIN 26G	Required	Drug List **
DIABETIC SUPPLIES	LANCETS MIS 21G COLR	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LAINCETS IVIIS 21G COLK	Required	Drug List **
DIABETIC SUPPLIES	MEIJER MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
DIADLTIC SOFFLILS	WEBER WIIS LANCETS	Required	Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 26G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS THIN 26G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS LANC 21G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	LANCET ULTRA MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
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DIABETIC SUPPLIES	SMART SENSE MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	E-Z JECT MIS 21G	-	· ·
J 1.5 2 1.1 0 0 0 1 1 2.1 2 0	2 2 3 2 6 1 1 1 1 1 2 2 3	Required	Drug List **

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DIABETIC SUPPLIES	E-Z JECT MIS 21G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PHARMACY COU MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS ULT THIN	Non-Covered/PA	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SUPER THIN MIS LANCETS	Required Non-Covered/PA	Refer to Comprehensive
		Required Non-Covered/PA	Drug List ** Refer to Comprehensive
DIABETIC SUPPLIES	LANCETS MIS 30G	Required	Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TGT LANCET MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS 21G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS 32G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS THIN 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-ZJECT LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET MICRO MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIVERSA	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	SMART SENSE MIS LANC 33G	Required Non-Covered/PA	Drug List ** Refer to Comprehensive
		Required	Drug List **

DIABETIC SUPPLIES	E-Z JECT MIS THIN 26G	Non-Covered/PA	Refer to Comprehensive
DIVIDE TIC SOLIT FILES	2 2 3 2 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Required	Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS LANC 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	TGT LANCET MIS 26G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIV 30G	Required	Drug List **
DIA DETIC CUIDDI IEC	A45U5D 1 ANG 5 ANG 118U9 / 24 G	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIV 21G	Required	Drug List **
DIA DETIC CUIDDI IEC	LANGETC AND DEC	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LANCETS MIS 26G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	REALITY TRIG MIS LANCETS	Required	Drug List **
DIA DETIC CUIDDI IEC	DEALITY ANGLANGETS	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	REALITY MIS LANCETS	Required	Drug List **
DIA DETIC CUIDDIUEC	AAEDI ANGE DI CAMO EVED 24 C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	MEDLANCE PLS MIS EXTR 21G	Required	Drug List **
51455TIQ 011551150	MEDLANCE PLS MIS 0.8MM	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES		Required	Drug List **
DIADETIC CUIDDUIEC	ACTULANCE MUCLITE 200	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ACTI-LANCE MIS LITE 28G	Required	Drug List **
DIADETIC CUIDDUIC	ACTULANCE MUSUUM 22C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ACTI-LANCE MIS UNIV 23G	Required	Drug List **
DIADETIC CUIDDUIC	ACTULANCE MICEPEC 17C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ACTI-LANCE MIS SPEC 17G	Required	Drug List **
DIADETIC CUIDDUIC	DRODUET LANCING 20C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	DROPLET LANC MIS 30G	Required	Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS PLUS 30G	Non-Covered/PA	Refer to Comprehensive
DIADETIC SUPPLIES	WEDLANCE WIIS FLOS 30G	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/21G	Non-Covered/PA	Refer to Comprehensive
DIADLTIC SUFFLIES	LAST TOOCH WIIS LANC/210	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/23G	Non-Covered/PA	Refer to Comprehensive
DIADETIC SOFT LIES	LAST TOOCH WIIS LANC/230	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/26G	Non-Covered/PA	Refer to Comprehensive
DIADETIC JOIT LIES	LAST TOOCH WIIS LANG/200	Required	Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS 26G	Non-Covered/PA	Refer to Comprehensive
DIVIDE LIC 2011 FIED	KNOGEN LANCE WIIJ 200	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/28G	Non-Covered/PA	Refer to Comprehensive
DIADLTIC JUFFLILJ	LAST TOOCH WIIS LANG/200	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/30G	Non-Covered/PA	Refer to Comprehensive
DIVIDE LIC DOLL FILED	ENOT TOOCH WIID ENNOYSOU	Required	Drug List **

