

CareFirst Formulary 2

Federal Employees Health Benefits Program

List of Covered Drugs

2023

PLEASE READ: This document contains information about the drugs we cover in this plan. This formulary is for members of the federal employees health benefits program.

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

Introduction

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

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

Using Your Formulary

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

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

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

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

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

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

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

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

Tier 0: \$0 Drugs	<ul style="list-style-type: none"> ■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share.
Tier 1: Generic Drugs \$	<ul style="list-style-type: none"> ■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs \$\$	<ul style="list-style-type: none"> ■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-preferred Brand Drugs \$\$\$	<ul style="list-style-type: none"> ■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.
Tier 4: Preferred Specialty Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Preferred specialty drugs are medications that may be used to treat complex and/or rare health conditions. These drugs may have a lower cost-share than non-preferred specialty drugs.
Tier 5: Non-Preferred Specialty Drugs \$\$\$\$	<ul style="list-style-type: none"> ■ Non-preferred specialty drugs often have a specialty drug option where your cost-share will be lower.

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

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

1

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

Drug Name	Drug Tier	Requirements/Limits
DEXEDRINE CAP 15MG CR	3	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	QL (1440 mL every 30 days)
<i>dextroamphetamine sulfate tab 2.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 7.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 10 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 15 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	1	QL (30 tabs every 30 days)
DYANAVEL XR CHW 5MG	3	QL (60 tabs every 30 days)
DYANAVEL XR CHW 10MG	3	QL (60 tabs every 30 days)
DYANAVEL XR CHW 15MG	3	QL (30 tabs every 30 days)
DYANAVEL XR CHW 20MG	3	QL (30 tabs every 30 days)
DYANAVEL XR SUS 2.5MG/ML	3	QL (300 mL every 30 days)
<i>methamphetamine hcl tab 5 mg</i>	1	QL (180 tabs every 30 days)
MYDAYIS CAP 12.5MG	2	QL (60 caps every 30 days)
MYDAYIS CAP 25MG	2	QL (60 caps every 30 days)
MYDAYIS CAP 37.5MG	2	QL (30 caps every 30 days)
MYDAYIS CAP 50MG	2	QL (30 caps every 30 days)

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

2

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

Drug Name	Drug Tier	Requirements/Limits
VYVANSE CAP 10MG	2	QL (60 caps every 30 days)
VYVANSE CAP 20MG	2	QL (60 caps every 30 days)
VYVANSE CAP 30MG	2	QL (60 caps every 30 days)
VYVANSE CAP 40MG	2	QL (30 caps every 30 days)
VYVANSE CAP 50MG	2	QL (30 caps every 30 days)
VYVANSE CAP 60MG	2	QL (30 caps every 30 days)
VYVANSE CAP 70MG	2	QL (30 caps every 30 days)
VYVANSE CHW 10MG	2	QL (60 tabs every 30 days)
VYVANSE CHW 20MG	2	QL (60 tabs every 30 days)
VYVANSE CHW 30MG	2	QL (60 tabs every 30 days)
VYVANSE CHW 40MG	2	QL (30 tabs every 30 days)
VYVANSE CHW 50MG	2	QL (30 tabs every 30 days)
VYVANSE CHW 60MG	2	QL (30 tabs every 30 days)

ANALEPTICS

<i>caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)</i>	1	
---	---	--

ANTI-OBESITY AGENTS

WEGOVY INJ 0.5MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 0.25MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1.7MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 1MG	2	PA; Coverage is subject to your plan/benefits
WEGOVY INJ 2.4MG	2	PA; Coverage is subject to your plan/benefits

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

3

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

Drug Name	Drug Tier	Requirements/Limits
ANTI-OBESITY AGENTS, INJECTABLE		
SAXENDA INJ 18MG/3ML	2	PA; Coverage is subject to your plan/benefits
ANTI-OBESITY AGENTS, ORAL		
ADIPEX-P CAP 37.5MG	3	PA; Coverage is subject to your plan/benefits
ADIPEX-P TAB 37.5MG	3	PA; Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 25 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>benzphetamine hcl tab 50 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab 25 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>orlistat cap 120 mg</i>	1	PA; Coverage is subject to your plan/benefits
PHENDIMETRAZ CAP 105MG ER	1	PA; Coverage is subject to your plan/benefits
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 15 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 30 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl tab 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 3.75-23	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 7.5-46MG	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 11.25-69	2	PA; Coverage is subject to your plan/benefits

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

4

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

Drug Name	Drug Tier	Requirements/Limits
QSYMIA CAP 15-92MG	2	PA; Coverage is subject to your plan/benefits
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	QL (60 caps every 30 days)
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	
KAPVAY TAB 0.1 MG	3	
STRATTERA CAP 10MG	3	QL (150 caps every 30 days)
STRATTERA CAP 18MG	3	QL (150 caps every 30 days)
STRATTERA CAP 25MG	3	QL (150 caps every 30 days)
STRATTERA CAP 40MG	3	QL (60 caps every 30 days)
STRATTERA CAP 60MG	3	QL (30 caps every 30 days)
STRATTERA CAP 80MG	3	QL (30 caps every 30 days)

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

5

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

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

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

6

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

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

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

7

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

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

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

8

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

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl tab er 10 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 20 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 18 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 36 mg</i>	1	QL (60 tabs every 30 days); MNPA
<i>methylphenidate hcl tab er 24hr 54 mg</i>	1	QL (30 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	1	QL (30 tabs every 30 days)
<i>modafinil tab 100 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>modafinil tab 200 mg</i>	1	PA, QL (60 tabs every 30 days)
QUILLICHEW CHW 20MG ER	3	QL (60 tabs every 30 days)
QUILLICHEW CHW 30MG ER	3	QL (60 tabs every 30 days)
QUILLICHEW CHW 40MG ER	3	QL (30 tabs every 30 days)
QUILLIVANT SUS 25MG/5ML	3	QL (420 mL every 30 days)
RITALIN LA CAP 10MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 20MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 30MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 40MG	3	QL (30 caps every 30 days)
RITALIN TAB 5MG	3	QL (210 tabs every 30 days)

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

9

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

Drug Name	Drug Tier	Requirements/Limits
RITALIN TAB 10MG	3	QL (210 tabs every 30 days)
RITALIN TAB 20MG	3	QL (120 tabs every 30 days)

ALLERGENIC EXTRACTS/BIOLOGICALS MISC**ALLERGENIC EXTRACTS**

GRASTEK SUB 2800BAU	2	
RAGWITEK SUB	2	

AMINOGLYCOSIDES**AMINOGLYCOSIDES**

ARIKAYCE SUS	5	PA
BETHKIS NEB 300/4ML	5	PA, QL (56 AMPULES PER 28 DAYS)
KITABIS PAK NEB 300/5ML	5	PA, QL (56 AMPULES PER 28 DAYS)
<i>neomycin sulfate tab 500 mg</i>	1	
<i>paromomycin sulfate cap 250 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)
<i>tobramycin nebu soln 300 mg/5ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)

ANALGESICS - ANTI-INFLAMMATORY**ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES**

ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
ADALIMU-ADAZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
AMJEVITA INJ 10/0.2ML	5	PA, QL (2 syringes per 28 days)
AMJEVITA INJ 20/0.4ML	5	PA, QL (4 SYRINGES PER 28 DAYS)

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

10

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

Drug Name	Drug Tier	Requirements/Limits
AMJEVITA INJ 40/0.8ML	5	PA, QL (4 PENS PER 28 DAYS); Loading dose: 8 per 14 days
AMJEVITA INJ 40/0.8ML	5	PA, QL (4 SYRINGES PER 28 DAYS); Loading dose: 8 per 14 days
HUMIRA INJ 10/0.1ML	4	PA, QL (2 SYRINGES PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 20/0.2ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 40/0.4ML	4	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

11

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

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

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

12

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

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN INJ 40MG/0.8	4	PA, QL (4 PENS PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 80/0.8ML	4	PA, QL (2 PENS PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ CD/UC/HS	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 6 pens per 28 days.
HUMIRA PEN INJ PS/UV	4	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 4 pens per 28 days.

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

13

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

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

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

14

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

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ INJ 40/0.4ML	4	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HYRIMOZ INJ 40/0.8ML	4	PA, QL (4 pen autoinjectors per 28 days)
HYRIMOZ INJ 40/0.8ML	4	PA, QL (4 syringes per 28 days)
HYRIMOZ INJ 80/0.8ML	4	PA, QL (2 pens PER 28 days); LOADING DOSE: 4 pens per 14 days
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 2 syringes per 28 days
HYRIMOZ-PED INJ CROHNS	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
HYRIMOZ-PLAQ INJ PSORIASI	4	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
ANTIRHEUMATIC - ENZYME INHIBITORS		
RINVOQ TAB 15MG ER	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits.

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

15

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
XELJANZ TAB 5MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ TAB 10MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ XR TAB 11MG	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

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

Drug Name	Drug Tier	Requirements/Limits
XELJANZ XR TAB 22MG	4	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
GOLD COMPOUNDS		
RIDAURA CAP 3MG	3	
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ 220MG	5	PA, QL (8 VIALS PER 28 DAYS)
INTERLEUKIN-6 RECEPTOR INHIBITORS		
KEVZARA INJ 150/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	4	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
celecoxib cap 50 mg	1	

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

18

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

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

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

19

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

Drug Name	Drug Tier	Requirements/Limits
<i>ketorolac tromethamine tab 10 mg</i>	1	
<i>meclofenamate sodium cap 50 mg</i>	1	
<i>meclofenamate sodium cap 100 mg</i>	1	
<i>mefenamic acid cap 250 mg</i>	1	
<i>meloxicam tab 7.5 mg</i>	1	
<i>meloxicam tab 15 mg</i>	1	
MOBIC TAB 7.5MG	3	
MOBIC TAB 15MG	3	
<i>nabumetone tab 500 mg</i>	1	
<i>nabumetone tab 750 mg</i>	1	
NALFON CAP 400MG	3	
NALFON TAB 600MG	3	
NAPROSYN SUS 125/5ML	3	
NAPROSYN TAB 500MG	3	
<i>naproxen sodium tab 275 mg</i>	1	
<i>naproxen sodium tab 550 mg</i>	1	
<i>naproxen tab 250 mg</i>	1	
<i>naproxen tab 375 mg</i>	1	
<i>naproxen tab 500 mg</i>	1	
<i>naproxen tab ec 375 mg</i>	1	
<i>naproxen tab ec 500 mg</i>	1	
<i>oxaprozin tab 600 mg</i>	1	
<i>piroxicam cap 10 mg</i>	1	
<i>piroxicam cap 20 mg</i>	1	
<i>sulindac tab 150 mg</i>	1	
<i>sulindac tab 200 mg</i>	1	
<i>tolmetin sodium cap 400 mg</i>	1	
<i>tolmetin sodium tab 600 mg</i>	1	
VIMOVO TAB 375-20MG	3	
VIMOVO TAB 500-20MG	3	
ZIPSOR CAP 25MG	3	

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

20

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

Drug Name	Drug Tier	Requirements/Limits
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20/30	4	PA, QL (55 TABLETS PER 28 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
OTEZLA TAB 30MG	4	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
PYRIMIDINE SYNTHESIS INHIBITORS		
ARAVA TAB 10MG	2	
ARAVA TAB 20MG	2	
leflunomide tab 10 mg	1	
leflunomide tab 20 mg	1	
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25/0.5ML	4	PA, QL (8 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

21

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

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

ANALGESICS - NONNARCOTIC**ANALGESIC COMBINATIONS**

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

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

22

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

Drug Name	Drug Tier	Requirements/Limits
ESGIC TAB	3	
SALICYLATES		
<i>aspirin chew tab 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>aspirin tab delayed release 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>diflunisal tab 500 mg</i>	1	
<i>salsalate tab 500 mg</i>	1	
<i>salsalate tab 750 mg</i>	1	
ANALGESICS - OPIOID		
OPIOID AGONISTS		
ACTIQ LOZ 200MCG	3	PA
ACTIQ LOZ 400MCG	3	PA
ACTIQ LOZ 600MCG	3	PA
ACTIQ LOZ 800MCG	3	PA
ACTIQ LOZ 1200MCG	3	PA
ACTIQ LOZ 1600MCG	3	PA
CODEINE SULF TAB 15MG	3	PA, QL (42 tabs every 30 days)
CODEINE SULF TAB 60MG	3	PA, QL (42 tabs every 30 days)
<i>codeine sulfate tab 30 mg</i>	1	PA, QL (42 tabs every 30 days)
CONZIP CAP 100MG	3	PA, QL (30 caps every 30 days)
CONZIP CAP 200MG	3	PA, QL (30 caps every 30 days)
CONZIP CAP 300MG	3	PA, QL (30 caps every 30 days)
DILAUDID LIQ 1MG/ML	3	PA, QL (16 mL per day)
DILAUDID TAB 2MG	3	PA, QL (180 tabs every 30 days)
DILAUDID TAB 4MG	3	PA, QL (4 tabs per day)
DILAUDID TAB 8MG	3	PA, QL (60 tabs every 30 days)

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

23

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

Drug Name	Drug Tier	Requirements/Limits
DURAGESIC DIS 12MCG/HR	3	PA, QL (10 patches every 30 days)
DURAGESIC DIS 25MCG/HR	3	PA, QL (10 patches every 30 days)
DURAGESIC DIS 50MCG/HR	3	PA
DURAGESIC DIS 75MCG/HR	3	PA
DURAGESIC DIS 100MCG/H	3	PA, QL (10 patches every 30 days)
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	1	PA
<i>fentanyl td patch 72hr 12 mcg/hr</i>	1	PA, QL (10 patches every 30 days)
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	PA, QL (10 patches every 30 days)
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA, QL (10 patches every 30 days)
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA, QL (10 patches every 25 days)

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

24

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

Drug Name	Drug Tier	Requirements/Limits
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA, QL (10 patches every 30 days)
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA, QL (10 patches every 30 days)
FENTORA TAB 100MCG	3	PA
FENTORA TAB 200MCG	3	PA
FENTORA TAB 400MCG	3	PA
FENTORA TAB 600MCG	3	PA
FENTORA TAB 800MCG	3	PA
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	1	PA, QL (30 tabs every 30 days)

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

25

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

Drug Name	Drug Tier	Requirements/Limits
HYDROMORPHON SUP 3MG	3	PA, QL (120 supp every 30 days)
<i>hydromorphone hcl liqd 1 mg/ml</i>	1	PA, QL (16 mL per day)
<i>hydromorphone hcl tab 2 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydromorphone hcl tab 4 mg</i>	1	PA, QL (4 tabs per day)
<i>hydromorphone hcl tab 8 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 8 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 12 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 16 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 32 mg</i>	1	PA
<i>meperidine hcl oral soln 50 mg/5ml</i>	1	PA
<i>meperidine hcl tab 50 mg</i>	1	PA
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (1.5 mL per day)
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (60 mL every 30 days)
<i>methadone hcl soln 5 mg/5ml</i>	1	PA, QL (450 mL every 30 days)
<i>methadone hcl soln 10 mg/5ml</i>	1	PA, QL (7.5 mL per day)
<i>methadone hcl tab 5 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>methadone hcl tab 10 mg</i>	1	PA, QL (1 tab per day)
<i>methadone hcl tab for oral susp 40 mg</i>	1	
METHADOSE CON 10MG/ML	3	QL (60 mL every 30 days)
METHADOSE SF CON 10MG/ML	3	QL (60 mL every 30 days)
<i>morphine sulfate beads cap er 24hr 30 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 45 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 30 days)

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

26

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

Drug Name	Drug Tier	Requirements/Limits
<i>morphine sulfate beads cap er 24hr 75 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 90 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 120 mg</i>	1	PA
<i>morphine sulfate cap er 24hr 10 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 20 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 30 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 40 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 50 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 80 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 100 mg</i>	1	PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	1	PA, QL (900 mL every 30 days)
<i>morphine sulfate oral soln 20 mg/5ml</i>	1	PA, QL (675 mL every 30 days)
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 27 days)
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 30 days)
<i>morphine sulfate suppos 5 mg</i>	1	PA, QL (180 supp every 30 days)
<i>morphine sulfate suppos 10 mg</i>	1	PA, QL (180 supp every 30 days)
<i>morphine sulfate suppos 20 mg</i>	1	PA, QL (120 supp every 30 days)
<i>morphine sulfate suppos 30 mg</i>	1	PA, QL (90 supp every 30 days)

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

27

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

Drug Name	Drug Tier	Requirements/Limits
<i>morphine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>morphine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 15 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 30 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 60 mg</i>	1	PA
<i>morphine sulfate tab er 100 mg</i>	1	PA
<i>morphine sulfate tab er 200 mg</i>	1	PA
MS CONTIN TAB 15MG ER	3	PA, QL (90 tabs every 30 days)
MS CONTIN TAB 30MG ER	3	PA, QL (90 tabs every 30 days)
MS CONTIN TAB 60MG ER	3	PA
MS CONTIN TAB 100MG ER	3	PA
MS CONTIN TAB 200MG ER	3	PA
NUCYNTA ER TAB 50MG	2	PA, QL (60 tabs every 30 days)
NUCYNTA ER TAB 100MG	2	PA, QL (60 tabs every 30 days)
NUCYNTA ER TAB 150MG	2	PA
NUCYNTA ER TAB 200MG	2	PA
NUCYNTA ER TAB 250MG	2	PA
NUCYNTA TAB 50MG	2	PA, QL (120 tabs every 30 days)
NUCYNTA TAB 75MG	2	PA, QL (90 tabs every 30 days)
NUCYNTA TAB 100MG	2	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 25 days)
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 30 days)

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

28

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

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (90 mL every 30 days)
<i>oxycodone hcl soln 5 mg/5ml</i>	1	PA, QL (900 mL every 30 days)
<i>oxycodone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone hcl tab 10 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone hcl tab 15 mg</i>	1	PA, QL (120 tabs every 30 days)
<i>oxycodone hcl tab 20 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>oxycodone hcl tab 30 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	1	PA, QL (120 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxymorphone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxymorphone hcl tab 10 mg</i>	1	PA, QL (90 tabs every 30 days)
ROXICODONE TAB 5MG	3	PA, QL (180 tabs every 30 days)
ROXICODONE TAB 15MG	3	PA, QL (120 tabs every 30 days)

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

29

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

Drug Name	Drug Tier	Requirements/Limits
ROXICODONE TAB 30MG	3	PA, QL (60 tabs every 30 days)
<i>tramadol hcl tab 50 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>tramadol hcl tab er 24hr 100 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr 200 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA
ULTRAM TAB 50MG	3	PA, QL (180 tabs every 30 days)
XTAMPZA ER CAP 9MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 13.5MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 18MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 27MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 36MG	2	PA, QL (60 caps every 30 days)
OPIOID COMBINATIONS		
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	PA, QL (2700 mL every 30 days)
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	PA, QL (390 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	PA, QL (360 tabs every 30 days)

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

30

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

Drug Name	Drug Tier	Requirements/Limits
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	PA, QL (300 caps every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	1	PA, QL (300 tabs every 30 days)
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	1	
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	1	
FIORICET CAP CODEINE	3	
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen soln 10-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	1	PA, QL (150 tabs every 30 days)

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

31

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

Drug Name	Drug Tier	Requirements/Limits
LORTAB ELX 10-300MG	3	PA, QL (2040 mL every 30 days)
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
ULTRACET TAB 37.5-325	3	PA, QL (240 tabs every 30 days)

OPIOID PARTIAL AGONISTS

BELBUCA MIS 75MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 150MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 300MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 450MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 600MCG	2	PA
BELBUCA MIS 750MCG	2	PA
BELBUCA MIS 900MCG	2	PA
BUNAVAIL MIS 4.2-0.7	3	
BUNAVAIL MIS 6.3-1MG	3	
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	0	
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	

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

32

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

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	0	
<i>buprenorphine td patch weekly 5 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 10 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 15 mcg/hr</i>	1	PA
<i>buprenorphine td patch weekly 20 mcg/hr</i>	1	PA
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1	QL (2.4 bottles every 30 days)
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA
ZUBSOLV SUB 0.7-0.18	2	
ZUBSOLV SUB 1.4-0.36	2	
ZUBSOLV SUB 2.9-0.71	2	
ZUBSOLV SUB 5.7-1.4	2	
ZUBSOLV SUB 8.6-2.1	2	
ZUBSOLV SUB 11.4-2.9	2	

ANDROGENS-ANABOLIC**ANABOLIC STEROIDS**

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

ANDROGENS

ANDRODERM DIS 2MG/24HR	2	PA
ANDRODERM DIS 4MG/24HR	2	PA
<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	

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

33

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

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

ANORECTAL AND RELATED PRODUCTS**INTRARECTAL STEROIDS**

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

RECTAL COMBINATIONS

ANALPRAM-HC CRE 1-1%	3	
ANALPRAM-HC LOT 2.5%	3	
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
PROCORT CRE	3	
PROCTOFOAM AER HC 1%	2	

RECTAL STEROIDS

ANUSOL-HC CRE 2.5%	2	
--------------------	---	--

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

34

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

Drug Name	Drug Tier	Requirements/Limits
<i>hydrocortisone acetate suppos 25 mg</i>	1	
<i>hydrocortisone perianal cream 1%</i>	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
PROCTOCORT CRE 1%	3	
PROCTOCORT SUP 30MG	3	
VASODILATING AGENTS		
RECTIV OIN 0.4%	3	
ANTHELMINTICS		
ANTHELMINTICS		
<i>albendazole tab 200 mg</i>	1	QL (336 tabs every year)
ALBENZA TAB 200MG	3	QL (336 tabs every year)
BENZNIDAZOLE TAB 12.5MG	3	
BENZNIDAZOLE TAB 100MG	3	
BILTRICIDE TAB 600MG	3	QL (24 tabs every year)
EMVERM CHW 100MG	2	QL (12 ea every year)
<i>ivermectin tab 3 mg</i>	1	PA, QL (9 tabs every 90 days)
<i>praziquantel tab 600 mg</i>	1	QL (24 tabs every year)
STROMECTION TAB 3MG	3	PA, QL (9 tabs every 90 days)
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
AEMCOLO TAB 194MG	3	
FLAGYL CAP 375MG	3	
FLAGYL TAB 500MG	3	
IMPAVIDO CAP 50MG	3	
<i>metronidazole cap 375 mg</i>	1	
<i>metronidazole tab 250 mg</i>	1	
<i>metronidazole tab 500 mg</i>	1	
PRIMSOL SOL 50MG/5ML	3	
<i>tinidazole tab 250 mg</i>	1	
<i>tinidazole tab 500 mg</i>	1	
<i>trimethoprim tab 100 mg</i>	1	
XIFAXAN TAB 200MG	3	QL (9 tabs every 30 days)
XIFAXAN TAB 550MG	2	

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

35

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

Drug Name	Drug Tier	Requirements/Limits
ANTI-INFECTIVE MISC. - COMBINATIONS		
BACTRIM DS TAB 800-160	3	
BACTRIM TAB 400-80MG	3	
<i>methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg</i>	1	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
ANTIPROTOZOAL AGENTS		
ALINIA SUS 100/5ML	3	
ALINIA TAB 500MG	3	
<i>atovaquone susp 750 mg/5ml</i>	1	
LAMPIT TAB 30MG	3	
LAMPIT TAB 120MG	3	
MEPRON SUS	3	
<i>nitazoxanide tab 500 mg</i>	1	
GLYCOPEPTIDES		
VANCOCIN CAP 125MG	2	QL (80 caps every 10 days)
VANCOCIN CAP 250MG	2	QL (80 caps every 10 days)
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1	QL (80 caps every 10 days)
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1	QL (80 caps every 10 days)
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	3	QL (450 mL every 10 days)
LEPROSTATICS		
<i>dapsone tab 25 mg</i>	1	
<i>dapsone tab 100 mg</i>	1	
LINCOSAMIDES		
CLEOCIN CAP 75MG	2	
CLEOCIN CAP 150MG	2	
CLEOCIN CAP 300MG	2	
CLEOCIN PED SOL 75MG/5ML	2	
<i>clindamycin hcl cap 75 mg</i>	1	
<i>clindamycin hcl cap 150 mg</i>	1	

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

36

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

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin hcl cap 300 mg</i>	1	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	1	
MONOBACTAMS		
CAYSTON INH 75MG	5	PA, QL (84 VIALS PER 28 DAYS)
OXAZOLIDINONES		
<i>linezolid for susp 100 mg/5ml</i>	1	PA
<i>linezolid tab 600 mg</i>	1	PA
SIVEXTRO TAB 200MG	3	
ZYVOX SUS 100MG/5M	3	PA
ZYVOX TAB 600MG	3	PA
PLEUROMUTILINS		
XENLETA TAB 600MG	3	
URINARY ANTI-INFECTIVES		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	2	
<i>methenamine hippurate tab 1 gm</i>	1	
<i>methenamine mandelate tab 0.5 gm</i>	1	
<i>methenamine mandelate tab 1 gm</i>	1	
MONUROL PAK GRANULES	3	
<i>nitrofurantoin macrocrystalline cap 25 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
RANEXA TAB 500MG	3	
RANEXA TAB 1000MG	3	
<i>ranolazine tab er 12hr 500 mg</i>	1	
<i>ranolazine tab er 12hr 1000 mg</i>	1	

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

37

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

Drug Name	Drug Tier	Requirements/Limits
NITRATES		
DILATRATE SR CAP 40MG	3	
ISORDIL TAB 5MG	3	
ISORDIL TAB 40MG	3	
<i>isosorbide dinitrate tab 5 mg</i>	1	
<i>isosorbide dinitrate tab 10 mg</i>	1	
<i>isosorbide dinitrate tab 20 mg</i>	1	
<i>isosorbide dinitrate tab 30 mg</i>	1	
<i>isosorbide mononitrate tab 10 mg</i>	1	
<i>isosorbide mononitrate tab 20 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	1	
NITRO-BID OIN 2%	3	
NITRO-DUR DIS 0.1MG/HR	2	
NITRO-DUR DIS 0.2MG/HR	2	
NITRO-DUR DIS 0.3MG/HR	2	
NITRO-DUR DIS 0.4MG/HR	2	
NITRO-DUR DIS 0.6MG/HR	2	
NITRO-DUR DIS 0.8MG/HR	2	
<i>nitroglycerin sl tab 0.3 mg</i>	1	
<i>nitroglycerin sl tab 0.4 mg</i>	1	
<i>nitroglycerin sl tab 0.6 mg</i>	1	
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	1	
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)</i>	1	
NITROLINGUAL SPR PUMPSRA	3	
NITROMIST AER 400MCG	3	
NITROSTAT SUB 0.3MG	3	
NITROSTAT SUB 0.4MG	3	
NITROSTAT SUB 0.6MG	3	

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

38

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

Drug Name	Drug Tier	Requirements/Limits
ANTIAXIETY AGENTS		
ANTIAXIETY AGENTS - MISC.		
<i>buspirone hcl tab 5 mg</i>	1	
<i>buspirone hcl tab 7.5 mg</i>	1	
<i>buspirone hcl tab 10 mg</i>	1	
<i>buspirone hcl tab 15 mg</i>	1	
<i>buspirone hcl tab 30 mg</i>	1	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl tab 10 mg</i>	1	
<i>hydroxyzine hcl tab 25 mg</i>	1	
<i>hydroxyzine hcl tab 50 mg</i>	1	
<i>hydroxyzine pamoate cap 25 mg</i>	1	
<i>hydroxyzine pamoate cap 50 mg</i>	1	
<i>hydroxyzine pamoate cap 100 mg</i>	1	
<i>meprobamate tab 200 mg</i>	1	
<i>meprobamate tab 400 mg</i>	1	
VISTARIL CAP 25MG	3	
VISTARIL CAP 50MG	3	
BENZODIAZEPINES		
ALPRAZOLAM CON 1 MG/ML	3	
<i>alprazolam orally disintegrating tab 0.5 mg</i>	1	
<i>alprazolam orally disintegrating tab 0.25 mg</i>	1	
<i>alprazolam orally disintegrating tab 1 mg</i>	1	
<i>alprazolam orally disintegrating tab 2 mg</i>	1	
<i>alprazolam tab 0.5 mg</i>	1	
<i>alprazolam tab 0.25 mg</i>	1	
<i>alprazolam tab 1 mg</i>	1	
<i>alprazolam tab 2 mg</i>	1	
<i>alprazolam tab er 24hr 0.5 mg</i>	1	
<i>alprazolam tab er 24hr 1 mg</i>	1	
<i>alprazolam tab er 24hr 2 mg</i>	1	
<i>alprazolam tab er 24hr 3 mg</i>	1	
<i>chlordiazepoxide hcl cap 5 mg</i>	1	
<i>chlordiazepoxide hcl cap 10 mg</i>	1	
<i>chlordiazepoxide hcl cap 25 mg</i>	1	

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

39

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

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

ANTIARRHYTHMICS**ANTIARRHYTHMICS TYPE I-A**

<i>disopyramide phosphate cap 100 mg</i>	1	
<i>disopyramide phosphate cap 150 mg</i>	1	
NORPACE CAP 100MG CR	2	
NORPACE CAP 150MG CR	2	
<i>quinidine gluconate tab er 324 mg</i>	1	
<i>quinidine sulfate tab 200 mg</i>	1	
<i>quinidine sulfate tab 300 mg</i>	1	

ANTIARRHYTHMICS TYPE I-B

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

ANTIARRHYTHMICS TYPE I-C

<i>flecainide acetate tab 50 mg</i>	1	
<i>flecainide acetate tab 100 mg</i>	1	

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

40

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

Drug Name	Drug Tier	Requirements/Limits
<i>flecainide acetate tab 150 mg</i>	1	
<i>propafenone hcl cap er 12hr 225 mg</i>	1	
<i>propafenone hcl cap er 12hr 325 mg</i>	1	
<i>propafenone hcl cap er 12hr 425 mg</i>	1	
<i>propafenone hcl tab 150 mg</i>	1	
<i>propafenone hcl tab 225 mg</i>	1	
<i>propafenone hcl tab 300 mg</i>	1	
RYTHMOL SR CAP 225MG	2	
RYTHMOL SR CAP 325MG	2	
RYTHMOL SR CAP 425MG	2	
ANTIARRHYTHMICS TYPE III		
<i>amiodarone hcl tab 100 mg</i>	1	
<i>amiodarone hcl tab 200 mg</i>	1	
<i>amiodarone hcl tab 400 mg</i>	1	
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	PA
MULTAQ TAB 400MG	2	
TIKOSYN CAP 125MCG	5	PA
TIKOSYN CAP 250MCG	5	PA
TIKOSYN CAP 500MCG	5	PA
ANTIASTHMATIC AND BRONCHODILATOR AGENTS		
ANTI-INFLAMMATORY AGENTS		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (240 mL every 30 days)
ANTIASTHMATIC - MONOCLONAL ANTIBODIES		
DUPIXENT INJ 100/0.67	4	PA, QL (2 SYRINGES PER 28 DAYS)
DUPIXENT INJ 200/1.14	4	PA, QL (2 PFS PER 28 DAYS); LOADING DOSE: 2 PFS PER 14 DAYS
FASENRA PEN INJ 30MG/ML	4	PA, QL (1 PENS PER 56 DAYS); LOADING DOSE: 3 PENS PER 84 DAYS
NUCALA INJ 40MG/0.4	4	PA, QL (1 SYRINGE PER 28 DAYS)

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

41

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

Drug Name	Drug Tier	Requirements/Limits
NUCALA INJ 100MG/ML	4	PA, QL (3 INJ PER 28 DAYS)
NUCALA INJ 100MG/ML	4	PA, QL (3 PFS PER 28 DAYS)
BRONCHODILATORS - ANTICHOLINERGICS		
ATROVENT HFA AER 17MCG	3	QL (2 packages every 25 days)
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (120 vials every 30 days)
SPIRIVA AER 1.25MCG	2	QL (1 package every 25 days)
SPIRIVA CAP HANDIHLR	2	QL (30 caps every 30 days)
SPIRIVA SPR 2.5MCG	2	QL (1 package every 25 days)
YUPELRI SOL	2	QL (90 mL every 30 days)
LEUKOTRIENE MODULATORS		
ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	
<i>zafirlukast tab 10 mg</i>	1	
<i>zafirlukast tab 20 mg</i>	1	
ZYFLO TAB 600MG	3	
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB 250MCG	2	
DALIRESP TAB 500MCG	2	
STEROID INHALANTS		
ARNUIITY ELPT INH 50MCG	2	QL (1 inhaler every 30 days)

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

42

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

Drug Name	Drug Tier	Requirements/Limits
ARNUIITY ELPT INH 100MCG	2	QL (30 blisters every 30 days)
ARNUIITY ELPT INH 200MCG	2	QL (30 blisters every 30 days)
<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (2 mL every 25 days)
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (3 mL every 25 days)
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (1 mL every 25 days)
FLOVENT DISK AER 50MCG	2	QL (3 inhalations every 25 days)
FLOVENT DISK AER 100MCG	2	QL (4 inhalations every 25 days)
FLOVENT DISK AER 250MCG	2	QL (4 inhalations every 25 days)
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days)
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days)
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days)
PULMICORT INH 90MCG	2	QL (3 inhalers every 25 days)
PULMICORT INH 180MCG	2	QL (2 inhalers every 25 days)
PULMICORT SUS 0.5MG/2	3	QL (2 mL every 25 days)
PULMICORT SUS 0.25MG/2	3	QL (3 mL every 25 days)
PULMICORT SUS 1MG/2ML	3	QL (1 mL every 25 days)
QVAR REDIIHA AER 80MCG	2	QL (2 packages every 25 days)
QVAR REDIIHAL AER 40MCG	2	QL (2 packages every 25 days)
SYMPATHOMIMETICS		
ADVAIR DISKU AER 100/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR DISKU AER 250/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9

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

43

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

Drug Name	Drug Tier	Requirements/Limits
ADVAIR DISKU AER 500/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR HFA AER 45/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 115/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 230/21	2	QL (1 package every 25 days)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1	QL (2 packages every 25 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (120 ea every 30 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (60 mL every 30 days)
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate syrup 2 mg/5ml</i>	1	
<i>albuterol sulfate tab 2 mg</i>	1	
<i>albuterol sulfate tab 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 8 mg</i>	1	
ANORO ELLIPT AER 62.5-25	2	QL (60 blisters every 30 days)
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (120 mL every 30 days)
BREO ELLIPTA INH 50-25MCG	2	QL (60 blisters every 30 days)
BREO ELLIPTA INH 100-25	2	QL (60 blisters every 30 days)
BREO ELLIPTA INH 200-25	2	QL (60 blisters every 30 days)
BREZTRI AERO AER SPHERE	2	QL (1 inhaler every 25 days)
BROVANA NEB 15MCG	3	QL (120 mL every 30 days)

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

44

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

Drug Name	Drug Tier	Requirements/Limits
COMBIVENT AER 20-100	3	QL (2 packages every 25 days)
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (60 mL every 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (540 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (90 ea every 30 days)
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (2 inhalers every 30 days)
PERFOROMIST NEB 20MCG	3	QL (120 mL every 30 days)
SEREVENT DIS AER 50MCG	2	QL (60 inhalations every 30 days)
STIOLTO AER 2.5-2.5	2	QL (1 package every 25 days)
STRIVERDI AER 2.5MCG	2	QL (1 package every 25 days)
SYMBICORT AER 80-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
SYMBICORT AER 160-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
<i>terbutaline sulfate tab 2.5 mg</i>	1	
<i>terbutaline sulfate tab 5 mg</i>	1	
TRELEGY AER 100MCG	2	QL (1 inhaler every 30 days)
TRELEGY AER 200MCG	2	QL (1 inhaler every 30 days)
XOPENEX CONC NEB 1.25/0.5	3	QL (90 ea every 30 days)
XOPENEX NEB 0.31MG	3	QL (300 mL every 30 days)
XOPENEX NEB 0.63MG	3	QL (300 mL every 30 days)
XOPENEX NEB 1.25/3ML	3	QL (300 mL every 30 days)

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

45

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

Drug Name	Drug Tier	Requirements/Limits
XANTHINES		
<i>theophylline elixir 80 mg/15ml</i>	1	
<i>theophylline elixir 80 mg/15ml</i>	3	
<i>theophylline tab er 12hr 300 mg</i>	1	
<i>theophylline tab er 12hr 450 mg</i>	1	
<i>theophylline tab er 24hr 400 mg</i>	1	
<i>theophylline tab er 24hr 600 mg</i>	1	
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
<i>warfarin sodium tab 1 mg</i>	1	
<i>warfarin sodium tab 2 mg</i>	1	
<i>warfarin sodium tab 2.5 mg</i>	1	
<i>warfarin sodium tab 3 mg</i>	1	
<i>warfarin sodium tab 4 mg</i>	1	
<i>warfarin sodium tab 5 mg</i>	1	
<i>warfarin sodium tab 6 mg</i>	1	
<i>warfarin sodium tab 7.5 mg</i>	1	
<i>warfarin sodium tab 10 mg</i>	1	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS ST P TAB 5MG	2	
ELIQUIS TAB 2.5MG	2	
ELIQUIS TAB 5MG	2	
XARELTO STAR TAB 15/20MG	2	
XARELTO TAB 2.5MG	2	
XARELTO TAB 10MG	2	
XARELTO TAB 15MG	2	
XARELTO TAB 20MG	2	
HEPARINS AND HEPARINOID-LIKE AGENTS		
ARIXTRA INJ 2.5/0.5	2	
ARIXTRA INJ 5/0.4ML	2	
ARIXTRA INJ 7.5/0.6	2	
ARIXTRA INJ 10/0.8ML	2	
<i>enoxaparin sodium inj 300 mg/3ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 30 mg/0.3ml</i>	1	

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

46

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

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin sodium inj soln pref syr 40 mg/0.4ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 60 mg/0.6ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 80 mg/0.8ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 100 mg/ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 120 mg/0.8ml</i>	1	
<i>enoxaparin sodium inj soln pref syr 150 mg/ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 5 mg/0.4ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml</i>	1	
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i>	1	
FRAGMIN INJ 2500/0.2	2	
FRAGMIN INJ 5000/0.2	2	
FRAGMIN INJ 7500/0.3	2	
FRAGMIN INJ 10000/ML	2	
FRAGMIN INJ 12500UNT	2	
FRAGMIN INJ 15000UNT	2	
FRAGMIN INJ 18000UNT	2	
FRAGMIN INJ 95000UNT	2	
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	1	PA
LOVENOX INJ 30/0.3ML	3	
LOVENOX INJ 40/0.4ML	3	
LOVENOX INJ 60/0.6ML	3	
LOVENOX INJ 80/0.8ML	3	

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

47

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

Drug Name	Drug Tier	Requirements/Limits
LOVENOX INJ 100MG/ML	3	
LOVENOX INJ 120/0.8	3	
LOVENOX INJ 150MG/ML	3	
LOVENOX INJ 300/3ML	3	

ANTICONVULSANTS**AMPA GLUTAMATE RECEPTOR ANTAGONISTS**

FYCOMPA SUS 0.5MG/ML	2	
FYCOMPA TAB 2MG	2	
FYCOMPA TAB 4MG	2	
FYCOMPA TAB 6MG	2	
FYCOMPA TAB 8MG	2	
FYCOMPA TAB 10MG	2	
FYCOMPA TAB 12MG	2	

ANTICONVULSANTS - BENZODIAZEPINES

<i>clobazam suspension 2.5 mg/ml</i>	1	
<i>clobazam tab 10 mg</i>	1	
<i>clobazam tab 20 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	
<i>clonazepam orally disintegrating tab 1 mg</i>	1	
<i>clonazepam orally disintegrating tab 2 mg</i>	1	
<i>clonazepam tab 0.5 mg</i>	1	
<i>clonazepam tab 1 mg</i>	1	
<i>clonazepam tab 2 mg</i>	1	
DIASTAT ACDL GEL 5-10MG	3	
DIASTAT ACDL GEL 12.5-20	3	
DIASTAT PED GEL 2.5M GEL	3	
<i>diazepam rectal gel delivery system 2.5 mg</i>	1	
<i>diazepam rectal gel delivery system 10 mg</i>	1	
<i>diazepam rectal gel delivery system 20 mg</i>	1	
KLONOPIN TAB 0.5MG	3	
KLONOPIN TAB 1MG	3	
KLONOPIN TAB 2MG	3	

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

48

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

Drug Name	Drug Tier	Requirements/Limits
NAYZILAM SPR 5MG	2	PA, QL (10 bottles every 30 days)
VALTOCO SPR 5MG	2	PA, QL (5 sprays every 30 days)
VALTOCO SPR 10MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 15MG	2	PA, QL (5 ea every 30 days)
VALTOCO SPR 20MG	2	PA, QL (5 ea every 30 days)

ANTICONVULSANTS - MISC.

APTIOM TAB 200MG	3	
APTIOM TAB 400MG	3	
APTIOM TAB 600MG	3	
APTIOM TAB 800MG	3	
BANZEL TAB 200MG	3	
BANZEL TAB 400MG	3	
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	
BRIVIACT TAB 75MG	3	
BRIVIACT TAB 100MG	3	
<i>carbamazepine cap er 12hr 100 mg</i>	1	
<i>carbamazepine cap er 12hr 200 mg</i>	1	
<i>carbamazepine cap er 12hr 300 mg</i>	1	
<i>carbamazepine chew tab 100 mg</i>	1	
<i>carbamazepine susp 100 mg/5ml</i>	1	
<i>carbamazepine tab 200 mg</i>	1	
<i>carbamazepine tab er 12hr 100 mg</i>	1	
<i>carbamazepine tab er 12hr 200 mg</i>	1	
<i>carbamazepine tab er 12hr 400 mg</i>	1	
CARBATROL CAP 100MG	3	
CARBATROL CAP 200MG	3	
CARBATROL CAP 300MG	3	

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

49

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

Drug Name	Drug Tier	Requirements/Limits
DIACOMIT CAP 250MG	5	QL (360 CAPSULES PER 30 DAYS)
DIACOMIT CAP 500MG	5	QL (180 CAPSULES PER 30 DAYS)
DIACOMIT PAK 250MG	5	QL (360 PACKETS PER 30 DAYS)
DIACOMIT PAK 500MG	5	QL (180 PACKETS PER 30 DAYS)
EPIDIOLEX SOL 100MG/ML	5	PA, QL (800 ML PER 30 DAYS)
FINTEPLA SOL 2.2MG/ML	5	PA, QL (360ML PER 30 DAYS)
<i>gabapentin cap 100 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 300 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 400 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin oral soln 250 mg/5ml</i>	1	
<i>gabapentin oral soln 250 mg/5ml</i>	1	QL (72 mL per day)
<i>gabapentin tab 600 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin tab 800 mg</i>	1	QL (120 tablets per 30 days)
KEPPRA SOL 100MG/ML	3	
KEPPRA TAB 250MG	3	
KEPPRA TAB 500MG	3	
KEPPRA TAB 750MG	3	
KEPPRA TAB 1000MG	3	
KEPPRA XR TAB 500MG	3	
KEPPRA XR TAB 750MG	3	
<i>lacosamide oral solution 10 mg/ml</i>	1	
<i>lacosamide tab 50 mg</i>	1	
<i>lacosamide tab 100 mg</i>	1	
<i>lacosamide tab 150 mg</i>	1	
<i>lacosamide tab 200 mg</i>	1	

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

50

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

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL CHW 5MG	3	
LAMICTAL CHW 25MG	3	
LAMICTAL KIT START 35	3	
LAMICTAL KIT START 49	3	
LAMICTAL KIT START 98	3	
LAMICTAL ODT KIT	3	
LAMICTAL ODT TAB 25MG	3	
LAMICTAL ODT TAB 50MG	3	
LAMICTAL ODT TAB 100MG	3	
LAMICTAL ODT TAB 200MG	3	
LAMICTAL TAB 25MG	3	
LAMICTAL TAB 100MG	3	
LAMICTAL TAB 150MG	3	
LAMICTAL TAB 200MG	3	
LAMICTAL XR KIT	3	
LAMICTAL XR TAB 25MG	3	
LAMICTAL XR TAB 50MG	3	
LAMICTAL XR TAB 100MG	3	
LAMICTAL XR TAB 200MG	3	
LAMICTAL XR TAB 250MG	3	
LAMICTAL XR TAB 300MG	3	
<i>lamotrigine orally disintegrating tab 25 mg</i>	1	
<i>lamotrigine orally disintegrating tab 50 mg</i>	1	
<i>lamotrigine orally disintegrating tab 100 mg</i>	1	
<i>lamotrigine orally disintegrating tab 200 mg</i>	1	
<i>lamotrigine tab 25 mg</i>	1	
<i>lamotrigine tab 25 mg (42) & 100 mg (7) starter kit</i>	1	
<i>lamotrigine tab 35 x 25 mg starter kit</i>	1	
<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit</i>	1	
<i>lamotrigine tab 100 mg</i>	1	
<i>lamotrigine tab 150 mg</i>	1	
<i>lamotrigine tab 200 mg</i>	1	
<i>lamotrigine tab chewable dispersible 5 mg</i>	1	

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

51

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

Drug Name	Drug Tier	Requirements/Limits
<i>lamotrigine tab chewable dispersible 25 mg</i>	1	
<i>lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit</i>	1	
<i>lamotrigine tab er 24hr 25 mg</i>	1	
<i>lamotrigine tab er 24hr 50 mg</i>	1	
<i>lamotrigine tab er 24hr 100 mg</i>	1	
<i>lamotrigine tab er 24hr 200 mg</i>	1	
<i>lamotrigine tab er 24hr 250 mg</i>	1	
<i>lamotrigine tab er 24hr 300 mg</i>	1	
<i>levetiracetam oral soln 100 mg/ml</i>	1	
<i>levetiracetam tab 250 mg</i>	1	
<i>levetiracetam tab 500 mg</i>	1	
<i>levetiracetam tab 750 mg</i>	1	
<i>levetiracetam tab 1000 mg</i>	1	
<i>levetiracetam tab er 24hr 500 mg</i>	1	
<i>levetiracetam tab er 24hr 750 mg</i>	1	
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	
NEURONTIN CAP 100MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 300MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 400MG	3	QL (180 capsules per 30 days)
NEURONTIN SOL 250/5ML	3	QL (72 mL per day)
NEURONTIN TAB 600MG	3	QL (180 tablets per 30 days)
NEURONTIN TAB 800MG	3	QL (120 tablets per 30 days)
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	1	
<i>oxcarbazepine tab 150 mg</i>	1	
<i>oxcarbazepine tab 300 mg</i>	1	
<i>oxcarbazepine tab 600 mg</i>	1	
OXTELLAR XR TAB 150MG	2	
OXTELLAR XR TAB 300MG	2	

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

52

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

Drug Name	Drug Tier	Requirements/Limits
OXTELLAR XR TAB 600MG	2	
<i>pregabalin cap 25 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 50 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 75 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 100 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 150 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 200 mg</i>	1	QL (90 caps every 30 days)
<i>pregabalin cap 225 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin cap 300 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin soln 20 mg/ml</i>	1	QL (1080 mL every 30 days)
<i>primidone tab 50 mg</i>	1	
<i>primidone tab 250 mg</i>	1	
QUDEXY XR CAP 25/24HR	3	
QUDEXY XR CAP 50/24HR	3	
QUDEXY XR CAP 100/24HR	3	
QUDEXY XR CAP 150/24HR	3	
QUDEXY XR CAP 200/24HR	3	
<i>rufinamide susp 40 mg/ml</i>	1	
TEGRETOL SUS 100/5ML	3	
TEGRETOL TAB 200MG	3	
TEGRETOL-XR TAB 100MG	3	
TEGRETOL-XR TAB 200MG	3	
TEGRETOL-XR TAB 400MG	3	
TOPAMAX SPR CAP 15MG	3	
TOPAMAX SPR CAP 25MG	3	
TOPAMAX TAB 25MG	3	
TOPAMAX TAB 50MG	3	

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

53

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

Drug Name	Drug Tier	Requirements/Limits
TOPAMAX TAB 100MG	3	
TOPAMAX TAB 200MG	3	
<i>topiramate cap er 24hr 200 mg</i>	1	
<i>topiramate sprinkle cap 15 mg</i>	1	
<i>topiramate sprinkle cap 25 mg</i>	1	
<i>topiramate tab 25 mg</i>	1	
<i>topiramate tab 50 mg</i>	1	
<i>topiramate tab 100 mg</i>	1	
<i>topiramate tab 200 mg</i>	1	
TRILEPTAL SUS 300MG/5M	3	
TRILEPTAL TAB 150MG	3	
TRILEPTAL TAB 300MG	3	
TRILEPTAL TAB 600MG	3	
TROKENDI XR CAP 25MG	2	
TROKENDI XR CAP 50MG	2	
TROKENDI XR CAP 100MG	2	
TROKENDI XR CAP 200MG	2	
VIMPAT SOL 10MG/ML	3	
VIMPAT TAB 50MG	3	
VIMPAT TAB 100MG	3	
VIMPAT TAB 150MG	3	
VIMPAT TAB 200MG	3	
<i>zonisamide cap 25 mg</i>	1	
<i>zonisamide cap 50 mg</i>	1	
<i>zonisamide cap 100 mg</i>	1	
CARBAMATES		
<i>felbamate susp 600 mg/5ml</i>	1	
<i>felbamate tab 400 mg</i>	1	
<i>felbamate tab 600 mg</i>	1	
FELBATOL SUS 600/5ML	3	
FELBATOL TAB 400MG	3	
FELBATOL TAB 600MG	3	
XCOPRI PAK 12.5-25	2	
XCOPRI PAK 50-100MG	2	
XCOPRI PAK 50-200MG	2	