DIABETIC SUPPLIES	LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	COMFORT ASSU MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	COMFORT ASSU MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRAVEL LANCE MIS ADV 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MICR MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS SUPR MIS THIN 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET CMFR MIS TCH 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PERFECT 28G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PERFECT 30G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLET MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET CMFR MIS TCH 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RIGHTEST MIS GL300	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	NOVA SURE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK SAFE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK SAFE MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET GP 28 MIS ULT THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **

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DIABETIC SUPPLIES	SUREFLEX MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	NOVA SAFETY MIS LANC 28G	Required	Drug List **
DIABETIC SUPPLIES	NOVA SAFETY MIS LANC 23G	Non-Covered/PA	Refer to Comprehensive
DIVIDE TIC 3011 ETES	140 474 374 211 1413 2744 230	Required	Drug List **
DIABETIC SUPPLIES	SAFETY 21G MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS GENT 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/32G	Required	Drug List **
D. A. D. ETTI O. G. J. D. J. J. G.		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	AGAMATRIX MIS 33G	Required	Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/33G	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	EAST TOUCH WITS LAINC/35G	Required	Drug List **
DIABETIC SUPPLIES	SMARTEST MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
511.1521116 5611 2125	3100 M 11 23 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Required	Drug List **
DIABETIC SUPPLIES	STERILANCE MIS TL 28G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	STERILANCE MIS TL 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	STERILANCE MIS TL 32G	Required	Drug List **
DIADETIC CUIDDUIC	LINIU ET NAIC 24 C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNILET MIS 21G	Required	Drug List **
DIABETIC SUPPLIES	UNILET G.P. MIS 21G	Non-Covered/PA	Refer to Comprehensive
DIADETIC SOLITEIES	ONIET G.I. WIS 210	Required	Drug List **
DIABETIC SUPPLIES	COMFORTOUCH MIS LANCET	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNILET SUPER MIS 23G	Non-Covered/PA	Refer to Comprehensive
		Required Non-Covered/PA	Drug List ** Refer to Comprehensive
DIABETIC SUPPLIES	UNILET SUPER MIS G.P. 23G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GLUCOCOM MIS 28G	Required	Drug List **
DIADETIC CUIDDUES	CITICOCOM MIS 30C	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GLUCOCOM MIS 30G	Required	Drug List **
DIABETIC SUPPLIES	GLUCOCOM MIS 33G	Non-Covered/PA	Refer to Comprehensive
51521.16 501.1 2125		Required	Drug List **
DIABETIC SUPPLIES	UNILET EXCEL MIS 23G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNILET EX II MIS 28G	Non-Covered/PA	Refer to Comprehensive Drug List **
		Required	ning rist

		Non-Covered/PA	Pofor to Comprehensive
DIABETIC SUPPLIES	LANCETS MIS	Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS THIN MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS 21G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS SAFE 25G	Non-Covered/PA	Refer to Comprehensive
	7.0001.12 27.11.02 7.11.2 20.0	Required	Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS SAFE 30G	Non-Covered/PA	Refer to Comprehensive
DIABLTIC SOFFLIES	ASSURE LANCE IVIS SALE SOO	Required	Drug List **
DIADETIC CUIDDUIEC	CD LANCETC AGE THAN	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	SB LANCETS MIS THIN	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	SB LANCETS MIS ULTR THN	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	TECHLITE MIS LANCETS	•	Drug List **
		Required	
DIABETIC SUPPLIES	TECHLITE MIS LANC 30G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	TECHLITE AST MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
DIABETIC 3011 LIE3	TECHETE AST WIIS LANCETS	Required	Drug List **
DIADETIC CUIDDUIEC	ASSURE PLUS MIS PEDIATRI	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES		Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ASSURE PLUS MIS HIGH 18G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ASSURE PLUS MIS NORM 21G	Required	Drug List **
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DIABETIC SUPPLIES	ASSURE PLUS MIS LOW 25G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS MCRO 28G	Non-Covered/PA	Refer to Comprehensive
	7.000112 / 200 11110 1110 120	Required	Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS LOW FLOW	Non-Covered/PA	Refer to Comprehensive
DIABLTIC SOFFEILS	ASSURE LAINCE WIIS LOW I LOW	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	ASSURE LANCE MIS MICRO	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	FORA LANCETS MIS 30G	Required	Drug List **
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DIABETIC SUPPLIES	EZ-LETS 21G MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	EZ-LETS 26G MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	EZ-LETS 28G MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
DIADELIC SOFFEES	LZ-LL13 ZOO IVII3 LAINCE13	Required	Drug List **
DIADETIC CURRUIEC	EZ LETC 30C MAIC LANCETC	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	EZ-LETS 30G MIS LANCETS	Required	Drug List **
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DIABETIC SUPPLIES	LANCETS ULTR MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FINE 30 MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS LITE 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS UNV 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS EXTR 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS COLOR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LITE TOUCH MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LITETOUCH MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS PLUS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CAREONE LANC MIS THIN 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AURORA LANCE MIS THIN 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KINNEY MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KINNEY THIN MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES DIABETIC SUPPLIES LANCET ULTRA MIS 28G DIABETIC SUPPLIES LANCET ULTRA MIS 28G DIABETIC SUPPLIES DIABETI
DIABETIC SUPPLIES LANCET ULTRA MIS 28G Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List **
DIABETIC SUPPLIES TRAVEL LANCE MIS 30G DIABETIC SUPPLIES TRAVEL LANCE MIS 30G DIABETIC SUPPLIES ON-THE-GO MIS LANC 30G DIABETIC SUPPLIES MEDICHOICE MIS LANCET DIABETIC SUPPLIES
DIABETIC SUPPLIES DIABETIC SUPPLIES ON-THE-GO MIS LANC 30G DIABETIC SUPPLIES ON-THE-GO MIS LANC 30G DIABETIC SUPPLIES MEDICHOICE MIS LANCET DIABETIC SUPPLIES CAREONE LANC MIS 30G DIABETIC SUPPLIES DIABETIC SUPPLI
DIABETIC SUPPLIES ON-THE-GO MIS LANC 30G DIABETIC SUPPLIES MEDICHOICE MIS LANCET DIABETIC SUPPLIES MEDICHOICE MIS LANCET DIABETIC SUPPLIES CAREONE LANC MIS 30G DIABETIC SUPPLIES DIABETIC SUPPLIE
DIABETIC SUPPLIES MEDICHOICE MIS LANCET MEDICHOICE MIS LANCET DIABETIC SUPPLIES MEDICHOICE MIS LANCET MEDICHOICE MIS LANCET MEDICHOICE MIS LANCET MEDICHOICE MIS LANCET Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List **
DIABETIC SUPPLIES MEDICHOICE MIS LANCET Mequired Drug List ** Non-Covered/PA Required Non-Covered/PA Refer to Comprehensive Drug List **
DIABETIC SUPPLIES CAREONE LANC MIS 30G DIABETIC SUPPLIES CAREONE LANC MIS 30G DIABETIC SUPPLIES LB LANCET MIS 28G DIABETIC SUPPLIES DIABETI
DIABETIC SUPPLIES CAREONE LANC MIS 30G Non-Covered/PA Refer to Comprehensive Drug List **
DIABETIC SUPPLIES LB LANCET MIS 28G DIABETIC SUPPLIES LB LANCET MIS 28G Non-Covered/PA Required Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Required Drug List ** Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Refer to Comprehensive Drug List **
DIABETIC SUPPLIES LB LANCET MIS 28G Non-Covered/PA Refer to Comprehensive Drug List ** Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES PX LANCETS MIS ULT THIN DIABETIC SUPPLIES PX LANCETS MIS ULT THIN PX LANCETS MIS ULT THIN Required Drug List ** Non-Covered/PA Refer to Comprehensive Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES PX LANCETS MIS ULT THIN Required Drug List ** Non-Covered/PA Refer to Comprehensive
Required Drug List ** Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES PC LANCETS MIS 30G Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES INCONTROL MIS LANC 33G Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES AURORA LANCE MIS 30G Non-Covered/PA Refer to Comprehensive Required Drug List **
Required Drug List ** Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES INCONTROL MIS LANC 30G Required Drug List **
Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES HLTHY ACCNTS MIS LANC 30G Required Drug List **
Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES HAEMOLANCE MIS LOW FLOW Required Drug List **
DIABETIC SUPPLIES HAEMOLANCE MIS RETRACT Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES PX LANCETS MIS 28G Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES HAEMOLANCE MIS PLUS Non-Covered/PA Refer to Comprehensive
Required Drug List **
DIABETIC SUPPLIES HAEMOLANCE MIS PLUS PED Non-Covered/PA Refer to Comprehensive Required Drug List **
Required Drug List ** Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES HAEMOLANCE MIS PLUS MAX Required Drug List **
Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES HAEMOLANCE MIS HIGH FLO Required Drug List **
Non-Covered/PA Refer to Comprehensive
DIABETIC SUPPLIES HAEMOLANCE MIS PLUS LOW Required Drug List **