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

54

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

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

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

55

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

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

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

56

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

Drug Name	Drug Tier	Requirements/Limits
<i>bupropion hcl tab 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 150 mg</i>	1	
<i>bupropion hcl tab er 12hr 200 mg</i>	1	
<i>bupropion hcl tab er 24hr 150 mg</i>	1	
<i>bupropion hcl tab er 24hr 300 mg</i>	1	
FORFIVO XL TAB 450MG	3	
<i>maprotiline hcl tab 25 mg</i>	1	
<i>maprotiline hcl tab 50 mg</i>	1	
<i>maprotiline hcl tab 75 mg</i>	1	
WELLBUTRIN TAB 100MG SR	3	
WELLBUTRIN TAB 150MG SR	3	
WELLBUTRIN TAB 200MG SR	3	
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM DIS 6MG/24HR	3	
EMSAM DIS 9MG/24HR	3	
EMSAM DIS 12MG/24H	3	
MARPLAN TAB 10MG	3	
NARDIL TAB 15MG	2	
PARNATE TAB 10MG	2	
<i>phenelzine sulfate tab 15 mg</i>	1	
<i>tranylcypromine sulfate tab 10 mg</i>	1	
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO SOL 56MG DOS	3	PA
SPRAVATO SOL 84MG DOS	3	PA
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
CELEXA TAB 10MG	3	
CELEXA TAB 20MG	3	
CELEXA TAB 40MG	3	
<i>citalopram hydrobromide oral soln 10 mg/5ml</i>	1	
<i>citalopram hydrobromide tab 10 mg (base equiv)</i>	1	
<i>citalopram hydrobromide tab 20 mg (base equiv)</i>	1	

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

57

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

Drug Name	Drug Tier	Requirements/Limits
<i>citalopram hydrobromide tab 40 mg (base equiv)</i>	1	
<i>escitalopram oxalate soln 5 mg/5ml (base equiv)</i>	1	
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	
<i>fluoxetine hcl cap 10 mg</i>	1	
<i>fluoxetine hcl cap 20 mg</i>	1	
<i>fluoxetine hcl cap 40 mg</i>	1	
<i>fluoxetine hcl cap delayed release 90 mg</i>	1	
<i>fluoxetine hcl solution 20 mg/5ml</i>	1	
<i>fluoxetine hcl tab 10 mg</i>	1	
<i>fluoxetine hcl tab 20 mg</i>	1	
FLUOXETINE TAB 60MG	3	
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	1	
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	1	
<i>fluvoxamine maleate tab 25 mg</i>	1	
<i>fluvoxamine maleate tab 50 mg</i>	1	
<i>fluvoxamine maleate tab 100 mg</i>	1	
<i>paroxetine hcl tab 10 mg</i>	1	
<i>paroxetine hcl tab 20 mg</i>	1	
<i>paroxetine hcl tab 30 mg</i>	1	
<i>paroxetine hcl tab 40 mg</i>	1	
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	1	
<i>paroxetine hcl tab er 24hr 25 mg</i>	1	
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	1	
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1	
<i>sertraline hcl tab 25 mg</i>	1	
<i>sertraline hcl tab 50 mg</i>	1	
<i>sertraline hcl tab 100 mg</i>	1	
SEROTONIN MODULATORS		
<i>nefazodone hcl tab 50 mg</i>	1	
<i>nefazodone hcl tab 100 mg</i>	1	

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

58

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

Drug Name	Drug Tier	Requirements/Limits
<i>nefazodone hcl tab 150 mg</i>	1	
<i>nefazodone hcl tab 200 mg</i>	1	
<i>nefazodone hcl tab 250 mg</i>	1	
<i>trazodone hcl tab 50 mg</i>	1	
<i>trazodone hcl tab 100 mg</i>	1	
<i>trazodone hcl tab 150 mg</i>	1	
<i>trazodone hcl tab 300 mg</i>	1	
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
DESVENLAFAX TAB 50MG ER	3	
DESVENLAFAX TAB 100MG ER	3	
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</i>	1	
FETZIMA CAP 20MG	3	
FETZIMA CAP 40MG	3	
FETZIMA CAP 80MG	3	
FETZIMA CAP 120MG	3	
FETZIMA CAP TITRATIO	3	
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	1	
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	1	

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

59

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

Drug Name	Drug Tier	Requirements/Limits
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	1	

TRICYCLIC AGENTS

<i>amitriptyline hcl tab 10 mg</i>	1	
<i>amitriptyline hcl tab 25 mg</i>	1	
<i>amitriptyline hcl tab 50 mg</i>	1	
<i>amitriptyline hcl tab 75 mg</i>	1	
<i>amitriptyline hcl tab 100 mg</i>	1	
<i>amitriptyline hcl tab 150 mg</i>	1	
<i>amoxapine tab 25 mg</i>	1	
<i>amoxapine tab 50 mg</i>	1	
<i>amoxapine tab 100 mg</i>	1	
<i>amoxapine tab 150 mg</i>	1	
ANAFRANIL CAP 25MG	2	
ANAFRANIL CAP 50MG	2	
ANAFRANIL CAP 75MG	2	
<i>clomipramine hcl cap 25 mg</i>	1	
<i>clomipramine hcl cap 50 mg</i>	1	
<i>clomipramine hcl cap 75 mg</i>	1	
<i>desipramine hcl tab 10 mg</i>	1	
<i>desipramine hcl tab 25 mg</i>	1	
<i>desipramine hcl tab 50 mg</i>	1	
<i>desipramine hcl tab 75 mg</i>	1	
<i>desipramine hcl tab 100 mg</i>	1	
<i>desipramine hcl tab 150 mg</i>	1	
<i>doxepin hcl cap 10 mg</i>	1	
<i>doxepin hcl cap 25 mg</i>	1	
<i>doxepin hcl cap 50 mg</i>	1	
<i>doxepin hcl cap 75 mg</i>	1	
<i>doxepin hcl cap 100 mg</i>	1	

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

60

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

Drug Name	Drug Tier	Requirements/Limits
<i>doxepin hcl cap 150 mg</i>	1	
<i>doxepin hcl conc 10 mg/ml</i>	1	
<i>imipramine hcl tab 10 mg</i>	1	
<i>imipramine hcl tab 25 mg</i>	1	
<i>imipramine hcl tab 50 mg</i>	1	
<i>imipramine pamoate cap 75 mg</i>	1	
<i>imipramine pamoate cap 100 mg</i>	1	
<i>imipramine pamoate cap 125 mg</i>	1	
<i>imipramine pamoate cap 150 mg</i>	1	
NORPRAMIN TAB 10MG	2	
NORPRAMIN TAB 25MG	2	
<i>nortriptyline hcl cap 10 mg</i>	1	
<i>nortriptyline hcl cap 25 mg</i>	1	
<i>nortriptyline hcl cap 50 mg</i>	1	
<i>nortriptyline hcl cap 75 mg</i>	1	
<i>nortriptyline hcl soln 10 mg/5ml</i>	1	
PAMELOR CAP 10MG	2	
PAMELOR CAP 25MG	2	
PAMELOR CAP 50MG	2	
PAMELOR CAP 75MG	2	
<i>protriptyline hcl tab 5 mg</i>	1	
<i>protriptyline hcl tab 10 mg</i>	1	
<i>trimipramine maleate cap 25 mg</i>	1	
<i>trimipramine maleate cap 50 mg</i>	1	
<i>trimipramine maleate cap 100 mg</i>	1	

ANTIDIABETICS**ALPHA-GLUCOSIDASE INHIBITORS**

<i>acarbose tab 25 mg</i>	1	
<i>acarbose tab 50 mg</i>	1	
<i>acarbose tab 100 mg</i>	1	
<i>miglitol tab 25 mg</i>	1	
<i>miglitol tab 50 mg</i>	1	
<i>miglitol tab 100 mg</i>	1	
PRECOSE TAB 25MG	2	
PRECOSE TAB 50MG	2	

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

61

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

Drug Name	Drug Tier	Requirements/Limits
PRECOSE TAB 100MG	2	
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN 60 INJ 1000MCG	2	ST
SYMLNPEN 120 INJ 1000MCG	2	ST
ANTIDIABETIC COMBINATIONS		
ACTOPLUS MET TAB 15-500MG	3	
ACTOPLUS MET TAB 15-850MG	3	
DUETACT TAB 30-2MG	3	
DUETACT TAB 30-4MG	3	
<i>glipizide-metformin hcl tab 2.5-250 mg</i>	1	
<i>glipizide-metformin hcl tab 2.5-500 mg</i>	1	
<i>glipizide-metformin hcl tab 5-500 mg</i>	1	
<i>glyburide-metformin tab 1.25-250 mg</i>	1	
<i>glyburide-metformin tab 2.5-500 mg</i>	1	
<i>glyburide-metformin tab 5-500 mg</i>	1	
GLYXAMBI TAB 10-5 MG	2	ST
GLYXAMBI TAB 25-5 MG	2	ST
JANUMET TAB 50-500MG	2	ST
JANUMET TAB 50-1000	2	ST
JANUMET XR TAB 50-500MG	2	ST
JANUMET XR TAB 50-1000	2	ST
JANUMET XR TAB 100-1000	2	ST
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	1	
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	1	
<i>pioglitazone hcl-metformin hcl tab 15-500 mg</i>	1	
<i>pioglitazone hcl-metformin hcl tab 15-850 mg</i>	1	
SOLIQUA INJ 100/33	2	ST, QL (10 pens every 30 days)
SYNJARDY TAB	2	ST
SYNJARDY TAB 5-500MG	2	ST
SYNJARDY TAB 5-1000MG	2	ST
SYNJARDY TAB 12.5-500	2	ST
SYNJARDY XR TAB	2	ST
SYNJARDY XR TAB 5-1000MG	2	ST
SYNJARDY XR TAB 10-1000	2	ST

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

62

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

Drug Name	Drug Tier	Requirements/Limits
SYNJARDY XR TAB 25-1000	2	ST
TRIJARDY XR TAB	2	ST
XIGDUO XR TAB 2.5-1000	2	ST
XIGDUO XR TAB 5-500MG	2	ST
XIGDUO XR TAB 5-1000MG	2	ST
XIGDUO XR TAB 10-500MG	2	ST
XIGDUO XR TAB 10-1000	2	ST
XULTOPHY INJ 100/3.6	2	ST, QL (5 pens every 30 days)
BIGUANIDES		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	
<i>metformin hcl tab 500 mg</i>	1	
<i>metformin hcl tab 850 mg</i>	1	
<i>metformin hcl tab 1000 mg</i>	1	
<i>metformin hcl tab er 24hr 500 mg</i>	1	
<i>metformin hcl tab er 24hr 750 mg</i>	1	
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
<i>diazoxide susp 50 mg/ml</i>	1	
GLUCAGEN INJ HYPOKIT	2	
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
GLUCAGON KIT 1MG	2	
GVOKE HYPO 1 INJ 1MG/.2ML	2	
GVOKE HYPO 1 INJ .5/.1ML	2	
GVOKE HYPO 2 INJ 1MG/.2ML	2	
GVOKE HYPO 2 INJ .5/.1ML	2	
GVOKE KIT SOL 1MG/0.2M	2	
GVOKE PFS INJ	2	
KORLYM TAB 300MG	5	PA, QL (120 TABLETS PER 30 DAYS)
PROGLYCEM SUS 50MG/ML	3	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST

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

63

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

Drug Name	Drug Tier	Requirements/Limits
JANUVIA TAB 100MG	2	ST
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB 0.8MG	3	
INCRETIN MIMETIC AGENTS		
OZEMPIC INJ 2MG/3ML	2	ST, QL (1 pen every 30 days)
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
OZEMPIC INJ 2/1.5ML	2	ST, QL (1 pen every 30 days); Starter Pen
OZEMPIC INJ 4MG/3ML	2	ST, QL (1 pen every 30 days)
OZEMPIC INJ 8MG/3ML	2	ST, QL (1 pen every 25 days)
RYBELSUS TAB 3MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 7MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 14MG	2	ST, QL (30 tabs every 30 days)
TRULICITY INJ 0.75/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 1.5/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 3/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 4.5/0.5	2	ST, QL (4 pens every 30 days)
VICTOZA INJ 18MG/3ML	2	ST, QL (3 pens every 30 days)
INSULIN		
BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	
FIASP INJ 100/ML	2	
FIASP PENFIL INJ U-100	2	
HUMULIN R INJ U-500	2	

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

64

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

Drug Name	Drug Tier	Requirements/Limits
LEVEMIR INJ	2	
LEVEMIR INJ FLEXPEN	2	
LEVEMIR INJ FLEXTOUC	2	
NOVOLIN INJ 70/30	2	
NOVOLIN INJ 70/30 FP	2	
NOVOLIN N INJ 100 UNIT	2	
NOVOLIN N INJ U-100	2	
NOVOLIN R INJ 100 UNIT	2	
NOVOLIN R INJ U-100	2	
NOVOLOG INJ 100/ML	2	
NOVOLOG INJ FLEXPEN	2	
NOVOLOG INJ PENFILL	2	
NOVOLOG MIX INJ 70/30	2	
NOVOLOG MIX INJ FLEXPEN	2	
TOUJEO MAX INJ 300IU/ML	2	
TOUJEO SOLO INJ 300IU/ML	2	
TRESIBA FLEX INJ 100UNIT	2	
TRESIBA FLEX INJ 200UNIT	2	
TRESIBA INJ 100UNIT	2	
INSULIN SENSITIZING AGENTS		
AVANDIA TAB 2MG	3	
AVANDIA TAB 4MG	3	
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	
MEGLITINIDE ANALOGUES		
<i>nateglinide tab 60 mg</i>	1	
<i>nateglinide tab 120 mg</i>	1	
<i>repaglinide tab 0.5 mg</i>	1	
<i>repaglinide tab 1 mg</i>	1	
<i>repaglinide tab 2 mg</i>	1	
STARLIX TAB 120MG	3	
SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS		
FARXIGA TAB 5MG	2	ST
FARXIGA TAB 10MG	2	ST

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

65

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

Drug Name	Drug Tier	Requirements/Limits
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
SULFONYLUREAS		
AMARYL TAB 1MG	3	
AMARYL TAB 2MG	3	
AMARYL TAB 4MG	3	
<i>glimepiride tab 1 mg</i>	1	
<i>glimepiride tab 2 mg</i>	1	
<i>glimepiride tab 4 mg</i>	1	
<i>glipizide tab 5 mg</i>	1	
<i>glipizide tab 10 mg</i>	1	
<i>glipizide tab er 24hr 2.5 mg</i>	1	
<i>glipizide tab er 24hr 5 mg</i>	1	
<i>glipizide tab er 24hr 10 mg</i>	1	
GLUCOTROL TAB 10MG	3	
GLUCOTROL XL TAB 2.5MG	3	
GLUCOTROL XL TAB 5MG	3	
GLUCOTROL XL TAB 10MG	3	
<i>glyburide micronized tab 1.5 mg</i>	1	
<i>glyburide micronized tab 3 mg</i>	1	
<i>glyburide micronized tab 6 mg</i>	1	
<i>glyburide tab 1.25 mg</i>	1	
<i>glyburide tab 2.5 mg</i>	1	
<i>glyburide tab 5 mg</i>	1	
GLYNASE TAB 1.5MG	3	
GLYNASE TAB 3MG	3	
GLYNASE TAB 6MG	3	
<i>tolbutamide tab 500 mg</i>	1	
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIDIARRHEAL/PROBIOTIC COMBINATIONS		
RESTORA RX CAP 60-1.25	3	
ANTIPERISTALTIC AGENTS		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
LOMOTIL TAB 2.5MG	2	

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

66

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

Drug Name	Drug Tier	Requirements/Limits
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP 100MG	3	
<i>deferasirox granules packet 90 mg</i>	1	PA
<i>deferasirox granules packet 180 mg</i>	1	PA
<i>deferasirox granules packet 360 mg</i>	1	PA
<i>deferasirox tab 90 mg</i>	1	PA
<i>deferasirox tab 180 mg</i>	1	PA
<i>deferasirox tab 360 mg</i>	1	PA
<i>deferasirox tab for oral susp 125 mg</i>	1	PA
<i>deferasirox tab for oral susp 250 mg</i>	1	PA
<i>deferasirox tab for oral susp 500 mg</i>	1	PA
<i>deferiprone tab 500 mg</i>	1	PA
ANTIDOTES AND SPECIFIC ANTAGONISTS		
<i>deferoxamine mesylate for inj 2 gm</i>	1	PA
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	4	QL (20 PACKETS PER 5 DAYS)
OPIOID ANTAGONISTS		
<i>naloxone hcl inj 0.4 mg/ml</i>	1	
<i>naloxone hcl inj 4 mg/10ml</i>	1	
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	1	
<i>naltrexone hcl tab 50 mg</i>	0	
NARCAN SPR 4MG	3	
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
ANZEMET TAB 50MG	3	QL (6 tabs every 21 days)
ANZEMET TAB 100MG	3	QL (6 tabs every 21 days)
<i>granisetron hcl tab 1 mg</i>	1	QL (12 tabs every 21 days)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1	QL (200 mL every 21 days)
<i>ondansetron hcl tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 24 mg</i>	1	QL (2 ea every 21 days)
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		

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

Drug Name	Drug Tier	Requirements/Limits
<i>ondansetron orally disintegrating tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron orally disintegrating tab 8 mg</i>	1	QL (18 tabs every 21 days)
SANCUSO DIS 3.1MG	2	QL (2 patches every 21 days)
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)
ANTIEMETICS - ANTICHOLINERGIC		
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
TIGAN CAP 300MG	3	
<i>trimethobenzamide hcl cap 300 mg</i>	1	
ANTIEMETICS - MISCELLANEOUS		
AKYNZEO CAP 300-0.5	3	QL (2 caps every 21 days)
BONJESTA TAB 20-20MG	3	
DICLEGIS TAB 10-10MG	3	
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	1	
<i>dronabinol cap 2.5 mg</i>	1	
<i>dronabinol cap 5 mg</i>	1	
<i>dronabinol cap 10 mg</i>	1	
MARINOL CAP 2.5MG	3	
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 ea every 21 days)
<i>aprepitant capsule therapy pack 80 & 125 mg</i>	1	QL (6 caps every 21 days)
EMEND CAP 80MG	3	QL (4 caps every 21 days)
EMEND SUS 125MG	3	QL (6 kits every 21 days)
EMEND TRIPAC PAK 80 & 125	3	QL (6 caps every 21 days)
VARUBI TAB 90MG	3	QL (4 tabs every 21 days)
ANTIFUNGALS		
ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)		
BREXAFEMME TAB 150MG	3	ST, QL (4 tabs every 7 days)

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

68

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

Drug Name	Drug Tier	Requirements/Limits
ANTIFUNGALS		
ANCOBON CAP 250MG	3	
ANCOBON CAP 500MG	3	
BIO-STATIN CAP 500000	3	
BIO-STATIN CAP 1000000	3	
<i>flucytosine cap 250 mg</i>	1	
<i>griseofulvin microsize susp 125 mg/5ml</i>	1	
<i>griseofulvin microsize tab 500 mg</i>	1	
<i>griseofulvin ultramicrosize tab 125 mg</i>	1	
<i>griseofulvin ultramicrosize tab 250 mg</i>	1	
<i>nystatin oral powder</i>	1	
<i>nystatin tab 500000 unit</i>	1	
<i>terbinafine hcl tab 250 mg</i>	1	
IMIDAZOLE-RELATED ANTIFUNGALS		
DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	
DIFLUCAN TAB 100MG	3	
DIFLUCAN TAB 150MG	3	
DIFLUCAN TAB 200MG	3	
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	
<i>fluconazole tab 50 mg</i>	1	
<i>fluconazole tab 100 mg</i>	1	
<i>fluconazole tab 150 mg</i>	1	
<i>fluconazole tab 200 mg</i>	1	
<i>itraconazole cap 100 mg</i>	1	
<i>itraconazole oral soln 10 mg/ml</i>	1	
<i>ketoconazole tab 200 mg</i>	1	
<i>posaconazole susp 40 mg/ml</i>	1	
SPORANOX CAP 100MG	3	
SPORANOX CAP PULSEPAK	3	
SPORANOX SOL 10MG/ML	3	
VFEND SUS 40MG/ML	2	PA
VFEND TAB 50MG	2	PA

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

69

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

Drug Name	Drug Tier	Requirements/Limits
VFEND TAB 200MG	2	PA
VIVJOA CAP 150MG	3	
<i>voriconazole for susp 40 mg/ml</i>	1	PA
<i>voriconazole tab 50 mg</i>	1	PA
<i>voriconazole tab 200 mg</i>	1	PA
ANTIHISTAMINES		
ANTIHISTAMINES - ETHANOLAMINES		
<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
<i>carbinoxamine maleate tab 4 mg</i>	1	
<i>clemastine fumarate tab 2.68 mg</i>	1	
KARBINAL ER SUS 4MG/5ML	3	
ANTIHISTAMINES - NON-SEDATING		
CLARINEX TAB 5MG	3	
<i>desloratadine tab 5 mg</i>	1	
<i>desloratadine tab orally disintegrating 2.5 mg</i>	1	
<i>desloratadine tab orally disintegrating 5 mg</i>	1	
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1	
ANTIHISTAMINES - PHENOTHIAZINES		
<i>promethazine hcl suppos 12.5 mg</i>	1	
<i>promethazine hcl suppos 25 mg</i>	1	
<i>promethazine hcl suppos 50 mg</i>	1	
<i>promethazine hcl syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl tab 12.5 mg</i>	1	
<i>promethazine hcl tab 25 mg</i>	1	
<i>promethazine hcl tab 50 mg</i>	1	
ANTIHISTAMINES - PIPERIDINES		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl tab 4 mg</i>	1	
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG	2	PA
ANTIHYPERLIPIDEMICS - COMBINATIONS		
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	

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

70

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

Drug Name	Drug Tier	Requirements/Limits
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	
NEXLIZET TAB 180/10MG	2	PA
VYTORIN TAB 10-10MG	3	
VYTORIN TAB 10-20MG	3	
VYTORIN TAB 10-40MG	3	
VYTORIN TAB 10-80MG	3	
ANTHYPERLIPIDEMICS - MISC.		
LOVAZA CAP 1GM	3	PA
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	PA
VASCEPA CAP 0.5GM	1	PA; Tier 1 with DAW9
VASCEPA CAP 1GM	1	PA; Tier 1 with DAW9
BILE ACID SEQUESTRANTS		
<i>cholestyramine light powder 4 gm/dose</i>	1	
<i>cholestyramine light powder packets 4 gm</i>	1	
<i>cholestyramine powder 4 gm/dose</i>	1	
<i>cholestyramine powder packets 4 gm</i>	1	
<i>colesevelam hcl packet for susp 3.75 gm</i>	1	
<i>colesevelam hcl tab 625 mg</i>	1	
COLESTID FLA GRA 5/7.5GM	3	
COLESTID FLA GRA 5GM	3	
COLESTID GRA 5GM	3	
COLESTID POW 5GM	3	
COLESTID TAB 1GM	3	
<i>colestipol hcl granule packets 5 gm</i>	1	
<i>colestipol hcl granules 5 gm</i>	1	
<i>colestipol hcl tab 1 gm</i>	1	
QUESTRAN POW 4GM	3	
QUESTRAN POW 4GM LITE	3	
WELCHOL PAK 3.75GM	3	
WELCHOL TAB 625MG	3	
FIBRIC ACID DERIVATIVES		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	

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

71

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

Drug Name	Drug Tier	Requirements/Limits
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	
<i>fenofibrate cap 150 mg</i>	1	
<i>fenofibrate micronized cap 43 mg</i>	1	
<i>fenofibrate micronized cap 67 mg</i>	1	
<i>fenofibrate micronized cap 134 mg</i>	1	
<i>fenofibrate micronized cap 200 mg</i>	1	
<i>fenofibrate tab 48 mg</i>	1	
<i>fenofibrate tab 54 mg</i>	1	
<i>fenofibrate tab 145 mg</i>	1	
<i>fenofibrate tab 160 mg</i>	1	
<i>fenofibric acid tab 35 mg</i>	1	
<i>fenofibric acid tab 105 mg</i>	1	
FENOGLIDE TAB 40MG	3	
FIBRICOR TAB 35MG	3	
FIBRICOR TAB 105MG	3	
<i>gemfibrozil tab 600 mg</i>	1	
LIPOFEN CAP 50MG	3	
LIPOFEN CAP 150MG	3	
LOPID TAB 600MG	3	
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	
HMG COA REDUCTASE INHIBITORS		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	1	
<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	1	
<i>fluvastatin sodium cap 20 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75

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

72

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

Drug Name	Drug Tier	Requirements/Limits
<i>fluvastatin sodium cap 40 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>fluvastatin sodium tab er 24 hr 80 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>lovastatin tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>pravastatin sodium tab 80 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 5 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>rosuvastatin calcium tab 20 mg</i>	1	
<i>rosuvastatin calcium tab 40 mg</i>	1	
<i>simvastatin tab 5 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 10 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 80 mg</i>	1	
ZOCOR TAB 10MG	3	
ZOCOR TAB 20MG	3	
ZOCOR TAB 40MG	3	

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

73

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

Drug Name	Drug Tier	Requirements/Limits
ZOCOR TAB 80MG	3	
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
<i>ezetimibe tab 10 mg</i>	1	
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP 5MG	5	PA, QL (28 CAPSULES PER 28 DAYS)
JUXTAPID CAP 10MG	5	PA, QL (28 CAPSULES PER 28 DAYS)
JUXTAPID CAP 20MG	5	PA, QL (56 CAPSULES PER 28 DAYS)
JUXTAPID CAP 30MG	5	PA, QL (56 CAPSULES PER 28 DAYS)
NICOTINIC ACID DERIVATIVES		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	
NIASPAN TAB 500MG ER	3	
NIASPAN TAB 750MG ER	3	
NIASPAN TAB 1000 ER	3	
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
REPATHA INJ 140MG/ML	2	PA, QL (3 SYRINGES PER 28 DAYS)
REPATHA PUSH INJ 420/3.5	2	PA, QL (1 CARTRIDGES PER 28 DAYS)
REPATHA SURE INJ 140MG/ML	2	PA, QL (3 PENS PER 28 DAYS)
ANTIHYPERTENSIVES		
ACE INHIBITORS		
ACCUPRIL TAB 5MG	3	
ACCUPRIL TAB 10MG	3	
ACCUPRIL TAB 20MG	3	
ACCUPRIL TAB 40MG	3	
ALTACE CAP 1.25MG	3	
ALTACE CAP 2.5MG	3	
ALTACE CAP 5MG	3	

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

74

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

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

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

75

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

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

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

76

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

Drug Name	Drug Tier	Requirements/Limits
<i>irbesartan tab 300 mg</i>	1	
<i>losartan potassium tab 25 mg</i>	1	
<i>losartan potassium tab 50 mg</i>	1	
<i>losartan potassium tab 100 mg</i>	1	
<i>olmesartan medoxomil tab 5 mg</i>	1	
<i>olmesartan medoxomil tab 20 mg</i>	1	
<i>olmesartan medoxomil tab 40 mg</i>	1	
<i>telmisartan tab 20 mg</i>	1	
<i>telmisartan tab 40 mg</i>	1	
<i>telmisartan tab 80 mg</i>	1	
<i>valsartan tab 40 mg</i>	1	
<i>valsartan tab 80 mg</i>	1	
<i>valsartan tab 160 mg</i>	1	
<i>valsartan tab 320 mg</i>	1	
ANTIADRENERGIC ANTIHYPERTENSIVES		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	2	
CATAPRES-TTS DIS 0.2/24HR	2	
CATAPRES-TTS DIS 0.3/24HR	2	
<i>clonidine hcl tab 0.1 mg</i>	1	
<i>clonidine hcl tab 0.2 mg</i>	1	
<i>clonidine hcl tab 0.3 mg</i>	1	
<i>clonidine td patch weekly 0.1 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.2 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.3 mg/24hr</i>	1	
<i>doxazosin mesylate tab 1 mg</i>	1	
<i>doxazosin mesylate tab 2 mg</i>	1	
<i>doxazosin mesylate tab 4 mg</i>	1	
<i>doxazosin mesylate tab 8 mg</i>	1	
<i>guanfacine hcl tab 1 mg</i>	1	
<i>guanfacine hcl tab 2 mg</i>	1	
<i>methyldopa tab 250 mg</i>	1	

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

77

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

Drug Name	Drug Tier	Requirements/Limits
<i>methyldopa tab 500 mg</i>	1	
MINIPRESS CAP 1MG	3	
MINIPRESS CAP 2MG	3	
MINIPRESS CAP 5MG	3	
<i>prazosin hcl cap 1 mg</i>	1	
<i>prazosin hcl cap 2 mg</i>	1	
<i>prazosin hcl cap 5 mg</i>	1	
<i>terazosin hcl cap 1 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 2 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 5 mg (base equivalent)</i>	1	
<i>terazosin hcl cap 10 mg (base equivalent)</i>	1	
ANTIHYPERTENSIVE COMBINATIONS		
ACCURETIC TAB 10-12.5	3	
ACCURETIC TAB 20-12.5	3	
ACCURETIC TAB 20-25MG	3	
<i>amlodipine besylate-benazepril hcl cap 2.5-10 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-10 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-20 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 5-40 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 10-20 mg</i>	1	
<i>amlodipine besylate-benazepril hcl cap 10-40 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 5-20 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 5-40 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 10-20 mg</i>	1	
<i>amlodipine besylate-olmesartan medoxomil tab 10-40 mg</i>	1	
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	1	

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

78

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

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

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

79

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

Drug Name	Drug Tier	Requirements/Limits
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	1	
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 5-12.5 mg</i>	1	
<i>enalapril maleate & hydrochlorothiazide tab 10-25 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>fosinopril sodium & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	1	
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 50-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-12.5 mg</i>	1	
<i>losartan potassium & hydrochlorothiazide tab 100-25 mg</i>	1	
LOTENSIN HCT TAB 10-12.5	3	
LOTENSIN HCT TAB 20-12.5	3	
LOTENSIN HCT TAB 20-25MG	3	
LOTREL CAP 5-10MG	2	
LOTREL CAP 5-20MG	2	
LOTREL CAP 10-20MG	2	
LOTREL CAP 10-40MG	2	
<i>methyldopa & hydrochlorothiazide tab 250-15 mg</i>	1	
<i>methyldopa & hydrochlorothiazide tab 250-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i>	1	
<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i>	1	

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

80

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

Drug Name	Drug Tier	Requirements/Limits
<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg</i>	1	
<i>olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg</i>	1	
<i>olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg</i>	1	
<i>propranolol & hydrochlorothiazide tab 40-25 mg</i>	1	
<i>propranolol & hydrochlorothiazide tab 80-25 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 10-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-12.5 mg</i>	1	
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	1	
TARKA TAB 2-180 CR	2	
TARKA TAB 2-240 CR	2	
TARKA TAB 4-240 CR	2	
TEKTURNA HCT TAB 150-12.5	2	
TEKTURNA HCT TAB 150-25MG	2	
TEKTURNA HCT TAB 300-12.5	2	
TEKTURNA HCT TAB 300-25MG	2	
<i>telmisartan-amlodipine tab 40-5 mg</i>	1	
<i>telmisartan-amlodipine tab 40-10 mg</i>	1	
<i>telmisartan-amlodipine tab 80-5 mg</i>	1	
<i>telmisartan-amlodipine tab 80-10 mg</i>	1	

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

81

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

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

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

82

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

Drug Name	Drug Tier	Requirements/Limits
SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS)		
<i>eplerenone tab 25 mg</i>	1	
<i>eplerenone tab 50 mg</i>	1	
INSPIRA TAB 25MG	2	
INSPIRA TAB 50MG	2	
VASODILATORS		
<i>hydralazine hcl tab 10 mg</i>	1	
<i>hydralazine hcl tab 25 mg</i>	1	
<i>hydralazine hcl tab 50 mg</i>	1	
<i>hydralazine hcl tab 100 mg</i>	1	
<i>minoxidil tab 2.5 mg</i>	1	
<i>minoxidil tab 10 mg</i>	1	
ANTIMALARIALS		
ANTIMALARIAL COMBINATIONS		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
COARTEM TAB 20-120MG	3	
MALARONE TAB 62.5-25	2	
MALARONE TAB 250-100	2	
ANTIMALARIALS		
<i>chloroquine phosphate tab 250 mg</i>	1	
<i>chloroquine phosphate tab 500 mg</i>	1	
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	
<i>mefloquine hcl tab 250 mg</i>	1	
PLAQUENIL TAB 200MG	2	
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	1	
PRIMAQUINE TAB 26.3MG	3	
<i>pyrimethamine tab 25 mg</i>	1	PA
QUALAQUIN CAP 324MG	3	
<i>quinine sulfate cap 324 mg</i>	1	

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

83

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

Drug Name	Drug Tier	Requirements/Limits
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
FIRDAPSE TAB 10MG	5	PA, QL (240 TABLETS PER 30 DAYS)
GUANIDINE TAB 125MG	3	
MESTINON SOL 60MG/5ML	3	
MESTINON TAB 60MG	3	
MESTINON TAB TIMESPAN	3	
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
RUZURGI TAB 10MG	5	PA, QL (300 TABLETS PER 30 DAYS)
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS		
<i>cycloserine cap 250 mg</i>	1	
<i>ethambutol hcl tab 100 mg</i>	1	
<i>ethambutol hcl tab 400 mg</i>	1	
<i>isoniazid syrup 50 mg/5ml</i>	1	
<i>isoniazid tab 100 mg</i>	1	
<i>isoniazid tab 300 mg</i>	1	
MYAMBUTOL TAB 400MG	2	
MYCOBUTIN CAP 150MG	3	
PASER GRA 4GM	3	
PRETOMANID TAB 200MG	3	
PRIFTIN TAB 150MG	3	
<i>pyrazinamide tab 500 mg</i>	1	
<i>rifabutin cap 150 mg</i>	1	
<i>rifampin cap 150 mg</i>	1	
<i>rifampin cap 300 mg</i>	1	
SIRTURO TAB 20MG	3	
SIRTURO TAB 100MG	3	
TRECTOR TAB 250MG	3	

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

84

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

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES		
ALKYLATING AGENTS		
ALKERAN TAB 2MG	0	
CYCLOPHOSPH TAB 25MG	0	
CYCLOPHOSPH TAB 50MG	0	
<i>cyclophosphamide cap 25 mg</i>	0	
<i>cyclophosphamide cap 50 mg</i>	0	
GLEOSTINE CAP 10MG	0	
GLEOSTINE CAP 40MG	0	
GLEOSTINE CAP 100MG	0	
LEUKERAN TAB 2MG	0	
<i>melphalan tab 2 mg</i>	0	
MYLERAN TAB 2MG	0	
TEMODAR CAP 100MG	0	PA
TEMODAR CAP 140MG	0	PA
TEMODAR CAP 180MG	0	PA
TEMODAR CAP 250MG	0	PA
<i>temozolomide cap 5 mg</i>	0	PA
<i>temozolomide cap 20 mg</i>	0	PA
<i>temozolomide cap 100 mg</i>	0	PA
<i>temozolomide cap 140 mg</i>	0	PA
<i>temozolomide cap 180 mg</i>	0	PA
<i>temozolomide cap 250 mg</i>	0	PA
ANTIMETABOLITES		
<i>azacitidine for inj 100 mg</i>	1	PA
<i>capecitabine tab 150 mg</i>	0	PA
<i>capecitabine tab 500 mg</i>	0	PA
<i>mercaptopurine tab 50 mg</i>	0	
<i>methotrexate sodium for inj 1 gm</i>	1	
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	1	
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	1	
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	1	

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

85

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

Drug Name	Drug Tier	Requirements/Limits
methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)	1	
methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)	1	
methotrexate sodium tab 2.5 mg (base equiv)	0	
ONUREG TAB 200MG	0	PA, QL (14 TABLETS PER 28 DAYS)
ONUREG TAB 300MG	0	PA, QL (14 TABLETS PER 28 DAYS)
PURIXAN SUS 20MG/ML	0	PA
TABLOID TAB 40MG	0	
TREXALL TAB 5MG	0	
TREXALL TAB 7.5MG	0	
TREXALL TAB 10MG	0	
TREXALL TAB 15MG	0	
VIDAZA INJ 100MG	5	PA
XATMEP SOL 2.5MG/ML	0	
XELODA TAB 150MG	0	PA, QL (120 tabs every 30 days)
XELODA TAB 500MG	0	PA, QL (300 tabs every 30 days)

ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS

INLYTA TAB 1MG	0	PA, QL (240 TABLETS PER 30 DAYS)
INLYTA TAB 5MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LENVIMA CAP 4MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 8 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 10 MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 12MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 14 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)

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

86

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

Drug Name	Drug Tier	Requirements/Limits
LENVIMA CAP 18 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 20 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 24 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA TAB 10MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 100MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VENCLEXTA TAB START PK	0	PA, QL (1 PACK EVERY 28 DAYS)
ANTINEOPLASTIC - EGFR INHIBITORS		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IRESSA TAB 250MG	0	PA, QL (30 TABLETS PER 30 DAYS)

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

87

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

Drug Name	Drug Tier	Requirements/Limits
TAGRISSO TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TAGRISSO TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TARCEVA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 150MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ODOMZO CAP 200MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
<i>abiraterone acetate tab 250 mg</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>abiraterone acetate tab 500 mg</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>anastrozole tab 1 mg</i>	0	
ARIMIDEX TAB 1MG	0	
AROMASIN TAB 25MG	0	
<i>bicalutamide tab 50 mg</i>	0	
CASODEX TAB 50MG	0	
EMCYT CAP 140MG	0	
ERLEADA TAB 60MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ERLEADA TAB 240MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>exemestane tab 25 mg</i>	0	
FARESTON TAB 60MG	0	
FEMARA TAB 2.5MG	0	
<i>flutamide cap 125 mg</i>	0	
<i>letrozole tab 2.5 mg</i>	0	

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

88

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

Drug Name	Drug Tier	Requirements/Limits
<i>leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)</i>	1	PA
LYSODREN TAB 500MG	0	
<i>megestrol acetate susp 40 mg/ml</i>	0	
<i>megestrol acetate tab 20 mg</i>	0	
<i>megestrol acetate tab 40 mg</i>	0	
<i>nilutamide tab 150 mg</i>	0	
NUBEQA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)
SOLTAMOX SOL 10MG/5ML	0	
<i>tamoxifen citrate tab 10 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>tamoxifen citrate tab 20 mg (base equivalent)</i>	0	\$0 copay for women > 35 years for the primary prevention of breast cancer
<i>toremifene citrate tab 60 mg (base equivalent)</i>	0	
XTANDI CAP 40MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XTANDI TAB 40MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XTANDI TAB 80MG	0	PA, QL (60 TABLETS PER 30 DAYS)
YONSA TAB 125MG	0	PA, QL (120 tabs every 30 days)
<i>ANTINEOPLASTIC - IMMUNOMODULATORS</i>		
POMALYST CAP 1MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 2MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 3MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 4MG	0	PA, QL (21 CAPSULES PER 28 DAYS)

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

89

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

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC COMBINATIONS		
INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (49 TABLETS PER 28 DAYS)
KISQALI 400 PAK FEMARA	0	PA, QL (70 TABLETS PER 28 DAYS)
KISQALI 600 PAK FEMARA	0	PA, QL (91 TABLETS PER 28 DAYS)
LONSURF TAB 15-6.14	0	PA, QL (100 TABLETS 28 DAYS)
LONSURF TAB 20-8.19	0	PA, QL (80 TABLETS 28 DAYS)
ANTINEOPLASTIC ENZYME INHIBITORS		
AFINITOR DIS TAB 2MG	0	PA, QL (60 TABLETS PER 30 DAYS)
AFINITOR DIS TAB 3MG	0	PA, QL (90 TABLETS PER 30 DAYS)
AFINITOR DIS TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ALECENSA CAP 150MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
ALUNBRIG PAK	0	PA, QL (30 TABLETS PER 30 DAYS)
ALUNBRIG TAB 30MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ALUNBRIG TAB 90MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ALUNBRIG TAB 180MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BALVERSA TAB 3MG	0	PA, QL (84 TABLETS PER 28 DAYS)
BALVERSA TAB 4MG	0	PA, QL (56 TABLETS PER 28 DAYS)
BALVERSA TAB 5MG	0	PA, QL (28 TABLETS PER 28 DAYS)

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

90

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

Drug Name	Drug Tier	Requirements/Limits
BOSULIF TAB 100MG	0	PA, QL (90 TABLETS PER 30 DAYS)
BOSULIF TAB 400MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BOSULIF TAB 500MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BRAFTOVI CAP 75MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
BRUKINSA CAP 80MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
CABOMETYX TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 60MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CALQUENCE CAP 100MG	0	PA, QL (60 caps every 30 days)
CALQUENCE TAB 100MG	0	PA, QL (60 tabs every 30 days)
CAPRELSA TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
CAPRELSA TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS)
COMETRIQ KIT 60MG	0	PA, QL (84 CAPSULES PER 28 DAYS)
COMETRIQ KIT 100MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COMETRIQ KIT 140MG	0	PA, QL (112 CAPSULES PER 28 DAYS)
COPIKTRA CAP 15MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COPIKTRA CAP 25MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COTELLIC TAB 20MG	0	PA, QL (63 TABLETS 28 DAYS)

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

91

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

Drug Name	Drug Tier	Requirements/Limits
<i>everolimus tab 2.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 7.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
IBRANCE CAP 75MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 100MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 125MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE TAB 75MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 100MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 125MG	0	PA, QL (21 TABLETS PER 28 DAYS)
ICLUSIG TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
IMBRUVICA CAP 70MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
IMBRUVICA CAP 140MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
IMBRUVICA SUS 70MG/ML	0	PA, QL (216 ML PER 36 DAYS)
IMBRUVICA TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)

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

92

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

Drug Name	Drug Tier	Requirements/Limits
IMBRUVICA TAB 280MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 420MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 560MG	0	PA, QL (30 TABLETS PER 30 DAYS)
JAKAFI TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 10MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 15MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 20MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
KISQALI TAB 200DOSE	0	PA, QL (21 TABLETS PER 28 DAYS)
KISQALI TAB 400DOSE	0	PA, QL (42 TABLETS 28 DAYS)
KISQALI TAB 600DOSE	0	PA, QL (63 TABLETS 28 DAYS)
KOSELUGO CAP 10MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
KOSELUGO CAP 25MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	0	PA, QL (180 TABLETS PER 30 DAYS)
LORBRENA TAB 25MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LORBRENA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
LUMAKRAS TAB 120MG	0	PA, QL (240 TABS PER 30 DAYS)
LUMAKRAS TAB 320MG	0	PA, QL (90 TABLETS PER 30 DAYS)

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

93

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

Drug Name	Drug Tier	Requirements/Limits
LYNPARZA TAB 100MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LYNPARZA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
MEKINIST SOL 0.05/ML	0	PA, QL (12 bottles per 28 days)
MEKINIST TAB 0.5MG	0	PA, QL (90 TABLETS PER 30 DAYS)
MEKINIST TAB 2MG	0	PA, QL (30 TABLETS PER 30 DAYS)
MEKTOVI TAB 15MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NERLYNX TAB 40MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NEXAVAR TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
NINLARO CAP 2.3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 4MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
PIQRAY 200MG TAB DOSE	0	PA, QL (28 TABLETS PER 28 DAYS)
PIQRAY 250MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
PIQRAY 300MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
ROZLYTREK CAP 100MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ROZLYTREK CAP 200MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
RUBRACA TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
RUBRACA TAB 250MG	0	PA, QL (120 TABLETS PER 30 DAYS)

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

94

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

Drug Name	Drug Tier	Requirements/Limits
RUBRACA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)
RYDAPT CAP 25MG	0	PA, QL (224 CAPSULES PER 28 DAYS)
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
SPRYCEL TAB 20MG	0	PA, QL (90 TABLETS PER 30 DAYS)
SPRYCEL TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 70MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
STIVARGA TAB 40MG	0	PA, QL (84 TABLETS PER 28 DAYS)
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 25 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 50 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 12.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 25MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 37.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 50MG	0	PA, QL (30 CAPSULES PER 30 DAYS)

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

95

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

Drug Name	Drug Tier	Requirements/Limits
TAFINLAR CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TAFINLAR CAP 75MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TAFINLAR TAB 10MG	0	PA, QL (4 bottles (210 tabs per bottle) per 28 days)
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 150MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 200MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VITRAKVI CAP 25MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
VITRAKVI CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
VITRAKVI SOL 20MG/ML	0	PA, QL (300 ML PER 30 DAYS)
VONJO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
VOTRIENT TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XOSPATA TAB 40MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ZEJULA CAP 100MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ZEJULA TAB 100MG	0	PA, QL (30 TABS PER 30 DAYS)
ZEJULA TAB 200MG	0	PA, QL (30 TABS PER 30 DAYS)

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

96

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

Drug Name	Drug Tier	Requirements/Limits
ZEJULA TAB 300MG	0	PA, QL (30 TABS PER 30 DAYS)
ZELBORAF TAB 240MG	0	PA, QL (240 TABLETS PER 30 DAYS)
ZOLINZA CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ 2MU/0.5	5	PA
<i>bexarotene cap 75 mg</i>	0	PA
HYDREA CAP 500MG	0	
<i>hydroxyurea cap 500 mg</i>	0	
INTRON A INJ 10MU	5	PA
INTRON A INJ 18MU	5	PA
INTRON A INJ 25MU	5	PA
INTRON A INJ 50MU	5	PA
MATULANE CAP 50MG	0	
TARGRETIN CAP 75MG	0	PA
<i>tretinoin cap 10 mg</i>	0	
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
<i>leucovorin calcium tab 5 mg</i>	0	
<i>leucovorin calcium tab 10 mg</i>	0	
<i>leucovorin calcium tab 15 mg</i>	0	
<i>leucovorin calcium tab 25 mg</i>	0	
MESNEX TAB 400MG	0	
MITOTIC INHIBITORS		
<i>etoposide cap 50 mg</i>	0	
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ADJUNCTIVE THERAPY		
<i>carbidopa tab 25 mg</i>	1	
LODOSYN TAB 25MG	3	

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

97

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

Drug Name	Drug Tier	Requirements/Limits
ANTIPARKINSON ANTICHOLINERGICS		
<i>benztropine mesylate tab 0.5 mg</i>	1	
<i>benztropine mesylate tab 1 mg</i>	1	
<i>benztropine mesylate tab 2 mg</i>	1	
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i>	1	
<i>trihexyphenidyl hcl tab 2 mg</i>	1	
<i>trihexyphenidyl hcl tab 5 mg</i>	1	
ANTIPARKINSON COMT INHIBITORS		
COMTAN TAB 200MG	3	
<i>entacapone tab 200 mg</i>	1	
TASMAR TAB 100MG	3	
<i>tolcapone tab 100 mg</i>	1	
ANTIPARKINSON DOPAMINERGICS		
<i>amantadine hcl cap 100 mg</i>	1	
<i>amantadine hcl soln 50 mg/5ml</i>	1	
<i>amantadine hcl tab 100 mg</i>	1	
<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	1	
<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	1	
<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	1	
<i>carbidopa & levodopa tab 10-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-100 mg</i>	1	
<i>carbidopa & levodopa tab 25-250 mg</i>	1	
<i>carbidopa & levodopa tab er 25-100 mg</i>	1	
<i>carbidopa & levodopa tab er 50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	

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

98

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

Drug Name	Drug Tier	Requirements/Limits
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	
INBRIJA CAP 42MG	4	PA, QL (300 CAPSULES PER 30 DAYS)
MIRAPEX ER TAB 0.75MG	3	
MIRAPEX ER TAB 0.375MG	3	
MIRAPEX ER TAB 1.5MG	3	
MIRAPEX ER TAB 2.25MG	3	
MIRAPEX ER TAB 3.75MG	3	
MIRAPEX ER TAB 3MG	3	
MIRAPEX ER TAB 4.5MG	3	
MIRAPEX TAB 0.5MG	3	
MIRAPEX TAB 0.75MG	3	
MIRAPEX TAB 0.125MG	3	
MIRAPEX TAB 1MG	3	
NEUPRO DIS 1MG/24HR	2	
NEUPRO DIS 2MG/24HR	2	
NEUPRO DIS 3MG/24HR	2	
NEUPRO DIS 4MG/24HR	2	
NEUPRO DIS 6MG/24HR	2	
NEUPRO DIS 8MG/24HR	2	
PARLODEL CAP 5MG	3	
PARLODEL TAB 2.5MG	3	
<i>pramipexole dihydrochloride tab 0.5 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.25 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.125 mg</i>	1	
<i>pramipexole dihydrochloride tab 1 mg</i>	1	
<i>pramipexole dihydrochloride tab 1.5 mg</i>	1	