DIABETIC SUPPLIES	COMFORT MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET G.P MIS SUPR 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCE MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	QC LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	QC LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ADV TRAVEL MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MOBILE LANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MM TWIST MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLETTOR MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLET OPD MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK PRO MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK PRO MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNITSTIK PRO MIS LANC 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET MICRO MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

		Non Covered/DA	Refer to Comprehensive
DIABETIC SUPPLIES	AIMSCO TWIST MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AIMSCO TWIST MIS 32G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DIATHRIVE MIS UT 30G	Non-Covered/PA	Refer to Comprehensive Drug List **
		Required	•
DIABETIC SUPPLIES	PIP LANCETS MIS 30G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	DIATHRIVE MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS 28G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	VIVAGUARD MIS 30G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	RELION ULTRA MIS THIN 30G	Non-Covered/PA	Refer to Comprehensive
5,,,52116 5611 2,126	MELION GENEVANIO TIMO GO	Required	Drug List **
DIABETIC SUPPLIES	PIP LANCETS MIS 28G	Non-Covered/PA	Refer to Comprehensive
DIVIDE LIE 3011 FIE3	TH EMICE 13 1/113 200	Required	Drug List **
DIABETIC SUPPLIES	CARESENS 30G MIS LANCETS	Non-Covered/PA	Refer to Comprehensive
DIABETIC 30FFEIE3	CARESENS SOO WIS LANCE IS	Required	Drug List **
DIADETIC CUIDDUIC	DDODLET DEDC MIC LANC 200	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	DROPLET PERS MIS LANC 30G	Required	Drug List **
DIADETIC CUIDDUIEC	CND LANCETC AME 200	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GNP LANCETS MIS 30G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GNP LANCETS MIS 28G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GNP LANCETS MIS 33G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	PX LANCETS MIS 33G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	VIVAGUARD MIS 28G	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GENTLE-LET MIS PLATFORM	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	PSS SEL PLAT MIS	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	LANCET CARRY MIS CASE	Required	Drug List **
		The state of the s	<u>-</u>
DIABETIC SUPPLIES	RIGHTEST ALT MIS ADAPTOR	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 1 MIS 2.4MM	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 1 MIS 3.0MM	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **

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DIABETIC SUPPLIES	UNISTIK 2 MIS NORMAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK 23G MIS NORMAL	Required	Drug List **
DIADETIC CUIDDUIEC	LINICTIV 2 NAIC EVEDA	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK 2 MIS EXTRA	Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS COMFORT	Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK Z WIIS COWIFORT	Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS	Non-Covered/PA	Refer to Comprehensive
DIADETIC SOLITEIES	5141511K 2 14115	Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS SUPER	Non-Covered/PA	Refer to Comprehensive
DIN IDE TIC SOLT EIES	ONISTIN 2 IVIIS SOF EN	Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS NEONATAL	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS NORMAL	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK CZT MIS NORMAL	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS EXTRA	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS XTR 21G	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS COMFORT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK CZT MIS COMFORT	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS NEONATAL	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	STERILANCE MIS 1.8MM	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	AUTOLET PLAT MIS 2.4MM	Non-Covered/PA	Refer to Comprehensive
		Required	Drug List **
DIABETIC SUPPLIES	AUTOLET PLAT MIS 3.0MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	AUTOLET PLAT MIS 1.8MM	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK 3 MIS 1.8MM	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK 2 MIS 2.4MM	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	UNISTIK 2 MIS 1.8MM	Required	Drug List **
		Non-Covered/PA	Refer to Comprehensive
DIABETIC SUPPLIES	GENTEEL TIPS MIS YELLOW	Required	Drug List **
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MULTIPLE SCLEROSIS AGENTS	REBIF REBIDO INJ 44/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS	REBIF REBIDO INJ TITRATN	Non-Covered/PA	Refer to Comprehensive
AGENTS		Required	Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF INJ 22/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF INJ 44/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF TITRTN INJ PACK	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA -	YUSIMRY INJ 40/0.8ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 40/0.4ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 40/0.8ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 80/0.8ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 10/0.2ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 20/0.2ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	AMJEVITA INJ 20/0.4ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	HADLIMA PUSH INJ 40/0.4ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA -	HADLIMA PUSH INJ 40/0.8ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA INJ 40/0.4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA -	HADLIMA INJ 40/0.8ML	Non-Covered/PA	Refer to Comprehensive
MONOCLONAL ANTIBODIES		Required	Drug List **
CALCITONIN GENE- RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AIMOVIG INJ 70MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE- RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AIMOVIG INJ 140MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 10MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 150MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 300MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 500MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

HEMATOPOIETIC GROWTH FACTORS	ZARXIO INJ 300/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ZARXIO INJ 480/0.8	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NEULASTA INJ 6MG/0.6M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NEULASTA KIT 6MG/0.6M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NYVEPRIA INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ZIEXTENZO INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	UDENYCA INJ 6MG/0.6	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	UDENYCA INJ 6MG/.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	FULPHILA INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	ZIMHI SOL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS	ENSPRYNG INJ	Non-Covered/PA Required	Refer to Comprehensive Drug List **
	M EDITS – EFFECTIVE FOR ALL MEMBERS NO IN COVERED/NON-COVERED STATUS. REVIS		
Analgesics – Opioid	OPIOID ANALGESICS – INITIAL USE	UPDATE TO REQUIRE PA FOR OPIOID NAÏVE - RESTRICT TO 5 DAYS' SUPPLY AND 90 MG MORPHINE EQUIVALENTS	
Antihypertensives	TEKTURNA TEKTURNA HCT	NEW STEP THERAPY – REQUIRE TRIAL OF ARB	
Anticonvulsants	BANZEL SUSPENSION/TABLET CLOBAZAM SUSPENSION/TABLET FYCOMPA SUSPENSION/TABLET GABITRIL TABLET SABRIL POWDER PACKET/TABLET VIGOPODER POWDER PACKET VIMPAT SOLUTION/TABLET	NEW PA	
Antidiabetics	SYMLIN		TEP THERAPY – LAIM FOR INSULIN THERAPY
Antihistamines – minimally	CETIRIZINE SYRUP (RX) LORATADINE 5 MG CHEWABLE (OTC)		V AGE EDIT – NDIVIDUALS 13 AND OLDER

LORATADINE 10 MG ODT (OTC)

sedating

FOR ALL LIQUID AND ODT FORMULATIONS

u	Antineoplastic / Adjunctive Therapies	OJEMDA	ADD PA
	Anticonvulsants	LIBERVANT	ADD PA

^{*}UM UPDATES WILL APPLY WHEN THE MEDICATION BECOMES AVAILABLE ON THE MARKET

^{**} COMPREHENSIVE DRUG LIST WILL BE AVAILABLE 7/1/2024

What action do I need to take?

Some drugs may no longer be covered. Determine if a change to a covered drug can be done. If so, a new prescription needs to be sent to the pharmacy.

If the non-covered drug cannot be changed, a prior authorization may be needed.

What if I have questions?

For members, call Pharmacy Customer Service at **866-781-5094 (TTY 1-866-773-9634)**, 24 hours a day, seven days a week.

For providers, you can find the *Comprehensive Drug List* on our website by visiting **www.HealthyBlueSC.com** and selecting **Providers**. If you need assistance with any other item, contact Provider Service at **866-757-8286**.