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

99

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

Drug Name	Drug Tier	Requirements/Limits
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 3 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.25 mg</i>	1	
<i>ropinirole hydrochloride tab 1 mg</i>	1	
<i>ropinirole hydrochloride tab 2 mg</i>	1	
<i>ropinirole hydrochloride tab 3 mg</i>	1	
<i>ropinirole hydrochloride tab 4 mg</i>	1	
<i>ropinirole hydrochloride tab 5 mg</i>	1	
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	1	
SINEMET TAB 10-100MG	3	
SINEMET TAB 25-100MG	3	
STALEVO 50 TAB	3	
STALEVO 75 TAB	3	
STALEVO 100 TAB	3	
STALEVO 125 TAB	3	
STALEVO 150 TAB	3	
STALEVO 200 TAB	3	

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

100

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

Drug Name	Drug Tier	Requirements/Limits
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
AZILECT TAB 0.5MG	3	
AZILECT TAB 1MG	3	
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	1	
<i>rasagiline mesylate tab 1 mg (base equiv)</i>	1	
<i>selegiline hcl cap 5 mg</i>	1	
<i>selegiline hcl tab 5 mg</i>	1	
ZELAPAR TAB 1.25MG	3	
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
<i>lithium carbonate cap 150 mg</i>	1	
<i>lithium carbonate cap 300 mg</i>	1	
<i>lithium carbonate cap 600 mg</i>	1	
<i>lithium carbonate tab 300 mg</i>	1	
<i>lithium carbonate tab er 300 mg</i>	1	
<i>lithium carbonate tab er 450 mg</i>	1	
LITHIUM SOL 8MEQ/5ML	3	
LITHOBID TAB 300MG CR	2	
ANTIPSYCHOTICS - MISC.		
EQUETRO CAP 100MG	3	
EQUETRO CAP 200MG	3	
EQUETRO CAP 300MG	3	
GEODON CAP 20MG	3	
GEODON CAP 40MG	3	
GEODON CAP 60MG	3	
GEODON CAP 80MG	3	
GEODON INJ 20MG	3	
<i>lurasidone hcl tab 20 mg</i>	1	
<i>lurasidone hcl tab 40 mg</i>	1	
<i>lurasidone hcl tab 60 mg</i>	1	
<i>lurasidone hcl tab 80 mg</i>	1	
<i>lurasidone hcl tab 120 mg</i>	1	
NUPLAZID CAP 34MG	5	PA, QL (30 CAPSULES PER 30 DAYS)

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

101

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

Drug Name	Drug Tier	Requirements/Limits
NUPLAZID TAB 10MG	5	PA, QL (30 TABLETS PER 30 DAYS)
VRAYLAR CAP 1.5-3MG	2	
VRAYLAR CAP 1.5MG	2	
VRAYLAR CAP 3MG	2	
VRAYLAR CAP 4.5MG	2	
VRAYLAR CAP 6MG	2	
<i>ziprasidone hcl cap 20 mg</i>	1	
<i>ziprasidone hcl cap 40 mg</i>	1	
<i>ziprasidone hcl cap 60 mg</i>	1	
<i>ziprasidone hcl cap 80 mg</i>	1	
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	1	
BENZISOXAZOLES		
INVEGA SUST INJ 39/0.25	3	
INVEGA SUST INJ 78/0.5ML	3	
INVEGA SUST INJ 117/0.75	3	
INVEGA SUST INJ 156MG/ML	3	
INVEGA SUST INJ 234/1.5	3	
INVEGA TAB 1.5MG	3	
INVEGA TAB 3MG	3	
INVEGA TAB 6MG	3	
INVEGA TAB 9MG	3	
<i>paliperidone tab er 24hr 1.5 mg</i>	1	
<i>paliperidone tab er 24hr 3 mg</i>	1	
<i>paliperidone tab er 24hr 6 mg</i>	1	
<i>paliperidone tab er 24hr 9 mg</i>	1	
PERSERIS INJ 90MG	2	
PERSERIS INJ 120MG	2	
RISPERDAL INJ 12.5MG	3	
RISPERDAL INJ 25MG	3	
RISPERDAL INJ 37.5MG	3	
RISPERDAL INJ 50MG	3	
RISPERDAL SOL 1MG/ML	3	
RISPERDAL TAB 0.5MG	3	

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

102

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

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

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

103

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

Drug Name	Drug Tier	Requirements/Limits
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	
<i>clozapine tab 200 mg</i>	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	
CLOZARIL TAB 200MG	3	
<i>loxapine succinate cap 5 mg</i>	1	
<i>loxapine succinate cap 10 mg</i>	1	
<i>loxapine succinate cap 25 mg</i>	1	
<i>loxapine succinate cap 50 mg</i>	1	
<i>olanzapine for im inj 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 5 mg</i>	1	
<i>olanzapine orally disintegrating tab 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 15 mg</i>	1	
<i>olanzapine orally disintegrating tab 20 mg</i>	1	
<i>olanzapine tab 2.5 mg</i>	1	
<i>olanzapine tab 5 mg</i>	1	
<i>olanzapine tab 7.5 mg</i>	1	
<i>olanzapine tab 10 mg</i>	1	
<i>olanzapine tab 15 mg</i>	1	
<i>olanzapine tab 20 mg</i>	1	
<i>quetiapine fumarate tab 25 mg</i>	1	
<i>quetiapine fumarate tab 50 mg</i>	1	
<i>quetiapine fumarate tab 100 mg</i>	1	
<i>quetiapine fumarate tab 200 mg</i>	1	
<i>quetiapine fumarate tab 300 mg</i>	1	
<i>quetiapine fumarate tab 400 mg</i>	1	

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

104

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

Drug Name	Drug Tier	Requirements/Limits
<i>quetiapine fumarate tab er 24hr 50 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 150 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 200 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 300 mg</i>	1	
<i>quetiapine fumarate tab er 24hr 400 mg</i>	1	
SAPHRIS SUB 2.5MG	3	
SAPHRIS SUB 5MG	3	
SAPHRIS SUB 10MG	3	
SEROQUEL TAB 25MG	3	
SEROQUEL TAB 50MG	3	
SEROQUEL TAB 100MG	3	
SEROQUEL TAB 200MG	3	
SEROQUEL TAB 300MG	3	
SEROQUEL TAB 400MG	3	
VERSACLOZ SUS 50MG/ML	3	
ZYPREXA INJ 10MG	3	
ZYPREXA RELP INJ 210MG	3	
ZYPREXA RELP INJ 300MG	3	
ZYPREXA RELP INJ 405MG	3	
ZYPREXA TAB 2.5MG	3	
ZYPREXA TAB 5MG	3	
ZYPREXA TAB 7.5MG	3	
ZYPREXA TAB 10MG	3	
ZYPREXA TAB 15MG	3	
ZYPREXA TAB 20MG	3	
ZYPREXA ZYDI TAB 5MG	3	
ZYPREXA ZYDI TAB 10MG	3	
ZYPREXA ZYDI TAB 15MG	3	
ZYPREXA ZYDI TAB 20MG	3	
DIHYDROINDOLONES		
<i>molindone hcl tab 5 mg</i>	1	
<i>molindone hcl tab 10 mg</i>	1	
<i>molindone hcl tab 25 mg</i>	1	
PHENOTHIAZINES		
<i>chlorpromazine hcl inj 25 mg/ml</i>	1	

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

105

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

Drug Name	Drug Tier	Requirements/Limits
<i>chlorpromazine hcl inj 50 mg/2ml</i>	1	
<i>chlorpromazine hcl tab 25 mg</i>	1	
<i>chlorpromazine hcl tab 50 mg</i>	1	
<i>chlorpromazine hcl tab 100 mg</i>	1	
<i>chlorpromazine hcl tab 200 mg</i>	1	
<i>fluphenazine decanoate inj 25 mg/ml</i>	1	
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	1	
<i>fluphenazine hcl inj 2.5 mg/ml</i>	1	
<i>fluphenazine hcl oral conc 5 mg/ml</i>	1	
<i>fluphenazine hcl tab 1 mg</i>	1	
<i>fluphenazine hcl tab 2.5 mg</i>	1	
<i>fluphenazine hcl tab 5 mg</i>	1	
<i>fluphenazine hcl tab 10 mg</i>	1	
<i>perphenazine tab 2 mg</i>	1	
<i>perphenazine tab 4 mg</i>	1	
<i>perphenazine tab 8 mg</i>	1	
<i>perphenazine tab 16 mg</i>	1	
<i>prochlorperazine edisylate inj 10 mg/2ml</i>	1	
<i>prochlorperazine edisylate inj 50 mg/10ml</i>	1	
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	1	
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	1	
<i>prochlorperazine suppos 25 mg</i>	1	
<i>thioridazine hcl tab 10 mg</i>	1	
<i>thioridazine hcl tab 25 mg</i>	1	
<i>thioridazine hcl tab 50 mg</i>	1	
<i>thioridazine hcl tab 100 mg</i>	1	
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	
QUINOLINONE DERIVATIVES		
ABILIFY MAIN INJ 300MG	2	
ABILIFY MAIN INJ 400MG	2	

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

106

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

Drug Name	Drug Tier	Requirements/Limits
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole orally disintegrating tab 10 mg</i>	1	
<i>aripiprazole orally disintegrating tab 15 mg</i>	1	
<i>aripiprazole tab 2 mg</i>	1	
<i>aripiprazole tab 5 mg</i>	1	
<i>aripiprazole tab 10 mg</i>	1	
<i>aripiprazole tab 15 mg</i>	1	
<i>aripiprazole tab 20 mg</i>	1	
<i>aripiprazole tab 30 mg</i>	1	
ARISTADA INJ 441MG/1.	3	
ARISTADA INJ 662MG/2	3	
ARISTADA INJ 882MG/3	3	
ARISTADA INJ 1064MG	3	QL (23.077 injections every year)
ARISTADA INJ INITIO	3	
REXULTI TAB 0.5MG	3	
REXULTI TAB 0.25MG	3	
REXULTI TAB 1MG	3	
REXULTI TAB 2MG	3	
REXULTI TAB 3MG	3	
REXULTI TAB 4MG	3	
THIOXANTHENES		
<i>thiothixene cap 1 mg</i>	1	
<i>thiothixene cap 2 mg</i>	1	
<i>thiothixene cap 5 mg</i>	1	
<i>thiothixene cap 10 mg</i>	1	
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
<i>formaldehyde solution 10%</i>	1	
GLUTARALDEHY SOL 25%	3	
<i>hydrogen peroxide soln 30%</i>	1	
CHLORINE ANTISEPTICS		
BENZALKONIUM SOL NF	3	
CHLORHEX GLU SOL 20%	3	

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

107

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

Drug Name	Drug Tier	Requirements/Limits
ANTIVIRALS		
ANTIRETROVIRALS		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	QL (900 ML PER 30 DAYS)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
BIKTARVY TAB	2	QL (30 TABLETS PER 30 DAYS)
CIMDUO TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
COMBIVIR TAB 150-300	3	QL (60 TABLETS PER 30 DAYS)
CRIXIVAN CAP 400MG	3	QL (180 CAPSULES PER 30 DAYS)
DESCOVY TAB 120-15MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis
DESCOVY TAB 200/25MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis

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

108

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

Drug Name	Drug Tier	Requirements/Limits
DOVATO TAB 50-300MG	2	QL (30 TABLETS PER 30 DAYS)
EDURANT TAB 25MG	2	QL (60 TABLETS PER 30 DAYS)
<i>efavirenz cap 50 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz cap 200 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz tab 600 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine caps 200 mg</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	0	QL (30 TABLETS PER 30 DAYS); \$0 copay for pre exposure prophylaxis
EMTRIVA CAP 200MG	2	QL (30 CAPSULES PER 30 DAYS)
EMTRIVA SOL 10MG/ML	2	QL (680 ML PER 28 DAYS)
EPIVIR SOL 10MG/ML	3	QL (960 ML PER 30 DAYS)
EPIVIR TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
EPIVIR TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)

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

109

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

Drug Name	Drug Tier	Requirements/Limits
EPZICOM TAB 600-300	3	QL (30 TABLETS PER 30 DAYS)
<i>etravirine tab 100 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>etravirine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
EVOTAZ TAB 300-150	2	QL (30 TABLETS PER 30 DAYS)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	QL (120 TABLETS PER 30 DAYS)
FUZEON INJ 90MG	2	PA, QL (60 VIALS PER 30 DAYS)
GENVOYA TAB	2	QL (30 TABLETS PER 30 DAYS)
INTELENCE TAB 25MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 100MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 200MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS CHW 25MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS CHW 100MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS HD TAB 600MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS POW 100MG	2	QL (60 PACKETS PER 30 DAYS)
ISENTRESS TAB 400MG	2	QL (120 TABLETS PER 30 DAYS)
JULUCA TAB 50-25MG	3	QL (30 TABLETS PER 30 DAYS)
KALETRA SOL	3	QL (480 ML PER 30 DAYS)
KALETRA TAB 100-25MG	3	QL (240 TABLETS PER 30 DAYS)

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

110

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

Drug Name	Drug Tier	Requirements/Limits
KALETRA TAB 200-50MG	3	QL (120 TABLETS PER 30 DAYS)
<i>lamivudine oral soln 10 mg/ml</i>	1	QL (960 ML PER 30 DAYS)
<i>lamivudine tab 150 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lamivudine tab 300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	1	QL (480 ML PER 30 DAYS)
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	QL (240 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>nevirapine susp 50 mg/5ml</i>	1	QL (1200 ML PER 30 ML DAYS)
<i>nevirapine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>nevirapine tab er 24hr 100 mg</i>	1	QL (90 TABLETS PER 30 DAYS)
<i>nevirapine tab er 24hr 400 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
NORVIR POW 100MG	2	QL (360 PACKETS PER 30 DAYS)
NORVIR SOL 80MG/ML	2	QL (480 ML PER 30 DAYS)
NORVIR TAB 100MG	2	QL (360 TABLETS PER 30 DAYS)
ODEFSEY TAB	2	QL (30 TABLETS PER 30 DAYS)
PREZCOBIX TAB 800-150	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA SUS 100MG/ML	2	QL (400 ML PER 30 DAYS)
PREZISTA TAB 75MG	2	QL (300 TABLETS PER 30 DAYS)

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

111

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

Drug Name	Drug Tier	Requirements/Limits
PREZISTA TAB 150MG	2	QL (180 TABLETS PER 30 DAYS)
PREZISTA TAB 600MG	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA TAB 800MG	2	QL (60 TABLETS PER 30 DAYS)
RETROVIR CAP 100MG	3	QL (180 CAPSULES PER 30 DAYS)
RETROVIR SYP 50MG/5ML	3	QL (1920 ML PER 30 DAYS)
REYATAZ CAP 150MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ CAP 200MG	3	QL (60 CAPSULES PER 30 DAYS)
REYATAZ CAP 300MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ POW 50MG	3	QL (180 PACKETS PER 30 DAYS)
<i>ritonavir tab 100 mg</i>	1	QL (360 TABLETS PER 30 DAYS)
RUKOBIA TAB 600MG ER	3	PA, QL (60 TABLETS PER 30 DAYS)
SELZENTRY SOL 20MG/ML	3	QL (1840 ML PER 30 DAYS)
SELZENTRY TAB 25MG	3	QL (240 TABLETS PER 30 DAYS)
SELZENTRY TAB 75MG	3	QL (60 TABLETS PER 30 DAYS)
SELZENTRY TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
SELZENTRY TAB 300MG	3	QL (120 TABLETS PER 30 DAYS)
<i>stavudine cap 15 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 20 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)

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

112

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

Drug Name	Drug Tier	Requirements/Limits
<i>stavudine cap 30 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 40 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
SUSTIVA CAP 50MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA CAP 200MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA TAB 600MG	3	QL (30 TABLETS PER 30 DAYS)
SYMFI LO TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMFI TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMTUZA TAB	2	QL (30 TABLETS PER 30 DAYS)
TEMIXYS TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
<i>tenofovir disoproxil fumarate tab 300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
TIVICAY PD TAB 5MG	2	QL (360 TABLETS PER 30 DAYS)
TIVICAY TAB 10MG	2	QL (240 TABLETS PER 30 DAYS)
TIVICAY TAB 25MG	2	QL (60 TABLETS PER 30 DAYS)
TIVICAY TAB 50MG	2	QL (60 TABLETS PER 30 DAYS)
TRIUMEQ PD TAB	3	QL (180 TABLETS PER 30 DAYS)
TRIUMEQ TAB	3	QL (30 TABLETS PER 30 DAYS)
TRIZIVIR TAB	3	QL (60 TABLETS PER 30 DAYS)
TYBOST TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)

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

113

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

Drug Name	Drug Tier	Requirements/Limits
VIRAMUNE SUS 50MG/5ML	3	QL (1200 ML PER 30 ML DAYS)
VIRAMUNE XR TAB 400MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD POW 40MG/GM	3	QL (240 GM PER 30 DAYS)
VIREAD TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 200MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 250MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
ZIAGEN SOL 20MG/ML	3	QL (900 ML PER 30 DAYS)
ZIAGEN TAB 300MG	3	QL (60 TABLETS PER 30 DAYS)
<i>zidovudine cap 100 mg</i>	1	QL (180 CAPSULES PER 30 DAYS)
<i>zidovudine syrup 10 mg/ml</i>	1	QL (1920 ML PER 30 DAYS)
<i>zidovudine tab 300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100	3	QL (40 tabs every 30 days)
PAXLOVID TAB 300-100	3	QL (60 tabs every 30 days)
CMV AGENTS		
LIVTENCITY TAB 200MG	5	PA, QL (120 TABLETS PER 30 DAYS)
PREVYMIS TAB 240MG	3	
PREVYMIS TAB 480MG	3	
<i>valganciclovir hcl for soln 50 mg/ml (base equiv)</i>	1	QL (1000 ML PER 30 DAYS)
<i>valganciclovir hcl tab 450 mg (base equivalent)</i>	1	QL (120 TABLETS FOR 30 DAYS)

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

114

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

Drug Name	Drug Tier	Requirements/Limits
HEPATITIS AGENTS		
<i>adefovir dipivoxil tab 10 mg</i>	1	
BARACLUDE SOL	2	QL (630 ML PER 30 DAYS)
<i>entecavir tab 0.5 mg</i>	1	QL (30 TABS PER 30 DAYS)
<i>entecavir tab 1 mg</i>	1	QL (30 TABS PER 30 DAYS)
EPCLUSA PAK 150-37.5	4	PA, QL (28 TABLETS PER 28 DAYS)
EPCLUSA PAK 150-37.5	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA PAK 200-50MG	4	PA, QL (28 TABLETS PER 28 DAYS)
EPCLUSA PAK 200-50MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
HARVONI PAK	4	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI PAK 45-200MG	4	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 45-200MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
HARVONI TAB 90-400MG	4	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5, 6
<i>lamivudine tab 100 mg (hbv)</i>	1	

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

115

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

Drug Name	Drug Tier	Requirements/Limits
PEGINTRON KIT 50MCG	5	
<i>ribavirin cap 200 mg</i>	1	PA
<i>ribavirin tab 200 mg</i>	1	PA
SOVALDI PAK 150MG	5	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI PAK 200MG	5	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI TAB 200MG	5	PA, QL (28 TABLETS PER 28 DAYS)
SOVALDI TAB 400MG	5	PA, QL (28 TABLETS PER 28 DAYS)
VEMLIDY TAB 25MG	2	QL (30 TABLETS PER 30 DAYS)
VOSEVI TAB	4	PA, QL (28 TABLETS PER 28 DAYS); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3)

HERPES AGENTS

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

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

116

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

Drug Name	Drug Tier	Requirements/Limits
INFLUENZA AGENTS		
<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	QL (28 caps every 90 days)
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	QL (180 mL every 90 days)
RELENZA MIS DISKHALE	2	QL (2 inhalers every 90 days)
<i>rimantadine hydrochloride tab 100 mg</i>	1	
TAMIFLU CAP 30MG	3	QL (28 caps every 90 days)
TAMIFLU CAP 45MG	3	QL (14 caps every 90 days)
TAMIFLU CAP 75MG	3	QL (14 caps every 90 days)
TAMIFLU SUS 6MG/ML	3	QL (180 mL every 90 days)
MISC. ANTIVIRALS		
FAVIPIRAVIR TAB 200MG	3	
LAGEVRIO CAP 200MG	3	QL (40 caps every 30 days)
TEMBEXA SUS 10MG/ML	3	
TEMBEXA TAB 100MG	3	
TPOXX CAP 200MG	3	
TPOXX INJ	3	
BETA BLOCKERS		
ALPHA-BETA BLOCKERS		
<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 20 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 40 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 80 mg</i>	1	
<i>carvedilol tab 3.125 mg</i>	1	
<i>carvedilol tab 6.25 mg</i>	1	
<i>carvedilol tab 12.5 mg</i>	1	
<i>carvedilol tab 25 mg</i>	1	
COREG TAB 3.125MG	3	
COREG TAB 6.25MG	3	
COREG TAB 12.5MG	3	
COREG TAB 25MG	3	

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

117

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

Drug Name	Drug Tier	Requirements/Limits
<i>labetalol hcl tab 100 mg</i>	1	
<i>labetalol hcl tab 200 mg</i>	1	
<i>labetalol hcl tab 300 mg</i>	1	
BETA BLOCKERS CARDIO-SELECTIVE		
<i>acebutolol hcl cap 200 mg</i>	1	
<i>acebutolol hcl cap 400 mg</i>	1	
<i>atenolol tab 25 mg</i>	1	
<i>atenolol tab 50 mg</i>	1	
<i>atenolol tab 100 mg</i>	1	
<i>betaxolol hcl tab 10 mg</i>	1	
<i>betaxolol hcl tab 20 mg</i>	1	
<i>bisoprolol fumarate tab 5 mg</i>	1	
<i>bisoprolol fumarate tab 10 mg</i>	1	
BYSTOLIC TAB 2.5MG	3	
BYSTOLIC TAB 5MG	3	
BYSTOLIC TAB 10MG	3	
BYSTOLIC TAB 20MG	3	
LOPRESSOR TAB 50MG	3	
LOPRESSOR TAB 100MG	3	
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	1	
<i>metoprolol tartrate tab 25 mg</i>	1	
<i>metoprolol tartrate tab 37.5 mg</i>	1	
<i>metoprolol tartrate tab 50 mg</i>	1	
<i>metoprolol tartrate tab 75 mg</i>	1	
<i>metoprolol tartrate tab 100 mg</i>	1	
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	1	

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

118

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

Drug Name	Drug Tier	Requirements/Limits
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	1	
TENORMIN TAB 25MG	3	
TENORMIN TAB 50MG	3	
TENORMIN TAB 100MG	3	
BETA BLOCKERS NON-SELECTIVE		
CORGARD TAB 20MG	3	
CORGARD TAB 40MG	3	
CORGARD TAB 80MG	3	
HEMANGEOL SOL 4.28/ML	3	
<i>nadolol tab 20 mg</i>	1	
<i>nadolol tab 40 mg</i>	1	
<i>nadolol tab 80 mg</i>	1	
<i>pindolol tab 5 mg</i>	1	
<i>pindolol tab 10 mg</i>	1	
<i>propranolol hcl cap er 24hr 60 mg</i>	1	
<i>propranolol hcl cap er 24hr 80 mg</i>	1	
<i>propranolol hcl cap er 24hr 120 mg</i>	1	
<i>propranolol hcl cap er 24hr 160 mg</i>	1	
<i>propranolol hcl oral soln 20 mg/5ml</i>	1	
<i>propranolol hcl oral soln 40 mg/5ml</i>	1	
<i>propranolol hcl tab 10 mg</i>	1	
<i>propranolol hcl tab 20 mg</i>	1	
<i>propranolol hcl tab 40 mg</i>	1	
<i>propranolol hcl tab 60 mg</i>	1	
<i>propranolol hcl tab 80 mg</i>	1	
<i>sotalol hcl (afib/af) tab 80 mg</i>	1	
<i>sotalol hcl (afib/af) tab 120 mg</i>	1	
<i>sotalol hcl (afib/af) tab 160 mg</i>	1	
<i>sotalol hcl tab 80 mg</i>	1	
<i>sotalol hcl tab 120 mg</i>	1	
<i>sotalol hcl tab 160 mg</i>	1	
<i>sotalol hcl tab 240 mg</i>	1	
SOTYLIZE SOL 5MG/ML	3	
<i>timolol maleate tab 5 mg</i>	1	
<i>timolol maleate tab 10 mg</i>	1	

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

119

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

Drug Name	Drug Tier	Requirements/Limits
<i>timolol maleate tab 20 mg</i>	1	
CALCIUM CHANNEL BLOCKERS		
CALCIUM CHANNEL BLOCKERS		
<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	1	
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	1	
<i>amlodipine besylate tab 10 mg (base equivalent)</i>	1	
CALAN SR TAB 120MG	3	
CALAN SR TAB 180MG	3	
CALAN SR TAB 240MG	3	
<i>diltiazem hcl cap er 12hr 60 mg</i>	1	
<i>diltiazem hcl cap er 12hr 90 mg</i>	1	
<i>diltiazem hcl cap er 12hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i>	1	
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>	1	
<i>diltiazem hcl tab 30 mg</i>	1	

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

120

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

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl tab 60 mg	1	
diltiazem hcl tab 90 mg	1	
diltiazem hcl tab 120 mg	1	
felodipine tab er 24hr 2.5 mg	1	
felodipine tab er 24hr 5 mg	1	
felodipine tab er 24hr 10 mg	1	
isradipine cap 2.5 mg	1	
isradipine cap 5 mg	1	
nicardipine hcl cap 20 mg	1	
nicardipine hcl cap 30 mg	1	
nifedipine cap 10 mg	1	
nifedipine cap 20 mg	1	
nifedipine tab er 24hr 30 mg	1	
nifedipine tab er 24hr 60 mg	1	
nifedipine tab er 24hr 90 mg	1	
nifedipine tab er 24hr osmotic release 30 mg	1	
nifedipine tab er 24hr osmotic release 60 mg	1	
nifedipine tab er 24hr osmotic release 90 mg	1	
nimodipine cap 30 mg	1	
nisoldipine tab er 24hr 8.5 mg	1	
nisoldipine tab er 24hr 17 mg	1	
nisoldipine tab er 24hr 20 mg	1	
nisoldipine tab er 24hr 25.5 mg	1	
nisoldipine tab er 24hr 30 mg	1	
nisoldipine tab er 24hr 34 mg	1	
nisoldipine tab er 24hr 40 mg	1	
NYMALIZE SOL	3	
PROCARDIA CAP 10MG	3	
PROCARDIA XL TAB 30MG CR	3	
PROCARDIA XL TAB 60MG CR	3	
PROCARDIA XL TAB 90MG CR	3	
SULAR TAB 8.5MG	3	
SULAR TAB 17MG	3	
SULAR TAB 34MG	3	
TIAZAC CAP 120MG/24	3	

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

121

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

Drug Name	Drug Tier	Requirements/Limits
TIAZAC CAP 180MG/24	3	
TIAZAC CAP 240MG/24	3	
TIAZAC CAP 300MG/24	3	
TIAZAC CAP 360MG/24	3	
TIAZAC CAP 420MG/24	3	
verapamil hcl cap er 24hr 100 mg	1	
verapamil hcl cap er 24hr 120 mg	1	
verapamil hcl cap er 24hr 180 mg	1	
verapamil hcl cap er 24hr 200 mg	1	
verapamil hcl cap er 24hr 240 mg	1	
verapamil hcl cap er 24hr 300 mg	1	
verapamil hcl cap er 24hr 360 mg	1	
verapamil hcl tab 40 mg	1	
verapamil hcl tab 80 mg	1	
verapamil hcl tab 120 mg	1	
verapamil hcl tab er 120 mg	1	
verapamil hcl tab er 180 mg	1	
verapamil hcl tab er 240 mg	1	
VERELAN CAP 120MG SR	3	
VERELAN CAP 180MG SR	3	
VERELAN CAP 240MG SR	3	
VERELAN CAP 360MG SR	3	
VERELAN PM CAP 100MG ER	3	
VERELAN PM CAP 200MG ER	3	
VERELAN PM CAP 300MG ER	3	

CARDIOTONICS**CARDIAC GLYCOSIDES**

digoxin oral soln 0.05 mg/ml	1	
digoxin tab 125 mcg (0.125 mg)	1	
digoxin tab 250 mcg (0.25 mg)	1	
LANOXIN TAB 0.0625MG	3	

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

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

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

122

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

Drug Name	Drug Tier	Requirements/Limits
CAMZYOS CAP 5MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 10MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
CAMZYOS CAP 15MG	5	PA, QL (30 CAPSULES PER 30 DAYS)

CARDIOVASCULAR AGENTS MISC. - COMBINATIONS

<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	
BIDIL TAB	3	
CADUET TAB 5-10MG	3	
CADUET TAB 5-20MG	3	
CADUET TAB 5-40MG	3	
CADUET TAB 5-80MG	3	
CADUET TAB 10-10MG	3	
CADUET TAB 10-20MG	3	

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

123

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

Drug Name	Drug Tier	Requirements/Limits
CADUET TAB 10-40MG	3	
CADUET TAB 10-80MG	3	
ENTRESTO TAB 24-26MG	2	
ENTRESTO TAB 49-51MG	2	
ENTRESTO TAB 97-103MG	2	
IMPOTENCE AGENTS		
CAVERJECT IM KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
CAVERJECT INJ 40MCG	3	QL (6 vials every 30 days); Coverage is subject to your plan/benefits
CAVERJECT KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 40MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
LEVITRA TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
LEVITRA TAB 20MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 125MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 250MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits

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

124

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

Drug Name	Drug Tier	Requirements/Limits
MUSE SUP 500MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 1000MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 25 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 50 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>sildenafil citrate tab 100 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
STAXYN TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 2.5 mg</i>	1	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 5 mg</i>	1	ST, QL (30 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>tadalafil tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>ildenafil hcl orally disintegrating tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>ildenafil hcl tab 2.5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits

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

125

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

Drug Name	Drug Tier	Requirements/Limits
<i>varденаfil hcl tab 5 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>varденаfil hcl tab 10 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
<i>varденаfil hcl tab 20 mg</i>	1	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits

PROSTAGLANDIN VASODILATORS

ORENITRAM TAB 0.25MG	4	PA
ORENITRAM TAB 0.125MG	4	PA
ORENITRAM TAB 1MG	4	PA
ORENITRAM TAB 2.5MG	4	PA
ORENITRAM TAB 5MG	4	PA
ORENITRAM TAB MONTH 1	4	PA
ORENITRAM TAB MONTH 2	4	PA
ORENITRAM TAB MONTH 3	4	PA
TYVASO DPI POW 16-32-48	5	QL (252 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 16-32MCG	5	QL (196 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 16MCG	5	QL (112 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 32-48MCG	5	QL (224 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 32MCG	5	QL (112 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 48MCG	5	QL (112 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 64MCG	5	QL (112 CARTRIDGES PER 28 DAYS)
TYVASO REFIL SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)

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

126

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

Drug Name	Drug Tier	Requirements/Limits
TYVASO START SOL 0.6MG/ML	5	PA, QL (28 AMPULES PER 28 DAYS)
VENTAVIS SOL 10MCG/ML	5	PA, QL (270 AMPULES PER 30 DAYS)
VENTAVIS SOL 20MCG/ML	5	PA, QL (270 AMPULES PER 30 DAYS)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
<i>ambrisentan tab 5 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<i>ambrisentan tab 10 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<i>bosentan tab 62.5 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>bosentan tab 125 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
OPSUMIT TAB 10MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	PA, QL (784 ML PER 30 DAYS)
<i>sildenafil citrate tab 20 mg</i>	1	PA, QL (360 TABLETS PER 30 DAYS)
<i>tadalafil tab 20 mg (pah)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI PACK TAB 200/800	4	PA, QL (1 PACK EVERY 28 DAYS)
UPTRAVI TAB 200MCG	4	PA, QL (140 TABLETS PER 28 DAYS)
UPTRAVI TAB 400MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 600MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 800MCG	4	PA, QL (60 TABLETS PER 30 DAYS)

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

127

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

Drug Name	Drug Tier	Requirements/Limits
UPTRAVI TAB 1000MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1200MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1400MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1600MCG	4	PA, QL (60 TABLETS PER 30 DAYS)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2.5MG	4	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2MG	4	PA, QL (90 TABLETS PER 30 DAYS)
SINUS NODE INHIBITORS		
CORLANOR SOL 5MG/5ML	3	PA
CORLANOR TAB 5MG	2	PA
CORLANOR TAB 7.5MG	2	PA
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP 61MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG	2	
VERQUVO TAB 5MG	2	
VERQUVO TAB 10MG	2	
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap 500 mg	1	
cefadroxil for susp 250 mg/5ml	1	
cefadroxil for susp 500 mg/5ml	1	

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

128

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

Drug Name	Drug Tier	Requirements/Limits
<i>cefadroxil tab 1 gm</i>	1	
<i>cephalexin cap 250 mg</i>	1	
<i>cephalexin cap 500 mg</i>	1	
<i>cephalexin cap 750 mg</i>	1	
<i>cephalexin for susp 125 mg/5ml</i>	1	
<i>cephalexin for susp 250 mg/5ml</i>	1	
<i>cephalexin tab 250 mg</i>	1	
<i>cephalexin tab 500 mg</i>	1	
KEFLEX CAP 750MG	3	
CEPHALOSPORINS - 2ND GENERATION		
<i>cefaclor cap 250 mg</i>	1	
<i>cefaclor cap 500 mg</i>	1	
CEFACLOR ER TAB 500MG	3	
<i>cefaclor for susp 125 mg/5ml</i>	1	
<i>cefaclor for susp 250 mg/5ml</i>	1	
<i>cefaclor for susp 375 mg/5ml</i>	1	
<i>cefprozil for susp 125 mg/5ml</i>	1	
<i>cefprozil for susp 250 mg/5ml</i>	1	
<i>cefprozil tab 250 mg</i>	1	
<i>cefprozil tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
CEPHALOSPORINS - 3RD GENERATION		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	
<i>cefdinir for susp 250 mg/5ml</i>	1	
<i>cefixime cap 400 mg</i>	1	
<i>cefixime for susp 100 mg/5ml</i>	1	
<i>cefixime for susp 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	1	
<i>cefpodoxime proxetil tab 100 mg</i>	1	
<i>cefpodoxime proxetil tab 200 mg</i>	1	
SUPRAX CAP 400MG	2	
SUPRAX CHW 100MG	2	

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

129

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

Drug Name	Drug Tier	Requirements/Limits
SUPRAX CHW 200MG	2	
SUPRAX SUS 100/5ML	2	
SUPRAX SUS 200/5ML	2	
SUPRAX SUS 500/5ML	2	

CONTRACEPTIVES**COMBINATION CONTRACEPTIVES - ORAL**

<i>desogest-eth estrad & eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	0	
<i>desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg</i>	0	
<i>desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	0	
ESTROSTEP FE TAB	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	0	
GENERESS FE CHW	0	
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg & eth est 0.01 mg</i>	0	
<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	0	
<i>levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg</i>	0	
<i>levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	

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

130

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

Drug Name	Drug Tier	Requirements/Limits
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	0	
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	0	
LO LOESTRIN TAB 1-10-10	0	
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	
<i>norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol tab 0.5 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg</i>	0	
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	0	

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

131

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

Drug Name	Drug Tier	Requirements/Limits
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	0	
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	0	
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	0	
SAFYRAL TAB	0	
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	0	
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS	0	QL (1 ring every 300 days)
<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	0	QL (13 rings every 300 days)
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG	0	
<i>levonorgestrel tab 1.5 mg</i>	0	
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 300 days)
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
DEPO-SQ PROV INJ 104	0	QL (6.154 injections every 300 days)
<i>medroxyprogesterone acetate im susp 150 mg/ml</i>	0	QL (4 injections every 59 days)
<i>medroxyprogesterone acetate im susp prefilled syr 150 mg/ml</i>	0	QL (4 injections every 300 days)
PROGESTIN CONTRACEPTIVES - ORAL		
<i>norethindrone tab 0.35 mg</i>	0	
ORTHO MICRON TAB 0.35MG	0	

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

132

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

Drug Name	Drug Tier	Requirements/Limits
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
<i>budesonide delayed release particles cap 3 mg</i>	1	
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	3	
DEXAMETHASON CON 1MG/ML	3	
<i>dexamethasone elixir 0.5 mg/5ml</i>	1	
<i>dexamethasone soln 0.5 mg/5ml</i>	1	
<i>dexamethasone tab 0.5 mg</i>	1	
<i>dexamethasone tab 0.75 mg</i>	1	
<i>dexamethasone tab 1 mg</i>	1	
<i>dexamethasone tab 1.5 mg</i>	1	
<i>dexamethasone tab 2 mg</i>	1	
<i>dexamethasone tab 4 mg</i>	1	
<i>dexamethasone tab 6 mg</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
ENTOCORT EC CAP 3MG DR	3	
<i>hydrocortisone tab 5 mg</i>	1	
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	
MEDROL TAB 2MG	3	
MEDROL TAB 4MG	3	
MEDROL TAB 8MG	3	
MEDROL TAB 16MG	3	
MEDROL TAB 32MG	3	
<i>methylprednisolone tab 4 mg</i>	1	
<i>methylprednisolone tab 8 mg</i>	1	
<i>methylprednisolone tab 16 mg</i>	1	
<i>methylprednisolone tab 32 mg</i>	1	
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1	
ORAPRED ODT TAB 10MG	3	
ORAPRED ODT TAB 15MG	3	

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

133

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

Drug Name	Drug Tier	Requirements/Limits
ORAPRED ODT TAB 30MG	3	
PEDIAPRED SOL 5MG/5ML	3	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i>	1	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	
<i>prednisolone soln 15 mg/5ml</i>	1	
PREDNISON CON 5MG/ML	3	
<i>prednisone oral soln 5 mg/5ml</i>	1	
<i>prednisone tab 1 mg</i>	1	
<i>prednisone tab 2.5 mg</i>	1	
<i>prednisone tab 5 mg</i>	1	
<i>prednisone tab 10 mg</i>	1	
<i>prednisone tab 20 mg</i>	1	
<i>prednisone tab 50 mg</i>	1	
<i>prednisone tab therapy pack 5 mg (21)</i>	1	
<i>prednisone tab therapy pack 5 mg (48)</i>	1	
<i>prednisone tab therapy pack 10 mg (21)</i>	1	
<i>prednisone tab therapy pack 10 mg (48)</i>	1	
SOLU-CORTEF INJ 100MG	3	PA
SOLU-CORTEF INJ 250MG	3	PA
SOLU-CORTEF INJ 500MG	3	PA
SOLU-CORTEF INJ 1000MG	3	PA
UCERIS TAB 9MG	3	
MINERALOCORTICIDS		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	

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

134

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

Drug Name	Drug Tier	Requirements/Limits
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	QL (6 tabs every 7 days)
TESSALON PER CAP 100MG	2	
COUGH/COLD/ALLERGY COMBINATIONS		
CLARINEX-D TAB 2.5-120	3	
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>	1	QL (45 mL every 7 days)
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	1	QL (60 mL every 7 days)
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	QL (10 mL every 7 days)
MAR-COF CG LIQ 225-7.5	3	QL (45 mL every 7 days)
NEOTUSS PLUS LIQ	3	
<i>promethazine & phenylephrine syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
TUSSICAPS CAP 10-8MG	3	QL (2 caps every 7 days)
TUZISTRA XR SUS	3	QL (20 mL every 7 days)
MISC. RESPIRATORY INHALANTS		
HYPERSAL NEB 3.5%	3	
HYPERSAL NEB 7%	3	
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
<i>sodium chloride soln nebu 7%</i>	1	

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

135

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

Drug Name	Drug Tier	Requirements/Limits
<i>sodium chloride soln nebu 10%</i>	1	
MUCOLYTICS		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
DERMATOLOGICALS		
ACNE PRODUCTS		
ABSORICA CAP 10MG	3	
ABSORICA CAP 20MG	3	
ABSORICA CAP 25MG	3	
ABSORICA CAP 30MG	3	
ABSORICA CAP 35MG	3	
ABSORICA CAP 40MG	3	
ACZONE GEL 5%	3	
ACZONE GEL 7.5%	3	
<i>adapalene cream 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.3%</i>	1	PA
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	1	PA
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	1	PA
ARAZLO LOT 0.045%	3	PA
ATRALIN GEL 0.05%	3	PA
BENZAMYCIN GEL 5-3%	3	QL (47 gm every 30 days)
<i>benzoyl peroxide foam 9.8%</i>	1	
<i>benzoyl peroxide liq 7%</i>	1	
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	1	QL (47 gm every 30 days)
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>	1	
CLEOCIN-T LOT 1%	3	QL (60 mL every 30 days)
CLINDAGEL GEL 1%	3	QL (60 mL every 30 days)
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	1	QL (50 gm every 30 days)
<i>clindamycin phosphate foam 1%</i>	1	
<i>clindamycin phosphate gel 1%</i>	1	QL (60 gm every 30 days)
<i>clindamycin phosphate lotion 1%</i>	1	QL (60 mL every 30 days)
<i>clindamycin phosphate soln 1%</i>	1	QL (60 mL every 30 days)

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

136

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

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate swab 1%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	1	QL (50 gm every 30 days)
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	1	QL (50 gm every 30 days)
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	1	PA
<i>dapsone gel 5%</i>	1	
<i>dapsone gel 7.5%</i>	1	
DIFFERIN CRE 0.1%	3	PA
DIFFERIN GEL 0.1%	3	PA
DIFFERIN GEL 0.3%	3	PA
EPIDUO FORTE GEL 0.3-2.5%	3	PA
EPIDUO GEL 0.1-2.5%	3	PA
ERYGEL GEL 2%	3	QL (60 gm every 30 days)
<i>erythromycin gel 2%</i>	1	QL (60 gm every 30 days)
<i>erythromycin pads 2%</i>	1	
<i>erythromycin soln 2%</i>	1	QL (60 mL every 30 days)
EVOCLIN AER 1%	3	
<i>isotretinoin cap 10 mg</i>	1	
<i>isotretinoin cap 20 mg</i>	1	
<i>isotretinoin cap 30 mg</i>	1	
<i>isotretinoin cap 40 mg</i>	1	
KLARON LOT 10%	3	
ONEXTON GEL 1.2-3.75	2	QL (50 gm every 30 days)
PR BENZOYL LIQ 7% WASH	1	
RETIN-A CRE 0.1%	3	PA
RETIN-A CRE 0.05%	3	PA
RETIN-A CRE 0.025%	3	PA
RETIN-A GEL 0.01%	3	PA
RETIN-A GEL 0.025%	3	PA
RETIN-A MICR GEL 0.1%	3	PA
RETIN-A MICR GEL 0.1%PUMP	3	PA
RETIN-A MICR GEL 0.04%	3	PA
RETIN-A MICR GEL 0.04%PMP	3	PA

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

137

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

Drug Name	Drug Tier	Requirements/Limits
RETIN-A MICR GEL 0.06%	3	PA
RETIN-A MICR GEL 0.08%	3	PA
RIAX AER 5.5%	3	
RIAX AER 9.5%	3	
<i>sulfacetamide sodium lotion 10% (acne)</i>	1	
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	1	
<i>sulfacetamide sodium w/ sulfur emulsion 10-1%</i>	1	
<i>tretinoin cream 0.1%</i>	1	PA
<i>tretinoin cream 0.05%</i>	1	PA
<i>tretinoin cream 0.025%</i>	1	PA
<i>tretinoin gel 0.01%</i>	1	PA
<i>tretinoin gel 0.05%</i>	1	PA
<i>tretinoin gel 0.025%</i>	1	PA
<i>tretinoin microsphere gel 0.1%</i>	1	PA
<i>tretinoin microsphere gel 0.04%</i>	1	PA
ZACLIR LOT 8%	3	
ANTI-INFLAMMATORY AGENTS - TOPICAL		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	PA, QL (150 mL every 21 days)
FLECTOR DIS 1.3%	3	
ANTIBIOTICS - TOPICAL		
ALTABAX OIN 1%	3	
CENTANY OIN 2%	3	QL (30 gm every 30 days)
<i>gentamicin sulfate cream 0.1%</i>	1	QL (120 gm every 25 days)
<i>gentamicin sulfate oint 0.1%</i>	1	QL (120 gm every 25 days)
<i>mupirocin oint 2%</i>	1	QL (30 gm every 25 days)
XEPI CRE 1%	3	PA
ANTIFUNGALS - TOPICAL		
<i>ciclopirox gel 0.77%</i>	1	QL (120 gm every 30 days)
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	QL (120 gm every 30 days)
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	QL (120 mL every 30 days)
<i>ciclopirox shampoo 1%</i>	1	QL (120 mL every 25 days)
<i>ciclopirox solution 8%</i>	1	

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

138

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

Drug Name	Drug Tier	Requirements/Limits
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	
<i>econazole nitrate cream 1%</i>	1	QL (60 gm every 30 days)
ECOZA AER 1%	3	QL (70 gm every 25 days)
ERTACZO CRE 2%	3	QL (60 gm every 25 days)
EXELDERM CRE 1%	3	QL (60 gm every 30 days)
EXELDERM SOL 1%	3	QL (60 mL every 25 days)
EXODERM LOT 25-1%	3	
EXTINA AER 2%	3	QL (100 gm every 30 days)
<i>iodoquinol-hc cream 1-1%</i>	1	
<i>iodoquinol-hydrocortisone in aloe vehicle cream 1-1.9%</i>	1	
JUBLIA SOL 10%	3	PA, QL (4 mL every 21 days)
KERYDIN SOL 5%	3	PA, QL (4 mL every 21 days)
<i>ketoconazole cream 2%</i>	1	QL (120 gm every 30 days)
<i>ketoconazole shampoo 2%</i>	1	QL (120 mL every 25 days)
LOPROX SHA 1%	3	QL (120 mL every 30 days)
LUZU CRE 1%	3	QL (60 gm every 30 days)
<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%</i>	1	QL (100 gm every 25 days)
<i>naftifine hcl cream 1%</i>	1	QL (60 gm every 30 days)
<i>naftifine hcl cream 2%</i>	1	QL (60 gm every 30 days)
<i>naftifine hcl gel 1%</i>	1	QL (120 gm every 25 days)
NAFTIN GEL 1%	2	QL (120 gm every 30 days)
NAFTIN GEL 2%	2	QL (60 gm every 30 days)
<i>nystatin cream 100000 unit/gm</i>	1	QL (120 gm every 30 days)
<i>nystatin oint 100000 unit/gm</i>	1	QL (120 gm every 30 days)
<i>nystatin topical powder 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin topical powder 100000 unit/gm</i>	1	QL (120 gm every 30 days)
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	

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

139

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

Drug Name	Drug Tier	Requirements/Limits
<i>oxiconazole nitrate cream 1%</i>	1	QL (60 gm every 30 days)
OXISTAT CRE 1%	3	QL (60 gm every 30 days)
OXISTAT LOT 1%	3	QL (60 mL every 30 days)
<i>sulconazole nitrate cream 1%</i>	1	QL (60 gm every 30 days)
<i>sulconazole nitrate solution 1%</i>	1	QL (60 mL every 30 days)
VUSION OIN	3	QL (100 gm every 30 days)
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	PA
EFUDEX CRE 5%	3	
FLUOROPLEX CRE 1%	3	
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
LEVULAN KERA SOL 20%	3	
PANRETIN GEL 0.1%	3	
PICATO GEL 0.05%	2	
PICATO GEL 0.015%	2	
TARGRETIN GEL 1%	5	PA
VALCHLOR GEL 0.016%	5	PA, QL (2 TUBES PER 30 DAYS)
ANTIPRURITICS - TOPICAL		
PRUDOXIN CRE 5%	3	ST, QL (90 gm every 30 days)
ZONALON CRE 5%	3	ST, QL (90 gm every 30 days)
ANTIPSORIATICS		
<i>acitretin cap 10 mg</i>	1	
<i>acitretin cap 17.5 mg</i>	1	
<i>acitretin cap 25 mg</i>	1	
<i>calcipotriene oint 0.005%</i>	1	PA
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	PA

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

140

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

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

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

141

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

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

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

142

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

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

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

143

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

Drug Name	Drug Tier	Requirements/Limits
STELARA INJ 45MG/0.5	4	PA, QL (1 VIALS PER 12 WEEKS); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
STELARA INJ 90MG/ML	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
<i>tazarotene cream 0.1%</i>	1	PA
TREMFYA INJ 100MG/ML	4	PA, QL (1 PENS PER 8 WEEKS); Preferred agent for Psoriasis ; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
TREMFYA INJ 100MG/ML	4	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for Psoriasis ; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
ANTISEBORRHEIC PRODUCTS		
<i>selenium sulfide lotion 2.5%</i>	1	

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

144

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

Drug Name	Drug Tier	Requirements/Limits
SODIUM SULFA LIQ 10% WASH	3	
ANTIVIRALS - TOPICAL		
<i>acyclovir oint 5%</i>	1	
DENAVIR CRE 1%	3	
<i>penciclovir cream 1%</i>	1	
XERESE CRE 5-1%	3	
ZOVIRAX CRE 5%	3	
ZOVIRAX OIN 5%	3	
BURN PRODUCTS		
<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	
SILVADENE CRE 1%	2	
<i>silver sulfadiazine cream 1%</i>	1	
SULFAMYLON CRE 85MG/GM	3	
SULFAMYLON PAK 5%	3	
CORTICOSTEROIDS - TOPICAL		
<i>alclometasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>alclometasone dipropionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>amcinonide cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>amcinonide lotion 0.1%</i>	1	QL (120 mL every 30 days)
<i>amcinonide oint 0.1%</i>	3	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone dipropionate augmented oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate aerosol foam 0.12%</i>	1	QL (120 gm every 30 days)
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)

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

145

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

Drug Name	Drug Tier	Requirements/Limits
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
BRYHALI LOT 0.01%	2	QL (120 gm every 30 days)
CAPEX SHA 0.01%	2	QL (120 mL every 30 days)
<i>clobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate emollient base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate foam 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate shampoo 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate soln 0.05%</i>	1	QL (120 mL every 30 days)
CLOBEX LOT 0.05%	2	QL (120 mL every 30 days)
CLOBEX SHA 0.05%	2	QL (120 mL every 30 days)
CLODERM CRE 0.1%	3	QL (120 gm every 30 days)
CUTIVATE LOT 0.05%	3	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS BODY	2	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS SCLP	2	QL (120 mL every 30 days)
DESONATE GEL 0.05%	3	QL (120 gm every 30 days)
<i>desonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desonide lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>desonide oint 0.05%</i>	1	QL (120 gm every 30 days)
DESOWEN CRE 0.05%	3	QL (120 gm every 30 days)
<i>desoximetasone cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone cream 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone oint 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone spray 0.25%</i>	1	QL (120 mL every 30 days)
DIPROLENE AF CRE 0.05%	3	QL (120 gm every 30 days)
DIPROLENE OIN 0.05%	3	QL (120 gm every 30 days)
DUOBRII LOT	3	
ENSTILAR AER	3	PA

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

146

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

Drug Name	Drug Tier	Requirements/Limits
EPIFOAM AER 1%	3	
<i>fluocinolone acetonide cream 0.01%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide cream 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oint 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide soln 0.01%</i>	1	QL (120 mL every 30 days)
<i>fluocinonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide emulsified base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide soln 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluticasone propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate oint 0.005%</i>	1	QL (120 gm every 30 days)
<i>halobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>halobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
HC/PRAMOXINE CRE 1-2.35%	3	
<i>hydrocortisone butyrate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate soln 0.1%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone cream 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone lotion 2.5%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone oint 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate cream 0.2%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate oint 0.2%</i>	1	QL (120 gm every 30 days)
KENALOG AER SPRAY	3	QL (120 gm every 30 days)
LOCOID LIPO CRE 0.1%	3	QL (120 gm every 30 days)
LOCOID LOT 0.1%	3	QL (120 mL every 30 days)
LUXIQ AER 0.12%	3	QL (120 gm every 30 days)
<i>mometasone furoate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate solution 0.1% (lotion)</i>	1	QL (120 mL every 30 days)
OLUX AER 0.05%	3	QL (120 gm every 30 days)
PANDEL CRE 0.1%	3	QL (120 gm every 30 days)

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

147

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

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

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

148

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

Drug Name	Drug Tier	Requirements/Limits
ECZEMA AGENTS		
DUPIXENT INJ 200MG	4	PA, QL (2 PENS (400 MG) PER 28 DAYS); LOADING DOSE:2 PENS (400 MG) PER 14 DAYS
DUPIXENT INJ 300/2ML	4	PA, QL (4 PENS PER 28 DAYS)
DUPIXENT INJ 300/2ML	4	PA, QL (4 PFS PER 28 DAYS)
EMOLLIENT/KERATOLYTIC AGENTS		
<i>urea cream 39%</i>	1	
<i>urea lotion 40%</i>	1	
EMOLLIENTS		
LACTIC ACID LOT 10%	3	
ENZYMES - TOPICAL		
SANTYL OIN 250/GM	3	
HAIR GROWTH AGENTS		
<i>finasteride tab 1 mg</i>	1	PA
LITFULO CAP 50MG	5	PA, QL (28 caps per 28 days)
IMMUNOMODULATING AGENTS - TOPICAL		
ALDARA CRE 5%	3	QL (21 ea every 30 days)
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	QL (21 ea every 30 days)
ZYCLARA CRE 3.75%	2	
ZYCLARA PUMP CRE 2.5%	2	
ZYCLARA PUMP CRE 3.75%	2	
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
<i>pimecrolimus cream 1%</i>	1	ST
PROTOPIC OIN 0.1%	3	ST
PROTOPIC OIN 0.03%	3	ST
<i>tacrolimus oint 0.1%</i>	1	ST
<i>tacrolimus oint 0.03%</i>	1	ST

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

149

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

Drug Name	Drug Tier	Requirements/Limits
KERATOLYTIC/ANTIMITOTIC AGENTS		
CONDYLOX GEL 0.5%	2	
GORDOFILM SOL	3	
<i>podofilox soln 0.5%</i>	1	
PYROGALL ACD OIN	3	
SALIMEZ FORT CRE 10%	3	
LINIMENTS		
TURPENTINE SOL SPIRITS	3	
LOCAL ANESTHETICS - TOPICAL		
ANACAINE OIN	3	
ETHYL CHLOR AER FINE PIN	3	
ETHYL CHLOR AER FN STRM	3	
ETHYL CHLOR AER MED JET	3	
ETHYL CHLOR AER MED STRM	3	
ETHYL CHLOR AER MIST	3	
<i>ethyl chloride aerosol spray</i>	1	
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 30 days)
<i>lidocaine hcl urethral/mucosal gel 2%</i>	1	QL (60 mL every 30 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (10 injections every 30 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (12 injections every 30 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (3 injections every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 30 days)
<i>lidocaine patch 5%</i>	1	QL (90 ea every 30 days)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 30 days)
LIDODERM DIS 5%	2	QL (90 ea every 30 days)
SYNERA DIS 70-70MG	3	QL (2 patches every 30 days)
MISC. TOPICAL		
ARNICA TIN FLOWER	3	
DRYSOL SOL 20%	3	
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	

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

150

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

Drug Name	Drug Tier	Requirements/Limits
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2%	2	
ROSACEA AGENTS		
<i>azelaic acid gel 15%</i>	1	PA
FINACEA AER 15%	2	PA
METROCREAM CRE 0.75%	3	
METROGEL GEL 1%	3	
METROLOTION LOT 0.75%	3	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
ORACEA CAP 40MG	1	Tier 1 with DAW9
RHOFADE CRE 1%	3	PA
SOOLANTRA CRE 1%	3	
SCABICIDES & PEDICULICIDES		
<i>crotamiton lotion 10%</i>	1	
ELIMITE CRE 5%	2	
<i>ivermectin lotion 0.5%</i>	1	
<i>lindane shampoo 1%</i>	1	
<i>malathion lotion 0.5%</i>	1	
NATROBA SUS 0.9%	3	
OVIDE LOT 0.5%	2	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
SULF LIME SOL	3	
TAR PRODUCTS		
<i>coal tar soln 20%</i>	1	
WOUND CARE PRODUCTS		
REGRANEX GEL 0.01%	3	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC TESTS		
ACCU-CHEK GUIDE	0	QL (150 strips every 30 days)

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

151

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

Drug Name	Drug Tier	Requirements/Limits
ACCU-CHEK TES AVIVA PL	0	QL (150 strips every 30 days)
ACCU-CHEK TES COMPACT	0	QL (150 strips every 30 days)
ACCU-CHEK TES SMART	0	QL (150 strips every 30 days)
ASSURE PRISM TES MULTI	0	PA, QL (150 strips every 30 days)
CHEMSTRIP K TES	0	
CHEMSTRIP TES UGK	0	
CVS KETONE TES CARE	0	
DIASTIX TES STRIPS	0	
FORA GTEL TES KETONE	0	
GENULTIMATE TES	0	PA, QL (150 strips every 30 days)
GLUCOCARD TES SHINE	0	PA, QL (150 strips every 30 days)
GOJJI BLOOD TES KETONE	0	
KETO-DIASTIX TES	0	
KETONE TES	0	
KETONE TEST TES	0	
KETOSTIX TES STRIP	0	
NOVA MAX PLS TES KETONE	0	
ONETOUCH TES ULTRA	0	QL (150 strips every 30 days)
ONETOUCH TES VERIO	0	
ONETOUCH TES VERIO	0	QL (150 strips every 30 days)
PRECISN XTRA TES KETONE	0	
PTS PANELS TES KETONE	0	
RELION TES KETONE	0	

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

CAMINO PRO LIQ 15PE	3	Coverage is subject to your plan/benefits
---------------------	---	---

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

152

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

Drug Name	Drug Tier	Requirements/Limits
COMPLEAT LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
COMPLEAT PED LIQ ORG BLND	3	PA; Coverage is subject to your plan/benefits
CRUCIAL LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
DIABETIC TF LIQ	3	PA; Coverage is subject to your plan/benefits
DIABETISOURC LIQ	3	PA; Coverage is subject to your plan/benefits
EAA SUPPLEME POW TROPICAL	3	Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
EO28 SPLASH LIQ ORANGE	3	PA; Coverage is subject to your plan/benefits
F.A.A. LIQ	3	PA; Coverage is subject to your plan/benefits
FIBERSOUR HN LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FIBERSOURCE LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
GLUCERNA 1.0 LIQ CARB VAN	3	PA; Coverage is subject to your plan/benefits
GLUCERNA LIQ 1.2 CAL	3	PA; Coverage is subject to your plan/benefits
GLUCERNA SEL LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
GLYTACTIN PAK BTMK/DLT	3	Coverage is subject to your plan/benefits
GLYTACTIN POW BETMLK15	3	Coverage is subject to your plan/benefits
GLYTACTIN POW RST LT10	3	Coverage is subject to your plan/benefits
GLYTROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits

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

153

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

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

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

154

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

Drug Name	Drug Tier	Requirements/Limits
NUTREN 1.0 LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.5 LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
NUTREN 2.0 LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NUTREN JR LIQ	3	PA; Coverage is subject to your plan/benefits
NUTREN LIQ JUNIOR	3	PA; Coverage is subject to your plan/benefits
NUTREN RENAL LIQ	3	PA; Coverage is subject to your plan/benefits
NUTRIRENAL LIQ	3	PA; Coverage is subject to your plan/benefits
OPTIMENTAL LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE HN LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA 1.5 LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA LIQ	3	PA; Coverage is subject to your plan/benefits
PEDIASURE EN LIQ /FIBER	3	PA; Coverage is subject to your plan/benefits
PEDIASURE LIQ PEPTIDE	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits

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

155

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

Drug Name	Drug Tier	Requirements/Limits
PEPTAMEN LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PERATIVE LIQ	3	PA; Coverage is subject to your plan/benefits
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHLEXY-10 POW	3	PA; Coverage is subject to your plan/benefits
PIVOT LIQ 1.5 CAL	3	PA; Coverage is subject to your plan/benefits
PKU EXPLORE5 POW UNFLAVOR	3	Coverage is subject to your plan/benefits
PPA/MMA POW EXPRESS	3	Coverage is subject to your plan/benefits
PRO-PHREE POW	3	Coverage is subject to your plan/benefits
PROMACTIN AA SUS PLUS	3	Coverage is subject to your plan/benefits
PROMOTE 1.0 LIQ W/ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/FB LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
REPLETE FIBE LIQ 1 CAL	3	PA; Coverage is subject to your plan/benefits

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

156

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

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

DIGESTIVE AIDS***DIGESTIVE ENZYMES***

CREON CAP 3000UNIT	2
CREON CAP 6000UNIT	2
CREON CAP 12000UNT	2
CREON CAP 24000UNT	2
CREON CAP 36000UNT	2
PANCREAZE CAP 2600UNIT	3

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

157

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

Drug Name	Drug Tier	Requirements/Limits
PANCREAZE CAP 4200UNIT	3	
PANCREAZE CAP 10500UNT	3	
PANCREAZE CAP 16800UNT	3	
PANCREAZE CAP 21000UNT	3	
PANCREAZE CAP 37000	3	
PERTZYE CAP 4000UNIT	3	
PERTZYE CAP 8000UNIT	3	
PERTZYE CAP 16000U	3	
PERTZYE CAP 24000U	3	
SUCRAID SOL 8500/ML	5	PA
SUCRAID SOL 8500/ML	5	PA
VIOKACE TAB 10440	2	
VIOKACE TAB 20880	2	
ZENPEP CAP 3000UNIT	2	
ZENPEP CAP 5000UNIT	2	
ZENPEP CAP 10000UNT	2	
ZENPEP CAP 15000UNT	2	
ZENPEP CAP 20000UNT	2	
ZENPEP CAP 25000UNT	2	
ZENPEP CAP 40000UNT	2	

DIURETICS**CARBONIC ANHYDRASE INHIBITORS**

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

DIURETIC COMBINATIONS

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

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

158

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

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

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

159

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

Drug Name	Drug Tier	Requirements/Limits
<i>spironolactone tab 50 mg</i>	1	
<i>spironolactone tab 100 mg</i>	1	
<i>triamterene cap 50 mg</i>	1	
<i>triamterene cap 100 mg</i>	1	
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
<i>chlorthalidone tab 25 mg</i>	1	
<i>chlorthalidone tab 50 mg</i>	1	
DIURIL SUS 250/5ML	3	
<i>hydrochlorothiazide cap 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 25 mg</i>	1	
<i>hydrochlorothiazide tab 50 mg</i>	1	
<i>indapamide tab 1.25 mg</i>	1	
<i>indapamide tab 2.5 mg</i>	1	
<i>metolazone tab 2.5 mg</i>	1	
<i>metolazone tab 5 mg</i>	1	
<i>metolazone tab 10 mg</i>	1	
ENDOCRINE AND METABOLIC AGENTS - MISC.		
BONE DENSITY REGULATORS		
ACTONEL TAB 35MG	3	
ACTONEL TAB 150MG	3	
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	
<i>alendronate sodium tab 5 mg</i>	1	
<i>alendronate sodium tab 10 mg</i>	1	
<i>alendronate sodium tab 35 mg</i>	1	
<i>alendronate sodium tab 70 mg</i>	1	
ATELVIA TAB	3	
BINOSTO TAB 70MG	3	
BONIVA TAB 150MG	3	
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1	
FORTEO INJ 600/2.4	4	PA, QL (1 PENS FOR 28 DAYS)
FOSAMAX + D TAB 70-2800	3	
FOSAMAX + D TAB 70-5600	3	
FOSAMAX TAB 70MG	3	

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

160

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

Drug Name	Drug Tier	Requirements/Limits
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	
NATPARA INJ 25MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 75MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 100MCG	5	PA, QL (2 CARTRIDGES PER 28 DAYS)
<i>risedronate sodium tab 5 mg</i>	1	
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	
<i>risedronate sodium tab 150 mg</i>	1	
<i>risedronate sodium tab delayed release 35 mg</i>	1	
TYMLOS INJ	4	PA, QL (1 PEN PER 30 DAYS)
CORTICOTROPIN		
ACTHAR INJ 80UNIT	5	PA, QL (35ML PER 21 DAYS)
CORTROPHIN GEL 80UNIT	5	PA, QL (35ML PER 21 DAYS)
FERTILITY REGULATORS		
<i>clomiphene citrate tab 50 mg</i>	1	Coverage is subject to your plan/benefits
GONAL-F INJ 450UNIT	4	PA, QL (10 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F INJ 1050UNIT	4	PA, QL (6 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits

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

161

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

Drug Name	Drug Tier	Requirements/Limits
GONAL-F RFF INJ 75UNIT	4	PA, QL (60 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 300/0.5	4	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 450/0.75	4	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 900/1.5	4	PA, QL (7 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	5	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	4	PA; Coverage is subject to your plan/benefits
GNRH/LHRH ANTAGONISTS		
CETROTIDE KIT 0.25MG	4	PA
GANIRELIX AC INJ 250/0.5	5	PA
<i>ganirelix acetate soln prefilled syringe 250 mcg/0.5ml</i>	1	PA
ORLISSA TAB 150MG	2	PA
ORLISSA TAB 200MG	2	PA
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA SV INJ 2MG	5	PA, QL (30 VIALS PER 30 DAYS)
GROWTH HORMONES		
GENOTROPIN INJ 0.2MG	4	PA
GENOTROPIN INJ 0.4MG	4	PA
GENOTROPIN INJ 0.6MG	4	PA
GENOTROPIN INJ 0.8MG	4	PA
GENOTROPIN INJ 1.2MG	4	PA

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

162

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

Drug Name	Drug Tier	Requirements/Limits
GENOTROPIN INJ 1.4MG	4	PA
GENOTROPIN INJ 1.6MG	4	PA
GENOTROPIN INJ 1.8MG	4	PA
GENOTROPIN INJ 1MG	4	PA
GENOTROPIN INJ 2MG	4	PA
GENOTROPIN INJ 5MG	4	PA
GENOTROPIN INJ 12MG	4	PA
NORDITROPIN INJ 5/1.5ML	4	PA
NORDITROPIN INJ 10/1.5ML	4	PA
NORDITROPIN INJ 15/1.5ML	4	PA
NORDITROPIN INJ 30/3ML	4	PA
SEROSTIM INJ 4MG	5	PA
SEROSTIM INJ 5MG	5	PA
SEROSTIM INJ 6MG	5	PA
ZORBTIVE INJ 8.8MG	5	PA
HORMONE RECEPTOR MODULATORS		
EVISTA TAB 60MG	0	
<i>raloxifene hcl tab 60 mg</i>	0	
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ 40MG/4ML	5	PA
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL SOL 2MG/ML	3	
METABOLIC MODIFIERS		
<i>calcitriol cap 0.5 mcg</i>	1	
<i>calcitriol cap 0.25 mcg</i>	1	
<i>calcitriol oral soln 1 mcg/ml</i>	1	
CARBAGLU TAB 200MG	5	PA
<i>carglumic acid soluble tab 200 mg</i>	1	PA
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
CYSTADANE POW	5	PA

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

163

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

Drug Name	Drug Tier	Requirements/Limits
<i>doxercalciferol cap 0.5 mcg</i>	1	
<i>doxercalciferol cap 1 mcg</i>	1	
<i>doxercalciferol cap 2.5 mcg</i>	1	
GALAFOLD CAP 123MG	5	PA, QL (14 CAPSULES PER 28 DAYS)
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	
<i>levocarnitine tab 330 mg</i>	1	
MYALEPT INJ 11.3MG	5	PA, QL (30 VIALS PER 30 DAYS)
<i>nitisinone cap 2 mg</i>	1	PA
<i>nitisinone cap 5 mg</i>	1	PA
<i>nitisinone cap 10 mg</i>	1	PA
NITYR TAB 2MG	5	PA
NITYR TAB 5MG	5	PA
NITYR TAB 10MG	5	PA
ORFADIN CAP 2MG	4	PA
ORFADIN CAP 5MG	4	PA
ORFADIN CAP 10MG	4	PA
ORFADIN CAP 20MG	4	PA
ORFADIN SUS 4MG/ML	4	PA
<i>paricalcitol cap 1 mcg</i>	1	
<i>paricalcitol cap 2 mcg</i>	1	
<i>paricalcitol cap 4 mcg</i>	1	
PHEBURANE MIS 483/GM	5	PA, QL (672 GRAMS (8 BOTTLES) PER 30 DAYS)
REVCovi INJ 1.6MG/ML	5	
ROCALTROL CAP 0.5MCG	2	
ROCALTROL CAP 0.25MCG	2	
ROCALTROL SOL 1MCG/ML	2	
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	PA
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	PA
<i>sapropterin dihydrochloride tab 100 mg</i>	1	PA

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

164

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

Drug Name	Drug Tier	Requirements/Limits
SENSIPAR TAB 30MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 60MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 90MG	5	PA, QL (120 TABLETS PER 30 DAYS)
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	1	PA, QL (798 GRAMS PER 30 DAYS)
<i>sodium phenylbutyrate tab 500 mg</i>	1	PA, QL (1200 TABLETS PER 30 DAYS)
STRENSIQ INJ 18/0.45	5	PA
STRENSIQ INJ 28/0.7ML	5	PA
STRENSIQ INJ 40MG/ML	5	PA
STRENSIQ INJ 80/0.8ML	5	PA
XURIDEN POW 2GM	5	QL (4 PACKETS PER DAY)
ZEMPLAR CAP 1MCG	2	
ZEMPLAR CAP 2MCG	2	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG	3	PA
KERENDIA TAB 20MG	3	PA
NATRIURETIC PEPTIDES		
VOXZOGO INJ 0.4MG	5	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 0.56MG	5	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 1.2MG	5	PA, QL (30 VIALS PER 30 DAYS)
POSTERIOR PITUITARY HORMONES		
DDAVP SOL 0.01%	3	
DDAVP TAB 0.1MG	3	
DDAVP TAB 0.2MG	3	
<i>desmopressin acetate nasal spray soln 0.01%</i>	1	
<i>desmopressin acetate nasal spray soln 0.01% (refrigerated)</i>	1	
<i>desmopressin acetate tab 0.1 mg</i>	1	

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

165

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

Drug Name	Drug Tier	Requirements/Limits
<i>desmopressin acetate tab 0.2 mg</i>	1	
NOCDURNA SUB 27.7MCG	3	
NOCDURNA SUB 55.3MCG	3	
STIMATE SOL 1.5MG/ML	5	PA
PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX TAB 200MG	3	
<i>mifepristone tab 200 mg</i>	1	
PROLACTIN INHIBITORS		
<i>cabergoline tab 0.5 mg</i>	1	
SOMATOSTATIC AGENTS		
<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml)</i>	1	PA, QL (90 vials every 30 days)
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml)</i>	1	PA, QL (90 VIALS PER 30 DAYS)
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	1	PA, QL (45 VIALS (45,000 UNITS) PER 30 DAYS)
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml)</i>	1	PA, QL (90 AMPULES PER 30 DAYS)
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	1	PA, QL (9 VIALS (45,000) PER 30 DAYS)
SANDOSTATIN INJ 50MCG/ML	5	PA, QL (90 ampules every 30 days)
SANDOSTATIN INJ 100MCG	5	PA, QL (90 VIALS PER 30 DAYS)
SANDOSTATIN INJ 500MCG	5	PA, QL (90 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.3MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.6MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.9MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK 15MG	5	PA, QL (56 TABLETS PER 28 DAYS)

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

166

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

Drug Name	Drug Tier	Requirements/Limits
JYNARQUE PAK 30-15MG	5	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 45-15MG	5	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 60-30MG	5	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 90-30MG	5	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE TAB 15MG	5	PA, QL (60 TABLETS PER 30 DAYS)
JYNARQUE TAB 30MG	5	PA, QL (30 TABLETS PER 30 DAYS)
SAMSCA TAB 15MG	5	PA, QL (60 TABLETS PER 30 DAYS)
SAMSCA TAB 30MG	5	PA, QL (30 TABLETS PER 30 DAYS)
<i>tolvaptan tab 30 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)

ESTROGENS**ESTROGEN COMBINATIONS**

ACTIVELLA TAB 1-0.5MG	3	
ANGELIQ TAB 0.5-1MG	3	
ANGELIQ TAB 0.25-0.5	3	
BIJUVA CAP 1-100MG	3	
CLIMARA PRO DIS WEEKLY	2	
COMBIPATCH DIS	2	
DUAVEE TAB 0.45-20	2	
<i>estradiol & norethindrone acetate tab 0.5-0.1 mg</i>	1	
<i>estradiol & norethindrone acetate tab 1-0.5 mg</i>	1	
FEMHRT TAB 0.5-2.5	3	
<i>norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg</i>	1	
<i>norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg</i>	1	

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

167

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

Drug Name	Drug Tier	Requirements/Limits
ORIAHNN CAP	2	PA
PREFEST TAB	3	
PREMPHASE TAB	2	
PREMPRO TAB	2	
PREMPRO TAB 0.3-1.5	2	
PREMPRO TAB 0.45-1.5	2	
PREMPRO TAB 0.625-5	2	
ESTROGENS		
ALORA DIS 0.1MG	3	
ALORA DIS 0.05MG	3	
ALORA DIS 0.025MG	3	
ALORA DIS 0.075MG	3	
CLIMARA DIS 0.1MG	3	
CLIMARA DIS 0.05MG	3	
CLIMARA DIS 0.06MG	3	
CLIMARA DIS 0.025MG	3	
CLIMARA DIS 0.075MG	3	
CLIMARA DIS 0.0375MG	3	
DELESTROGEN INJ 10MG/ML	3	PA
DELESTROGEN INJ 20MG/ML	3	PA
DELESTROGEN INJ 40MG/ML	3	PA
DEPO-ESTRADI INJ 5MG/ML	3	PA
DIVIGEL GEL 0.5MG	2	
DIVIGEL GEL 0.25MG	2	
DIVIGEL GEL 0.75MG	2	
DIVIGEL GEL 1.25MG	2	
DIVIGEL GEL 1MG/GM	2	
ELESTRIN GEL 0.06%	3	
ESTRACE TAB 0.5MG	3	
ESTRACE TAB 1MG	3	
ESTRACE TAB 2MG	3	
<i>estradiol tab 0.5 mg</i>	1	
<i>estradiol tab 1 mg</i>	1	
<i>estradiol tab 2 mg</i>	1	
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	1	

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

168

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

Drug Name	Drug Tier	Requirements/Limits
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	1	
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	1	
<i>estradiol td gel 1 mg/gm (0.1%)</i>	1	
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	1	
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.06 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.025 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	1	
<i>estradiol valerate im in oil 20 mg/ml</i>	1	PA
<i>estradiol valerate im in oil 40 mg/ml</i>	1	PA
ESTROGEL GEL	3	
EVAMIST SPR 1.53MG	2	
MENOSTAR DIS 14MCG	3	
PREMARIN INJ 25MG	3	PA

FLUOROQUINOLONES**FLUOROQUINOLONES**

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

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

169

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

Drug Name	Drug Tier	Requirements/Limits
<i>levofloxacin tab 500 mg</i>	1	
<i>levofloxacin tab 750 mg</i>	1	
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1	
<i>ofloxacin tab 300 mg</i>	1	
<i>ofloxacin tab 400 mg</i>	1	
GASTROINTESTINAL AGENTS - MISC.		
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB 3MG	3	
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP 50MG	5	PA
CHOLBAM CAP 250MG	5	PA
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB 5MG	5	PA, QL (30 TABLETS PER 30 DAYS)
OCALIVA TAB 10MG	5	PA, QL (30 TABLETS PER 30 DAYS)
GALLSTONE SOLUBILIZING AGENTS		
CHENODAL TAB 250MG	5	
URSO 250 TAB 250MG	2	
URSO FORTE TAB 500MG	2	
<i>ursodiol cap 300 mg</i>	1	
<i>ursodiol tab 250 mg</i>	1	
<i>ursodiol tab 500 mg</i>	1	
GASTROINTESTINAL ANTIALLERGY AGENTS		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	
GASTROCROM CON 100/5ML	3	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
<i>lubiprostone cap 8 mcg</i>	1	
<i>lubiprostone cap 24 mcg</i>	1	
GASTROINTESTINAL STIMULANTS		
METOCLOPRAMI TAB 10MG ODT	3	
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	1	

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

170

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

Drug Name	Drug Tier	Requirements/Limits
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	1	
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	1	
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	1	
REGLAN TAB 5MG	3	
REGLAN TAB 10MG	3	
INFLAMMATORY BOWEL AGENTS		
APRISO CAP 0.375GM	3	
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
<i>balsalazide disodium cap 750 mg</i>	1	
CANASA SUP 1000MG	3	
DIPENTUM CAP 250MG	3	
<i>mesalamine cap dr 400 mg</i>	1	
<i>mesalamine cap er 24hr 0.375 gm</i>	1	
<i>mesalamine cap er 500 mg</i>	1	
<i>mesalamine enema 4 gm</i>	1	
<i>mesalamine rectal enema 4 gm & cleanser wipe kit</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	
<i>mesalamine tab delayed release 800 mg</i>	1	
PENTASA CAP 250MG CR	2	
PENTASA CAP 500MG CR	2	
ROWASA KIT 4GM	3	
SFROWASA ENE 4GM	3	

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

171

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

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

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

172

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

Drug Name	Drug Tier	Requirements/Limits
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
<i>alvimopan cap 12 mg</i>	1	
ENTEREG CAP 12MG	3	
MOVANTIK TAB 12.5MG	2	PA
MOVANTIK TAB 25MG	2	PA
RELISTOR INJ 8/0.4ML	3	PA
RELISTOR INJ 12/0.6ML	3	PA
RELISTOR TAB 150MG	3	PA
SYMPROIC TAB 0.2MG	2	PA
PHOSPHATE BINDER AGENTS		
AURYXIA TAB 210MG	3	
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	
PHOSLYRA SOL	2	
RENAGEL TAB 800MG	3	
REVELA POW 0.8GM	3	
REVELA POW 2.4GM	3	
REVELA TAB 800MG	3	
<i>sevelamer carbonate packet 0.8 gm</i>	1	
<i>sevelamer carbonate packet 2.4 gm</i>	1	
<i>sevelamer carbonate tab 800 mg</i>	1	
<i>sevelamer hcl tab 400 mg</i>	1	
<i>sevelamer hcl tab 800 mg</i>	1	
VELPHORO CHW 500MG	2	
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT 5MG	5	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB 250MG	5	PA, QL (90 TABLETS PER 30 DAYS)
GENITOURINARY AGENTS - MISCELLANEOUS		
ACIDIFIERS		
K-PHOS TAB NO 2	3	

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

173

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

Drug Name	Drug Tier	Requirements/Limits
ALKALINIZERS		
ORACIT SOL	3	
<i>pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	1	
<i>potassium citrate & citric acid powder pack 3300-1002 mg</i>	1	
<i>potassium citrate & citric acid soln 1100-334 mg/5ml</i>	1	
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
<i>sodium citrate & citric acid soln 500-334 mg/5ml</i>	1	
UROCIT-K 5 TAB	2	
UROCIT-K 10 TAB	2	
UROCIT-K 15 TAB	2	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG	4	PA
CYSTAGON CAP 150MG	4	PA
PROSTATIC HYPERTROPHY AGENTS		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	
AVODART CAP 0.5MG	3	
CARDURA XL TAB 4MG	3	
CARDURA XL TAB 8MG	3	
<i>dutasteride cap 0.5 mg</i>	1	
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	
<i>finasteride tab 5 mg</i>	1	
FLOMAX CAP 0.4MG	3	
PROSCAR TAB 5MG	3	
<i>silodosin cap 4 mg</i>	1	
<i>silodosin cap 8 mg</i>	1	
<i>tamsulosin hcl cap 0.4 mg</i>	1	
URINARY ANALGESICS		
<i>phenazopyridine hcl tab 200 mg</i>	1	

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

174

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

Drug Name	Drug Tier	Requirements/Limits
URINARY STONE AGENTS		
<i>tiopronin tab 100 mg</i>	1	PA
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	
GOUT AGENTS		
<i>allopurinol tab 100 mg</i>	1	
<i>allopurinol tab 300 mg</i>	1	
<i>colchicine tab 0.6 mg</i>	1	QL (120 tabs per 30 days)
<i>febuxostat tab 40 mg</i>	1	
<i>febuxostat tab 80 mg</i>	1	
MITIGARE CAP 0.6MG	1	QL (60 caps per 30 days); Tier 1 with DAW9
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
URICOSURICS		
<i>probenecid tab 500 mg</i>	1	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ 30MG/ML	5	PA
HEMLIBRA INJ 60/0.4	5	PA
HEMLIBRA INJ 105/0.7	5	PA
HEMLIBRA INJ 150/ML	5	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR INJ 30MG/3ML	5	PA, QL (45 syringes every 90 days)
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	1	PA, QL (45 syringes every 90 days)
COMPLEMENT INHIBITORS		
RUCONEST INJ 2100UNIT	4	PA, QL (60 VIALS PER 90 DAYS)
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB 100MG	4	PA, QL (60 TABLETS PER 30 DAYS)

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

175

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

Drug Name	Drug Tier	Requirements/Limits
TAVALISSE TAB 150MG	4	PA, QL (60 TABLETS PER 30 DAYS)
HEMATORHEOLOGIC AGENTS		
<i>pentoxifylline tab er 400 mg</i>	1	
PLASMA KALLIKREIN INHIBITORS		
KALBITOR INJ 10MG/ML	5	PA, QL (30 CARTONS (900 MG) PER 90 DAYS)
ORLADEYO CAP 110MG	4	PA, QL (28 CAPSULES PER 28 DAYS)
ORLADEYO CAP 150MG	4	PA, QL (28 CAPSULES PER 28 DAYS)
PLATELET AGGREGATION INHIBITORS		
AGRYLIN CAP 0.5MG	2	
<i>anagrelide hcl cap 0.5 mg</i>	1	
<i>anagrelide hcl cap 1 mg</i>	1	
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	1	
BRILINTA TAB 60MG	2	
BRILINTA TAB 90MG	2	
<i>cilostazol tab 50 mg</i>	1	
<i>cilostazol tab 100 mg</i>	1	
<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	1	
<i>clopidogrel bisulfate tab 300 mg (base equiv)</i>	1	
<i>dipyridamole tab 25 mg</i>	1	
<i>dipyridamole tab 50 mg</i>	1	
<i>dipyridamole tab 75 mg</i>	1	
EFFIENT TAB 5MG	3	
EFFIENT TAB 10MG	3	
<i>prasugrel hcl tab 5 mg (base equiv)</i>	1	
<i>prasugrel hcl tab 10 mg (base equiv)</i>	1	
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG	4	PA, QL (56 CAPSULES PER 28 DAYS)
<i>miglustat cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)

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

176

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

Drug Name	Drug Tier	Requirements/Limits
ZAVESCA CAP 100MG	5	PA, QL (90 CAPSULES PER 30 DAYS)
AGENTS FOR SICKLE CELL DISEASE		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	
ENDARI POW 5GM	5	PA, QL (180 PACKETS PER 30 DAYS)
SIKLOS TAB 100MG	3	
SIKLOS TAB 1000MG	3	
COBALAMINS		
<i>cyanocobalamin inj 1000 mcg/ml</i>	1	PA
NASCOBAL SPR 500MCG	3	
FOLIC ACID/FOLATES		
<i>folic acid cap 0.8 mg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 1 mg</i>	1	
<i>folic acid tab 400 mcg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 800 mcg</i>	0	\$0 copay for women younger than 55
HEMATOPOIETIC GROWTH FACTORS		
DOPTELET TAB 20MG	5	PA, QL (60 tabs every 30 days)
DOPTELET TAB 20MG	5	PA, QL (90 tabs every 30 days)
FYLNETRA INJ 6MG/0.6	4	PA, QL (2 SYRINGES PER 28 DAYS)
MULPLETA TAB 3MG	5	PA, QL (7 TABLETS PER 14 DAYS)
NIVESTYM INJ 300/0.5	4	PA
NIVESTYM INJ 300MCG	4	PA
NIVESTYM INJ 480/0.8	4	PA
NIVESTYM INJ 480MCG	4	PA

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

177

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

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

HEMOSTATICS**HEMOSTATICS - SYSTEMIC**

AMICAR TAB 500MG	3	
AMICAR TAB 1000MG	3	
<i>aminocaproic acid oral soln 0.25 gm/ml</i>	1	
<i>aminocaproic acid tab 500 mg</i>	1	
<i>aminocaproic acid tab 1000 mg</i>	1	
LYSTEDA TAB 650MG	3	
<i>tranexamic acid tab 650 mg</i>	1	

HEMOSTATICS - TOPICAL

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

HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS**BARBITURATE HYPNOTICS**

<i>phenobarbital elixir 20 mg/5ml</i>	1	
<i>phenobarbital tab 15 mg</i>	1	
<i>phenobarbital tab 16.2 mg</i>	1	
<i>phenobarbital tab 30 mg</i>	1	

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

178

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

Drug Name	Drug Tier	Requirements/Limits
<i>phenobarbital tab 32.4 mg</i>	1	
<i>phenobarbital tab 60 mg</i>	1	
<i>phenobarbital tab 64.8 mg</i>	1	
<i>phenobarbital tab 97.2 mg</i>	1	
<i>phenobarbital tab 100 mg</i>	1	
HYPNOTICS - TRICYCLIC AGENTS		
<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
NON-BARBITURATE HYPNOTICS		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	
EDLUAR SUB 5MG	3	
EDLUAR SUB 10MG	3	
<i>estazolam tab 1 mg</i>	1	
<i>estazolam tab 2 mg</i>	1	
<i>eszopiclone tab 1 mg</i>	1	
<i>eszopiclone tab 2 mg</i>	1	
<i>eszopiclone tab 3 mg</i>	1	
<i>flurazepam hcl cap 15 mg</i>	1	
<i>flurazepam hcl cap 30 mg</i>	1	
HALCION TAB 0.25MG	3	
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	
RESTORIL CAP 22.5MG	3	
RESTORIL CAP 30MG	3	
<i>temazepam cap 7.5 mg</i>	1	
<i>temazepam cap 15 mg</i>	1	
<i>temazepam cap 22.5 mg</i>	1	
<i>temazepam cap 30 mg</i>	1	
<i>triazolam tab 0.25 mg</i>	1	
<i>triazolam tab 0.125 mg</i>	1	
<i>zaleplon cap 5 mg</i>	1	

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

179

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

Drug Name	Drug Tier	Requirements/Limits
<i>zaleplon cap 10 mg</i>	1	
<i>zolpidem tartrate tab 5 mg</i>	1	
<i>zolpidem tartrate tab 10 mg</i>	1	
<i>zolpidem tartrate tab er 6.25 mg</i>	1	
<i>zolpidem tartrate tab er 12.5 mg</i>	1	
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB 5MG	2	
BELSOMRA TAB 10MG	2	
BELSOMRA TAB 15MG	2	
BELSOMRA TAB 20MG	2	
SELECTIVE MELATONIN RECEPTOR AGONISTS		
HETLIOZ CAP 20MG	5	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	5	PA, QL (5 ML PER DAY)
<i>ramelteon tab 8 mg</i>	1	
<i>tasimelteon capsule 20 mg</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
LAXATIVES		
LAXATIVE COMBINATIONS		
<i>bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit</i>	0	\$0 copay for members age 45 through 75
CLENPIQ SOL	0	\$0 copay for members age 45 through 75
NULYTELY SOL LMN/LIME	3	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm</i>	1	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	
PEG-PREP KIT	0	\$0 copay for members age 45 through 75
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	0	\$0 copay for members age 45 through 75
LAXATIVES - MISCELLANEOUS		
KRISTALOSE PAK 10GM	3	

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

180

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

Drug Name	Drug Tier	Requirements/Limits
KRISTALOSE PAK 20GM	3	
<i>lactulose solution 10 gm/15ml</i>	1	
STIMULANT LAXATIVES		
CASCARA EXT SAGRADA	3	
MACROLIDES		
AZITHROMYCIN		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin powd pack for susp 1 gm</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
ZITHROMAX POW 1GM PAK	3	
ZITHROMAX SUS 100/5ML	3	
ZITHROMAX SUS 200/5ML	3	
ZITHROMAX TAB 250MG	3	
ZITHROMAX TAB 500MG	3	
ZITHROMAX TAB TRI-PAK	3	
ZITHROMAX TAB Z-PAK	3	
CLARITHROMYCIN		
<i>clarithromycin for susp 125 mg/5ml</i>	1	
<i>clarithromycin for susp 250 mg/5ml</i>	1	
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
ERYTHROMYCINS		
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate tab 400 mg</i>	1	
<i>erythromycin stearate tab 250 mg</i>	1	
<i>erythromycin tab 250 mg</i>	1	
<i>erythromycin tab 500 mg</i>	1	
<i>erythromycin tab delayed release 250 mg</i>	1	

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

181

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

Drug Name	Drug Tier	Requirements/Limits
<i>erythromycin tab delayed release 333 mg</i>	1	
<i>erythromycin tab delayed release 500 mg</i>	1	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	1	
FIDAXOMICIN		
DIFICID SUS	2	
DIFICID TAB 200MG	2	
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 boxes every 30 days); OTC
FC FEMALE MIS CONDOM	0	QL (12 boxes every 30 days); OTC
FEMCAP MIS 22MM	0	QL (1 each every 300 days)
FEMCAP MIS 26MM	0	QL (1 each every 300 days)
FEMCAP MIS 30MM	0	QL (1 each every 300 days)
OMNIFLEX DPR	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 60	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 65	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 70	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 75	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 80	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 85	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 90	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 95	0	QL (1 each every 300 days)
DIABETIC SUPPLIES		
ACCU-CHEK KIT FASTCLIX	0	
ACCU-CHEK KIT SOFTCLIX	0	
ACCU-CHEK LIQ GUIDE	0	
ACCU-CHEK LIQ SMART	0	
ACCU-CHEK MIS MLTICLIX	0	
ACCU-CHEK SOL	0	
ACCU-CHEK SOL COMPACT	0	
ACCU-TREND SOL GLUCOSE	0	

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

182

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

Drug Name	Drug Tier	Requirements/Limits
ACTI-LANCE MIS 28G	0	
ACTI-LANCE MIS LITE 28G	0	
ACTI-LANCE MIS SPEC 17G	0	
ACTI-LANCE MIS UNIV 23G	0	
ADJ LANCING MIS DEVICE	0	
ADV LANCING MIS DEVICE	0	
ADV TRAVEL MIS LANC 28G	0	
ADVANCE LIQ CONTROL	0	
ADVANCE LIQ INTUITIO	0	
ADVANCE NORM LIQ CONTROL	0	
ADVATE SAFE MIS LANC 26G	0	
ADVOCATE LIQ HIGH	0	
ADVOCATE LIQ LOW	0	
ADVOCATE MIS LANC 30G	0	
ADVOCATE MIS LANC DEV	0	
ADVOCATE MIS LANCETS	0	
ADVOCATE+ SOL REDI-COD	0	
AGAMATRIX MIS 33G	0	
AGAMATRIX SOL HIGH	0	
AGAMATRIX SOL LEVEL 2	0	
AGAMATRIX SOL LEVEL 4	0	
AGAMATRIX SOL NORM/HGH	0	
AGAMATRIX SOL NORMAL	0	
AIMSCO TWIST MIS 32G	0	
AIMSCO TWIST MIS 33G	0	
AQUALANCE MIS 30G	0	
ASSURE 3 LIQ CONTROL	0	
ASSURE 4 LIQ LEVEL1/2	0	
ASSURE CMFRT MIS 28G	0	
ASSURE DOSE SOL NORM/HGH	0	
ASSURE DOSE SOL NORMAL	0	
ASSURE II LIQ LEVEL1/2	0	
ASSURE II LIQ LEVEL 1	0	
ASSURE LANCE MIS 21G	0	
ASSURE LANCE MIS 28G	0	

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

183

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

Drug Name	Drug Tier	Requirements/Limits
ASSURE LANCE MIS LOW FLOW	0	
ASSURE LANCE MIS MICRO	0	
ASSURE LANCE MIS SAFE 25G	0	
ASSURE LANCE MIS SAFE 30G	0	
ASSURE PLUS MIS HIGH 18G	0	
ASSURE PLUS MIS LOW 25G	0	
ASSURE PLUS MIS MCRO 28G	0	
ASSURE PLUS MIS NORM 21G	0	
ASSURE PLUS MIS PEDIATRI	0	
ASSURE PRISM SOL LEVEL1/2	0	
ASSURE PRO LIQ LEVEL1/2	0	
AURORA LANCE MIS 30G	0	
AURORA LANCE MIS THIN 23G	0	
AUTO LANCET MIS	0	
AUTO-LANCET MIS	0	
AUTO-LANCET MIS MINI	0	
AUTOLET II KIT CLINISAF	0	
AUTOLET IMPR MIS LANC DEV	0	
AUTOLET LANC MIS DEVICE	0	
AUTOLET LITE KIT	0	
AUTOLET LITE KIT CLINISAF	0	
AUTOLET LITE KIT STARTER	0	
AUTOLET MINI MIS	0	
AUTOLET PLAT MIS 1.8MM	0	
AUTOLET PLAT MIS 2.4MM	0	
AUTOLET PLAT MIS 3.0MM	0	
AUTOLET PLUS MIS	0	
AUTOLET PLUS MIS LANC DEV	0	
BD LANCET UF MIS 30G	0	
BD LANCET UF MIS 33G	0	
BD MICROTAIN MIS LANCETS	0	
CARDIOCOM MIS LANCING	0	
CAREONE ADV MIS LANCING	0	
CAREONE LANC MIS 30G	0	
CAREONE LANC MIS THIN 23G	0	

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

184

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

Drug Name	Drug Tier	Requirements/Limits
CARESENS 30G MIS LANCETS	0	
CARESENS SOL CONTROL	0	
CARETOUCH MIS EJECTOR	0	
CARETOUCH MIS LANC 26G	0	
CARETOUCH MIS LANC 28G	0	
CARETOUCH MIS LANC 30G	0	
CARETOUCH MIS TWIST 28	0	
CARETOUCH MIS TWIST 30	0	
CARETOUCH MIS TWIST 33	0	
CLEANLET 28G MIS LANCETS	0	
CLEVER CHECK MIS	0	
CLEVER CHECK MIS 30G	0	
CLEVR CHOICE LIQ HIGH	0	
CLEVR CHOICE LIQ LOW	0	
COAGUCHEK MIS LANCETS	0	
COMFORT ASSU MIS LANC 28G	0	
COMFORT ASSU MIS LANC 33G	0	
COMFORT EZ MIS 21G	0	
COMFORT EZ MIS 23G	0	
COMFORT EZ MIS 28G	0	
COMFORT MIS LANCETS	0	
COMFORT TCH MIS LANC 28G	0	
COMFORT TCH MIS LANC 31G	0	
COMFORTOUCH MIS LANCET	0	
CONTOUR HIGH LIQ CONTROL	0	
CONTOUR LOW LIQ CONTROL	0	
CONTOUR NEXT SOL LEVEL 1	0	
CONTOUR NEXT SOL LEVEL 2	0	
CONTOUR NORM LIQ CONTROL	0	
CONTROL HIGH SOL UNISTRIP	0	
CONTROL LOW SOL UNISTRIP	0	
CONTROL NORM SOL EASY STP	0	
CONTROL SOL LIQ HI/MID/L	0	
CONTROL SOL LIQ HIGH/LOW	0	
CONTROL SOL LIQ LEVEL 2	0	

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

185

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

Drug Name	Drug Tier	Requirements/Limits
CONTROL SOL LIQ MID	0	
CONTROL SOL NORMAL	0	
COOL CONTROL SOL A	0	
COOL CONTROL SOL B	0	
CVS LANCETS MIS 21G	0	
CVS LANCETS MIS 30G	0	
CVS LANCETS MIS 33G	0	
CVS LANCETS MIS ORIGINAL	0	
CVS LANCETS MIS THIN 26G	0	
CVS LANCETS MIS THIN 30G	0	
CVS LANCETS MIS THIN 33G	0	
CVS LANCING MIS DEVICE	0	
DEXCOM G5 MIS RECEIVER	0	
DEXCOM G5 MIS TRANSMIT	0	
DEXCOM G6 MIS RECEIVER	0	
DEXCOM G6 MIS SENSOR	0	QL (3 sensors per month)
DEXCOM G6 MIS TRANSMIT	0	
DEXCOM G7 MIS RECEIVER	0	
DEXCOM G7 MIS SENSOR	0	QL (3 sensors per month)
DIATHRIVE LIQ CONTROL	0	
DIATHRIVE MIS LANCETS	0	
DIATHRIVE MIS LANCING	0	
DIATHRIVE MIS UT 30G	0	
DIATRUE CONT SOL LEVEL 1	0	
DIATRUE CONT SOL LEVEL 2	0	
DIATRUE CONT SOL LEVEL 3	0	
DROPLET LANC MIS 30G	0	
DROPLET LANC MIS DEVICE	0	
DROPLET PERS MIS LANC 30G	0	
DUO-CARE LIQ LEVEL1/2	0	
E-Z JECT MIS 21G	0	
E-Z JECT MIS 21G COLR	0	
E-Z JECT MIS 30G	0	
E-Z JECT MIS 32G COLR	0	
E-Z JECT MIS LANC 21G	0	

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

186

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

Drug Name	Drug Tier	Requirements/Limits
E-Z JECT MIS THIN 26G	0	
E-ZJECT LANC MIS 33G	0	
EASY COMFORT MIS 30G	0	
EASY COMFORT MIS LANC/30G	0	
EASY COMFORT MIS TWIST	0	
EASY MINI MIS	0	
EASY MINI MIS EJECT	0	
EASY PLUS II SOL HIGH	0	
EASY PLUS II SOL LOW	0	
EASY TALK SOL HIGH	0	
EASY TALK SOL LOW	0	
EASY TALK SOL NORMAL	0	
EASY TOUCH MIS	0	
EASY TOUCH MIS LANC/21G	0	
EASY TOUCH MIS LANC/23G	0	
EASY TOUCH MIS LANC/26G	0	
EASY TOUCH MIS LANC/28G	0	
EASY TOUCH MIS LANC/30G	0	
EASY TOUCH MIS LANC/32G	0	
EASY TOUCH MIS LANC/33G	0	
EASY TOUCH SOL CONTROL	0	
EASY TOUCH SOL HIGH/LOW	0	
EASY TRAK II LIQ NORMAL	0	
EASY TRAK SOL HIGH	0	
EASY TRAK SOL LOW	0	
EASY TRAK SOL NORMAL	0	
EASYGLUCO SOL PLUS	0	
EASYMAX 15 LIQ LEVEL2-3	0	
EASYMAX 15 SOL LEVEL 2	0	
EASYMAX LIQ NORM/HIG	0	
EASYMAX SOL NORMAL	0	
EASYSSTEP HGH SOL CONTROL	0	
EASYSSTEP LOW SOL CONTROL	0	
ELEMENT CONT LIQ NORMAL	0	
ELEMENT LIQ HIGH	0	

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

187

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

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

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

188

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

Drug Name	Drug Tier	Requirements/Limits
FORACARE GDH SOL LOW	0	
FORACARE GDH SOL NORMAL	0	
FORTISCARE SOL CNTL HI	0	
FORTISCARE SOL CNTL LOW	0	
FORTISCARE SOL CNTL NML	0	
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS UNISTICK	0	
G4 PLAT PED MIS RVC/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS PEDIATRC	0	QL (1 each every year)
G4 PLATINUM MIS RCV/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS RECEIVER	0	
G4 PLATINUM MIS TRANSMIT	0	
G4 SENSOR MIS	0	QL (3 sensors per month)
G5/G4 MIS SENSOR	0	QL (3 sensors per month)
GE100 CONTRL SOL NORMAL	0	
GENTEEL LANC KIT BLUE	0	
GENTEEL MIS LANCETS	0	
GENTEEL MIS NOZZLES	0	
GENTEEL PLUS MIS BLACK	0	
GENTEEL PLUS MIS BLUE	0	
GENTEEL PLUS MIS PINK	0	
GENTEEL PLUS MIS PURPLE	0	
GENTEEL PLUS MIS WHITE	0	
GENTEEL TIPS MIS BLUE	0	
GENTEEL TIPS MIS CLEAR	0	
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	
GENTEEL TIPS MIS YELLOW	0	
GENTLE-LET MIS 26G	0	
GENTLE-LET MIS 28G	0	
GENTLE-LET MIS LANCETS	0	
GENTLE-LET MIS PLATFORM	0	

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

189

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

Drug Name	Drug Tier	Requirements/Limits
GLOBAL 28G MIS LANCETS	0	
GLOBAL 30G MIS LANCETS	0	
GLOBAL LANC MIS DEVICE	0	
GLUC CONTROL LIQ NORMAL	0	
GLUC CONTROL SOL	0	
GLUC CONTROL SOL MID	0	
GLUC CONTROL SOL NORMAL	0	
GLUCOCARD 01 LIQ NORM/HGH	0	
GLUCOCARD 01 SOL NORMAL	0	
GLUCOCARD LIQ LEVEL 1	0	
GLUCOCARD SOL NORMAL	0	
GLUCOCARD SOL SHINE	0	
GLUCOCOM MIS 28G	0	
GLUCOCOM MIS 30G	0	
GLUCOCOM MIS 33G	0	
GLUCOCOM TES HIGH CON	0	
GLUCOCOM TES NORM CON	0	
GLUCOSE CONT LIQ HIGH/LOW	0	
GLUCOSE CONT SOL HIGH	0	
GLUCOSE CONT SOL NORMAL	0	
GLUCOSE CONT SOL PRECISIO	0	
GNP LANCETS MIS 21G	0	
GNP LANCETS MIS THIN	0	
GNP LANCETS MIS THIN 26G	0	
GOJJI CNTRL SOL NORMAL	0	
GOJJI LANCET MIS 30G	0	
GOJJI MIS LANC DEV	0	
GOODSENSE MIS LANC 26G	0	
GOODSENSE MIS LANC 30G	0	
GOODSENSE MIS LANC 33G	0	
GOODSENSE MIS LANC DVC	0	
HAEMOLANCE MIS HIGH FLO	0	
HAEMOLANCE MIS LOW FLOW	0	
HAEMOLANCE MIS PLUS	0	
HAEMOLANCE MIS PLUS LOW	0	

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

190

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

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

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

191

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

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

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

192

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

Drug Name	Drug Tier	Requirements/Limits
MEDLANCE PLS MIS 0.8MM	0	
MEDLANCE PLS MIS EXTR 21G	0	
MEDLANCE PLS MIS LITE 25G	0	
MEDLANCE PLS MIS UNIV 21G	0	
MEIJER LANCE MIS COLOR	0	
MEIJER LANCE MIS UNIV 21G	0	
MEIJER LANCE MIS UNIV 30G	0	
MEIJER LANCE MIS UNIVERSA	0	
MEIJER MIS LANCETS	0	
MICRO THIN MIS LANC 33G	0	
MICRODOT CON SOL HIGH/LOW	0	
MICROLET MIS LANCETS	0	
MICROLET MIS NEXT	0	
MINI LANCING MIS DEVICE	0	
MM LANCING MIS DEVICE	0	
MM TWIST MIS LANCETS	0	
MOBILE LANCE MIS 30G	0	
MONOLET MIS LANCETS	0	
MONOLET OPD MIS LANCETS	0	
MONOLETTOR MIS LANCETS	0	
MPD SFTY LAN MIS 21G	0	
MPD SFTY LAN MIS 23G	0	
MPD SFTY LAN MIS 28G	0	
MPD SFTY LAN MIS 30G	0	
MULTI-LANCET KIT DEVICE	0	
MULTI-LANCET MIS DEVICE	0	
MYGLUCOHEALT MIS LANC 30G	0	
MYGLUCOHEALT SOL LO/NL/HI	0	
NEUTEK 2TEK SOL CONTROL	0	
NOVA MAX GLU LIQ /KET CON	0	
NOVA SAFETY MIS LANC 23G	0	
NOVA SAFETY MIS LANC 28G	0	
NOVA SURE MIS LANCETS	0	
NOVA SUREFLX MIS LANC DEV	0	
OMNIPOD 5 G6 KIT INTRO	0	PA, QL (1 kit per 999 days)

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

193

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

Drug Name	Drug Tier	Requirements/Limits
OMNIPOD 5 G6 MIS PODS	0	PA, QL (10 pods per month)
OMNIPOD DASH KIT PDM	0	PA, QL (1 kit per 999 days)
OMNIPOD MIS CLASSIC	0	PA, QL (10 pods per month)
OMNIPOD PDM KIT CLASSIC	0	PA, QL (1 kit per 999 days)
ON-THE-GO MIS LANC 30G	0	
ONETOUCH DEL MIS LANC DEV	0	
ONETOUCH DEL MIS PLUS 30G	0	
ONETOUCH DEL MIS PLUS 33G	0	
ONETOUCH FP MIS LANCETS	0	
ONETOUCH KIT ULTRA 2	0	
ONETOUCH KIT VERIO FL	0	
ONETOUCH KIT VERIO RE	0	
ONETOUCH LIQ ULT CONT	0	
ONETOUCH LIQ VERIO	0	
ONETOUCH LIQ VERIO 4	0	
ONETOUCH MIS 30G	0	
ONETOUCH MIS LANC DEV	0	
ONETOUCH MIS LANCETS	0	
ONETOUCH SOL KIT COMPLETE	0	
ONETOUCH SOL KIT FIT	0	
ONETOUCH SOL KIT REFILL	0	
ONETOUCH US MIS LANCETS	0	
PC LANCETS MIS 30G	0	
PENLET II KIT BLOOD	0	
PENLET II MIS REPL CAP	0	
PERFECT 28G MIS LANCETS	0	
PERFECT 30G MIS LANCETS	0	
PHARMACY COU MIS LANCETS	0	
PIP LANCETS MIS 28G	0	
PIP LANCETS MIS 30G	0	
POCKETCHEM SOL EZ	0	
PRECISION LIQ CONTROL	0	
PRECISION LIQ GLUC/KET	0	

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

194

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

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

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

195

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

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

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

196

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

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

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

197

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

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

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

198

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

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

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

199

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

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

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

200

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

Drug Name	Drug Tier	Requirements/Limits
MISC. DEVICES		
ALCOH-GLOVE PAD CONTOURE	0	
ALCOH-WIPE MIS 12"X12"	3	
ALCOHOL PAD	0	
ALCOHOL PAD 70%	0	
ALCOHOL PAD PREP	0	
ALCOHOL PAD SWABSTIC	0	
ALCOHOL PREP PAD	0	
ALCOHOL PREP PAD 70%	0	
ALCOHOL PREP PAD MED 70%	0	
ALCOHOL PREP PAD PADS 70%	0	
ALCOHOL SWAB PAD	0	
ALCOHOL SWAB PAD 70%	0	
ALCOHOL SWAB PAD EX-THICK	0	
ALCOHOL WIPE PAD	0	
APLICARE ALC PAD SWABSTIC	0	
BD SWAB BFLY PAD SNGL USE	0	
CARETOUCH PAD ALCOHOL	0	
CURITY PREP PAD ALCOHOL	0	
CURITY SWABS PAD ALCOHOL	0	
EASY COMFORT PAD ALCOHOL	0	
FIFTY50 PREP PAD PADS	0	
GLOBAL PREP PAD PADS	0	
GNP ALCOHOL PAD SWABS	0	
HM STERILE PAD ALCHOL	0	
INCONTROL PAD ALCOHOL	0	
PREP PADS PAD	0	
PRO COMFORT PAD ALCOHOL	0	
PURE COMFORT PAD	0	
QC ALCOHOL PAD SWABS	0	
REALITY SWAB PAD	0	
SAPS CARE PAD ALCOHOL	0	
SAPS HEALTH PAD ALCOHOL	0	
SB ALCOHOL PAD PREP	0	
SM ALCOHOL PAD PREP	0	

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

201

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

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

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

202

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

Drug Name	Drug Tier	Requirements/Limits
FLEXICHAMBER MIS MASK LRG	3	
FLEXICHAMBER MIS MASK SM	3	
HOLD CHAMBER MIS ADLT LG	3	
HOLD CHAMBER MIS MEDIUM	3	
HOLD CHAMBER MIS SMALL	3	
INSPIRACHAMB MIS LARGE	3	
INSPIRACHAMB MIS MEDIUM	3	
INSPIRACHAMB MIS MOUTHPC	3	
INSPIRACHAMB MIS SMALL	3	
INSPIREASE MIS DD SYST	3	
INSPIREASE MIS RES BAG	3	
MICROCHAMBER MIS	3	
OPTICHAMBER MIS DIA MD	3	
OPTICHAMBER MIS DIA SM	3	
OPTICHAMBER MIS DIAMOND	3	
POCKET CHAMB MIS	3	
POCKET SPACE MIS	3	
RITFLO MIS	3	
TRUZONE PEAK MIS FLOW MTR	3	

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

AJOVY INJ 225/1.5	2	ST, QL (3 auto-injectors every 75 days)
AJOVY INJ 225/1.5	2	ST, QL (3 syringes every 75 days)
EMGALITY INJ 100MG/ML	2	ST, QL (3 syringes every 30 days)
EMGALITY INJ 120MG/ML	2	ST, QL (2 pens every 25 days); Loading Dose: 2 injectors per month; Maintenance Dose: 1 injector per month

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

203

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

Drug Name	Drug Tier	Requirements/Limits
EMGALITY INJ 120MG/ML	2	ST, QL (2 syringes every 25 days); Loading Dose: 2 syringes per month; Maintenance Dose: 1 syringe per month
NURTEC TAB 75MG ODT	2	PA, QL (16 tabs every 30 days)
QULIPTA TAB 10MG	2	ST, PA, QL (30 tabs every 30 days)
QULIPTA TAB 30MG	2	ST, PA, QL (30 tabs every 30 days)
QULIPTA TAB 60MG	2	ST, PA, QL (30 tabs every 30 days)
UBRELVY TAB 50MG	2	PA, QL (16 ea every 30 days)
UBRELVY TAB 100MG	2	PA, QL (16 ea every 30 days)

MIGRAINE PRODUCTS

ERGOMAR SUB 2MG	3	
MIGRANAL SPR 4MG/ML	3	QL (8.01 mL every 30 days)

SEROTONIN AGONISTS

<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 30 days)
AMERGE TAB 1MG	3	QL (12 tabs every 30 days)
AMERGE TAB 2.5MG	3	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
FROVA TAB 2.5MG	3	QL (30 tabs every 30 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
IMITREX INJ 4MG/0.5	3	QL (12 injections every 30 days)

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

204

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

Drug Name	Drug Tier	Requirements/Limits
IMITREX INJ 4MG/0.5	3	QL (36 injections every 30 days)
IMITREX INJ 6MG/0.5	3	QL (12 injections every 30 days)
IMITREX INJ 6MG/0.5	3	QL (24 injections every 30 days)
IMITREX SPR 5MG/ACT	3	QL (30 inhalers every 30 days)
IMITREX SPR 20MG/ACT	3	QL (12 inhalers every 30 days)
IMITREX TAB 25MG	3	QL (12 tabs every 30 days)
IMITREX TAB 50MG	3	QL (12 tabs every 30 days)
IMITREX TAB 100MG	3	QL (12 tabs every 30 days)
<i>naratriptan hcl tab 1 mg (base equiv)</i>	1	QL (12 tabs every 30 days)
<i>naratriptan hcl tab 2.5 mg (base equiv)</i>	1	QL (12 tabs every 30 days)
ONZETRA XSAI MIS 11MG	2	QL (16 nosepieces every 30 days)
RELPAX TAB 20MG	3	QL (12 tabs every 30 days)
RELPAX TAB 40MG	3	QL (12 tabs every 30 days)
REYVOW TAB 50MG	3	ST, QL (4 tabs every 30 days)
REYVOW TAB 100MG	3	ST, QL (8 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 5 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate oral disintegrating tab 10 mg (base eq)</i>	1	QL (30 tabs every 30 days)
<i>rizatriptan benzoate tab 5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>rizatriptan benzoate tab 10 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
<i>sumatriptan nasal spray 5 mg/act</i>	1	QL (30 inhalers every 30 days)
<i>sumatriptan nasal spray 20 mg/act</i>	1	QL (12 inhalers every 30 days)
<i>sumatriptan succinate inj 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)

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

205

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

Drug Name	Drug Tier	Requirements/Limits
<i>sumatriptan succinate solution auto-injector 4 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution auto-injector 6 mg/0.5ml</i>	1	QL (12 injections every 30 days)
<i>sumatriptan succinate solution cartridge 4 mg/0.5ml</i>	1	QL (36 injections every 30 days)
<i>sumatriptan succinate solution cartridge 6 mg/0.5ml</i>	1	QL (24 injections every 30 days)
<i>sumatriptan succinate solution prefilled syringe 6 mg/0.5ml</i>	1	QL (24 injections every 30 days)
<i>sumatriptan succinate tab 25 mg</i>	1	QL (12 tabs every 30 days)
<i>sumatriptan succinate tab 50 mg</i>	1	QL (12 tabs every 30 days)
<i>sumatriptan succinate tab 100 mg</i>	1	QL (12 tabs every 30 days)
ZEMBRACE SYM INJ 3/0.5ML	2	QL (24 injections every 30 days)
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	1	QL (12 inhalers every 30 days)
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	1	QL (12 bottles every 30 days)
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan orally disintegrating tab 5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan tab 2.5 mg</i>	1	QL (12 tabs every 30 days)
<i>zolmitriptan tab 5 mg</i>	1	QL (12 tabs every 30 days)
ZOMIG SPR 2.5MG	3	QL (12 inhalers every 30 days)
ZOMIG SPR 5MG	3	QL (12 bottles every 30 days)
ZOMIG TAB 2.5MG	3	QL (12 tabs every 30 days)
ZOMIG TAB 5MG	3	QL (12 tabs every 30 days)
ZOMIG ZMT TAB 2.5 MG	3	QL (12 tabs every 30 days)
ZOMIG ZMT TAB 5MG ODT	3	QL (12 tabs every 30 days)

MINERALS & ELECTROLYTES**POTASSIUM**

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

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

206

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

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

MISCELLANEOUS THERAPEUTIC CLASSES**CHELATING AGENTS**

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

IMMUNOMODULATORS

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

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

207

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

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

IMMUNOSUPPRESSIVE AGENTS

ASTAGRAF XL CAP 0.5MG	3	PA
ASTAGRAF XL CAP 1MG	3	PA
ASTAGRAF XL CAP 5MG	3	PA
azathioprine tab 50 mg	1	
azathioprine tab 75 mg	2	
azathioprine tab 100 mg	2	
CELLCEPT CAP 250MG	3	PA
CELLCEPT IV INJ 500MG	3	PA
CELLCEPT SUS 200MG/ML	3	PA
CELLCEPT TAB 500MG	3	PA
cyclosporine cap 25 mg	1	
cyclosporine cap 100 mg	1	
cyclosporine modified cap 25 mg	1	
cyclosporine modified cap 50 mg	1	
cyclosporine modified cap 100 mg	1	
cyclosporine modified oral soln 100 mg/ml	1	

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

208

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

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

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

209

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

Drug Name	Drug Tier	Requirements/Limits
<i>sirolimus tab 0.5 mg</i>	1	
<i>sirolimus tab 1 mg</i>	1	
<i>sirolimus tab 2 mg</i>	1	
<i>tacrolimus cap 0.5 mg</i>	1	
<i>tacrolimus cap 1 mg</i>	1	
<i>tacrolimus cap 5 mg</i>	1	
ZORTRESS TAB 0.5MG	3	PA
ZORTRESS TAB 0.25MG	3	PA
ZORTRESS TAB 0.75MG	3	PA
ZORTRESS TAB 1MG	3	PA
POTASSIUM REMOVING AGENTS		
LOKELMA PAK 5GM	2	
LOKELMA PAK 10GM	2	
<i>sodium polystyrene sulfonate oral susp 15 gm/60ml</i>	1	
<i>sodium polystyrene sulfonate powder</i>	1	
VELTASSA POW 8.4GM	2	
VELTASSA POW 16.8GM	2	
VELTASSA POW 25.2GM	2	
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP 50MG	5	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	5	PA, QL (120 CAPSULES PER 30 DAYS)
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA INJ 200MG/ML	5	PA, QL (4 INJ PER 28 DAYS); LOADING DOSE: 8 SYR PER 28 DAYS
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
<i>lidocaine hcl laryngotracheal soln 4%</i>	1	
<i>lidocaine hcl viscous soln 2%</i>	1	
ANTI-INFECTIVES - THROAT		
<i>clotrimazole troche 10 mg</i>	1	QL (90 ea every 30 days)
<i>nystatin susp 100000 unit/ml</i>	1	
PA - Prior Authorization QL - Quantity Limits ST - Step Therapy		210

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

Drug Name	Drug Tier	Requirements/Limits
ORAVIG TAB 50MG	3	
ANTISEPTICS - MOUTH/THROAT		
<i>chlorhexidine gluconate soln 0.12%</i>	1	
PERIDEX SOL 0.12%	3	
DENTAL PRODUCTS		
NAFRINSE DLY SOL /NEUTRAL	3	
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
<i>sodium fluoride gel 1.1% (0.5% f)</i>	1	
STEROIDS - MOUTH/THROAT/DENTAL		
<i>triamcinolone acetonide dental paste 0.1%</i>	1	
THROAT PRODUCTS - MISC.		
<i>cevimeline hcl cap 30 mg</i>	1	
EVOXAC CAP 30MG	2	
ORAFATE PST 10%	3	
<i>pilocarpine hcl tab 5 mg</i>	1	
<i>pilocarpine hcl tab 7.5 mg</i>	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	2	
SALAGEN TAB 7.5MG	2	
MULTIVITAMINS		
PRENATAL VITAMINS		
CITRANATAL CAP HARMONY	2	
CITRANATAL CAP MEDLEY	2	
CITRANATAL MIS	2	
CITRANATAL MIS 90 DHA	2	
CITRANATAL MIS B-CALM	2	
CITRANATAL PAK ASSURE	2	
CITRANATAL PAK DHA	2	
CITRANATAL TAB BLOOM	2	
CITRANATAL TAB RX	2	
<i>prenat w/o a w/feum-methfol-fa-dha cap 27-0.6-0.4-300 mg</i>	1	
<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg</i>	1	

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

211

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

Drug Name	Drug Tier	Requirements/Limits
<i>prenatal vit w/ fe fum-methylfolate-fa tab 27-0.6-0.4 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa chew tab 29-1 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>	1	
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	1	

MUSCULOSKELETAL THERAPY AGENTS**CENTRAL MUSCLE RELAXANTS**

<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	
<i>carisoprodol tab 350 mg</i>	1	QL (84 tabs every 30 days)
<i>chlorzoxazone tab 500 mg</i>	1	
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
LYVISPAH GRA 5MG	3	
LYVISPAH GRA 10MG	3	
LYVISPAH GRA 20MG	3	
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
SKELAXIN TAB 800MG	3	
SOMA TAB 250MG	3	QL (84 tabs every 30 days)
SOMA TAB 350MG	3	QL (84 tabs every 30 days)
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	1	
ZANAFLEX CAP 2MG	3	
ZANAFLEX CAP 4MG	3	
ZANAFLEX CAP 6MG	3	
ZANAFLEX TAB 4MG	3	

DIRECT MUSCLE RELAXANTS

DANTRIUM CAP 25MG	2	
-------------------	---	--

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

212

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

Drug Name	Drug Tier	Requirements/Limits
DANTRIUM CAP 50MG	2	
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
MUSCLE RELAXANT COMBINATIONS		
<i>carisoprodol w/ aspirin & codeine tab 200-325-16 mg</i>	1	QL (168 tabs every 30 days)
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 package (23gm) per 25 days)
DYMISTA SPR 137-50	3	QL (1 package (23gm) per 25 days)
NASAL AGENTS - MISC.		
NOZIN NASAL MIS SANITIZE	0	
NASAL ANTIALLERGY		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	1	
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 package (30.5gm) per 25 days)
PATANASE SPR 0.6%	3	QL (1 package (30.5gm) per 25 days)
NASAL ANTICHOLINERGICS		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	
NASAL STEROIDS		
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	1	QL (3 packages (25mL each) per 25 days)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	1	QL (1 package (16gm) per 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	1	QL (2 packages (17gm each) per 25 days)

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

213

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

Drug Name	Drug Tier	Requirements/Limits
NASONEX SPR 50MCG/AC	3	QL (2 packages (17gm each) per 25 days)
XHANCE MIS 93MCG	3	PA, QL (2 packages (16mL each) per 25 days)

NEUROMUSCULAR AGENTS**ALS AGENTS**

RADICAVA ORS SUS 105/5ML	5	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RADICAVA ORS SUS STARTER	5	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RILUTEK TAB 50MG	3	
<i>riluzole tab 50 mg</i>	1	

SPINAL MUSCULAR ATROPHY AGENTS (SMA)

EVRYSDI SOL	5	PA, QL (2 BOTTLES (120 MG) PER 24 DAYS)
-------------	---	---

NUTRIENTS**MISC. NUTRITIONAL SUBSTANCES**

ALTEMIA EMU	3	
-------------	---	--

OPHTHALMIC AGENTS**BETA-BLOCKERS - OPHTHALMIC**

<i>betaxolol hcl ophth soln 0.5%</i>	1	
BETOPTIC-S SUS 0.25% OP	2	
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	
<i>carteolol hcl ophth soln 1%</i>	1	
COMBIGAN SOL 0.2/0.5%	3	
COSOPT PF SOL 2%-0.5%	3	
COSOPT SOL 2-0.5%OP	3	
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	
ISTALOL SOL 0.5% OP	3	
<i>levobunolol hcl ophth soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	

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

214

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

Drug Name	Drug Tier	Requirements/Limits
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	
<i>timolol maleate ophth soln 0.5%</i>	1	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	
<i>timolol maleate ophth soln 0.25%</i>	1	
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	
TIMOPTIC SOL 0.5% OP	3	
TIMOPTIC SOL 0.25% OP	3	
TIMOPTIC-XE SOL 0.5% OP	3	
TIMOPTIC-XE SOL 0.25% OP	3	
CYCLOPLEGIC MYDRIATICS		
ATROPINE SUL SOL 1% OP	3	
CYCLOGYL SOL 0.5% OP	3	
CYCLOGYL SOL 1% OP	3	
CYCLOGYL SOL 2% OP	3	
CYCLOMYDRIL SOL OP	3	
<i>cyclopentolate hcl ophth soln 0.5%</i>	1	
<i>cyclopentolate hcl ophth soln 1%</i>	1	
<i>cyclopentolate hcl ophth soln 2%</i>	1	
ISOPTO ATROP SOL 1% OP	3	
<i>phenylephrine hcl ophth soln 2.5%</i>	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
MIOTICS		
ISOPTO CARP SOL 1% OP	3	
ISOPTO CARP SOL 2% OP	3	
ISOPTO CARP SOL 4% OP	3	
PHOSPHOLINE SOL 0.125%OP	3	
<i>pilocarpine hcl ophth soln 1%</i>	1	
<i>pilocarpine hcl ophth soln 2%</i>	1	
<i>pilocarpine hcl ophth soln 4%</i>	1	
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	

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

215

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

Drug Name	Drug Tier	Requirements/Limits
<i>brimonidine tartrate ophth soln 0.2%</i>	1	
<i>brimonidine tartrate ophth soln 0.15%</i>	1	
IOPIDINE SOL 1% OP	3	
SIMBRINZA SUS 1-0.2%	2	
OPHTHALMIC ANTI-INFECTIVES		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
BESIVANCE SUS 0.6%	2	
BETADINE SOL 5% OP	3	
BLEPH-10 SOL 10% OP	3	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	1	
<i>erythromycin ophth oint 5 mg/gm</i>	1	
<i>gatifloxacin ophth soln 0.5%</i>	1	
<i>gentamicin sulfate ophth oint 0.3%</i>	1	
<i>gentamicin sulfate ophth soln 0.3%</i>	1	QL (4 mL every 25 days)
<i>levofloxacin ophth soln 0.5%</i>	1	
MITOSOL KIT 0.2MG	3	
MOXEZA SOL 0.5%	3	
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
NATACYN SUS 5% OP	3	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	1	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
OCUFLOX DRO 0.3% OP	3	
<i>ofloxacin ophth soln 0.3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
POLYTRIM SOL OP	3	
POVIDONE IOD SOL 5%	3	
<i>sulfacetamide sodium ophth oint 10%</i>	1	
<i>sulfacetamide sodium ophth soln 10%</i>	1	

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

216

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

Drug Name	Drug Tier	Requirements/Limits
<i>tobramycin ophth soln 0.3%</i>	1	
TOBREX OIN 0.3% OP	3	
TOBREX SOL 0.3% OP	3	
<i>trifluridine ophth soln 1%</i>	1	
VIGAMOX DRO 0.5%	3	
ZYMAXID SOL 0.5%	3	
OPHTHALMIC IMMUNOMODULATORS		
RESTASIS EMU 0.05% OP	1	
RESTASIS MUL EMU 0.05% OP	2	
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5%	2	
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA SOL 0.02%	2	
ROCKLATAN DRO	2	
OPHTHALMIC LOCAL ANESTHETICS		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
<i>proparacaine hcl ophth soln 0.5%</i>	1	
<i>tetracaine hcl ophth soln 0.5%</i>	1	
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE SOL 20MCG/ML	5	PA, QL (16 CARTONS PER 56 DAYS - ONE TIME TREATMENT)
OPHTHALMIC STEROIDS		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
DUREZOL EMU 0.05%	3	
<i>fluorometholone ophth susp 0.1%</i>	1	
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	

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

217

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

Drug Name	Drug Tier	Requirements/Limits
MAXITROL OIN 0.1% OP	3	
MAXITROL SUS 0.1% OP	3	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	
<i>neomycin-polymyxin-hc ophth susp</i>	1	
PRED SOD PHO SOL 1% OP	3	
PRED-G S.O.P OIN OP	3	
PRED-G SUS OP	3	
<i>prednisolone acetate ophth susp 1%</i>	1	
PREDNISOLONE SUS 1%	3	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1%	2	
TOBRADEX SUS 0.3-0.1%	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
OPHTHALMIC SURGICAL AIDS		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
OPHTHALMICS - MISC.		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ALOCRIAL SOL 2%	3	
ALOMIDE SOL 0.1% OP	3	
<i>azelastine hcl ophth soln 0.05%</i>	1	
AZOPT SUS 1% OP	3	
<i>brinzolamide ophth susp 1%</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>cromolyn sodium ophth soln 4%</i>	1	
CYSTARAN SOL 0.44%	5	PA, QL (4 BOTTLES PER 28 DAYS)

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

218

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

Drug Name	Drug Tier	Requirements/Limits
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	
DORZOLAMIDE SOL 2%	3	
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
ILEVRO DRO 0.3% OP	2	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
PROLENSA SOL 0.07%	2	
TRUSOPT SOL 2% OP	3	
PROSTAGLANDINS - OPHTHALMIC		
<i>bimatoprost ophth soln 0.03%</i>	1	
<i>latanoprost ophth soln 0.005%</i>	1	
LUMIGAN SOL 0.01%	2	
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	
VYZULTA SOL 0.024%	3	
XALATAN SOL 0.005%	3	
ZIOPTAN DRO 0.0015%	3	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
<i>acetic acid otic soln 2%</i>	1	
OTIC ANTI-INFECTIVES		
CETRAXAL SOL 0.2%	3	
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
OTIC COMBINATIONS		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
CORTISPORIN SUS -TC OTIC	3	
<i>neomycin-polymyxin-hc otic soln 1%</i>	1	

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

219

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

Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	1	
OTIC STEROIDS		
<i>DERMOTIC OIL 0.01%</i>	3	
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
OXYTOCICS		
ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING		
<i>CERVIDIL VAG MIS 10MG INS</i>	3	
<i>PREPIDIL GEL 0.5MG/3G</i>	3	
<i>PROSTIN E2 SUP 20MG</i>	3	
OXYTOCICS		
<i>methylergonovine maleate tab 0.2 mg</i>	1	PA, QL (120 tabs every 30 days)
PENICILLINS		
AMINOPENICILLINS		
<i>amoxicillin (trihydrate) cap 250 mg</i>	1	
<i>amoxicillin (trihydrate) cap 500 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	1	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) tab 500 mg</i>	1	
<i>amoxicillin (trihydrate) tab 875 mg</i>	1	
<i>ampicillin cap 500 mg</i>	1	
NATURAL PENICILLINS		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	

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

220

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

Drug Name	Drug Tier	Requirements/Limits
PENICILLIN COMBINATIONS		
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin & k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 500-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML	3	
AUGMENTIN SUS 250/5ML	3	
AUGMENTIN SUS ES-600	3	
AUGMENTIN TAB 500MG	3	
PENICILLINASE-RESISTANT PENICILLINS		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
PROGESTINS		
PROGESTINS		
AYGESTIN TAB 5MG	3	
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	
<i>medroxyprogesterone acetate tab 5 mg</i>	1	
<i>medroxyprogesterone acetate tab 10 mg</i>	1	
<i>megestrol acetate susp 625 mg/5ml</i>	1	
<i>norethindrone acetate tab 5 mg</i>	1	
<i>progesterone cap 100 mg</i>	1	
<i>progesterone cap 200 mg</i>	1	
<i>progesterone im in oil 50 mg/ml</i>	1	

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

221

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

Drug Name	Drug Tier	Requirements/Limits
PROVERA TAB 2.5MG	3	
PROVERA TAB 5MG	3	
PROVERA TAB 10MG	3	

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.**AGENTS FOR CHEMICAL DEPENDENCY**

<i>acamprosate calcium tab delayed release 333 mg</i>	1	
<i>disulfiram tab 250 mg</i>	1	
<i>disulfiram tab 500 mg</i>	1	

ANTI-CATAPLECTIC AGENTS

SOD OXYBATE SOL 500MG/ML	4	PA, QL (540 ML PER 30 DAYS)
XYWAV SOL 0.5GM/ML	4	PA, QL (540 ML (270 GRAMS) PER 30 DAYS)

ANTIDEMENTIA AGENTS

ARICEPT TAB 5MG	3	
ARICEPT TAB 10MG	3	
ARICEPT TAB 23MG	3	
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	1	
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 5 mg</i>	1	
<i>donepezil hydrochloride tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 23 mg</i>	1	
EXELON DIS 4.6MG/24	3	
EXELON DIS 9.5MG/24	3	
EXELON DIS 13.3/24	3	
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	
<i>galantamine hydrobromide tab 4 mg</i>	1	
<i>galantamine hydrobromide tab 8 mg</i>	1	
<i>galantamine hydrobromide tab 12 mg</i>	1	

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

222

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

Drug Name	Drug Tier	Requirements/Limits
<i>memantine hcl cap er 24hr 7 mg</i>	1	
<i>memantine hcl cap er 24hr 14 mg</i>	1	
<i>memantine hcl cap er 24hr 21 mg</i>	1	
<i>memantine hcl cap er 24hr 28 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl tab 5 mg</i>	1	
<i>memantine hcl tab 10 mg</i>	1	
<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack</i>	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
NAMENDA XR CAP 7MG	3	
NAMENDA XR CAP 14MG	3	
NAMENDA XR CAP 21MG	3	
NAMENDA XR CAP 28MG	3	
NAMENDA XR CAP TITRATIO	3	
NAMZARIC CAP	2	
NAMZARIC CAP 7-10MG	2	
NAMZARIC CAP 14-10MG	2	
NAMZARIC CAP 21-10MG	2	
NAMZARIC CAP 28-10MG	2	
RAZADYNE ER CAP 8MG	3	
RAZADYNE ER CAP 16MG	3	
RAZADYNE ER CAP 24MG	3	
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	1	
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	

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

223

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

Drug Name	Drug Tier	Requirements/Limits
COMBINATION PSYCHOTHERAPEUTICS		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-50 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 2-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-10 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-25 mg</i>	1	
<i>perphenazine-amitriptyline tab 4-50 mg</i>	1	
SYMBYAX CAP 3-25MG	3	
SYMBYAX CAP 6-25MG	3	
SYMBYAX CAP 6-50MG	3	
SYMBYAX CAP 12-50MG	3	
FIBROMYALGIA AGENTS		
SAVELLA MIS TITR PAK	3	
SAVELLA TAB 12.5MG	3	
SAVELLA TAB 25MG	3	
SAVELLA TAB 50MG	3	
SAVELLA TAB 100MG	3	
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG	4	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO TAB 9MG	4	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO TAB 12MG	4	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 6MG	4	PA, QL (90 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 12MG	4	PA, QL (120 TABLETS PER 30 DAYS)

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

224

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

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO XR TAB 24MG	4	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO XR TAB TITR KIT	4	PA, QL (42 TABLETS PER 28 DAYS)
INGREZZA CAP 40-80MG	4	PA
INGREZZA CAP 40MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 60MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 80MG	4	PA, QL (30 CAPSULES PER 30 DAYS)
<i>tetrabenazine tab 12.5 mg</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
<i>tetrabenazine tab 25 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)

MULTIPLE SCLEROSIS AGENTS

AMPYRA TAB 10MG	5	PA, QL (60 TABLETS PER 30 DAYS)
AVONEX PEN KIT 30MCG	4	PA, QL (4 PENS PER 28 DAYS)
AVONEX PREFL KIT 30MCG	4	PA, QL (4 SYRINGES PER 28 DAYS)
BETASERON INJ 0.3MG	4	PA, QL (14 KITS PER 28 DAYS)
COPAXONE INJ 20MG/ML	4	PA, QL (30 SYRINGES PER 30 DAYS)
COPAXONE INJ 40MG/ML	4	PA, QL (12 SYRINGES PER 28 DAYS)
<i>dalfampridine tab er 12hr 10 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	PA, QL (14 CAPSULES PER 28 DAYS)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)

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

225

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

Drug Name	Drug Tier	Requirements/Limits
<i> fingolimod hcl cap 0.5 mg (base equiv)</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
<i> glatiramer acetate soln prefilled syringe 20 mg/ml</i>	1	PA, QL (30 SYRINGES PER 30 DAYS)
<i> glatiramer acetate soln prefilled syringe 40 mg/ml</i>	1	PA, QL (12 SYRINGES PER 28 DAYS)
KESIMPTA INJ 20/.4ML	4	PA, QL (1 PENS PER 28 DAYS); LOADING DOSE: 3 PENS PER 15 DAYS
MAVENCLAD PAK 10MG(4)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(5)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(6)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(7)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(8)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(9)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(10)	5	PA, QL (20 TABLETS PER 9 MONTHS)
MAYZENT PAK STARTER	4	PA, QL (7 TABLETS PER 4 DAYS)
MAYZENT TAB 0.25MG	4	PA, QL (12 TABLETS PER 5 DAYS)
MAYZENT TAB 1MG	4	PA, QL (30 TABLETS PER 30 DAYS)
MAYZENT TAB 2MG	4	PA, QL (30 TABLETS PER 30 DAYS)
PLEGRIDY INJ	5	PA, QL (1 CARTON PER 28 DAYS)
PLEGRIDY INJ	5	PA, QL (1 KIT PER 28 DAYS)

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

226

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

Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY INJ PEN	5	PA, QL (2 PENS PER 28 DAYS)
PLEGRIDY INJ STARTER	5	PA, QL (1 PACK PER 28 DAYS)
PLEGRIDY PEN INJ STARTER	5	PA, QL (1 PACK PER 28 DAYS)
REBIF INJ 22/0.5	4	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF INJ 44/0.5	4	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF REBIDO INJ 22/0.5	4	PA, QL (12 SYR PER 28 DAYS)
REBIF REBIDO INJ 44/0.5	4	PA, QL (12 SYR PER 28 DAYS)
REBIF REBIDO INJ TITRATN	4	PA, QL (12 INJ PER 28 DAYS)
REBIF TITRTN INJ PACK	4	PA, QL (12 SYRINGES PER 28 DAYS)
<i>teriflunomide tab 7 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>teriflunomide tab 14 mg</i>	1	PA, QL (30 tabs every 30 days)
VUMERITY CAP 231MG	4	PA, QL (120 CAPSULES PER 30 DAYS)
ZEPOSIA 7DAY CAP STR PACK	4	PA, QL (7 TABLETS PER 7 DAYS)
ZEPOSIA CAP .92MG	4	PA, QL (30 TABLETS PER 30 DAYS)
ZEPOSIA CAP STR KIT	4	PA, QL (1 Starter Kit per 28 days)
ZEPOSIA CAP STR KIT	4	PA, QL (37 TABLETS PER 37 DAYS)
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
GRALISE TAB 300MG	2	QL (150 tabs every 30 days)
GRALISE TAB 450MG	2	QL (90 tablets per 25 days)

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

227

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

Drug Name	Drug Tier	Requirements/Limits
GRALISE TAB 600MG	2	QL (90 tabs every 30 days)
GRALISE TAB 750MG	2	QL (60 tablets per 25 days)
GRALISE TAB 900MG	2	QL (60 tablets per 25 days)
<i>pregabalin tab er 24hr 82.5 mg</i>	1	QL (60 tabs every 30 days)
<i>pregabalin tab er 24hr 165 mg</i>	1	QL (60 tabs every 30 days)
<i>pregabalin tab er 24hr 330 mg</i>	1	QL (60 tabs every 30 days)
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUDEXTA CAP 20-10MG	2	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
<i>ergoloid mesylates tab 1 mg</i>	1	
<i>pimozide tab 1 mg</i>	1	
<i>pimozide tab 2 mg</i>	1	
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deterrent) tab er 12hr 150 mg</i>	0	\$0 limited to 2 treatment cycles/year
CHANTIX PAK 1MG	0	
CHANTIX TAB 0.5& 1MG	0	
CHANTIX TAB 0.5MG	0	
CHANTIX TAB 1MG	0	
NICODERM CQ DIS 7MG/24HR	0	
NICODERM CQ DIS 14MG/24H	0	
NICODERM CQ DIS 21MG/24H	0	
NICORETTE GUM 2MG	0	
NICORETTE GUM 2MG CINN	0	
NICORETTE GUM 2MG MINT	0	
NICORETTE GUM 2MG ORIG	0	
NICORETTE GUM 2MGFRUIT	0	
NICORETTE GUM 4MG	0	
NICORETTE GUM 4MG CINN	0	
NICORETTE GUM 4MG MINT	0	
NICORETTE GUM 4MG ORIG	0	
NICORETTE GUM 4MGFRUIT	0	
NICORETTE LOZ 2MG MINT	0	
NICORETTE LOZ 4MG MINT	0	
NICORETTE ST GUM 2MG MINT	0	

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

228

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

Drug Name	Drug Tier	Requirements/Limits
NICORETTE ST GUM 2MG ORIG	0	
NICORETTE ST GUM 4MG ORIG	0	
<i>nicotine polacrilex gum 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex gum 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 7 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
NICOTROL INH	0	
NICOTROL NS SPR 10MG/ML	0	
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ 284/1.5	4	PA, QL (4 PFS PER 28 DAYS)
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP 7.5MG	3	
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
KALYDECO GRA 5.8MG	5	PA, QL (56 packets per 28 days)
KALYDECO GRA 13.4MG	5	PA, QL (56 packets per 28 days)
KALYDECO PAK 25MG	5	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 50MG	5	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 75MG	5	PA, QL (56 PACKETS PER 28 DAYS)

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

229

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

Drug Name	Drug Tier	Requirements/Limits
KALYDECO TAB 150MG	5	PA, QL (1 CARTON (56 TABS) PER 28 DAYS)
ORKAMBI GRA 75-94MG	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 100-125	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 150-188	5	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI TAB 100-125	5	PA, QL (112 TABLETS PER 28 DAYS)
ORKAMBI TAB 200-125	5	PA, QL (112 TABLETS PER 28 DAYS)
PULMOZYME SOL 1MG/ML	5	PA, QL (60 AMPULES PER 30 DAYS)
SYMDEKO TAB 50-75MG	5	PA, QL (56 TABLETS PER 28 DAYS)
SYMDEKO TAB 100-150	5	PA, QL (56 TABLETS PER 28 DAYS)
TRIKAFTA PAK 59.5MG	5	PA, QL (56 packets per 28 days)
TRIKAFTA PAK 75MG	5	PA, QL (56 packets per 28 days)
TRIKAFTA TAB	5	PA, QL (84 TABLETS PER 28 DAYS)
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP 267MG	3	PA, QL (270 CAPSULES PER 30 DAYS)
ESBRIET TAB 267MG	3	PA, QL (270 TABLETS PER 30 DAYS)
ESBRIET TAB 801MG	4	PA, QL (90 TABLETS PER 30 DAYS)
OFEV CAP 100MG	4	PA, QL (60 CAPSULES PER 30 DAYS)
OFEV CAP 150MG	4	PA, QL (60 CAPSULES PER 30 DAYS)

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

230

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

Drug Name	Drug Tier	Requirements/Limits
<i>pirfenidone tab 267 mg</i>	1	QL (270 TABLETS PER 30 DAYS)
<i>pirfenidone tab 801 mg</i>	1	QL (90 TABLETS PER 30 DAYS)

SULFONAMIDES**SULFONAMIDES**

<i>sulfadiazine tab 500 mg</i>	3
--------------------------------	---

TETRACYCLINES**AMINOMETHYLCYCLINES**

NUZYRA TAB 150MG	3
------------------	---

TETRACYCLINES

<i>demeclocycline hcl tab 150 mg</i>	1
<i>demeclocycline hcl tab 300 mg</i>	1
<i>doxycycline hyclate cap 50 mg</i>	1
<i>doxycycline hyclate cap 100 mg</i>	1
<i>doxycycline hyclate tab 20 mg</i>	1
<i>doxycycline hyclate tab 100 mg</i>	1
<i>doxycycline monohydrate cap 50 mg</i>	1
<i>doxycycline monohydrate cap 100 mg</i>	1
<i>doxycycline monohydrate for susp 25 mg/5ml</i>	1
<i>doxycycline monohydrate tab 50 mg</i>	1
<i>doxycycline monohydrate tab 75 mg</i>	1
<i>doxycycline monohydrate tab 100 mg</i>	1
<i>doxycycline monohydrate tab 150 mg</i>	1
<i>minocycline hcl cap 50 mg</i>	1
<i>minocycline hcl cap 75 mg</i>	1
<i>minocycline hcl cap 100 mg</i>	1
<i>minocycline hcl tab 50 mg</i>	1
<i>minocycline hcl tab 75 mg</i>	1
<i>minocycline hcl tab 100 mg</i>	1
SOLODYN TAB 55MG	3
SOLODYN TAB 65MG	3
SOLODYN TAB 80MG	3
SOLODYN TAB 105MG	3
SOLODYN TAB 115MG	3

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

231

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

Drug Name	Drug Tier	Requirements/Limits
<i>tetracycline hcl cap 250 mg</i>	1	QL (120 caps every 25 days)
<i>tetracycline hcl cap 500 mg</i>	1	QL (120 caps every 25 days)
VIBRAMYCIN CAP 100MG	3	
VIBRAMYCIN SUS 25MG/5ML	2	
VIBRAMYCIN SYP 50MG/5ML	2	

THYROID AGENTS**ANTITHYROID AGENTS**

<i>methimazole tab 5 mg</i>	1	
<i>methimazole tab 10 mg</i>	1	
<i>propylthiouracil tab 50 mg</i>	1	
TAPAZOLE TAB 5MG	2	
TAPAZOLE TAB 10MG	2	

THYROID HORMONES

ARMOUR THYRO TAB 15MG	3	
ARMOUR THYRO TAB 30MG	3	
ARMOUR THYRO TAB 60MG	3	
ARMOUR THYRO TAB 90MG	3	
ARMOUR THYRO TAB 120MG	3	
ARMOUR THYRO TAB 180MG	3	
ARMOUR THYRO TAB 240MG	3	
ARMOUR THYRO TAB 300MG	3	
<i>levothyroxine sodium tab 25 mcg</i>	1	
<i>levothyroxine sodium tab 50 mcg</i>	1	
<i>levothyroxine sodium tab 75 mcg</i>	1	
<i>levothyroxine sodium tab 88 mcg</i>	1	
<i>levothyroxine sodium tab 100 mcg</i>	1	
<i>levothyroxine sodium tab 112 mcg</i>	1	
<i>levothyroxine sodium tab 125 mcg</i>	1	
<i>levothyroxine sodium tab 137 mcg</i>	1	
<i>levothyroxine sodium tab 150 mcg</i>	1	
<i>levothyroxine sodium tab 175 mcg</i>	1	
<i>levothyroxine sodium tab 200 mcg</i>	1	
<i>levothyroxine sodium tab 300 mcg</i>	1	

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

232

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

Drug Name	Drug Tier	Requirements/Limits
<i>liothyronine sodium tab 5 mcg</i>	1	
<i>liothyronine sodium tab 25 mcg</i>	1	
<i>liothyronine sodium tab 50 mcg</i>	1	
NP THYROID TAB 15MG	3	
NP THYROID TAB 30MG	3	
NP THYROID TAB 60MG	3	
NP THYROID TAB 90MG	3	
NP THYROID TAB 120MG	3	
SYNTHROID TAB 25MCG	2	
SYNTHROID TAB 50MCG	2	
SYNTHROID TAB 75MCG	2	
SYNTHROID TAB 88MCG	2	
SYNTHROID TAB 100MCG	2	
SYNTHROID TAB 112MCG	2	
SYNTHROID TAB 125MCG	2	
SYNTHROID TAB 137MCG	2	
SYNTHROID TAB 150MCG	2	
SYNTHROID TAB 175MCG	2	
SYNTHROID TAB 200MCG	2	
SYNTHROID TAB 300MCG	2	

ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS**ANTISPASMODICS**

ANASPAZ TAB 0.125MG	2	
BELLA/OPIUM SUP 16.2-30	3	
BELLA/OPIUM SUP 16.2-60	3	
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	
CUVPOSA SOL 1MG/5ML	3	
<i>dicyclomine hcl cap 10 mg</i>	1	
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	1	
<i>dicyclomine hcl tab 20 mg</i>	1	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	1	
<i>glycopyrrolate tab 1 mg</i>	1	
<i>glycopyrrolate tab 2 mg</i>	1	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	1	

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

233

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

Drug Name	Drug Tier	Requirements/Limits
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	
LEVBIID TAB 0.375 ER	3	
LEVSIN TAB 0.125MG	2	
LEVSIN/SL SUB 0.125MG	2	
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
SYMAX DUOTAB TAB	3	
H-2 ANTAGONISTS		
<i>cimetidine hcl soln 300 mg/5ml</i>	1	
<i>cimetidine tab 300 mg</i>	1	
<i>cimetidine tab 400 mg</i>	1	
<i>cimetidine tab 800 mg</i>	1	
<i>famotidine for susp 40 mg/5ml</i>	1	
<i>famotidine tab 40 mg</i>	1	
<i>nizatidine cap 150 mg</i>	1	
<i>nizatidine cap 300 mg</i>	1	
<i>nizatidine oral soln 15 mg/ml</i>	1	
PEPCID TAB 40MG	3	
MISC. ANTI-ULCER		
<i>sucralfate tab 1 gm</i>	1	
PROTON PUMP INHIBITORS		
DEXILANT CAP 30MG DR	3	QL (90 caps every year)
DEXILANT CAP 60MG DR	3	QL (90 caps every year)
<i>dexlansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year)
<i>dexlansoprazole cap delayed release 60 mg</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year)

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

234

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

Drug Name	Drug Tier	Requirements/Limits
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	1	QL (90 packets every year)
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	1	QL (90 packets every year)
<i>lansoprazole cap delayed release 15 mg</i>	1	QL (90 caps every year)
<i>lansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year)
<i>lansoprazole tab delayed release orally disintegrating 15 mg</i>	1	QL (90 ea every year)
<i>lansoprazole tab delayed release orally disintegrating 30 mg</i>	1	QL (90 ea every year)
<i>omeprazole cap delayed release 10 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 20 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 40 mg</i>	1	QL (90 caps every year)
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1	QL (90 tabs every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 ea every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 tabs every year)
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	1	QL (90 vials every year)
PROTONIX INJ 40MG	3	QL (90 vials every year)
RABEPRAZOLE CAP 10MG DR	3	QL (90 caps every year)
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year)
ULCER DRUGS - PROSTAGLANDINS		
CYTOTEC TAB 100MCG	2	
CYTOTEC TAB 200MCG	2	
<i>misoprostol tab 100 mcg</i>	1	
<i>misoprostol tab 200 mcg</i>	1	
ULCER THERAPY COMBINATIONS		
<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
OMECLAMOX- MIS PAK	3	
PYLERA CAP	2	
TALICIA CAP	3	
VOQUEZNA PAK DUAL PAK	3	

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

235

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

Drug Name	Drug Tier	Requirements/Limits
VOQUEZNA PAK TRIP PK	3	
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	1	
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	1	
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	
GELNIQUE GEL 10%	3	
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride tab 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 10 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 15 mg</i>	1	
<i>solifenacin succinate tab 5 mg</i>	1	
<i>solifenacin succinate tab 10 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 2 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 4 mg</i>	1	
<i>tolterodine tartrate tab 1 mg</i>	1	
<i>tolterodine tartrate tab 2 mg</i>	1	
<i>tropium chloride cap er 24hr 60 mg</i>	1	
<i>tropium chloride tab 20 mg</i>	1	
VESICARE LS SUS 5MG/5ML	3	
VESICARE TAB 5MG	3	
VESICARE TAB 10MG	3	
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
MYRBETRIQ SUS 8MG/ML	2	
MYRBETRIQ TAB 25MG	2	
MYRBETRIQ TAB 50MG	2	

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

236

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

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

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

237

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

Drug Name	Drug Tier	Requirements/Limits
IMVEXXY STRT SUP 4MCG	2	
IMVEXXY STRT SUP 10MCG	2	
VAGIFEM TAB 10MCG	1	Tier 1 with DAW9
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG	2	
CRINONE GEL 8% VAG	2	
ENDOMETRIN SUP 100MG	2	
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
AUVI-Q INJ 0.1MG	2	QL (3 pens every 300 days)
AUVI-Q INJ 0.3MG	2	QL (6 pens every 300 days)
AUVI-Q INJ 0.15MG	2	QL (3 pens every 300 days)
<i>epinephrine inj 30 mg/30ml (1 mg/ml) (1:1000)</i>	1	
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	QL (3 pens every 300 days)
EPIPEN 2-PAK INJ 0.3MG	2	QL (6 pens every 300 days)
EPIPEN-JR INJ 0.15MG	2	QL (6 pens every 300 days)
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
<i>droxidopa cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)
<i>droxidopa cap 200 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
<i>droxidopa cap 300 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
VASOPRESSORS		
EPINEPHRINE INJ 0.2MG	3	

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

238

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

Drug Name	Drug Tier	Requirements/Limits
<i>midodrine hcl tab 2.5 mg</i>	1	
<i>midodrine hcl tab 5 mg</i>	1	
<i>midodrine hcl tab 10 mg</i>	1	

VITAMINS

OIL SOLUBLE VITAMINS

DRISDOL CAP 50000UNT	3	
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	
MEPHYTON TAB 5MG	3	
<i>phytonadione tab 5 mg</i>	1	

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

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

Index

A	
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	108
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	108
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	108
<i>abacavir sulfate tab 300 mg (base equiv)</i>	108
ABILIFY MAIN INJ 300MG.....	106
ABILIFY MAIN INJ 400MG.....	106
<i>abiraterone acetate tab 250 mg</i>	88
<i>abiraterone acetate tab 500 mg</i>	88
ABSORICA CAP 10MG.....	136
ABSORICA CAP 20MG.....	136
ABSORICA CAP 25MG.....	136
ABSORICA CAP 30MG.....	136
ABSORICA CAP 35MG.....	136
ABSORICA CAP 40MG	136
<i>acamprosate calcium tab delayed release 333 mg</i>	222
<i>acarbose tab 100 mg</i>	61
<i>acarbose tab 25 mg</i>	61
<i>acarbose tab 50 mg</i>	61
ACCOLATE TAB 10MG	42
ACCOLATE TAB 20MG	42
ACCU-CHEK GUIDE	151
ACCU-CHEK KIT FASTCLIX	182
ACCU-CHEK KIT SOFTCLIX	182
ACCU-CHEK LIQ GUIDE	182
ACCU-CHEK LIQ SMART.....	182
ACCU-CHEK MIS MLTICLIX.....	182
ACCU-CHEK SOL.....	182
ACCU-CHEK SOL COMPACT	182
ACCU-CHEK TES AVIVA PL	152
ACCU-CHEK TES COMPACT	152
ACCU-CHEK TES SMART	152
ACCUPRIL TAB 10MG.....	74
ACCUPRIL TAB 20MG.....	74
ACCUPRIL TAB 40MG.....	74
ACCUPRIL TAB 5MG	74
ACCURETIC TAB 10-12.5.....	78
ACCURETIC TAB 20-12.5	78
ACCURETIC TAB 20-25MG	78
ACCUTREND SOL GLUCOSE	182
<i>acebutolol hcl cap 200 mg</i>	118
<i>acebutolol hcl cap 400 mg</i>	118
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	31
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	31
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	30
<i>acetaminophen w/ codeine tab 300-15 mg</i>	30
<i>acetaminophen w/ codeine tab 300-30 mg</i>	30
<i>acetaminophen w/ codeine tab 300-60 mg</i>	31
<i>acetazolamide cap er 12hr 500 mg</i>	158
<i>acetazolamide tab 125 mg</i>	158
<i>acetazolamide tab 250 mg</i>	158
<i>acetic acid otic soln 2%</i>	219
<i>acetylcysteine inhal soln 10%</i>	136
<i>acetylcysteine inhal soln 20%</i>	136
<i>acitretin cap 10 mg</i>	140
<i>acitretin cap 17.5 mg</i>	140
<i>acitretin cap 25 mg</i>	140
ACTHAR INJ 80UNIT	161
ACTI-LANCE MIS 28G.....	183
ACTI-LANCE MIS LITE 28G.....	183
ACTI-LANCE MIS SPEC 17G.....	183
ACTI-LANCE MIS UNIV 23G.....	183
ACTIMMUNE INJ 2MU/0.5	97
ACTIQ LOZ 1200MCG.....	23
ACTIQ LOZ 1600MCG.....	23
ACTIQ LOZ 200MCG	23
ACTIQ LOZ 400MCG	23
ACTIQ LOZ 600MCG	23
ACTIQ LOZ 800MCG	23
ACTIVELLA TAB 1-0.5MG.....	167
ACTONEL TAB 150MG.....	160
ACTONEL TAB 35MG	160
ACTOPLUS MET TAB 15-500MG.....	62

ACTOPLUS MET TAB 15-850MG	62	ADVOCATE MIS LANC DEV	183
ACULAR LS SOL 0.4%	218	ADVOCATE MIS LANCETS.....	183
ACULAR SOL 0.5% OP	218	ADV TRAVEL MIS LANC 28G	183
<i>acyclovir cap 200 mg</i>	116	AEMCOLO TAB 194MG	35
<i>acyclovir oint 5%</i>	145	AERCHMBR PLS MIS FLOW-VU	202
<i>acyclovir susp 200 mg/5ml</i>	116	AERCHMBR PLS MIS LRG MASK	202
<i>acyclovir tab 400 mg</i>	116	AERCHMBR PLS MIS MED MASK	202
<i>acyclovir tab 800 mg</i>	116	AERCHMBR PLS MIS SM MASK.....	202
ACZONE GEL 5%.....	136	AERCHMBR Z- MIS STAT PLS	202
ACZONE GEL 7.5%.....	136	AEROCHAMBER KIT ACTION	202
ADALIMU-ADAZ INJ 40/0.4ML	10	AEROCHAMBER MIS CHAMBER.....	202
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	136	AEROCHAMBER MIS FLOSIGNA.....	202
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	136	AEROCHAMBER MIS MV.....	202
<i>adapalene cream 0.1%</i>	136	AEROCHAMBER MIS PLUS	202
<i>adapalene gel 0.1%</i>	136	AEROVENT MIS PLUS	202
<i>adapalene gel 0.3%</i>	136	AFINITOR DIS TAB 2MG	90
ADASUVE INH 10MG.....	103	AFINITOR DIS TAB 3MG	90
<i>adefovir dipivoxil tab 10 mg</i>	115	AFINITOR DIS TAB 5MG	90
ADEMPAS TAB 0.5MG.....	128	AGAMATRIX MIS 33G.....	183
ADEMPAS TAB 1.5MG.....	128	AGAMATRIX SOL HIGH	183
ADEMPAS TAB 1MG.....	128	AGAMATRIX SOL LEVEL 2	183
ADEMPAS TAB 2.5MG	128	AGAMATRIX SOL LEVEL 4	183
ADEMPAS TAB 2MG	128	AGAMATRIX SOL NORM/HGH.....	183
ADIPEX-P CAP 37.5MG.....	4	AGAMATRIX SOL NORMAL	183
ADIPEX-P TAB 37.5MG	4	AGRYLIN CAP 0.5MG	176
ADJ LANCING MIS DEVICE.....	183	AIMSCO TWIST MIS 32G.....	183
ADVAIR DISKU AER 100/50	43	AIMSCO TWIST MIS 33G.....	183
ADVAIR DISKU AER 250/50	43	AJOVY INJ 225/1.5	203
ADVAIR DISKU AER 500/50.....	44	AKTEN GEL 3.5%.....	217
ADVAIR HFA AER 115/21	44	AKYNZEO CAP 300-0.5.....	68
ADVAIR HFA AER 230/21.....	44	<i>albendazole tab 200 mg</i>	35
ADVAIR HFA AER 45/21.....	44	ALBENZA TAB 200MG	35
ADVANCE LIQ CONTROL.....	183	<i>albuterol sulfate inhal aero 108 mcg/act</i> <i>(90mcg base equiv)</i>	44
ADVANCE LIQ INTUITIO.....	183	<i>albuterol sulfate soln nebu 0.083% (2.5</i> <i>mg/3ml)</i>	44
ADVANCE NORM LIQ CONTROL.....	183	<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	44
ADVOCATE SAFE MIS LANC 26G	183	<i>albuterol sulfate soln nebu 0.63 mg/3ml</i> <i>(base equiv)</i>	44
ADV LANCING MIS DEVICE	183	<i>albuterol sulfate soln nebu 1.25 mg/3ml</i> <i>(base equiv)</i>	44
ADVOCATE+ SOL REDI-COD	183	<i>albuterol sulfate syrup 2 mg/5ml</i>	44
ADVOCATE LIQ HIGH	183		
ADVOCATE LIQ LOW	183		
ADVOCATE MIS LANC 30G	183		

<i>albuterol sulfate tab 2 mg</i>	44	<i>allopurinol tab 100 mg</i>	175
<i>albuterol sulfate tab 4 mg</i>	44	<i>allopurinol tab 300 mg</i>	175
<i>albuterol sulfate tab er 12hr 4 mg</i>	44	<i>almotriptan malate tab 12.5 mg</i>	204
<i>albuterol sulfate tab er 12hr 8 mg</i>	44	<i>almotriptan malate tab 6.25 mg</i>	204
ALCAINE SOL 0.5% OP	217	ALOCRI SOL 2%	218
<i>alclometasone dipropionate cream 0.05%</i>	145	ALOMIDE SOL 0.1% OP	218
<i>alclometasone dipropionate oint 0.05%</i>	145	ALORA DIS 0.025MG	168
ALCOH-GLOVE PAD CONTOURE	201	ALORA DIS 0.05MG	168
ALCOHOL PAD	201	ALORA DIS 0.075MG	168
ALCOHOL PAD 70%	201	ALORA DIS 0.1MG	168
ALCOHOL PAD PREP.....	201	<i>alose tron hcl tab 0.5 mg (base equiv)</i>	172
ALCOHOL PAD SWABSTIC.....	201	<i>alose tron hcl tab 1 mg (base equiv)</i>	172
ALCOHOL PREP PAD.....	201	ALPHAGAN P SOL 0.1%	215
ALCOHOL PREP PAD 70%	201	ALPHAGAN P SOL 0.15%	215
ALCOHOL PREP PAD MED 70%	201	ALPRAZOLAM CON 1 MG/ML.....	39
ALCOHOL PREP PAD PADS 70%	201	<i>alprazolam orally disintegrating tab 0.25</i> <i>mg</i>	39
ALCOHOL SWAB PAD	201	<i>alprazolam orally disintegrating tab 0.5 mg</i>	39
ALCOHOL SWAB PAD 70%.....	201	<i>alprazolam orally disintegrating tab 1 mg</i>	39
ALCOHOL SWAB PAD EX-THICK	201	<i>alprazolam orally disintegrating tab 2 mg</i>	39
ALCOHOL WIPE PAD.....	201	<i>alprazolam tab 0.25 mg</i>	39
ALCOH-WIPE MIS 12.....	201	<i>alprazolam tab 0.5 mg</i>	39
ALDACTAZIDE TAB 25/25	158	<i>alprazolam tab 1 mg</i>	39
ALDACTAZIDE TAB 50/50.....	158	<i>alprazolam tab 2 mg</i>	39
ALDACTONE TAB 100MG	159	<i>alprazolam tab er 24hr 0.5 mg</i>	39
ALDACTONE TAB 25MG	159	<i>alprazolam tab er 24hr 1 mg</i>	39
ALDACTONE TAB 50MG	159	<i>alprazolam tab er 24hr 2 mg</i>	39
ALDARA CRE 5%.....	149	<i>alprazolam tab er 24hr 3 mg</i>	39
ALECENSA CAP 150MG.....	90	ALTABAX OIN 1%	138
<i>alendronate sodium oral soln 70 mg/75ml</i>	160	ALTACE CAP 1.25MG	74
<i>alendronate sodium tab 10 mg</i>	160	ALTACE CAP 10MG	75
<i>alendronate sodium tab 35 mg</i>	160	ALTACE CAP 2.5MG.....	74
<i>alendronate sodium tab 5 mg</i>	160	ALTACE CAP 5MG	74
<i>alendronate sodium tab 70 mg</i>	160	ALTEMIA EMU.....	214
<i>alfuzosin hcl tab er 24hr 10 mg</i>	174	ALUNBRIG PAK	90
ALINIA SUS 100/5ML	36	ALUNBRIG TAB 180MG.....	90
ALINIA TAB 500MG.....	36	ALUNBRIG TAB 30MG	90
<i>aliskiren fumarate tab 150 mg (base</i> <i>equivalent)</i>	82	ALUNBRIG TAB 90MG	90
<i>aliskiren fumarate tab 300 mg (base</i> <i>equivalent)</i>	82	<i>alvimopan cap 12 mg</i>	173
ALKERAN TAB 2MG.....	85	<i>amantadine hcl cap 100 mg</i>	98
		<i>amantadine hcl soln 50 mg/5ml</i>	98
		<i>amantadine hcl tab 100 mg</i>	98

AMARYL TAB 1MG.....	66	<i>amlodipine besylate-atorvastatin calcium</i>	
AMARYL TAB 2MG.....	66	<i>tab 2.5-10 mg.....</i>	123
AMARYL TAB 4MG.....	66	<i>amlodipine besylate-atorvastatin calcium</i>	
AMBIEN CR TAB 12.5MG.....	179	<i>tab 2.5-20 mg.....</i>	123
AMBIEN CR TAB 6.25MG.....	179	<i>amlodipine besylate-atorvastatin calcium</i>	
AMBIEN TAB 10MG.....	179	<i>tab 2.5-40 mg.....</i>	123
AMBIEN TAB 5MG.....	179	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>ambrisentan tab 10 mg.....</i>	127	<i>tab 5-10 mg.....</i>	123
<i>ambrisentan tab 5 mg.....</i>	127	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>amcinonide cream 0.1%.....</i>	145	<i>tab 5-20 mg.....</i>	123
<i>amcinonide lotion 0.1%.....</i>	145	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>amcinonide oint 0.1%.....</i>	145	<i>tab 5-40 mg.....</i>	123
AMERGE TAB 1MG.....	204	<i>amlodipine besylate-atorvastatin calcium</i>	
AMERGE TAB 2.5MG.....	204	<i>tab 5-80 mg.....</i>	123
AMICAR TAB 1000MG.....	178	<i>amlodipine besylate-benazepril hcl cap 10-</i>	
AMICAR TAB 500MG.....	178	<i>20 mg.....</i>	78
<i>amiloride & hydrochlorothiazide tab 5-50</i>		<i>amlodipine besylate-benazepril hcl cap 10-</i>	
<i>mg.....</i>	158	<i>40 mg.....</i>	78
<i>amiloride hcl tab 5 mg.....</i>	159	<i>amlodipine besylate-benazepril hcl cap 2.5-</i>	
<i>aminocaproic acid oral soln 0.25 gm/ml.....</i>	178	<i>10 mg.....</i>	78
<i>aminocaproic acid tab 1000 mg.....</i>	178	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>aminocaproic acid tab 500 mg.....</i>	178	<i>10 mg.....</i>	78
<i>amiodarone hcl tab 100 mg.....</i>	41	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>amiodarone hcl tab 200 mg.....</i>	41	<i>20 mg.....</i>	78
<i>amiodarone hcl tab 400 mg.....</i>	41	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>amitriptyline hcl tab 100 mg.....</i>	60	<i>40 mg.....</i>	78
<i>amitriptyline hcl tab 10 mg.....</i>	60	<i>amlodipine besylate-olmesartan</i>	
<i>amitriptyline hcl tab 150 mg.....</i>	60	<i>medoxomil tab 10-20 mg.....</i>	78
<i>amitriptyline hcl tab 25 mg.....</i>	60	<i>amlodipine besylate-olmesartan</i>	
<i>amitriptyline hcl tab 50 mg.....</i>	60	<i>medoxomil tab 10-40 mg.....</i>	78
<i>amitriptyline hcl tab 75 mg.....</i>	60	<i>amlodipine besylate-olmesartan</i>	
AMJEVITA INJ 10/0.2ML.....	10	<i>medoxomil tab 5-20 mg.....</i>	78
AMJEVITA INJ 20/0.4ML.....	10	<i>amlodipine besylate-olmesartan</i>	
AMJEVITA INJ 40/0.8ML.....	11	<i>medoxomil tab 5-40 mg.....</i>	78
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 10 mg (base</i>	
<i>tab 10-10 mg.....</i>	123	<i>equivalent).....</i>	120
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 2.5 mg (base</i>	
<i>tab 10-20 mg.....</i>	123	<i>equivalent).....</i>	120
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 5 mg (base</i>	
<i>tab 10-40 mg.....</i>	123	<i>equivalent).....</i>	120
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate-valsartan tab 10-160</i>	
<i>tab 10-80 mg.....</i>	123	<i>mg.....</i>	79

<i>amlodipine besylate-valsartan tab 10-320 mg</i>	79	<i>amoxicillin & k clavulanate for susp 250-62.5 mg/5ml</i>	221
<i>amlodipine besylate-valsartan tab 5-160 mg</i>	78	<i>amoxicillin & k clavulanate for susp 400-57 mg/5ml</i>	221
<i>amlodipine besylate-valsartan tab 5-320 mg</i>	79	<i>amoxicillin & k clavulanate for susp 600-42.9 mg/5ml</i>	221
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i>	79	<i>amoxicillin & k clavulanate tab 250-125 mg</i>	221
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i>	79	<i>amoxicillin & k clavulanate tab 500-125 mg</i>	221
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i>	79	<i>amoxicillin & k clavulanate tab 875-125 mg</i>	221
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i>	79	<i>amoxicillin & k clavulanate tab er 12hr 1000-62.5 mg</i>	221
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i>	79	AMPHETAMI ER SUS 1.25/ML	1
<i>amoxapine tab 100 mg</i>	60	<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i>	1
<i>amoxapine tab 150 mg</i>	60	<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i>	1
<i>amoxapine tab 25 mg</i>	60	<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i>	1
<i>amoxapine tab 50 mg</i>	60	<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i>	1
<i>amoxicil cap & clarithro tab & lansopraz cap dr 500 & 500 & 30mg</i>	235	<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i>	1
<i>amoxicillin (trihydrate) cap 250 mg</i>	220	<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i>	1
<i>amoxicillin (trihydrate) cap 500 mg</i>	220	<i>amphetamine-dextroamphetamine tab 10 mg</i>	1
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	220	<i>amphetamine-dextroamphetamine tab 12.5 mg</i>	1
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	220	<i>amphetamine-dextroamphetamine tab 15 mg</i>	1
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	220	<i>amphetamine-dextroamphetamine tab 20 mg</i>	1
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	220	<i>amphetamine-dextroamphetamine tab 30 mg</i>	1
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	220	<i>amphetamine-dextroamphetamine tab 5 mg</i>	1
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	220	<i>amphetamine-dextroamphetamine tab 7.5 mg</i>	1
<i>amoxicillin (trihydrate) tab 500 mg</i>	220	<i>amphetamine sulfate tab 10 mg</i>	1
<i>amoxicillin (trihydrate) tab 875 mg</i>	220	<i>amphetamine sulfate tab 5 mg</i>	1
<i>amoxicillin & k clavulanate chew tab 200-28.5 mg</i>	221		
<i>amoxicillin & k clavulanate chew tab 400-57 mg</i>	221		
<i>amoxicillin & k clavulanate for susp 200-28.5 mg/5ml</i>	221		

<i>ampicillin cap 500 mg</i>	220	<i>arformoterol tartrate soln nebu 15 mcg/2ml</i>	
AMPYRA TAB 10MG	225	(base equiv)	44
ANACAINE OIN	150	ARICEPT TAB 10MG	222
ANAFRANIL CAP 25MG.....	60	ARICEPT TAB 23MG	222
ANAFRANIL CAP 50MG.....	60	ARICEPT TAB 5MG	222
ANAFRANIL CAP 75MG.....	60	ARIKAYCE SUS.....	10
<i>anagrelide hcl cap 0.5 mg</i>	176	ARIMIDEX TAB 1MG.....	88
<i>anagrelide hcl cap 1 mg</i>	176	<i>aripiprazole orally disintegrating tab 10 mg</i>	
ANALPRAM-HC CRE 1-1%.....	34	.....	107
ANALPRAM-HC LOT 2.5%	34	<i>aripiprazole orally disintegrating tab 15 mg</i>	
ANASPAZ TAB 0.125MG	233	.....	107
<i>anastrozole tab 1 mg</i>	88	<i>aripiprazole oral solution 1 mg/ml</i>	107
ANCOBON CAP 250MG.....	69	<i>aripiprazole tab 10 mg</i>	107
ANCOBON CAP 500MG	69	<i>aripiprazole tab 15 mg</i>	107
ANDRODERM DIS 2MG/24HR	33	<i>aripiprazole tab 20 mg</i>	107
ANDRODERM DIS 4MG/24HR	33	<i>aripiprazole tab 2 mg</i>	107
ANGELIQ TAB 0.25-0.5	167	<i>aripiprazole tab 30 mg</i>	107
ANGELIQ TAB 0.5-1MG	167	<i>aripiprazole tab 5 mg</i>	107
ANNOVERA MIS.....	132	ARISTADA INJ 1064MG.....	107
ANORO ELLIPT AER 62.5-25.....	44	ARISTADA INJ 441MG/1.....	107
ANTARA CAP 30MG.....	71	ARISTADA INJ 662MG/2.....	107
ANTARA CAP 90MG	71	ARISTADA INJ 882MG/3.....	107
ANUSOL-HC CRE 2.5%.....	34	ARISTADA INJ INITIO	107
ANZEMET TAB 100MG	67	ARIXTRA INJ 10/0.8ML.....	46
ANZEMET TAB 50MG.....	67	ARIXTRA INJ 2.5/0.5.....	46
APLICARE ALC PAD SWABSTIC	201	ARIXTRA INJ 5/0.4ML	46
<i>apraclonidine hcl ophth soln 0.5% (base</i>		ARIXTRA INJ 7.5/0.6.....	46
<i>equivalent)</i>	215	<i>armodafinil tab 150 mg</i>	6
<i>aprepitant capsule 125 mg</i>	68	<i>armodafinil tab 200 mg</i>	6
<i>aprepitant capsule 40 mg</i>	68	<i>armodafinil tab 250 mg</i>	6
<i>aprepitant capsule 80 mg</i>	68	<i>armodafinil tab 50 mg</i>	6
<i>aprepitant capsule therapy pack 80 & 125</i>		ARMOUR THYRO TAB 120MG.....	232
<i>mg</i>	68	ARMOUR THYRO TAB 15MG.....	232
APRISO CAP 0.375GM	171	ARMOUR THYRO TAB 180MG	232
APTIOM TAB 200MG	49	ARMOUR THYRO TAB 240MG.....	232
APTIOM TAB 400MG	49	ARMOUR THYRO TAB 300MG.....	232
APTIOM TAB 600MG	49	ARMOUR THYRO TAB 30MG	232
APTIOM TAB 800MG	49	ARMOUR THYRO TAB 60MG	232
AQUALANCE MIS 30G.....	183	ARMOUR THYRO TAB 90MG	232
ARAVA TAB 10MG	21	ARNICA TIN FLOWER.....	150
ARAVA TAB 20MG.....	21	ARNUIITY ELPT INH 100MCG	43
ARAZLO LOT 0.045%	136	ARNUIITY ELPT INH 200MCG.....	43
ARCALYST INJ 220MG.....	18	ARNUIITY ELPT INH 50MCG	42

AROMASIN TAB 25MG	88	<i>atazanavir sulfate cap 300 mg (base equiv)</i>	
ARTISS SOL 10ML.....	178	.....	108
ARTISS SOL 2ML	178	ATELVIA TAB	160
ARTISS SOL 4ML	178	<i>atenolol & chlorthalidone tab 100-25 mg..</i>	79
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	104	<i>atenolol & chlorthalidone tab 50-25 mg ...</i>	79
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	103	<i>atenolol tab 100 mg</i>	118
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	103	<i>atenolol tab 25 mg</i>	118
.....	103	<i>atenolol tab 50 mg</i>	118
<i>aspirin chew tab 81 mg</i>	23	<i>atomoxetine hcl cap 100 mg (base equiv) ..</i>	5
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	176	<i>atomoxetine hcl cap 10 mg (base equiv)</i>	5
.....	176	<i>atomoxetine hcl cap 18 mg (base equiv).....</i>	5
<i>aspirin tab delayed release 81 mg</i>	23	<i>atomoxetine hcl cap 25 mg (base equiv)</i>	5
ASSURE 3 LIQ CONTROL	183	<i>atomoxetine hcl cap 40 mg (base equiv)....</i>	5
ASSURE 4 LIQ LEVEL1/2	183	<i>atomoxetine hcl cap 60 mg (base equiv)....</i>	5
ASSURE CMFRT MIS 28G.....	183	<i>atomoxetine hcl cap 80 mg (base equiv)....</i>	5
ASSURE DOSE SOL NORM/HGH	183	<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	72
ASSURE DOSE SOL NORMAL.....	183	<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	72
ASSURE II LIQ LEVEL 1	183	<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	72
ASSURE II LIQ LEVEL1/2	183	<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	72
ASSURE LANCE MIS 21G	183	<i>atovaquone-proguanil hcl tab 250-100 mg</i>	83
ASSURE LANCE MIS 28G	183	.....	83
ASSURE LANCE MIS LOW FLOW.....	184	<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	83
ASSURE LANCE MIS MICRO.....	184	.....	83
ASSURE LANCE MIS SAFE 25G.....	184	<i>atovaquone susp 750 mg/5ml</i>	36
ASSURE LANCE MIS SAFE 30G.....	184	ATRALIN GEL 0.05%	136
ASSURE PLUS MIS HIGH 18G	184	ATROPINE SUL SOL 1% OP	215
ASSURE PLUS MIS LOW 25G	184	ATROVENT HFA AER 17MCG	42
ASSURE PLUS MIS MCRO 28G.....	184	AUGMENTIN SUS 125/5ML	221
ASSURE PLUS MIS NORM 21G	184	AUGMENTIN SUS 250/5ML	221
ASSURE PLUS MIS PEDIATRI	184	AUGMENTIN SUS ES-600	221
ASSURE PRISM SOL LEVEL1/2.....	184	AUGMENTIN TAB 500MG.....	221
ASSURE PRISM TES MULTI.....	152	AURORA LANCE MIS 30G.....	184
ASSURE PRO LIQ LEVEL1/2	184	AURORA LANCE MIS THIN 23G.....	184
ASTAGRAF XL CAP 0.5MG	208	AURYXIA TAB 210MG.....	173
ASTAGRAF XL CAP 1MG.....	208	AUSTEDO TAB 12MG.....	224
ASTAGRAF XL CAP 5MG.....	208	AUSTEDO TAB 6MG	224
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	108	AUSTEDO TAB 9MG	224
.....	108	AUSTEDO XR TAB 12MG.....	224
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	108	AUSTEDO XR TAB 24MG.....	225
.....	108		

AUSTEDO XR TAB 6MG	224	AZILECT TAB 0.5MG	101
AUSTEDO XR TAB TITR KIT	225	AZILECT TAB 1MG.....	101
AUTO LANCET MIS	184	<i>azithromycin for susp 100 mg/5ml</i>	181
AUTO-LANCET MIS.....	184	<i>azithromycin for susp 200 mg/5ml.....</i>	181
AUTO-LANCET MIS MINI	184	<i>azithromycin powd pack for susp 1 gm</i>	181
AUTOLET II KIT CLINISAF	184	<i>azithromycin tab 250 mg</i>	181
AUTOLET IMPR MIS LANC DEV	184	<i>azithromycin tab 500 mg</i>	181
AUTOLET LANC MIS DEVICE.....	184	<i>azithromycin tab 600 mg</i>	181
AUTOLET LITE KIT.....	184	AZOPT SUS 1% OP	218
AUTOLET LITE KIT CLINISAF.....	184	AZSTARYS CAP 26.1-5.2	6
AUTOLET LITE KIT STARTER.....	184	AZSTARYS CAP 39.2-7.8	6
AUTOLET MINI MIS.....	184	AZSTARYS CAP 52.3-10.....	6
AUTOLET PLAT MIS 1.8MM	184	AZULFIDINE TAB 500MG.....	171
AUTOLET PLAT MIS 2.4MM.....	184	AZULFIDINE TAB 500MG EN.....	171
AUTOLET PLAT MIS 3.0MM	184	B	
AUTOLET PLUS MIS.....	184	<i>bacitracin ophth oint 500 unit/gm</i>	216
AUTOLET PLUS MIS LANC DEV	184	<i>bacitracin-polymyxin b ophth oint</i>	216
AUVI-Q INJ 0.15MG	238	<i>bacitracin-polymyxin-neomycin-hc ophth</i>	
AUVI-Q INJ 0.1MG	238	<i>oint 1%</i>	217
AUVI-Q INJ 0.3MG.....	238	<i>baclofen tab 10 mg</i>	212
AVALIDE TAB 150-12.5	79	<i>baclofen tab 20 mg.....</i>	212
AVALIDE TAB 300-12.5	79	<i>baclofen tab 5 mg.....</i>	212
AVANDIA TAB 2MG	65	BACTRIM DS TAB 800-160	36
AVANDIA TAB 4MG.....	65	BACTRIM TAB 400-80MG.....	36
AVAPRO TAB 150MG.....	76	<i>balsalazide disodium cap 750 mg.....</i>	171
AVAPRO TAB 300MG.....	76	BALVERSA TAB 3MG	90
AVAPRO TAB 75MG	76	BALVERSA TAB 4MG	90
AVODART CAP 0.5MG	174	BALVERSA TAB 5MG	90
AVONEX PEN KIT 30MCG	225	BANZEL TAB 200MG.....	49
AVONEX PREFL KIT 30MCG	225	BANZEL TAB 400MG	49
AYGESTIN TAB 5MG	221	BAQSIMI ONE POW 3MG/DOSE	63
<i>azacitidine for inj 100 mg</i>	85	BAQSIMI TWO POW 3MG/DOSE	63
<i>azathioprine tab 100 mg</i>	208	BARACLUDGE SOL	115
<i>azathioprine tab 50 mg</i>	208	BASAGLAR INJ 100UNIT	64
<i>azathioprine tab 75 mg</i>	208	BAXDELA TAB 450MG	169
<i>azelaic acid gel 15%.....</i>	151	BD LANCET UF MIS 30G	184
<i>azelastine hcl-fluticasone prop nasal spray</i>		BD LANCET UF MIS 33G.....	184
<i>137-50 mcg/act.....</i>	213	BD MICROTAIN MIS LANCETS.....	184
<i>azelastine hcl nasal spray 0.1% (137</i>		BD SWAB BFLY PAD SNGL USE.....	201
<i>mcg/spray)</i>	213	BD U-500 MIS 31GX6MM	202
<i>azelastine hcl nasal spray 0.15% (205.5</i>		BD ULTRAFINE INSULIN	
<i>mcg/spray)</i>	213	SYRINGES/NEEDLES.....	202
<i>azelastine hcl ophth soln 0.05%.....</i>	218	BD ULTRAFINE PEN NEEDLES.....	202

BELBUCA MIS 150MCG.....	32	<i>benztropine mesylate tab 2 mg</i>	98
BELBUCA MIS 300MCG.....	32	BESIVANCE SUS 0.6%.....	216
BELBUCA MIS 450MCG.....	32	BETADINE SOL 5% OP	216
BELBUCA MIS 600MCG.....	32	<i>betamethasone dipropionate augmented</i>	
BELBUCA MIS 750MCG.....	32	<i>cream 0.05%</i>	145
BELBUCA MIS 75MCG.....	32	<i>betamethasone dipropionate augmented</i>	
BELBUCA MIS 900MCG.....	32	<i>gel 0.05%</i>	145
BELLA/OPIUM SUP 16.2-30	233	<i>betamethasone dipropionate augmented</i>	
BELLA/OPIUM SUP 16.2-60	233	<i>lotion 0.05%</i>	145
BELSOMRA TAB 10MG.....	180	<i>betamethasone dipropionate augmented</i>	
BELSOMRA TAB 15MG.....	180	<i>oint 0.05%</i>	145
BELSOMRA TAB 20MG	180	<i>betamethasone dipropionate cream 0.05%</i>	
BELSOMRA TAB 5MG.....	180	.....	145
<i>benazepril & hydrochlorothiazide tab 10-</i>		<i>betamethasone dipropionate lotion 0.05%</i>	
<i>12.5 mg</i>	79	.....	145
<i>benazepril & hydrochlorothiazide tab 20-</i>		<i>betamethasone valerate aerosol foam</i>	
<i>12.5 mg</i>	79	<i>0.12%</i>	145
<i>benazepril & hydrochlorothiazide tab 20-25</i>		<i>betamethasone valerate cream 0.1% (base</i>	
<i>mg</i>	79	<i>equivalent)</i>	145
<i>benazepril & hydrochlorothiazide tab 5-</i>		<i>betamethasone valerate lotion 0.1% (base</i>	
<i>6.25 mg</i>	79	<i>equivalent)</i>	146
<i>benazepril hcl tab 10 mg</i>	75	<i>betamethasone valerate oint 0.1% (base</i>	
<i>benazepril hcl tab 20 mg</i>	75	<i>equivalent)</i>	146
<i>benazepril hcl tab 40 mg</i>	75	BETASERON INJ 0.3MG	225
<i>benazepril hcl tab 5 mg</i>	75	<i>betaxolol hcl ophth soln 0.5%</i>	214
BENLYSTA INJ 200MG/ML	210	<i>betaxolol hcl tab 10 mg</i>	118
BENZALKONIUM SOL NF	107	<i>betaxolol hcl tab 20 mg</i>	118
BENZAMYCIN GEL 5-3%.....	136	<i>bethanechol chloride tab 10 mg</i>	237
BENZNIDAZOLE TAB 100MG	35	<i>bethanechol chloride tab 25 mg</i>	237
BENZNIDAZOLE TAB 12.5MG.....	35	<i>bethanechol chloride tab 50 mg</i>	237
<i>benzonatate cap 100 mg</i>	135	<i>bethanechol chloride tab 5 mg</i>	237
<i>benzonatate cap 150 mg</i>	135	BETHKIS NEB 300/4ML	10
<i>benzonatate cap 200 mg</i>	135	BETOPTIC-S SUS 0.25% OP	214
<i>benzoyl peroxide-erythromycin gel 5-3%</i>		<i>bexarotene cap 75 mg</i>	97
.....	136	<i>bicalutamide tab 50 mg</i>	88
<i>benzoyl peroxide foam 9.8%</i>	136	BIDIL TAB.....	123
<i>benzoyl peroxide-hydrocortisone lotion 5-</i>		BIJUVA CAP 1-100MG.....	167
<i>0.5%</i>	136	BIKTARVY TAB	108
<i>benzoyl peroxide liq 7%</i>	136	BILTRICIDE TAB 600MG.....	35
<i>benzphetamine hcl tab 25 mg</i>	4	<i>bimatoprost ophth soln 0.03%</i>	219
<i>benzphetamine hcl tab 50 mg</i>	4	BINOSTO TAB 70MG	160
<i>benztropine mesylate tab 0.5 mg</i>	98	BIO-STATIN CAP 1000000	69
<i>benztropine mesylate tab 1 mg</i>	98	BIO-STATIN CAP 500000	69

<i>bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit</i>	180	BRIVIACT TAB 50MG	49
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	235	BRIVIACT TAB 75MG	49
<i>bisoprolol & hydrochlorothiazide tab 10-6.25 mg</i>	79	<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	218
<i>bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg</i>	79	<i>bromocriptine mesylate cap 5 mg (base equivalent)</i>	98
<i>bisoprolol & hydrochlorothiazide tab 5-6.25 mg</i>	79	<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i>	98
<i>bisoprolol fumarate tab 10 mg</i>	118	BROVANA NEB 15MCG	44
<i>bisoprolol fumarate tab 5 mg</i>	118	BRUKINSA CAP 80MG	91
BLEPH-10 SOL 10% OP	216	BRYHALI LOT 0.01%	146
BLEPHAMIDE OIN S.O.P.	217	<i>budesonide delayed release particles cap 3 mg</i>	133
BLEPHAMIDE SUS OP	217	<i>budesonide inhalation susp 0.25 mg/2ml</i>	43
BONIVA TAB 150MG	160	<i>budesonide inhalation susp 0.5 mg/2ml</i>	43
BONJESTA TAB 20-20MG	68	<i>budesonide inhalation susp 1 mg/2ml</i>	43
<i>bosentan tab 125 mg</i>	127	<i>bumetanide tab 0.5 mg</i>	159
<i>bosentan tab 62.5 mg</i>	127	<i>bumetanide tab 1 mg</i>	159
BOSULIF TAB 100MG	91	<i>bumetanide tab 2 mg</i>	159
BOSULIF TAB 400MG	91	BUMEX TAB 0.5MG	159
BOSULIF TAB 500MG	91	BUNAVAIL MIS 4.2-0.7	32
BRAFTOVI CAP 75MG	91	BUNAVAIL MIS 6.3-1MG	32
BREATHE EASE MIS LG MASK	202	<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	33
BREATHE EASE MIS MED MASK	202	<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	32
BREATHE EASE MIS SM MASK	202	<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	32
BREO ELLIPTA INH 100-25	44	<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	33
BREO ELLIPTA INH 200-25	44	<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	33
BREO ELLIPTA INH 50-25MCG	44	<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	33
BREXAFEMME TAB 150MG	68	<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	32
BREZTRI AERO AER SPHERE	44	<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	32
BRILINTA TAB 60MG	176	<i>buprenorphine td patch weekly 10 mcg/hr</i>	33
BRILINTA TAB 90MG	176	<i>buprenorphine td patch weekly 15 mcg/hr</i>	33
<i>brimonidine tartrate ophth soln 0.15%</i>	216		
<i>brimonidine tartrate ophth soln 0.2%</i>	216		
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	214		
<i>brinzolamide ophth susp 1%</i>	218		
BRISDELLE CAP 7.5MG	229		
BRIVIACT SOL 10MG/ML	49		
BRIVIACT TAB 100MG	49		
BRIVIACT TAB 10MG	49		
BRIVIACT TAB 25MG	49		

<i>buprenorphine td patch weekly 20 mcg/hr</i>.....33	CADUET TAB 10-80MG .....124
<i>buprenorphine td patch weekly 5 mcg/hr</i> 33	CADUET TAB 5-10MG .....123
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>.....33	CADUET TAB 5-20MG .....123
<i>bupropion hcl (smoking deterrent) tab er</i> <i>12hr 150 mg</i> .....228	CADUET TAB 5-40MG .....123
<i>bupropion hcl tab 100 mg</i> .....57	CADUET TAB 5-80MG .....123
<i>bupropion hcl tab 75 mg</i> .....56	<i>caffeine citrate oral soln 60 mg/3ml (10</i> <i>mg/ml base equiv)</i> .....3
<i>bupropion hcl tab er 12hr 100 mg</i> .....57	CALAN SR TAB 120MG .....120
<i>bupropion hcl tab er 12hr 150 mg</i> .....57	CALAN SR TAB 180MG .....120
<i>bupropion hcl tab er 12hr 200 mg</i> .....57	CALAN SR TAB 240MG .....120
<i>bupropion hcl tab er 24hr 150 mg</i> .....57	<i>calcipotriene oint 0.005%</i> .....140
<i>bupropion hcl tab er 24hr 300 mg</i> .....57	<i>calcipotriene soln 0.005% (50 mcg/ml)</i> .140
<i>bupirone hcl tab 10 mg</i> .....39	<i>calcitonin (salmon) nasal soln 200 unit/act</i>.....160
<i>bupirone hcl tab 15 mg</i> .....39	<i>calcitriol cap 0.25 mcg</i> .....163
<i>bupirone hcl tab 30 mg</i> .....39	<i>calcitriol cap 0.5 mcg</i> .....163
<i>bupirone hcl tab 5 mg</i> .....39	<i>calcitriol oral soln 1 mcg/ml</i> .....163
<i>bupirone hcl tab 7.5 mg</i> .....39	<i>calcium acetate (phosphate binder) cap</i> <i>667 mg (169 mg ca)</i> .....173
<i>butalbital-acetaminophen-caffeine tab 50-</i> <i>325-40 mg</i> .....22	CALQUENCE CAP 100MG .....91
<i>butalbital-acetaminophen-caff w/ cod cap</i> <i>50-300-40-30 mg</i> .....31	CALQUENCE TAB 100MG .....91
<i>butalbital-acetaminophen-caff w/ cod cap</i> <i>50-325-40-30 mg</i> .....31	CAMINO PRO LIQ 15PE .....152
<i>butalbital-acetaminophen tab 50-325 mg</i> 22	CAMZYOS CAP 10MG .....123
<i>butalbital-aspirin-caffeine cap 50-325-40</i> <i>mg</i> .....22	CAMZYOS CAP 15MG .....123
<i>butalbital-aspirin-caff w/ codeine cap 50-</i> <i>325-40-30 mg</i> .....31	CAMZYOS CAP 2.5MG .....122
<i>butorphanol tartrate nasal soln 10 mg/ml</i> 33	CAMZYOS CAP 5MG .....123
BYSTOLIC TAB 10MG .....118	CANASA SUP 1000MG .....171
BYSTOLIC TAB 2.5MG .....118	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 16-12.5 mg</i> .....79
BYSTOLIC TAB 20MG .....118	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 32-12.5 mg</i> .....79
BYSTOLIC TAB 5MG .....118	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 32-25 mg</i> .....79
C	<i>candesartan cilexetil tab 16 mg</i> .....76
<i>cabergoline tab 0.5 mg</i> .....166	<i>candesartan cilexetil tab 32 mg</i> .....76
CABOMETRYX TAB 20MG .....91	<i>candesartan cilexetil tab 4 mg</i> .....76
CABOMETRYX TAB 40MG .....91	<i>candesartan cilexetil tab 8 mg</i> .....76
CABOMETRYX TAB 60MG .....91	<i>capecitabine tab 150 mg</i> .....85
CADUET TAB 10-10MG .....123	<i>capecitabine tab 500 mg</i> .....85
CADUET TAB 10-20MG .....123	CAPEX SHA 0.01% .....146
CADUET TAB 10-40MG .....124	CAPRELSA TAB 100MG .....91
	CAPRELSA TAB 300MG .....91

<i>captopril & hydrochlorothiazide tab 25-15 mg</i>	79	<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	99
<i>captopril & hydrochlorothiazide tab 25-25 mg</i>	79	<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	99
<i>captopril & hydrochlorothiazide tab 50-15 mg</i>	80	<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	99
<i>captopril & hydrochlorothiazide tab 50-25 mg</i>	80	<i>carbidopa tab 25 mg</i>	97
<i>captopril tab 100 mg</i>	75	<i>carbinoxamine maleate soln 4 mg/5ml</i>	70
<i>captopril tab 12.5 mg</i>	75	<i>carbinoxamine maleate tab 4 mg</i>	70
<i>captopril tab 25 mg</i>	75	CARDIOCOM MIS LANCING	184
<i>captopril tab 50 mg</i>	75	CARDURA TAB 1MG	77
CARBAGLU TAB 200MG	163	CARDURA TAB 2MG	77
<i>carbamazepine cap er 12hr 100 mg</i>	49	CARDURA TAB 4MG	77
<i>carbamazepine cap er 12hr 200 mg</i>	49	CARDURA TAB 8MG	77
<i>carbamazepine cap er 12hr 300 mg</i>	49	CARDURA XL TAB 4MG	174
<i>carbamazepine chew tab 100 mg</i>	49	CARDURA XL TAB 8MG	174
<i>carbamazepine susp 100 mg/5ml</i>	49	CAREONE ADV MIS LANCING	184
<i>carbamazepine tab 200 mg</i>	49	CAREONE LANC MIS 30G	184
<i>carbamazepine tab er 12hr 100 mg</i>	49	CAREONE LANC MIS THIN 23G	184
<i>carbamazepine tab er 12hr 200 mg</i>	49	CARESENS 30G MIS LANCETS	185
<i>carbamazepine tab er 12hr 400 mg</i>	49	CARESENS SOL CONTROL	185
CARBATROL CAP 100MG	49	CARETOUCH MIS EJECTOR	185
CARBATROL CAP 200MG	49	CARETOUCH MIS LANC 26G	185
CARBATROL CAP 300MG	49	CARETOUCH MIS LANC 28G	185
<i>carbidopa & levodopa orally disintegrating tab 10-100 mg</i>	98	CARETOUCH MIS LANC 30G	185
<i>carbidopa & levodopa orally disintegrating tab 25-100 mg</i>	98	CARETOUCH MIS TWIST 28	185
<i>carbidopa & levodopa orally disintegrating tab 25-250 mg</i>	98	CARETOUCH MIS TWIST 30	185
<i>carbidopa & levodopa tab 10-100 mg</i>	98	CARETOUCH MIS TWIST 33	185
<i>carbidopa & levodopa tab 25-100 mg</i>	98	CARETOUCH PAD ALCOHOL	201
<i>carbidopa & levodopa tab 25-250 mg</i>	98	<i>carglumic acid soluble tab 200 mg</i>	163
<i>carbidopa & levodopa tab er 25-100 mg</i> ..	98	<i>carisoprodol tab 350 mg</i>	212
<i>carbidopa & levodopa tab er 50-200 mg</i> .	98	<i>carisoprodol w/ aspirin & codeine tab 200-325-16 mg</i>	213
<i>carbidopa-levodopa-entacapone tabs 12.5-50-200 mg</i>	98	<i>carteolol hcl ophth soln 1%</i>	214
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	98	<i>carvedilol phosphate cap er 24hr 10 mg</i> ..	117
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	99	<i>carvedilol phosphate cap er 24hr 20 mg</i> .	117
		<i>carvedilol phosphate cap er 24hr 40 mg</i> .	117
		<i>carvedilol phosphate cap er 24hr 80 mg</i> .	117
		<i>carvedilol tab 12.5 mg</i>	117
		<i>carvedilol tab 25 mg</i>	117
		<i>carvedilol tab 3.125 mg</i>	117
		<i>carvedilol tab 6.25 mg</i>	117
		CASCARA EXT SAGRADA	181

CASODEX TAB 50MG	88	CELEXA TAB 40MG	57
CATAPRES-TTS DIS 0.1/24HR	77	CELLCEPT CAP 250MG.....	208
CATAPRES-TTS DIS 0.2/24HR	77	CELLCEPT IV INJ 500MG.....	208
CATAPRES-TTS DIS 0.3/24HR	77	CELLCEPT SUS 200MG/ML.....	208
CAVERJECT IM KIT 10MCG	124	CELLCEPT TAB 500MG.....	208
CAVERJECT INJ 40MCG.....	124	CELONTIN CAP 300MG.....	55
CAVERJECT KIT 20MCG	124	CENTANY OIN 2%.....	138
CAYA DPR	182	<i>cephalexin cap 250 mg</i>	129
CAYSTON INH 75MG	37	<i>cephalexin cap 500 mg</i>	129
<i>cefaclor cap 250 mg</i>	129	<i>cephalexin cap 750 mg</i>	129
<i>cefaclor cap 500 mg</i>	129	<i>cephalexin for susp 125 mg/5ml</i>	129
CEFACTOR ER TAB 500MG	129	<i>cephalexin for susp 250 mg/5ml</i>	129
<i>cefaclor for susp 125 mg/5ml</i>	129	<i>cephalexin tab 250 mg</i>	129
<i>cefaclor for susp 250 mg/5ml</i>	129	<i>cephalexin tab 500 mg</i>	129
<i>cefaclor for susp 375 mg/5ml</i>	129	CEQUR SIMPL KIT PATCH 2U.....	202
<i>cefadroxil cap 500 mg</i>	128	CERDELGA CAP 84MG.....	176
<i>cefadroxil for susp 250 mg/5ml</i>	128	CERVIDIL VAG MIS 10MG INS.....	220
<i>cefadroxil for susp 500 mg/5ml</i>	128	CETRAXAL SOL 0.2%	219
<i>cefadroxil tab 1 gm</i>	129	CETROTIDE KIT 0.25MG	162
<i>cefdinir cap 300 mg</i>	129	<i>cevimeline hcl cap 30 mg</i>	211
<i>cefdinir for susp 125 mg/5ml</i>	129	CHANTIX PAK 1MG.....	228
<i>cefdinir for susp 250 mg/5ml</i>	129	CHANTIX TAB 0.5& 1MG	228
<i>cefixime cap 400 mg</i>	129	CHANTIX TAB 0.5MG.....	228
<i>cefixime for susp 100 mg/5ml</i>	129	CHANTIX TAB 1MG.....	228
<i>cefixime for susp 200 mg/5ml</i>	129	CHEMET CAP 100MG.....	67
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	129	CHEMSTRIP K TES	152
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	129	CHEMSTRIP TES UGK.....	152
<i>cefpodoxime proxetil tab 100 mg</i>	129	CHENODAL TAB 250MG.....	170
<i>cefpodoxime proxetil tab 200 mg</i>	129	<i>chlordiazepoxide-amitriptyline tab 10-25</i> <i>mg</i>	224
<i>cefprozil for susp 125 mg/5ml</i>	129	<i>chlordiazepoxide-amitriptyline tab 5-12.5</i> <i>mg</i>	224
<i>cefprozil for susp 250 mg/5ml</i>	129	<i>chlordiazepoxide hcl cap 10 mg</i>	39
<i>cefprozil tab 250 mg</i>	129	<i>chlordiazepoxide hcl cap 25 mg</i>	39
<i>cefprozil tab 500 mg</i>	129	<i>chlordiazepoxide hcl cap 5 mg</i>	39
<i>cefuroxime axetil tab 250 mg</i>	129	<i>chlordiazepoxide hcl-clidinium bromide</i> <i>cap 5-2.5 mg</i>	233
<i>cefuroxime axetil tab 500 mg</i>	129	CHLORHEX GLU SOL 20%.....	107
<i>celecoxib cap 100 mg</i>	19	<i>chlorhexidine gluconate soln 0.12%</i>	211
<i>celecoxib cap 200 mg</i>	19	<i>chloroquine phosphate tab 250 mg</i>	83
<i>celecoxib cap 400 mg</i>	19	<i>chloroquine phosphate tab 500 mg</i>	83
<i>celecoxib cap 50 mg</i>	18	<i>chlorpromazine hcl inj 25 mg/ml</i>	105
CELEXA TAB 10MG	57	<i>chlorpromazine hcl inj 50 mg/2ml</i>	106
CELEXA TAB 20MG	57		

<i>chlorpromazine hcl tab 100 mg</i>	106	<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	
<i>chlorpromazine hcl tab 200 mg</i>	106	.....	169
<i>chlorpromazine hcl tab 25 mg</i>	106	<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	
<i>chlorpromazine hcl tab 50 mg</i>	106	.....	169
<i>chlorthalidone tab 25 mg</i>	160	<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	
<i>chlorthalidone tab 50 mg</i>	160	.....	169
<i>chlorzoxazone tab 500 mg</i>	212	<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	
CHOLBAM CAP 250MG	170	.....	169
CHOLBAM CAP 50MG	170	CIPRO TAB 250MG	169
<i>cholestyramine light powder 4 gm/dose</i> ..	71	CIPRO TAB 500MG	169
<i>cholestyramine light powder packets 4 gm</i>		<i>citalopram hydrobromide oral soln 10</i>	
.....	71	<i>mg/5ml</i>	57
<i>cholestyramine powder 4 gm/dose</i>	71	<i>citalopram hydrobromide tab 10 mg (base</i>	
<i>cholestyramine powder packets 4 gm</i>	71	<i>equiv)</i>	57
<i>choline fenofibrate cap dr 135 mg</i>		<i>citalopram hydrobromide tab 20 mg (base</i>	
<i>(fenofibric acid equiv)</i>	72	<i>equiv)</i>	57
<i>choline fenofibrate cap dr 45 mg (fenofibric</i>		<i>citalopram hydrobromide tab 40 mg (base</i>	
<i>acid equiv)</i>	72	<i>equiv)</i>	58
<i>ciclopirox gel 0.77%</i>	138	CITRANATAL CAP HARMONY	211
<i>ciclopirox olamine cream 0.77% (base</i>		CITRANATAL CAP MEDLEY	211
<i>equiv)</i>	138	CITRANATAL MIS.....	211
<i>ciclopirox olamine susp 0.77% (base equiv)</i>		CITRANATAL MIS 90 DHA.....	211
.....	138	CITRANATAL MIS B-CALM.....	211
<i>ciclopirox shampoo 1%</i>	138	CITRANATAL PAK ASSURE	211
<i>ciclopirox solution 8%</i>	138	CITRANATAL PAK DHA.....	211
<i>cilostazol tab 100 mg</i>	176	CITRANATAL TAB BLOOM	211
<i>cilostazol tab 50 mg</i>	176	CITRANATAL TAB RX	211
CIMDUO TAB 300-300.....	108	CLARINEX-D TAB 2.5-120	135
<i>cimetidine hcl soln 300 mg/5ml</i>	234	CLARINEX TAB 5MG	70
<i>cimetidine tab 300 mg</i>	234	<i>clarithromycin for susp 125 mg/5ml</i>	181
<i>cimetidine tab 400 mg</i>	234	<i>clarithromycin for susp 250 mg/5ml</i>	181
<i>cimetidine tab 800 mg</i>	234	<i>clarithromycin tab 250 mg</i>	181
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	163	<i>clarithromycin tab 500 mg</i>	181
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	163	<i>clarithromycin tab er 24hr 500 mg</i>	181
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	163	CLEANLET 28G MIS LANCETS.....	185
CIPRO (10%) SUS 500MG/5	169	<i>clemastine fumarate tab 2.68 mg</i>	70
CIPRO (5%) SUS 250MG/5	169	CLENPIQ SOL.....	180
<i>ciprofloxacin-dexamethasone otic susp</i>		CLEOCIN CAP 150MG	36
<i>0.3-0.1%</i>	219	CLEOCIN CAP 300MG	36
<i>ciprofloxacin hcl ophth soln 0.3% (base</i>		CLEOCIN CAP 75MG.....	36
<i>equivalent)</i>	216	CLEOCIN CRE 2% VAG	237
<i>ciprofloxacin hcl otic soln 0.2% (base</i>		CLEOCIN PED SOL 75MG/5ML	36
<i>equivalent)</i>	219	CLEOCIN SUP 100MG	237

CLEOCIN-T LOT 1%.....	136	<i>clobetasol propionate oint 0.05%</i>	146
CLEVER CHECK MIS	185	<i>clobetasol propionate shampoo 0.05%</i> ..	146
CLEVER CHECK MIS 30G.....	185	<i>clobetasol propionate soln 0.05%</i>	146
CLEVR CHOICE LIQ HIGH	185	CLOBEX LOT 0.05%	146
CLEVR CHOICE LIQ LOW	185	CLOBEX SHA 0.05%.....	146
CLIMARA DIS 0.025MG.....	168	CLODERM CRE 0.1%.....	146
CLIMARA DIS 0.0375MG	168	<i>clomiphene citrate tab 50 mg</i>	161
CLIMARA DIS 0.05MG.....	168	<i>clomipramine hcl cap 25 mg</i>	60
CLIMARA DIS 0.06MG.....	168	<i>clomipramine hcl cap 50 mg</i>	60
CLIMARA DIS 0.075MG.....	168	<i>clomipramine hcl cap 75 mg</i>	60
CLIMARA DIS 0.1MG.....	168	<i>clonazepam orally disintegrating tab 0.125</i>	
CLIMARA PRO DIS WEEKLY	167	<i>mg</i>	48
CLINDAGEL GEL 1%.....	136	<i>clonazepam orally disintegrating tab 0.25</i>	
<i>clindamycin hcl cap 150 mg</i>	36	<i>mg</i>	48
<i>clindamycin hcl cap 300 mg</i>	37	<i>clonazepam orally disintegrating tab 0.5 mg</i>	
<i>clindamycin hcl cap 75 mg</i>	36	.....	48
<i>clindamycin palmitate hcl for soln 75</i>		<i>clonazepam orally disintegrating tab 1 mg</i>	
<i>mg/5ml (base equiv)</i>	37	.....	48
<i>clindamycin phosphate-benzoyl peroxide</i>		<i>clonazepam orally disintegrating tab 2 mg</i>	
<i>gel 1.2-2.5%</i>	137	.....	48
<i>clindamycin phosphate-benzoyl peroxide</i>		<i>clonazepam tab 0.5 mg</i>	48
<i>gel 1-5%</i>	137	<i>clonazepam tab 1 mg</i>	48
<i>clindamycin phosphate foam 1%</i>	136	<i>clonazepam tab 2 mg</i>	48
<i>clindamycin phosphate gel 1%</i>	136	<i>clonidine hcl tab 0.1 mg</i>	77
<i>clindamycin phosphate lotion 1%</i>	136	<i>clonidine hcl tab 0.2 mg</i>	77
<i>clindamycin phosphate soln 1%</i>	136	<i>clonidine hcl tab 0.3 mg</i>	77
<i>clindamycin phosphate swab 1%</i>	137	<i>clonidine hcl tab er 12hr 0.1 mg</i>	5
<i>clindamycin phosphate-tretinoin gel 1.2-</i>		<i>clonidine td patch weekly 0.1 mg/24hr</i>	77
<i>0.025%</i>	137	<i>clonidine td patch weekly 0.2 mg/24hr</i>	77
<i>clindamycin phosphate vaginal cream 2%</i>		<i>clonidine td patch weekly 0.3 mg/24hr</i>	77
.....	237	<i>clopidogrel bisulfate tab 300 mg (base</i>	
<i>clindamycin phosph-benzoyl peroxide</i>		<i>equiv)</i>	176
<i>(refrig) gel 1.2 (1)-5%</i>	136	<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	
CLINDESSE CRE 2%	237	.....	176
<i>clobazam suspension 2.5 mg/ml</i>	48	<i>clorazepate dipotassium tab 15 mg</i>	40
<i>clobazam tab 10 mg</i>	48	<i>clorazepate dipotassium tab 3.75 mg</i>	40
<i>clobazam tab 20 mg</i>	48	<i>clorazepate dipotassium tab 7.5 mg</i>	40
<i>clobetasol propionate cream 0.05%</i>	146	<i>clotrimazole troche 10 mg</i>	210
<i>clobetasol propionate emollient base cream</i>		<i>clotrimazole w/ betamethasone cream 1-</i>	
<i>0.05%</i>	146	<i>0.05%</i>	139
<i>clobetasol propionate foam 0.05%</i>	146	<i>clotrimazole w/ betamethasone lotion 1-</i>	
<i>clobetasol propionate gel 0.05%</i>	146	<i>0.05%</i>	139
<i>clobetasol propionate lotion 0.05%</i>	146		

<i>clozapine orally disintegrating tab 100 mg</i>.....104	COMETRIQ KIT 60MG.....91
<i>clozapine orally disintegrating tab 12.5 mg</i>.....104	COMFORT ASSU MIS LANC 28G .....185
<i>clozapine orally disintegrating tab 150 mg</i>.....104	COMFORT ASSU MIS LANC 33G .....185
<i>clozapine orally disintegrating tab 200 mg</i>.....104	COMFORT EZ MIS 21G.....185
<i>clozapine orally disintegrating tab 25 mg</i>.....104	COMFORT EZ MIS 23G .....185
<i>clozapine tab 100 mg</i>.....104	COMFORT EZ MIS 28G .....185
<i>clozapine tab 200 mg</i>.....104	COMFORT MIS LANCETS .....185
<i>clozapine tab 25 mg</i>.....104	COMFORTOUCH MIS LANCET.....185
<i>clozapine tab 50 mg</i>.....104	COMFORT TCH MIS LANC 28G .....185
CLOZARIL TAB 100MG.....104	COMFORT TCH MIS LANC 31G.....185
CLOZARIL TAB 200MG .....104	COMPACT SPAC MIS CHAMBER.....202
CLOZARIL TAB 25MG.....104	COMPACT SPAC MIS LG MASK.....202
CLOZARIL TAB 50MG.....104	COMPACT SPAC MIS MD MASK .....202
COAGUCHEK MIS LANCETS .....185	COMPACT SPAC MIS SM MASK.....202
<i>coal tar soln 20%</i>.....151	COMPLEAT LIQ CLS SYS .....153
COARTEM TAB 20-120MG .....83	COMPLEAT PED LIQ ORG BLND.....153
<i>codeine sulfate tab 30 mg</i> .....23	COMTAN TAB 200MG .....98
CODEINE SULF TAB 15MG.....23	CONDYLOX GEL 0.5%.....150
CODEINE SULF TAB 60MG.....23	CONTOUR HIGH LIQ CONTROL.....185
<i>colchicine tab 0.6 mg</i>.....175	CONTOUR LOW LIQ CONTROL .....185
<i>colchicine w/ probenecid tab 0.5-500 mg</i>.....175	CONTOUR NEXT SOL LEVEL 1.....185
<i>colesevelam hcl packet for susp 3.75 gm</i> .71	CONTOUR NEXT SOL LEVEL 2.....185
<i>colesevelam hcl tab 625 mg</i>.....71	CONTOUR NORM LIQ CONTROL .....185
COLESTID FLA GRA 5/7.5GM.....71	CONTROL HIGH SOL UNISTRIP .....185
COLESTID FLA GRA 5GM .....71	CONTROL LOW SOL UNISTRIP.....185
COLESTID GRA 5GM .....71	CONTROL NORM SOL EASY STP .....185
COLESTID POW 5GM.....71	CONTROL SOL LIQ HI/MID/L.....185
COLESTID TAB 1GM .....71	CONTROL SOL LIQ HIGH/LOW .....185
<i>colestipol hcl granule packets 5 gm</i>.....71	CONTROL SOL LIQ LEVEL 2 .....185
<i>colestipol hcl granules 5 gm</i>.....71	CONTROL SOL LIQ MID .....186
<i>colestipol hcl tab 1 gm</i>.....71	CONTROL SOL NORMAL .....186
COMBIGAN SOL 0.2/0.5% .....214	CONZIP CAP 100MG .....23
COMBIPATCH DIS.....167	CONZIP CAP 200MG.....23
COMBIVENT AER 20-100 .....45	CONZIP CAP 300MG.....23
COMBIVIR TAB 150-300 .....108	COOL CONTROL SOL A .....186
COMETRIQ KIT 100MG .....91	COOL CONTROL SOL B.....186
COMETRIQ KIT 140MG .....91	COPAXONE INJ 20MG/ML .....225
	COPAXONE INJ 40MG/ML .....225
	COPIKTRA CAP 15MG.....91
	COPIKTRA CAP 25MG .....91
	COREG TAB 12.5MG.....117
	COREG TAB 25MG .....117
	COREG TAB 3.125MG .....117

COREG TAB 6.25MG.....	117	CVS LANCETS MIS 33G.....	186
CORGARD TAB 20MG.....	119	CVS LANCETS MIS ORIGINAL.....	186
CORGARD TAB 40MG.....	119	CVS LANCETS MIS THIN 26G.....	186
CORGARD TAB 80MG.....	119	CVS LANCETS MIS THIN 30G.....	186
CORLANOR SOL 5MG/5ML.....	128	CVS LANCETS MIS THIN 33G.....	186
CORLANOR TAB 5MG.....	128	CVS LANCING MIS DEVICE.....	186
CORLANOR TAB 7.5MG.....	128	<i>cyanocobalamin inj 1000 mcg/ml.....</i>	177
CORTEF TAB 10MG.....	133	<i>cyclobenzaprine hcl tab 10 mg.....</i>	212
CORTEF TAB 20MG.....	133	<i>cyclobenzaprine hcl tab 5 mg.....</i>	212
CORTEF TAB 5MG.....	133	CYCLOGYL SOL 0.5% OP.....	215
CORTENEMA ENE 100MG.....	34	CYCLOGYL SOL 1% OP.....	215
CORTIFOAM AER 90MG.....	34	CYCLOGYL SOL 2% OP.....	215
CORTISPORIN SUS -TC OTIC.....	219	CYCLOMYDRIL SOL OP.....	215
CORTROPHIN GEL 80UNIT.....	161	<i>cyclopentolate hcl ophth soln 0.5%.....</i>	215
COSENTYX INJ 150MG/ML.....	141	<i>cyclopentolate hcl ophth soln 1%.....</i>	215
COSENTYX INJ 300DOSE.....	141	<i>cyclopentolate hcl ophth soln 2%.....</i>	215
COSENTYX INJ 75MG/0.5.....	141	<i>cyclophosphamide cap 25 mg.....</i>	85
COSENTYX PEN INJ 150MG/ML.....	142	<i>cyclophosphamide cap 50 mg.....</i>	85
COSENTYX PEN INJ 300DOSE.....	142	CYCLOPHOSPH TAB 25MG.....	85
COSENTYX UNO INJ 300/2ML.....	142	CYCLOPHOSPH TAB 50MG.....	85
COSOFT PF SOL 2%-0.5%.....	214	<i>cycloserine cap 250 mg.....</i>	84
COSOFT SOL 2-0.5%OP.....	214	CYCLOSET TAB 0.8MG.....	64
COTELIC TAB 20MG.....	91	<i>cyclosporine cap 100 mg.....</i>	208
CREON CAP 12000UNT.....	157	<i>cyclosporine cap 25 mg.....</i>	208
CREON CAP 24000UNT.....	157	<i>cyclosporine modified cap 100 mg.....</i>	208
CREON CAP 3000UNIT.....	157	<i>cyclosporine modified cap 25 mg.....</i>	208
CREON CAP 36000UNT.....	157	<i>cyclosporine modified cap 50 mg.....</i>	208
CREON CAP 6000UNIT.....	157	<i>cyclosporine modified oral soln 100 mg/ml.....</i>	208
CRINONE GEL 4% VAG.....	238	<i>.....</i>	208
CRINONE GEL 8% VAG.....	238	<i>cyproheptadine hcl syrup 2 mg/5ml.....</i>	70
CRIXIVAN CAP 400MG.....	108	<i>cyproheptadine hcl tab 4 mg.....</i>	70
<i>cromolyn sodium ophth soln 4%.....</i>	218	CYSTADANE POW.....	163
<i>cromolyn sodium oral conc 100 mg/5ml.....</i>	170	CYSTAGON CAP 150MG.....	174
<i>cromolyn sodium soln nebu 20 mg/2ml.....</i>	41	CYSTAGON CAP 50MG.....	174
<i>crotamiton lotion 10%.....</i>	151	CYSTARAN SOL 0.44%.....	218
CRUCIAL LIQ UNFLAVOR.....	153	CYTOTEC TAB 100MCG.....	235
CURITY PREP PAD ALCOHOL.....	201	CYTOTEC TAB 200MCG.....	235
CURITY SWABS PAD ALCOHOL.....	201	D	
CUTIVATE LOT 0.05%.....	146	<i>dalfampridine tab er 12hr 10 mg.....</i>	225
CUVPOSA SOL 1MG/5ML.....	233	DALIRESP TAB 250MCG.....	42
CVS KETONE TES CARE.....	152	DALIRESP TAB 500MCG.....	42
CVS LANCETS MIS 21G.....	186	<i>danazol cap 100 mg.....</i>	33
CVS LANCETS MIS 30G.....	186	<i>danazol cap 200 mg.....</i>	33

<i>danazol cap 50 mg</i>	33	DEPO-ESTRADI INJ 5MG/ML.....	168
DANTRIUM CAP 25MG.....	212	DEPO-PROVERA INJ 150MG/ML.....	132
DANTRIUM CAP 50MG.....	213	DEPO-SQ PROV INJ 104.....	132
<i>dantrolene sodium cap 100 mg</i>	213	DERMA-SMOOTH OIL /FS BODY.....	146
<i>dantrolene sodium cap 25 mg</i>	213	DERMA-SMOOTH OIL /FS SCLP.....	146
<i>dantrolene sodium cap 50 mg</i>	213	DERMOTIC OIL 0.01%.....	220
<i>dapsone gel 5%</i>	137	DESCOVY TAB 120-15MG.....	108
<i>dapsone gel 7.5%</i>	137	DESCOVY TAB 200/25MG.....	108
<i>dapsone tab 100 mg</i>	36	<i>desipramine hcl tab 100 mg</i>	60
<i>dapsone tab 25 mg</i>	36	<i>desipramine hcl tab 10 mg</i>	60
<i>darifenacin hydrobromide tab er 24hr 15</i> <i>mg (base equiv)</i>	236	<i>desipramine hcl tab 150 mg</i>	60
<i>darifenacin hydrobromide tab er 24hr 7.5</i> <i>mg (base equiv)</i>	236	<i>desipramine hcl tab 25 mg</i>	60
DAYPRO TAB 600MG.....	19	<i>desipramine hcl tab 50 mg</i>	60
DDAVP SOL 0.01%.....	165	<i>desipramine hcl tab 75 mg</i>	60
DDAVP TAB 0.1MG.....	165	<i>desloratadine tab 5 mg</i>	70
DDAVP TAB 0.2MG.....	165	<i>desloratadine tab orally disintegrating 2.5</i> <i>mg</i>	70
<i>deferasirox granules packet 180 mg</i>	67	<i>desloratadine tab orally disintegrating 5 mg</i>	70
<i>deferasirox granules packet 360 mg</i>	67	<i>desmopressin acetate nasal spray soln</i> <i>0.01%</i>	165
<i>deferasirox granules packet 90 mg</i>	67	<i>desmopressin acetate nasal spray soln</i> <i>0.01% (refrigerated)</i>	165
<i>deferasirox tab 180 mg</i>	67	<i>desmopressin acetate tab 0.1 mg</i>	165
<i>deferasirox tab 360 mg</i>	67	<i>desmopressin acetate tab 0.2 mg</i>	166
<i>deferasirox tab 90 mg</i>	67	<i>desogest-eth estrad & eth estrad tab 0.15-</i> <i>0.02/0.01 mg(21/5)</i>	130
<i>deferasirox tab for oral susp 125 mg</i>	67	<i>desogest-ethin est tab 0.1-0.025/0.125-</i> <i>0.025/0.15-0.025mg-mg</i>	130
<i>deferasirox tab for oral susp 250 mg</i>	67	<i>desogestrel & ethinyl estradiol tab 0.15 mg-</i> <i>30 mcg</i>	130
<i>deferasirox tab for oral susp 500 mg</i>	67	DESONATE GEL 0.05%.....	146
<i>deferiprone tab 500 mg</i>	67	<i>desonide cream 0.05%</i>	146
<i>deferroxamine mesylate for inj 2 gm</i>	67	<i>desonide lotion 0.05%</i>	146
DELESTROGEN INJ 10MG/ML.....	168	<i>desonide oint 0.05%</i>	146
DELESTROGEN INJ 20MG/ML.....	168	DESOWEN CRE 0.05%.....	146
DELESTROGEN INJ 40MG/ML.....	168	<i>desoximetasone cream 0.05%</i>	146
<i>demeclocycline hcl tab 150 mg</i>	231	<i>desoximetasone cream 0.25%</i>	146
<i>demeclocycline hcl tab 300 mg</i>	231	<i>desoximetasone gel 0.05%</i>	146
DEMSEER CAP 250MG.....	76	<i>desoximetasone oint 0.25%</i>	146
DENAVIR CRE 1%.....	145	<i>desoximetasone spray 0.25%</i>	146
DEPAKOTE ER TAB 250MG.....	56	DESOPYN TAB 5MG.....	1
DEPAKOTE ER TAB 500MG.....	56		
DEPAKOTE SPR CAP 125MG.....	56		
DEPAKOTE TAB 125MG DR.....	56		
DEPAKOTE TAB 250MG DR.....	56		
DEPAKOTE TAB 500MG DR.....	56		
DEPEN TITRA TAB 250MG.....	207		

<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	59	<i>dexlansoprazole cap delayed release 60 mg</i>	234
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	59	<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	6
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	59	<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	6
DESVENLAFAX TAB 100MG ER	59	<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	6
DESVENLAFAX TAB 50MG ER	59	<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	6
DETROL TAB 1MG	236	<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	6
DETROL TAB 2MG	236	<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>	7
DEXAMETHASON CON 1MG/ML	133	<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>	7
<i>dexamethasone elixir 0.5 mg/5ml</i>	133	<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	6
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	217	<i>dexmethylphenidate hcl tab 10 mg</i>	7
<i>dexamethasone soln 0.5 mg/5ml</i>	133	<i>dexmethylphenidate hcl tab 2.5 mg</i>	7
<i>dexamethasone tab 0.5 mg</i>	133	<i>dexmethylphenidate hcl tab 5 mg</i>	7
<i>dexamethasone tab 0.75 mg</i>	133	<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	2
<i>dexamethasone tab 1.5 mg</i>	133	<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	2
<i>dexamethasone tab 1 mg</i>	133	<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	2
<i>dexamethasone tab 2 mg</i>	133	<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	2
<i>dexamethasone tab 4 mg</i>	133	<i>dextroamphetamine sulfate tab 10 mg</i>	2
<i>dexamethasone tab 6 mg</i>	133	<i>dextroamphetamine sulfate tab 15 mg</i>	2
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	133	<i>dextroamphetamine sulfate tab 2.5 mg</i>	2
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	133	<i>dextroamphetamine sulfate tab 20 mg</i>	2
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	133	<i>dextroamphetamine sulfate tab 30 mg</i>	2
DEXCOM G5 MIS RECEIVER	186	<i>dextroamphetamine sulfate tab 5 mg</i>	2
DEXCOM G5 MIS TRANSMIT	186	<i>dextroamphetamine sulfate tab 7.5 mg</i>	2
DEXCOM G6 MIS RECEIVER	186	DIABETIC TF LIQ	153
DEXCOM G6 MIS SENSOR	186	DIABETISOURC LIQ	153
DEXCOM G6 MIS TRANSMIT	186	DIACOMIT CAP 250MG	50
DEXCOM G7 MIS RECEIVER	186	DIACOMIT CAP 500MG	50
DEXCOM G7 MIS SENSOR	186	DIACOMIT PAK 250MG	50
DEXEDRINE CAP 10MG CR	1	DIACOMIT PAK 500MG	50
DEXEDRINE CAP 15MG CR	2	DIASTAT ACDL GEL 12.5-20	48
DEXEDRINE CAP 5MG CR	1	DIASTAT ACDL GEL 5-10MG	48
DEXILANT CAP 30MG DR	234		
DEXILANT CAP 60MG DR	234		
<i>dexlansoprazole cap delayed release 30 mg</i>	234		

DIASTAT PED GEL 2.5M GEL	48	<i>dicyclomine hcl cap 10 mg</i>	233
DIASTIX TES STRIPS	152	<i>dicyclomine hcl oral soln 10 mg/5ml</i>	233
DIATHRIVE LIQ CONTROL	186	<i>dicyclomine hcl tab 20 mg</i>	233
DIATHRIVE MIS LANCETS	186	<i>diethylpropion hcl tab 25 mg</i>	4
DIATHRIVE MIS LANCING.....	186	<i>diethylpropion hcl tab er 24hr 75 mg</i>	4
DIATHRIVE MIS UT 30G	186	DIFFERIN CRE 0.1%	137
DIATRUE CONT SOL LEVEL 1.....	186	DIFFERIN GEL 0.1%	137
DIATRUE CONT SOL LEVEL 2.....	186	DIFFERIN GEL 0.3%.....	137
DIATRUE CONT SOL LEVEL 3.....	186	DIFICID SUS.....	182
<i>diazepam conc 5 mg/ml</i>	40	DIFICID TAB 200MG	182
<i>diazepam oral soln 1 mg/ml</i>	40	DIFLUCAN SUS 10MG/ML	69
<i>diazepam rectal gel delivery system 10 mg</i>	48	DIFLUCAN SUS 40MG/ML	69
<i>diazepam rectal gel delivery system 2.5 mg</i>	48	DIFLUCAN TAB 100MG	69
<i>diazepam rectal gel delivery system 20 mg</i>	48	DIFLUCAN TAB 150MG	69
<i>diazepam tab 10 mg</i>	40	DIFLUCAN TAB 200MG	69
<i>diazepam tab 2 mg</i>	40	DIFLUCAN TAB 50MG.....	69
<i>diazepam tab 5 mg</i>	40	<i>diflunisal tab 500 mg</i>	23
<i>diazoxide susp 50 mg/ml</i>	63	<i>difluprednate ophth emulsion 0.05%</i>	217
DIBENZYLINE CAP 10MG.....	76	<i>digoxin oral soln 0.05 mg/ml</i>	122
<i>dichlorphenamide tab 50 mg</i>	158	<i>digoxin tab 125 mcg (0.125 mg)</i>	122
DICLEGIS TAB 10-10MG.....	68	<i>digoxin tab 250 mcg (0.25 mg)</i>	122
<i>diclofenac epolamine patch 1.3%</i>	138	DILANTIN-125 SUS 125/5ML	55
<i>diclofenac potassium tab 50 mg</i>	19	DILANTIN CAP 100MG.....	55
<i>diclofenac sodium (actinic keratoses) gel</i> <i>3%</i>	140	DILANTIN CAP 30MG.....	55
<i>diclofenac sodium ophth soln 0.1%</i>	219	DILANTIN CHW 50MG.....	55
<i>diclofenac sodium soln 1.5%</i>	138	DILATRATE SR CAP 40MG.....	38
<i>diclofenac sodium tab delayed release 25</i> <i>mg</i>	19	DILAUDID LIQ 1MG/ML	23
<i>diclofenac sodium tab delayed release 50</i> <i>mg</i>	19	DILAUDID TAB 2MG.....	23
<i>diclofenac sodium tab delayed release 75</i> <i>mg</i>	19	DILAUDID TAB 4MG	23
<i>diclofenac sodium tab er 24hr 100 mg</i>	19	DILAUDID TAB 8MG	23
<i>diclofenac w/ misoprostol tab delayed</i> <i>release 50-0.2 mg</i>	19	<i>diltiazem hcl cap er 12hr 120 mg</i>	120
<i>diclofenac w/ misoprostol tab delayed</i> <i>release 75-0.2 mg</i>	19	<i>diltiazem hcl cap er 12hr 60 mg</i>	120
<i>dicloxacillin sodium cap 250 mg</i>	221	<i>diltiazem hcl cap er 12hr 90 mg</i>	120
<i>dicloxacillin sodium cap 500 mg</i>	221	<i>diltiazem hcl cap er 24hr 120 mg</i>	120
		<i>diltiazem hcl cap er 24hr 180 mg</i>	120
		<i>diltiazem hcl cap er 24hr 240 mg</i>	120
		<i>diltiazem hcl coated beads cap er 24hr 120</i> <i>mg</i>	120
		<i>diltiazem hcl coated beads cap er 24hr 180</i> <i>mg</i>	120
		<i>diltiazem hcl coated beads cap er 24hr 240</i> <i>mg</i>	120

<i>diltiazem hcl coated beads cap er 24hr 300 mg</i>.....120	<i>divalproex sodium cap delayed release sprinkle 125 mg</i>.....56
<i>diltiazem hcl coated beads cap er 24hr 360 mg</i>.....120	<i>divalproex sodium tab delayed release 125 mg</i> .....56
<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i> .....120	<i>divalproex sodium tab delayed release 250 mg</i> .....56
<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i> .....120	<i>divalproex sodium tab delayed release 500 mg</i> .....56
<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i>.....120	<i>divalproex sodium tab er 24 hr 250 mg</i> ....56
<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i> .....120	<i>divalproex sodium tab er 24 hr 500 mg</i>....56
<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i> .....120	<i>DIVIGEL GEL 0.25MG</i>.....168
<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i>.....120	<i>DIVIGEL GEL 0.5MG</i>.....168
<i>diltiazem hcl tab 120 mg</i> .....121	<i>DIVIGEL GEL 0.75MG</i>.....168
<i>diltiazem hcl tab 30 mg</i> .....120	<i>DIVIGEL GEL 1.25MG</i>.....168
<i>diltiazem hcl tab 60 mg</i> .....121	<i>DIVIGEL GEL 1MG/GM</i> .....168
<i>diltiazem hcl tab 90 mg</i> .....121	<i>dofetilide cap 125 mcg (0.125 mg)</i>.....41
<i>dimethyl fumarate capsule delayed release 120 mg</i> .....225	<i>dofetilide cap 250 mcg (0.25 mg)</i> .....41
<i>dimethyl fumarate capsule delayed release 240 mg</i>.....225	<i>dofetilide cap 500 mcg (0.5 mg)</i> .....41
<i>dimethyl fumarate capsule dr starter pack 120 mg & 240 mg</i> .....225	<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>.....222
<i>DIPENTUM CAP 250MG</i>.....171	<i>donepezil hydrochloride orally disintegrating tab 5 mg</i> .....222
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>.....66	<i>donepezil hydrochloride tab 10 mg</i> .....222
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i> .....66	<i>donepezil hydrochloride tab 23 mg</i>.....222
<i>DIPROLENE AF CRE 0.05%</i> .....146	<i>donepezil hydrochloride tab 5 mg</i> .....222
<i>DIPROLENE OIN 0.05%</i>.....146	<i>DOPTELET TAB 20MG</i> .....177
<i>dipyridamole tab 25 mg</i>.....176	<i>DORAL TAB 15MG</i> .....179
<i>dipyridamole tab 50 mg</i>.....176	<i>dorzolamide hcl ophth soln 2%</i> .....219
<i>dipyridamole tab 75 mg</i>.....176	<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>.....214
<i>disopyramide phosphate cap 100 mg</i>.....40	<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i> .....214
<i>disopyramide phosphate cap 150 mg</i>.....40	<i>DORZOLAMIDE SOL 2%</i>.....219
<i>disulfiram tab 250 mg</i>.....222	<i>DOVATO TAB 50-300MG</i> .....109
<i>disulfiram tab 500 mg</i> .....222	<i>DOVONEX CRE 0.005%</i> .....142
<i>DITROPAN XL TAB 10MG</i> .....236	<i>doxazosin mesylate tab 1 mg</i>.....77
<i>DITROPAN XL TAB 5MG</i>.....236	<i>doxazosin mesylate tab 2 mg</i> .....77
<i>DIURIL SUS 250/5ML</i> .....160	<i>doxazosin mesylate tab 4 mg</i> .....77
	<i>doxazosin mesylate tab 8 mg</i> .....77
	<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i> .....179
	<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i> .....179

<i>doxepin hcl cap 100 mg</i>	60	<i>droxidopa cap 200 mg</i>	238
<i>doxepin hcl cap 10 mg</i>	60	<i>droxidopa cap 300 mg</i>	238
<i>doxepin hcl cap 150 mg</i>	61	DRYSOL SOL 20%	150
<i>doxepin hcl cap 25 mg</i>	60	DUAVEE TAB 0.45-20	167
<i>doxepin hcl cap 50 mg</i>	60	DUETACT TAB 30-2MG	62
<i>doxepin hcl cap 75 mg</i>	60	DUETACT TAB 30-4MG	62
<i>doxepin hcl conc 10 mg/ml</i>	61	DUEXIS TAB 800-26.6	19
<i>doxercalciferol cap 0.5 mcg</i>	164	<i>duloxetine hcl enteric coated pellets cap 20</i> <i>mg (base eq)</i>	59
<i>doxercalciferol cap 1 mcg</i>	164	<i>duloxetine hcl enteric coated pellets cap 30</i> <i>mg (base eq)</i>	59
<i>doxercalciferol cap 2.5 mcg</i>	164	<i>duloxetine hcl enteric coated pellets cap 40</i> <i>mg (base eq)</i>	59
<i>doxycycline hyclate cap 100 mg</i>	231	<i>duloxetine hcl enteric coated pellets cap 60</i> <i>mg (base eq)</i>	59
<i>doxycycline hyclate cap 50 mg</i>	231	DUOBRII LOT	146
<i>doxycycline hyclate tab 100 mg</i>	231	DUO-CARE LIQ LEVEL1/2	186
<i>doxycycline hyclate tab 20 mg</i>	231	DUPIXENT INJ 100/0.67	41
<i>doxycycline monohydrate cap 100 mg</i>	231	DUPIXENT INJ 200/1.14	41
<i>doxycycline monohydrate cap 50 mg</i>	231	DUPIXENT INJ 200MG	149
<i>doxycycline monohydrate for susp 25</i> <i>mg/5ml</i>	231	DUPIXENT INJ 300/2ML	149
<i>doxycycline monohydrate tab 100 mg</i>	231	DURAGESIC DIS 100MCG/H	24
<i>doxycycline monohydrate tab 150 mg</i>	231	DURAGESIC DIS 12MCG/HR	24
<i>doxycycline monohydrate tab 50 mg</i>	231	DURAGESIC DIS 25MCG/HR	24
<i>doxycycline monohydrate tab 75 mg</i>	231	DURAGESIC DIS 50MCG/HR	24
<i>doxylamine-pyridoxine tab delayed release</i> <i>10-10 mg</i>	68	DURAGESIC DIS 75MCG/HR	24
DRISDOL CAP 50000UNT	239	DUREZOL EMU 0.05%	217
<i>dronabinol cap 10 mg</i>	68	<i>dutasteride cap 0.5 mg</i>	174
<i>dronabinol cap 2.5 mg</i>	68	<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	174
<i>dronabinol cap 5 mg</i>	68	DYANAVEL XR CHW 10MG	2
DROPLET LANC MIS 30G	186	DYANAVEL XR CHW 15MG	2
DROPLET LANC MIS DEVICE	186	DYANAVEL XR CHW 20MG	2
DROPLET PERS MIS LANC 30G	186	DYANAVEL XR CHW 5MG	2
<i>drospirenone-ethinyl estradiol tab 3-0.02</i> <i>mg</i>	130	DYANAVEL XR SUS 2.5MG/ML	2
<i>drospirenone-ethinyl estradiol tab 3-0.03</i> <i>mg</i>	130	DYMISTA SPR 137-50	213
<i>drospirenone-ethinyl estrad-levomefolate</i> <i>tab 3-0.02-0.451 mg</i>	130	E	
<i>drospirenone-ethinyl estrad-levomefolate</i> <i>tab 3-0.03-0.451 mg</i>	130	EAA SUPPLEME POW TROPICAL	153
DROXIA CAP 200MG	177	EASIVENT MIS	202
DROXIA CAP 300MG	177	EASIVENT MIS MASK LG	202
DROXIA CAP 400MG	177	EASIVENT MIS MASK MED	202
<i>droxidopa cap 100 mg</i>	238	EASIVENT MIS MASK SM	202
		EASY COMFORT MIS 30G	187

EASY COMFORT MIS LANC/30G.....	187	<i>efavirenz cap 50 mg</i>	109
EASY COMFORT MIS TWIST	187	<i>efavirenz-emtricitabine-tenofovir df tab</i>	
EASY COMFORT PAD ALCOHOL.....	201	<i>600-200-300 mg</i>	109
EASYGLUCO SOL PLUS.....	187	<i>efavirenz-lamivudine-tenofovir df tab 400-</i>	
EASYMAX 15 LIQ LEVEL2-3	187	<i>300-300 mg</i>	109
EASYMAX 15 SOL LEVEL 2	187	<i>efavirenz-lamivudine-tenofovir df tab 600-</i>	
EASYMAX LIQ NORM/HIG	187	<i>300-300 mg</i>	109
EASYMAX SOL NORMAL	187	<i>efavirenz tab 600 mg</i>	109
EASY MINI MIS.....	187	EFFIENT TAB 10MG	176
EASY MINI MIS EJECT	187	EFFIENT TAB 5MG.....	176
EASY PLUS II SOL HIGH.....	187	EFUDEX CRE 5%	140
EASY PLUS II SOL LOW	187	EGRIFTA SV INJ 2MG.....	162
EASystEP HGh SOL CONTROL	187	ELEMENT CONT LIQ NORMAL.....	187
EASystEP LOW SOL CONTROL	187	ELEMENT LIQ HIGH	187
EASY TALK SOL HIGH	187	ELEMENT LIQ LOW	188
EASY TALK SOL LOW	187	ELEMNT COMPA SOL LEVEL 2	188
EASY TALK SOL NORMAL	187	ELEMNT COMPA SOL LEVEL 3	188
EASY TOUCH MIS.....	187	ELESTRIN GEL 0.06%.....	168
EASY TOUCH MIS LANC/21G	187	<i>eletriptan hydrobromide tab 20 mg (base</i>	
EASY TOUCH MIS LANC/23G	187	<i>equivalent)</i>	204
EASY TOUCH MIS LANC/26G	187	<i>eletriptan hydrobromide tab 40 mg (base</i>	
EASY TOUCH MIS LANC/28G	187	<i>equivalent)</i>	204
EASY TOUCH MIS LANC/30G	187	ELIMITE CRE 5%	151
EASY TOUCH MIS LANC/32G	187	ELIQUIS ST P TAB 5MG.....	46
EASY TOUCH MIS LANC/33G	187	ELIQUIS TAB 2.5MG	46
EASY TOUCH SOL CONTROL.....	187	ELIQUIS TAB 5MG.....	46
EASY TOUCH SOL HIGH/LOW	187	ELLA TAB 30MG	132
EASY TRAK II LIQ NORMAL	187	EMBRACE CNTR LIQ HIGH	188
EASY TRAK SOL HIGH	187	EMBRACE EVO LIQ LEVEL 1.....	188
EASY TRAK SOL LOW	187	EMBRACE LANC MIS /EJECTOR.....	188
EASY TRAK SOL NORMAL	187	EMBRACE LANC MIS THIN 30G.....	188
EC-NAPROSYN TAB 375MG.....	19	EMBRACE PRO LIQ GLUCOSE	188
EC-NAPROSYN TAB 500MG	19	EMBRACE SOL LOW	188
<i>econazole nitrate cream 1%</i>	139	EMBRACE TALK SOL HIGH/L2.....	188
ECOZA AER 1%	139	EMBRACE TALK SOL LOW/L1.....	188
EDECRIIN TAB 25MG.....	159	EMCYT CAP 140MG	88
EDEX KIT 10MCG	124	EMEND CAP 80MG.....	68
EDEX KIT 20MCG	124	EMEND SUS 125MG.....	68
EDEX KIT 40MCG	124	EMEND TRIPAC PAK 80 & 125	68
EDLUAR SUB 10MG	179	EMGALITY INJ 100MG/ML.....	203
EDLUAR SUB 5MG.....	179	EMGALITY INJ 120MG/ML	203, 204
EDURANT TAB 25MG	109	EMSAM DIS 12MG/24H.....	57
<i>efavirenz cap 200 mg</i>	109	EMSAM DIS 6MG/24HR.....	57

EMSAM DIS 9MG/24HR.....	57	<i>enoxaparin sodium inj soln pref syr 80</i>	
<i>emtricitabine caps 200 mg</i>	109	<i>mg/0.8ml</i>	47
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSPRYNG INJ	209
<i>tab 100-150 mg</i>	109	ENSTILAR AER.....	146
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENSURE PLANT LIQ CHOCOLAT	153
<i>tab 133-200 mg</i>	109	<i>entacapone tab 200 mg</i>	98
<i>emtricitabine-tenofovir disoproxil fumarate</i>		<i>entecavir tab 0.5 mg</i>	115
<i>tab 167-250 mg</i>	109	<i>entecavir tab 1 mg</i>	115
<i>emtricitabine-tenofovir disoproxil fumarate</i>		ENTEREG CAP 12MG.....	173
<i>tab 200-300 mg</i>	109	ENTOCORT EC CAP 3MG DR	133
EMTRIVA CAP 200MG	109	ENTRESTO TAB 24-26MG.....	124
EMTRIVA SOL 10MG/ML.....	109	ENTRESTO TAB 49-51MG	124
EMVERM CHW 100MG.....	35	ENTRESTO TAB 97-103MG.....	124
<i>enalapril maleate & hydrochlorothiazide tab</i>		ENVARBUS XR TAB 0.75MG.....	209
<i>10-25 mg</i>	80	ENVARBUS XR TAB 1MG	209
<i>enalapril maleate & hydrochlorothiazide tab</i>		ENVARBUS XR TAB 4MG.....	209
<i>5-12.5 mg</i>	80	EO28 SPLASH LIQ ORANGE	153
<i>enalapril maleate oral soln 1 mg/ml</i>	75	EPANED SOL 1MG/ML	75
<i>enalapril maleate tab 10 mg</i>	75	EPCLUSA PAK 150-37.5	115
<i>enalapril maleate tab 2.5 mg</i>	75	EPCLUSA PAK 200-50MG.....	115
<i>enalapril maleate tab 20 mg</i>	75	EPCLUSA TAB 200-50MG	115
<i>enalapril maleate tab 5 mg</i>	75	EPCLUSA TAB 400-100.....	115
ENBREL INJ 25/0.5ML.....	21	EPIDIOLEX SOL 100MG/ML	50
ENBREL INJ 50MG/ML	22	EPIDUO FORTE GEL 0.3-2.5%	137
ENBREL MINI INJ 50MG/ML.....	22	EPIDUO GEL 0.1-2.5%.....	137
ENBREL SRCLK INJ 50MG/ML.....	22	EPIFOAM AER 1%	147
ENCARE SUP 100MG.....	237	<i>epinastine hcl ophth soln 0.05%</i>	219
ENDARI POW 5GM	177	EPINEPHRINE INJ 0.2MG	238
ENDOMETRIN SUP 100MG.....	238	<i>epinephrine inj 30 mg/30ml (1 mg/ml)</i>	
<i>enoxaparin sodium inj 300 mg/3ml</i>	46	<i>(1:1000)</i>	238
<i>enoxaparin sodium inj soln pref syr 100</i>		<i>epinephrine solution auto-injector 0.15</i>	
<i>mg/ml</i>	47	<i>mg/0.15ml (1:1000)</i>	238
<i>enoxaparin sodium inj soln pref syr 120</i>		<i>epinephrine solution auto-injector 0.15</i>	
<i>mg/0.8ml</i>	47	<i>mg/0.3ml (1:2000)</i>	238
<i>enoxaparin sodium inj soln pref syr 150</i>		<i>epinephrine solution auto-injector 0.3</i>	
<i>mg/ml</i>	47	<i>mg/0.3ml (1:1000)</i>	238
<i>enoxaparin sodium inj soln pref syr 30</i>		EPIPEN 2-PAK INJ 0.3MG	238
<i>mg/0.3ml</i>	46	EPIPEN-JR INJ 0.15MG.....	238
<i>enoxaparin sodium inj soln pref syr 40</i>		EPIVIR SOL 10MG/ML	109
<i>mg/0.4ml</i>	47	EPIVIR TAB 150MG.....	109
<i>enoxaparin sodium inj soln pref syr 60</i>		EPIVIR TAB 300MG.....	109
<i>mg/0.6ml</i>	47	<i>eplerenone tab 25 mg</i>	83
		<i>eplerenone tab 50 mg</i>	83

EPZICOM TAB 600-300.....	110	escitalopram oxalate soln 5 mg/5ml (base equiv)	58
EQL LANCETS MIS 21G COLR	188	escitalopram oxalate tab 10 mg (base equiv)	58
EQL LANCETS MIS 33G COLR.....	188	escitalopram oxalate tab 20 mg (base equiv)	58
EQL LANCETS MIS THIN 26G	188	escitalopram oxalate tab 5 mg (base equiv)	58
EQL LANCETS MIS THIN 30G.....	188	ESGIC TAB.....	23
EQUETRO CAP 100MG	101	esomeprazole magnesium cap delayed release 20 mg (base eq).....	234
EQUETRO CAP 200MG	101	esomeprazole magnesium cap delayed release 40 mg (base eq)	234
EQUETRO CAP 300MG	101	esomeprazole magnesium for delayed release susp packet 10 mg	234
ergocalciferol cap 1.25 mg (50000 unit).239		esomeprazole magnesium for delayed release susp packet 20 mg.....	235
ergoloid mesylates tab 1 mg.....	228	esomeprazole magnesium for delayed release susp packet 40 mg.....	235
ERGOMAR SUB 2MG.....	204	estazolam tab 1 mg.....	179
ERIVEDGE CAP 150MG	88	estazolam tab 2 mg	179
ERLEADA TAB 240MG	88	ESTRACE TAB 0.5MG	168
ERLEADA TAB 60MG	88	ESTRACE TAB 1MG	168
erlotinib hcl tab 100 mg (base equivalent)87		ESTRACE TAB 2MG.....	168
erlotinib hcl tab 150 mg (base equivalent)87		ESTRACE VAG CRE 0.01%.....	237
erlotinib hcl tab 25 mg (base equivalent)..87		estradiol & norethindrone acetate tab 0.5-0.1 mg	167
ERTACZO CRE 2%.....	139	estradiol & norethindrone acetate tab 1-0.5 mg	167
ERYGEL GEL 2%	137	estradiol tab 0.5 mg	168
erythromycin ethylsuccinate for susp 200 mg/5ml	181	estradiol tab 1 mg	168
erythromycin ethylsuccinate for susp 400 mg/5ml	181	estradiol tab 2 mg.....	168
erythromycin ethylsuccinate tab 400 mg181		estradiol td gel 0.25 mg/0.25gm (0.1%) .169	
erythromycin gel 2%	137	estradiol td gel 0.5 mg/0.5gm (0.1%).....	168
erythromycin ophth oint 5 mg/gm	216	estradiol td gel 0.75 mg/0.75gm (0.1%) .169	
erythromycin pads 2%.....	137	estradiol td gel 1.25 mg/1.25gm (0.1%) ...169	
erythromycin soln 2%	137	estradiol td gel 1 mg/gm (0.1%)	169
erythromycin stearate tab 250 mg	181	estradiol td patch twice weekly 0.025 mg/24hr	169
erythromycin tab 250 mg.....	181	estradiol td patch twice weekly 0.0375 mg/24hr	169
erythromycin tab 500 mg	181	estradiol td patch twice weekly 0.05 mg/24hr	169
erythromycin tab delayed release 250 mg	181		
erythromycin tab delayed release 333 mg	182		
erythromycin tab delayed release 500 mg	182		
erythromycin w/ delayed release particles cap 250 mg.....	182		
ESBRIET CAP 267MG.....	230		
ESBRIET TAB 267MG	230		
ESBRIET TAB 801MG.....	230		

<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	169	<i>etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr</i>	132
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	169	<i>etoposide cap 50 mg</i>	97
<i>estradiol td patch weekly 0.025 mg/24hr</i>	169	<i>etravirine tab 100 mg</i>	110
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	169	<i>etravirine tab 200 mg</i>	110
<i>estradiol td patch weekly 0.05 mg/24hr</i>	169	<i>EUCRISA OIN 2%</i>	151
<i>estradiol td patch weekly 0.06 mg/24hr</i>	169	<i>EVAMIST SPR 1.53MG</i>	169
<i>estradiol td patch weekly 0.075 mg/24hr</i>	169	<i>EVENCARE G2 SOL LOW/HIGH</i>	188
<i>estradiol td patch weekly 0.1 mg/24hr</i>	169	<i>EVENCARE G3 SOL LOW/HIGH</i>	188
<i>estradiol vaginal cream 0.1 mg/gm</i>	237	<i>EVENCARE SOL LIQ LOW/HIGH</i>	188
<i>estradiol valerate im in oil 20 mg/ml</i>	169	<i>EVENCAR MINI SOL NORMAL</i>	188
<i>estradiol valerate im in oil 40 mg/ml</i>	169	<i>everolimus tab 0.25 mg</i>	209
<i>ESTROGEL GEL</i>	169	<i>everolimus tab 0.5 mg</i>	209
<i>ESTROSTEP FE TAB</i>	130	<i>everolimus tab 0.75 mg</i>	209
<i>eszopiclone tab 1 mg</i>	179	<i>everolimus tab 2.5 mg</i>	92
<i>eszopiclone tab 2 mg</i>	179	<i>everolimus tab 5 mg</i>	92
<i>eszopiclone tab 3 mg</i>	179	<i>everolimus tab 7.5 mg</i>	92
<i>ethacrynic acid tab 25 mg</i>	159	<i>EVISTA TAB 60MG</i>	163
<i>ethambutol hcl tab 100 mg</i>	84	<i>EVOCLIN AER 1%</i>	137
<i>ethambutol hcl tab 400 mg</i>	84	<i>EVOLUTION SOL NORMAL</i>	188
<i>ethosuximide cap 250 mg</i>	55	<i>EVOTAZ TAB 300-150</i>	110
<i>ethosuximide soln 250 mg/5ml</i>	55	<i>EVOXAC CAP 30MG</i>	211
<i>ETHYL CHLOR AER FINE PIN</i>	150	<i>EVRYSDI SOL</i>	214
<i>ETHYL CHLOR AER FN STRM</i>	150	<i>EXELDERM CRE 1%</i>	139
<i>ETHYL CHLOR AER MED JET</i>	150	<i>EXELDERM SOL 1%</i>	139
<i>ETHYL CHLOR AER MED STRM</i>	150	<i>EXELON DIS 13.3/24</i>	222
<i>ETHYL CHLOR AER MIST</i>	150	<i>EXELON DIS 4.6MG/24</i>	222
<i>ethyl chloride aerosol spray</i>	150	<i>EXELON DIS 9.5MG/24</i>	222
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg</i>	130	<i>exemestane tab 25 mg</i>	88
<i>ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg</i>	130	<i>EXODERM LOT 25-1%</i>	139
<i>etodolac cap 200 mg</i>	19	<i>EXTINA AER 2%</i>	139
<i>etodolac cap 300 mg</i>	19	<i>ezetimibe-simvastatin tab 10-10 mg</i>	70
<i>etodolac tab 400 mg</i>	19	<i>ezetimibe-simvastatin tab 10-20 mg</i>	71
<i>etodolac tab 500 mg</i>	19	<i>ezetimibe-simvastatin tab 10-40 mg</i>	71
<i>etodolac tab er 24hr 400 mg</i>	19	<i>ezetimibe-simvastatin tab 10-80 mg</i>	71
<i>etodolac tab er 24hr 500 mg</i>	19	<i>ezetimibe tab 10 mg</i>	74
<i>etodolac tab er 24hr 600 mg</i>	19	<i>E-ZJECT LANC MIS 33G</i>	187
		<i>E-Z JECT MIS 21G</i>	186
		<i>E-Z JECT MIS 21G COLR</i>	186
		<i>E-Z JECT MIS 30G</i>	186
		<i>E-Z JECT MIS 32G COLR</i>	186
		<i>E-Z JECT MIS LANC 21G</i>	186
		<i>E-Z JECT MIS THIN 26G</i>	187

EZ-LETS 21G MIS LANCETS	188	<i>fenofibrate tab 160 mg</i>	72
EZ-LETS 26G MIS LANCETS	188	<i>fenofibrate tab 48 mg</i>	72
EZ-LETS 28G MIS LANCETS	188	<i>fenofibrate tab 54 mg</i>	72
EZ-LETS 30G MIS LANCETS	188	<i>fenofibric acid tab 105 mg</i>	72
F		<i>fenofibric acid tab 35 mg</i>	72
F.A.A. LIQ	153	FENOGLIDE TAB 40MG.....	72
<i>famciclovir tab 125 mg</i>	116	<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	24
<i>famciclovir tab 250 mg</i>	116	<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	24
<i>famciclovir tab 500 mg</i>	116	<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	24
<i>famotidine for susp 40 mg/5ml</i>	234	<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	24
<i>famotidine tab 40 mg</i>	234	<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	24
FARESTON TAB 60MG.....	88	<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	24
FARXIGA TAB 10MG	65	<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	24
FARXIGA TAB 5MG.....	65	<i>fentanyl citrate lozenge on a handle 200 mcg</i>	24
FASENRA PEN INJ 30MG/ML	41	<i>fentanyl citrate lozenge on a handle 400 mcg</i>	24
FASTCLIX MIS LANCETS.....	188	<i>fentanyl citrate lozenge on a handle 600 mcg</i>	24
FAVIPIRAVIR TAB 200MG.....	117	<i>fentanyl citrate lozenge on a handle 800 mcg</i>	24
FC2 FEMALE MIS CONDOM	182	<i>fentanyl td patch 72hr 100 mcg/hr</i>	25
FC FEMALE MIS CONDOM	182	<i>fentanyl td patch 72hr 12 mcg/hr</i>	24
<i>febuxostat tab 40 mg</i>	175	<i>fentanyl td patch 72hr 25 mcg/hr</i>	24
<i>febuxostat tab 80 mg</i>	175	<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	24
<i>felbamate susp 600 mg/5ml</i>	54	<i>fentanyl td patch 72hr 50 mcg/hr</i>	24
<i>felbamate tab 400 mg</i>	54	<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	24
<i>felbamate tab 600 mg</i>	54	<i>fentanyl td patch 72hr 75 mcg/hr</i>	24
FELBATOL SUS 600/5ML.....	54	<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	25
FELBATOL TAB 400MG	54	FENTORA TAB 100MCG.....	25
FELBATOL TAB 600MG	54	FENTORA TAB 200MCG	25
FELDENE CAP 10MG	19	FENTORA TAB 400MCG.....	25
FELDENE CAP 20MG	19	FENTORA TAB 600MCG.....	25
<i>felodipine tab er 24hr 10 mg</i>	121	FENTORA TAB 800MCG.....	25
<i>felodipine tab er 24hr 2.5 mg</i>	121	FESOTERODINE fumarate tab er 24hr 4 mg.	236
<i>felodipine tab er 24hr 5 mg</i>	121	<i>fenofibrate tab 145 mg</i>	72
FEMARA TAB 2.5MG	88		
FEMCAP MIS 22MM.....	182		
FEMCAP MIS 26MM.....	182		
FEMCAP MIS 30MM.....	182		
FEMHRT TAB 0.5-2.5.....	167		
<i>fenofibrate cap 150 mg</i>	72		
<i>fenofibrate micronized cap 134 mg</i>	72		
<i>fenofibrate micronized cap 200 mg</i>	72		
<i>fenofibrate micronized cap 43 mg</i>	72		
<i>fenofibrate micronized cap 67 mg</i>	72		
<i>fenofibrate tab 145 mg</i>	72		

FETZIMA CAP 120MG.....	59	<i>fluconazole tab 100 mg</i>	69
FETZIMA CAP 20MG	59	<i>fluconazole tab 150 mg</i>	69
FETZIMA CAP 40MG	59	<i>fluconazole tab 200 mg</i>	69
FETZIMA CAP 80MG	59	<i>fluconazole tab 50 mg</i>	69
FETZIMA CAP TITRATIO	59	<i>flucytosine cap 250 mg</i>	69
FIASP FLEX INJ TOUCH	64	<i>fludrocortisone acetate tab 0.1 mg</i>	134
FIASP INJ 100/ML.....	64	<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	213
FIASP PENFIL INJ U-100	64	<i>fluocinolone acetonide (otic) oil 0.01%</i> ..	220
FIBERSOURCE LIQ CLS SYS	153	<i>fluocinolone acetonide cream 0.01%</i>	147
FIBERSOUR HN LIQ CLS SYS.....	153	<i>fluocinolone acetonide cream 0.025%</i> ...	147
FIBRICOR TAB 105MG.....	72	<i>fluocinolone acetonide oil 0.01% (body oil)</i>	147
FIBRICOR TAB 35MG.....	72	<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	147
FIFTY50 PREP PAD PADS	201	<i>fluocinolone acetonide oint 0.025%</i>	147
FIFTY50 SAFE MIS LANCETS	188	<i>fluocinolone acetonide soln 0.01%</i>	147
FINACEA AER 15%	151	<i>fluocinonide cream 0.05%</i>	147
<i>finasteride tab 1 mg</i>	149	<i>fluocinonide emulsified base cream 0.05%</i>	147
<i>finasteride tab 5 mg</i>	174	<i>fluocinonide gel 0.05%</i>	147
FINE 30 MIS.....	188	<i>fluocinonide oint 0.05%</i>	147
FINGERSTIX MIS LANCETS.....	188	<i>fluocinonide soln 0.05%</i>	147
<i>finngolimod hcl cap 0.5 mg (base equiv)</i> ..	226	<i>fluorometholone ophth susp 0.1%</i>	217
FINTEPLA SOL 2.2MG/ML.....	50	FLUOROPLEX CRE 1%	140
FIORICET CAP CODEINE	31	<i>fluorouracil cream 5%</i>	140
FIRAZYR INJ 30MG/3ML.....	175	<i>fluorouracil soln 2%</i>	140
FIRDAPSE TAB 10MG	84	<i>fluorouracil soln 5%</i>	140
FLAGYL CAP 375MG	35	<i>fluoxetine hcl cap 10 mg</i>	58
FLAGYL TAB 500MG	35	<i>fluoxetine hcl cap 20 mg</i>	58
<i>flavoxate hcl tab 100 mg</i>	237	<i>fluoxetine hcl cap 40 mg</i>	58
<i>flecainide acetate tab 100 mg</i>	40	<i>fluoxetine hcl cap delayed release 90 mg</i>	58
<i>flecainide acetate tab 150 mg</i>	41	<i>fluoxetine hcl solution 20 mg/5ml</i>	58
<i>flecainide acetate tab 50 mg</i>	40	<i>fluoxetine hcl tab 10 mg</i>	58
FLECTOR DIS 1.3%	138	<i>fluoxetine hcl tab 20 mg</i>	58
FLEXICHAMBER MIS.....	202	FLUOXETINE TAB 60MG.....	58
FLEXICHAMBER MIS MASK LRG	203	<i>fluphenazine decanoate inj 25 mg/ml</i>	106
FLEXICHAMBER MIS MASK SM	203	<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	106
FLOMAX CAP 0.4MG.....	174	<i>fluphenazine hcl inj 2.5 mg/ml</i>	106
FLOVENT DISK AER 100MCG	43	<i>fluphenazine hcl oral conc 5 mg/ml</i>	106
FLOVENT DISK AER 250MCG.....	43	<i>fluphenazine hcl tab 10 mg</i>	106
FLOVENT DISK AER 50MCG	43	<i>fluphenazine hcl tab 1 mg</i>	106
FLOVENT HFA AER 110MCG.....	43	<i>fluphenazine hcl tab 2.5 mg</i>	106
FLOVENT HFA AER 220MCG	43		
FLOVENT HFA AER 44MCG	43		
<i>fluconazole for susp 10 mg/ml</i>	69		
<i>fluconazole for susp 40 mg/ml</i>	69		

<i>fluphenazine hcl tab 5 mg</i>	106	FORA CONTROL SOL NORMAL	188
<i>flurazepam hcl cap 15 mg</i>	179	FORA GTEL TES KETONE	152
<i>flurazepam hcl cap 30 mg</i>	179	FORA LANCETS MIS 30G	188
<i>flurbiprofen sodium ophth soln 0.03%</i>	219	FORA MIS LANCETS	188
<i>flurbiprofen tab 100 mg</i>	19	FORA MIS LANCING	188
<i>flurbiprofen tab 50 mg</i>	19	FORFIVO XL TAB 450MG.....	57
<i>flutamide cap 125 mg</i>	88	<i>formaldehyde solution 10%</i>	107
<i>fluticasone propionate cream 0.05%</i>	147	<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	45
<i>fluticasone propionate lotion 0.05%</i>	147	FORTEO INJ 600/2.4	160
<i>fluticasone propionate nasal susp 50</i> <i>mcg/act</i>	213	FORTISCARE SOL CNTL HI	189
<i>fluticasone propionate oint 0.005%</i>	147	FORTISCARE SOL CNTL LOW	189
<i>fluvastatin sodium cap 20 mg (base</i> <i>equivalent)</i>	72	FORTISCARE SOL CNTL NML	189
<i>fluvastatin sodium cap 40 mg (base</i> <i>equivalent)</i>	73	FOSAMAX + D TAB 70-2800	160
<i>fluvastatin sodium tab er 24 hr 80 mg (base</i> <i>equivalent)</i>	73	FOSAMAX + D TAB 70-5600	160
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	58	FOSAMAX TAB 70MG	160
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	58	<i>fosamprenavir calcium tab 700 mg (base</i> <i>equiv)</i>	110
<i>fluvoxamine maleate tab 100 mg</i>	58	<i>fosfomycin tromethamine powd pack 3 gm</i> <i>(base equivalent)</i>	37
<i>fluvoxamine maleate tab 25 mg</i>	58	<i>fosinopril sodium & hydrochlorothiazide tab</i> <i>10-12.5 mg</i>	80
<i>fluvoxamine maleate tab 50 mg</i>	58	<i>fosinopril sodium & hydrochlorothiazide tab</i> <i>20-12.5 mg</i>	80
FOCALIN TAB 10MG	7	<i>fosinopril sodium tab 10 mg</i>	75
FOCALIN TAB 2.5MG	7	<i>fosinopril sodium tab 20 mg</i>	75
FOCALIN TAB 5MG	7	<i>fosinopril sodium tab 40 mg</i>	75
<i>folic acid cap 0.8 mg</i>	177	FRAGMIN INJ 10000/ML	47
<i>folic acid tab 1 mg</i>	177	FRAGMIN INJ 12500UNT	47
<i>folic acid tab 400 mcg</i>	177	FRAGMIN INJ 15000UNT	47
<i>folic acid tab 800 mcg</i>	177	FRAGMIN INJ 18000UNT	47
<i>fondaparinux sodium subcutaneous inj 10</i> <i>mg/0.8ml</i>	47	FRAGMIN INJ 2500/0.2	47
<i>fondaparinux sodium subcutaneous inj 2.5</i> <i>mg/0.5ml</i>	47	FRAGMIN INJ 5000/0.2	47
<i>fondaparinux sodium subcutaneous inj 5</i> <i>mg/0.4ml</i>	47	FRAGMIN INJ 7500/0.3	47
<i>fondaparinux sodium subcutaneous inj 7.5</i> <i>mg/0.6ml</i>	47	FRAGMIN INJ 95000UNT	47
FORACARE GDH SOL HIGH	188	FREESTYLE LIQ CONTROL	189
FORACARE GDH SOL LOW	189	FREESTYLE MIS LANCETS	189
FORACARE GDH SOL NORMAL	189	FREESTYLE MIS UNISTICK	189
FORA CONTROL SOL HIGH	188	FROVA TAB 2.5MG	204
FORA CONTROL SOL LOW	188	<i>frovatriptan succinate tab 2.5 mg (base</i> <i>equivalent)</i>	204
		<i>furosemide oral soln 10 mg/ml</i>	159
		<i>furosemide oral soln 8 mg/ml</i>	159

<i>furosemide tab 20 mg</i>	159	<i>ganirelix acetate soln prefilled syringe 250</i>	
<i>furosemide tab 40 mg</i>	159	<i>mcg/0.5ml</i>	162
<i>furosemide tab 80 mg</i>	159	GANIRELIX AC INJ 250/0.5	162
FUZEON INJ 90MG	110	GASTROCROM CON 100/5ML.....	170
FYCOMPA SUS 0.5MG/ML	48	<i>gatifloxacin ophth soln 0.5%</i>	216
FYCOMPA TAB 10MG.....	48	GATTEX KIT 5MG	173
FYCOMPA TAB 12MG.....	48	GE100 CONTRL SOL NORMAL.....	189
FYCOMPA TAB 2MG	48	GELFILM MIS OP	218
FYCOMPA TAB 4MG	48	GELNIQUE GEL 10%	236
FYCOMPA TAB 6MG	48	<i>gemfibrozil tab 600 mg</i>	72
FYCOMPA TAB 8MG	48	GENERESS FE CHW	130
FYLNETRA INJ 6MG/0.6	177	GENOTROPIN INJ 0.2MG.....	162
G		GENOTROPIN INJ 0.4MG.....	162
G4 PLATINUM MIS PEDIATRC	189	GENOTROPIN INJ 0.6MG.....	162
G4 PLATINUM MIS RCV/SHAR	189	GENOTROPIN INJ 0.8MG.....	162
G4 PLATINUM MIS RECEIVER.....	189	GENOTROPIN INJ 1.2MG.....	162
G4 PLATINUM MIS TRANSMIT	189	GENOTROPIN INJ 1.4MG	163
G4 PLAT PED MIS RVC/SHAR.....	189	GENOTROPIN INJ 1.6MG	163
G4 SENSOR MIS	189	GENOTROPIN INJ 1.8MG	163
G5/G4 MIS SENSOR	189	GENOTROPIN INJ 12MG.....	163
<i>gabapentin cap 100 mg</i>	50	GENOTROPIN INJ 1MG.....	163
<i>gabapentin cap 300 mg</i>	50	GENOTROPIN INJ 2MG	163
<i>gabapentin cap 400 mg</i>	50	GENOTROPIN INJ 5MG	163
<i>gabapentin oral soln 250 mg/5ml</i>	50	<i>gentamicin sulfate cream 0.1%</i>	138
<i>gabapentin tab 600 mg</i>	50	<i>gentamicin sulfate oint 0.1%</i>	138
<i>gabapentin tab 800 mg</i>	50	<i>gentamicin sulfate ophth oint 0.3%</i>	216
GABITRIL TAB 12MG.....	55	<i>gentamicin sulfate ophth soln 0.3%</i>	216
GABITRIL TAB 16MG.....	55	GENTEEL LANC KIT BLUE.....	189
GABITRIL TAB 2MG	55	GENTEEL MIS LANCETS	189
GABITRIL TAB 4MG	55	GENTEEL MIS NOZZLES.....	189
GALAFOLD CAP 123MG	164	GENTEEL PLUS MIS BLACK.....	189
<i>galantamine hydrobromide cap er 24hr 16</i>		GENTEEL PLUS MIS BLUE.....	189
<i>mg</i>	222	GENTEEL PLUS MIS PINK	189
<i>galantamine hydrobromide cap er 24hr 24</i>		GENTEEL PLUS MIS PURPLE.....	189
<i>mg</i>	222	GENTEEL PLUS MIS WHITE	189
<i>galantamine hydrobromide cap er 24hr 8</i>		GENTEEL TIPS MIS BLUE	189
<i>mg</i>	222	GENTEEL TIPS MIS CLEAR	189
<i>galantamine hydrobromide oral soln 4</i>		GENTEEL TIPS MIS GREEN	189
<i>mg/ml</i>	222	GENTEEL TIPS MIS ORANGE.....	189
<i>galantamine hydrobromide tab 12 mg</i>	222	GENTEEL TIPS MIS RAINBOW	189
<i>galantamine hydrobromide tab 4 mg</i>	222	GENTEEL TIPS MIS VIOLET.....	189
<i>galantamine hydrobromide tab 8 mg</i>	222	GENTEEL TIPS MIS YELLOW	189
		GENTLE-LET MIS 26G	189

GENTLE-LET MIS 28G	189	GLUCERNA LIQ 1.2 CAL.....	153
GENTLE-LET MIS LANCETS	189	GLUCERNA SEL LIQ VANILLA	153
GENTLE-LET MIS PLATFORM	189	GLUCOCARD 01 LIQ NORM/HGH	190
GENULTIMATE TES	152	GLUCOCARD 01 SOL NORMAL.....	190
GENVOYA TAB	110	GLUCOCARD LIQ LEVEL 1.....	190
GEODON CAP 20MG.....	101	GLUCOCARD SOL NORMAL	190
GEODON CAP 40MG.....	101	GLUCOCARD SOL SHINE.....	190
GEODON CAP 60MG.....	101	GLUCOCARD TES SHINE.....	152
GEODON CAP 80MG.....	101	GLUCOCOM MIS 28G.....	190
GEODON INJ 20MG.....	101	GLUCOCOM MIS 30G.....	190
GILOTRIF TAB 20MG.....	87	GLUCOCOM MIS 33G.....	190
GILOTRIF TAB 30MG.....	87	GLUCOCOM TES HIGH CON	190
GILOTRIF TAB 40MG.....	87	GLUCOCOM TES NORM CON	190
<i>glatiramer acetate soln prefilled syringe 20</i>		GLUCOSE CONT LIQ HIGH/LOW	190
<i>mg/ml</i>	<i>226</i>	GLUCOSE CONT SOL HIGH.....	190
<i>glatiramer acetate soln prefilled syringe 40</i>		GLUCOSE CONT SOL NORMAL.....	190
<i>mg/ml</i>	<i>226</i>	GLUCOSE CONT SOL PRECISIO	190
GLEOSTINE CAP 100MG.....	85	GLUCOTROL TAB 10MG	66
GLEOSTINE CAP 10MG	85	GLUCOTROL XL TAB 10MG.....	66
GLEOSTINE CAP 40MG	85	GLUCOTROL XL TAB 2.5MG	66
<i>glimepiride tab 1 mg</i>	<i>66</i>	GLUCOTROL XL TAB 5MG	66
<i>glimepiride tab 2 mg.....</i>	<i>66</i>	GLUTARALDEHY SOL 25%.....	107
<i>glimepiride tab 4 mg.....</i>	<i>66</i>	<i>glyburide-metformin tab 1.25-250 mg</i>	<i>62</i>
<i>glipizide-metformin hcl tab 2.5-250 mg ..</i>	<i>62</i>	<i>glyburide-metformin tab 2.5-500 mg</i>	<i>62</i>
<i>glipizide-metformin hcl tab 2.5-500 mg ..</i>	<i>62</i>	<i>glyburide-metformin tab 5-500 mg</i>	<i>62</i>
<i>glipizide-metformin hcl tab 5-500 mg</i>	<i>62</i>	<i>glyburide micronized tab 1.5 mg.....</i>	<i>66</i>
<i>glipizide tab 10 mg</i>	<i>66</i>	<i>glyburide micronized tab 3 mg</i>	<i>66</i>
<i>glipizide tab 5 mg.....</i>	<i>66</i>	<i>glyburide micronized tab 6 mg</i>	<i>66</i>
<i>glipizide tab er 24hr 10 mg.....</i>	<i>66</i>	<i>glyburide tab 1.25 mg</i>	<i>66</i>
<i>glipizide tab er 24hr 2.5 mg</i>	<i>66</i>	<i>glyburide tab 2.5 mg.....</i>	<i>66</i>
<i>glipizide tab er 24hr 5 mg</i>	<i>66</i>	<i>glyburide tab 5 mg.....</i>	<i>66</i>
GLOBAL 28G MIS LANCETS	190	<i>glycopyrrolate oral soln 1 mg/5ml</i>	<i>233</i>
GLOBAL 30G MIS LANCETS.....	190	<i>glycopyrrolate tab 1 mg.....</i>	<i>233</i>
GLOBAL LANC MIS DEVICE	190	<i>glycopyrrolate tab 2 mg.....</i>	<i>233</i>
GLOBAL PREP PAD PADS.....	201	GLYNASE TAB 1.5MG	66
GLUCAGEN INJ HYPOKIT.....	63	GLYNASE TAB 3MG.....	66
<i>glucagon (rdna) for inj kit 1 mg.....</i>	<i>63</i>	GLYNASE TAB 6MG	66
GLUCAGON KIT 1MG.....	63	GLYTACTIN PAK BTMK/DLT	153
GLUC CONTROL LIQ NORMAL	190	GLYTACTIN POW BETMLK15	153
GLUC CONTROL SOL	190	GLYTACTIN POW RST LT10.....	153
GLUC CONTROL SOL MID	190	GLYTROL LIQ PREBIO1.....	153
GLUC CONTROL SOL NORMAL.....	190	GLYXAMBI TAB 10-5 MG	62
GLUCERNA 1.0 LIQ CARB VAN.....	153	GLYXAMBI TAB 25-5 MG.....	62

GNP ALCOHOL PAD SWABS.....	201	<i>guanfacine hcl tab er 24hr 4 mg (base</i>	
GNP LANCETS MIS 21G.....	190	<i>equiv).....</i>	5
GNP LANCETS MIS THIN	190	GUANIDINE TAB 125MG	84
GNP LANCETS MIS THIN 26G.....	190	GVOKE HYPO 1 INJ .5/.1ML.....	63
GOJJI BLOOD TES KETONE	152	GVOKE HYPO 1 INJ 1MG/.2ML.....	63
GOJJI CNTRL SOL NORMAL.....	190	GVOKE HYPO 2 INJ .5/.1ML	63
GOJJI LANCET MIS 30G	190	GVOKE HYPO 2 INJ 1MG/.2ML.....	63
GOJJI MIS LANC DEV.....	190	GVOKE KIT SOL 1MG/0.2M	63
GONAL-F INJ 1050UNIT.....	161	GVOKE PFS INJ	63
GONAL-F INJ 450UNIT	161	GYNAZOLE-1 CRE 2%	237
GONAL-F RFF INJ 300/0.5	162	GYNOL II GEL 3%.....	237
GONAL-F RFF INJ 450/0.75	162	H	
GONAL-F RFF INJ 75UNIT.....	162	HAEMOLANCE MIS HIGH FLO	190
GONAL-F RFF INJ 900/1.5	162	HAEMOLANCE MIS LOW FLOW	190
GOODSENSE MIS LANC 26G	190	HAEMOLANCE MIS PLUS	190
GOODSENSE MIS LANC 30G	190	HAEMOLANCE MIS PLUS LOW	190
GOODSENSE MIS LANC 33G.....	190	HAEMOLANCE MIS PLUS MAX.....	191
GOODSENSE MIS LANC DVC.....	190	HAEMOLANCE MIS PLUS PED.....	191
GORDOFILM SOL	150	HAEMOLANCE MIS RETRACT	191
GRALISE TAB 300MG.....	227	HALCION TAB 0.25MG.....	179
GRALISE TAB 450MG.....	227	HALDOL DECAN INJ 100MG/ML.....	103
GRALISE TAB 600MG	228	HALDOL DECAN INJ 50MG/ML	103
GRALISE TAB 750MG.....	228	HALDOL INJ 5MG/ML	103
GRALISE TAB 900MG	228	<i>halobetasol propionate cream 0.05%</i>	147
<i>granisetron hcl tab 1 mg</i>	67	<i>halobetasol propionate oint 0.05%.....</i>	147
GRASTEK SUB 2800BAU.....	10	<i>haloperidol decanoate im soln 100 mg/ml</i>	
<i>griseofulvin microsize susp 125 mg/5ml...69</i>		<i>.....</i>	103
<i>griseofulvin microsize tab 500 mg</i>	69	<i>haloperidol decanoate im soln 50 mg/ml</i>	
<i>griseofulvin ultramicrosize tab 125 mg</i>	69	<i>.....</i>	103
<i>griseofulvin ultramicrosize tab 250 mg.....69</i>		<i>haloperidol lactate inj 5 mg/ml.....</i>	103
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>		<i>haloperidol lactate oral conc 2 mg/ml.....</i>	103
<i>.....</i>	135	<i>haloperidol tab 0.5 mg.....</i>	103
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>		<i>haloperidol tab 10 mg</i>	103
<i>.....</i>	135	<i>haloperidol tab 1 mg.....</i>	103
<i>guanfacine hcl tab 1 mg.....</i>	77	<i>haloperidol tab 20 mg.....</i>	103
<i>guanfacine hcl tab 2 mg</i>	77	<i>haloperidol tab 2 mg</i>	103
<i>guanfacine hcl tab er 24hr 1 mg (base</i>		<i>haloperidol tab 5 mg</i>	103
<i>equiv).....</i>	5	HARVONI PAK	115
<i>guanfacine hcl tab er 24hr 2 mg (base</i>		HARVONI PAK 45-200MG.....	115
<i>equiv).....</i>	5	HARVONI TAB 45-200MG	115
<i>guanfacine hcl tab er 24hr 3 mg (base</i>		HARVONI TAB 90-400MG.....	115
<i>equiv).....</i>	5	HC/PRAMOXINE CRE 1-2.35%.....	147
		HC LANCING MIS DEVICE	191

HCU EXP20 PAK UNFLAVOR	154	<i>hydralazine hcl tab 25 mg</i>	83
HCU EXPRESS PAK	154	<i>hydralazine hcl tab 50 mg</i>	83
HEMANGEOL SOL 4.28/ML	119	HYDREA CAP 500MG	97
HEMLIBRA INJ 105/0.7	175	<i>hydrochlorothiazide cap 12.5 mg</i>	160
HEMLIBRA INJ 150/ML	175	<i>hydrochlorothiazide tab 12.5 mg</i>	160
HEMLIBRA INJ 30MG/ML	175	<i>hydrochlorothiazide tab 25 mg</i>	160
HEMLIBRA INJ 60/0.4	175	<i>hydrochlorothiazide tab 50 mg</i>	160
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	47	<i>hydrocodone-acetaminophen soln 10-325</i> <i>mg/15ml</i>	31
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	47	<i>hydrocodone-acetaminophen soln 7.5-325</i> <i>mg/15ml</i>	31
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	47	<i>hydrocodone-acetaminophen tab 10-300</i> <i>mg</i>	31
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	47	<i>hydrocodone-acetaminophen tab 10-325</i> <i>mg</i>	31
<i>heparin sodium (porcine) pf inj 5000</i> <i>unit/0.5ml</i>	47	<i>hydrocodone-acetaminophen tab 5-300</i> <i>mg</i>	31
HETLIOZ CAP 20MG	180	<i>hydrocodone-acetaminophen tab 5-325</i> <i>mg</i>	31
HETLIOZ LQ SUS 4MG/ML	180	<i>hydrocodone-acetaminophen tab 7.5-300</i> <i>mg</i>	31
HIPREX TAB 1GM	37	<i>hydrocodone-acetaminophen tab 7.5-325</i> <i>mg</i>	31
HLTHY ACCNTS MIS LANC 30G	191	<i>hydrocodone bitart-homatropine</i> <i>methylbromide tab 5-1.5 mg</i>	135
HM STERILE PAD ALCHOL	201	<i>hydrocodone bitart-homatropine</i> <i>methylbrom soln 5-1.5 mg/5ml</i>	135
HOLD CHAMBER MIS ADLT LG	203	<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	25
HOLD CHAMBER MIS MEDIUM	203	<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	25
HOLD CHAMBER MIS SMALL	203	<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	25
HOMACTIN AA LIQ PLUS	154	<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	25
HUMIRA INJ 10/0.1ML	11	<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	25
HUMIRA INJ 20/0.2ML	11	<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	25
HUMIRA INJ 40/0.4ML	11	<i>hydrocodone bitartrate tab er 24hr deter</i> <i>100 mg</i>	25
HUMIRA KIT 40MG/0.8	12	<i>hydrocodone bitartrate tab er 24hr deter</i> <i>120 mg</i>	25
HUMIRA PEDIA INJ CROHNS	12	<i>hydrocodone bitartrate tab er 24hr deter 20</i> <i>mg</i>	25
HUMIRA PEN INJ 40/0.4ML	12		
HUMIRA PEN INJ 40MG/0.8	13		
HUMIRA PEN INJ 80/0.8ML	13		
HUMIRA PEN INJ CD/UC/HS	13		
HUMIRA PEN INJ PS/UV	13		
HUMIRA PEN KIT CD/UC/HS	14		
HUMIRA PEN KIT PED UC	14		
HUMIRA PEN KIT PS/UV	14		
HUMULIN R INJ U-500	64		
HYCAMTIN CAP 0.25MG	97		
HYCAMTIN CAP 1MG	97		
<i>hydralazine hcl tab 100 mg</i>	83		
<i>hydralazine hcl tab 10 mg</i>	83		

<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>.....25	<i>hydroxyurea cap 500 mg</i>.....97
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>.....25	<i>hydroxyzine hcl syrup 10 mg/5ml</i>.....39
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>.....25	<i>hydroxyzine hcl tab 10 mg</i> .....39
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>.....25	<i>hydroxyzine hcl tab 25 mg</i> .....39
<i>hydrocodone-ibuprofen tab 10-200 mg</i> ....31	<i>hydroxyzine hcl tab 50 mg</i>.....39
<i>hydrocodone-ibuprofen tab 5-200 mg</i>.....31	<i>hydroxyzine pamoate cap 100 mg</i>.....39
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i> ...31	<i>hydroxyzine pamoate cap 25 mg</i>.....39
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i> .....135	<i>hydroxyzine pamoate cap 50 mg</i> .....39
<i>hydrocortisone acetate suppos 25 mg</i> .....35	<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>.....233
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>.....34	<i>hyoscyamine sulfate sl tab 0.125 mg</i> .....234
<i>hydrocortisone butyrate cream 0.1%</i> .....147	<i>hyoscyamine sulfate soln 0.125 mg/ml</i> ..234
<i>hydrocortisone butyrate oint 0.1%</i> .....147	<i>hyoscyamine sulfate tab 0.125 mg</i> .....234
<i>hydrocortisone butyrate soln 0.1%</i> .....147	<i>hyoscyamine sulfate tab disint 0.125 mg</i> 234
<i>hydrocortisone cream 2.5%</i> .....147	<i>HYPERSAL NEB 3.5%</i> .....135
<i>hydrocortisone enema 100 mg/60ml</i> .....34	<i>HYPERSAL NEB 7%</i>.....135
<i>hydrocortisone lotion 2.5%</i> .....147	<i>HYPOLANCE KIT LANCING</i>.....191
<i>hydrocortisone oint 2.5%</i> .....147	<i>HYRIMOZ</i> .....14
<i>hydrocortisone perianal cream 1%</i>.....35	<i>HYRIMOZ INJ 10/0.1ML</i>.....14
<i>hydrocortisone perianal cream 2.5%</i> .....35	<i>HYRIMOZ INJ 20/0.2ML</i>.....14
<i>hydrocortisone tab 10 mg</i>.....133	<i>HYRIMOZ INJ 40/0.4ML</i>.....14, 15
<i>hydrocortisone tab 20 mg</i> .....133	<i>HYRIMOZ INJ 40/0.8ML</i> .....15
<i>hydrocortisone tab 5 mg</i> .....133	<i>HYRIMOZ INJ 80/0.8ML</i> .....15
<i>hydrocortisone valerate cream 0.2%</i> .....147	<i>HYRIMOZ-PED INJ CROHNS</i> .....15
<i>hydrocortisone valerate oint 0.2%</i> .....147	<i>HYRIMOZ-PLAQ INJ PSORIASI</i> .....15
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>.....220	I
<i>hydrogen peroxide soln 30%</i> .....107	<i>ibandronate sodium tab 150 mg (base equivalent)</i>.....161
<i>hydromorphone hcl liqd 1 mg/ml</i>.....26	<i>IBRANCE CAP 100MG</i> .....92
<i>hydromorphone hcl tab 2 mg</i> .....26	<i>IBRANCE CAP 125MG</i>.....92
<i>hydromorphone hcl tab 4 mg</i>.....26	<i>IBRANCE CAP 75MG</i> .....92
<i>hydromorphone hcl tab 8 mg</i>.....26	<i>IBRANCE TAB 100MG</i> .....92
<i>hydromorphone hcl tab er 24hr 12 mg</i> .....26	<i>IBRANCE TAB 125MG</i>.....92
<i>hydromorphone hcl tab er 24hr 16 mg</i>.....26	<i>IBRANCE TAB 75MG</i> .....92
<i>hydromorphone hcl tab er 24hr 32 mg</i> .....26	<i>ibuprofen tab 400 mg</i> .....19
<i>hydromorphone hcl tab er 24hr 8 mg</i> .....26	<i>ibuprofen tab 600 mg</i> .....19
<i>HYDROMORPHON SUP 3MG</i>.....26	<i>ibuprofen tab 800 mg</i> .....19
<i>hydroxychloroquine sulfate tab 200 mg</i> ...83	<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>.....175
	<i>ICLUSIG TAB 30MG</i> .....92
	<i>IDHIFA TAB 100MG</i>.....92
	<i>IDHIFA TAB 50MG</i> .....92
	<i>ILEVRO DRO 0.3% OP</i>.....219

<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	45	<i>isotretinoin cap 10 mg</i>	137
<i>ipratropium bromide inhal soln 0.02%</i>	42	<i>isotretinoin cap 20 mg</i>	137
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	213	<i>isotretinoin cap 30 mg</i>	137
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	213	<i>isotretinoin cap 40 mg</i>	137
<i>irbesartan-hydrochlorothiazide tab 150-12.5 mg</i>	80	ISOVACTIN AA LIQ PLUS	154
<i>irbesartan-hydrochlorothiazide tab 300-12.5 mg</i>	80	<i>isradipine cap 2.5 mg</i>	121
<i>irbesartan tab 150 mg</i>	76	<i>isradipine cap 5 mg</i>	121
<i>irbesartan tab 300 mg</i>	77	ISTALOL SOL 0.5% OP	214
<i>irbesartan tab 75 mg</i>	76	<i>itraconazole cap 100 mg</i>	69
IRESSA TAB 250MG	87	<i>itraconazole oral soln 10 mg/ml</i>	69
ISENTRESS CHW 100MG	110	<i>ivermectin lotion 0.5%</i>	151
ISENTRESS CHW 25MG	110	<i>ivermectin tab 3 mg</i>	35
ISENTRESS HD TAB 600MG	110	J	
ISENTRESS POW 100MG	110	JAKAFI TAB 10MG	93
ISENTRESS TAB 400MG	110	JAKAFI TAB 15MG	93
<i>isoniazid syrup 50 mg/5ml</i>	84	JAKAFI TAB 20MG	93
<i>isoniazid tab 100 mg</i>	84	JAKAFI TAB 25MG	93
<i>isoniazid tab 300 mg</i>	84	JAKAFI TAB 5MG	93
ISOPTO ATROP SOL 1% OP	215	JANUMET TAB 50-1000	62
ISOPTO CARP SOL 1% OP	215	JANUMET TAB 50-500MG	62
ISOPTO CARP SOL 2% OP	215	JANUMET XR TAB 100-1000	62
ISOPTO CARP SOL 4% OP	215	JANUMET XR TAB 50-1000	62
ISORDIL TAB 40MG	38	JANUMET XR TAB 50-500MG	62
ISORDIL TAB 5MG	38	JANUVIA TAB 100MG	64
<i>isosorbide dinitrate tab 10 mg</i>	38	JANUVIA TAB 25MG	63
<i>isosorbide dinitrate tab 20 mg</i>	38	JANUVIA TAB 50MG	63
<i>isosorbide dinitrate tab 30 mg</i>	38	JARDIANCE TAB 10MG	66
<i>isosorbide dinitrate tab 5 mg</i>	38	JARDIANCE TAB 25MG	66
<i>isosorbide mononitrate tab 10 mg</i>	38	JEVITY 1.2 LIQ CAL	154
<i>isosorbide mononitrate tab 20 mg</i>	38	JEVITY 1.5 LIQ CAL	154
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	38	JEVITY 1 CAL LIQ	154
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	38	JUBLIA SOL 10%	139
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	38	JULUCA TAB 50-25MG	110
ISOSOURCE HN LIQ	154	JUXTAPID CAP 10MG	74
ISOSOURCE LIQ	154	JUXTAPID CAP 20MG	74
		JUXTAPID CAP 30MG	74
		JUXTAPID CAP 5MG	74
		JYNARQUE PAK 15MG	166
		JYNARQUE PAK 30-15MG	167
		JYNARQUE PAK 45-15MG	167
		JYNARQUE PAK 60-30MG	167
		JYNARQUE PAK 90-30MG	167
		JYNARQUE TAB 15MG	167

JYNARQUE TAB 30MG.....	167	KEVZARA INJ 200/1.14	18
K		KINNEY MIS LANCETS	191
KALBITOR INJ 10MG/ML	176	KINNEY THIN MIS LANCETS	191
KALETRA SOL.....	110	KISQALI 200 PAK FEMARA	90
KALETRA TAB 100-25MG	110	KISQALI 400 PAK FEMARA.....	90
KALETRA TAB 200-50MG.....	111	KISQALI 600 PAK FEMARA.....	90
KALYDECO GRA 13.4MG	229	KISQALI TAB 200DOSE.....	93
KALYDECO GRA 5.8MG.....	229	KISQALI TAB 400DOSE.....	93
KALYDECO PAK 25MG	229	KISQALI TAB 600DOSE.....	93
KALYDECO PAK 50MG.....	229	KITABIS PAK NEB 300/5ML	10
KALYDECO PAK 75MG	229	KLARON LOT 10%	137
KALYDECO TAB 150MG	230	KLONOPIN TAB 0.5MG.....	48
KAPVAY TAB 0.1 MG.....	5	KLONOPIN TAB 1MG	48
KARBINAL ER SUS 4MG/5ML.....	70	KLONOPIN TAB 2MG	48
KEFLEX CAP 750MG.....	129	KORLYM TAB 300MG	63
KENALOG AER SPRAY.....	147	KOSELUGO CAP 10MG.....	93
KEPPRA SOL 100MG/ML.....	50	KOSELUGO CAP 25MG.....	93
KEPPRA TAB 1000MG	50	K-PHOS TAB NO 2.....	173
KEPPRA TAB 250MG	50	KRISTALOSE PAK 10GM	180
KEPPRA TAB 500MG	50	KRISTALOSE PAK 20GM.....	181
KEPPRA TAB 750MG	50	KROGER LANCE MIS	191
KEPPRA XR TAB 500MG	50	KROGER LANCE MIS 26G	191
KEPPRA XR TAB 750MG	50	KROGER LANCE MIS THIN	191
KERENDIA TAB 10MG.....	165	KROGER LANCE MIS THIN 30G.....	191
KERENDIA TAB 20MG	165	K-TAB TAB 10MEQ CR.....	206
KERYDIN SOL 5%.....	139	K-TAB TAB 20MEQ.....	207
KESIMPTA INJ 20/.4ML	226	K-TAB TAB 8MEQ CR.....	206
<i>ketoconazole cream 2%</i>	139	L	
<i>ketoconazole shampoo 2%</i>	139	<i>labetalol hcl tab 100 mg</i>	118
<i>ketoconazole tab 200 mg</i>	69	<i>labetalol hcl tab 200 mg</i>	118
KETO-DIASTIX TES	152	<i>labetalol hcl tab 300 mg</i>	118
KETONE TES.....	152	<i>lacosamide oral solution 10 mg/ml</i>	50
KETONE TEST TES	152	<i>lacosamide tab 100 mg</i>	50
<i>ketoprofen cap 50 mg</i>	19	<i>lacosamide tab 150 mg</i>	50
<i>ketoprofen cap 75 mg</i>	19	<i>lacosamide tab 200 mg</i>	50
<i>ketorolac tromethamine ophth soln 0.4%</i>	219	<i>lacosamide tab 50 mg</i>	50
<i>ketorolac tromethamine ophth soln 0.5%</i>	219	LACTIC ACID LOT 10%.....	149
<i>ketorolac tromethamine tab 10 mg</i>	20	<i>lactulose (encephalopathy) solution 10</i> <i>gm/15ml</i>	172
KETOSTIX TES STRIP	152	<i>lactulose solution 10 gm/15ml</i>	181
KEYEYIS TAB 50MG.....	158	LAGEVRIO CAP 200MG	117
KEVZARA INJ 150/1.14	18	LAMICTAL CHW 25MG.....	51
		LAMICTAL CHW 5MG.....	51

LAMICTAL KIT START 35	51	<i>lamotrigine tab chewable dispersible 5 mg</i>	51
LAMICTAL KIT START 49	51	.....	51
LAMICTAL KIT START 98	51	<i>lamotrigine tab disint 25 (14) & 50 mg (14) &</i>	
LAMICTAL ODT KIT	51	<i>100 mg (7) kit</i>	52
LAMICTAL ODT TAB 100MG.....	51	<i>lamotrigine tab er 24hr 100 mg</i>	52
LAMICTAL ODT TAB 200MG	51	<i>lamotrigine tab er 24hr 200 mg</i>	52
LAMICTAL ODT TAB 25MG.....	51	<i>lamotrigine tab er 24hr 250 mg</i>	52
LAMICTAL ODT TAB 50MG	51	<i>lamotrigine tab er 24hr 25 mg</i>	52
LAMICTAL TAB 100MG.....	51	<i>lamotrigine tab er 24hr 300 mg</i>	52
LAMICTAL TAB 150MG.....	51	<i>lamotrigine tab er 24hr 50 mg</i>	52
LAMICTAL TAB 200MG	51	LAMPIT TAB 120MG	36
LAMICTAL TAB 25MG.....	51	LAMPIT TAB 30MG.....	36
LAMICTAL XR KIT	51	LANAFLEX PAK	154
LAMICTAL XR TAB 100MG.....	51	LANCET AUTO MIS INJECTOR	191
LAMICTAL XR TAB 200MG	51	LANCET CARRY MIS CASE.....	191
LAMICTAL XR TAB 250MG	51	LANCET DEVIC MIS 30G.....	191
LAMICTAL XR TAB 25MG.....	51	LANCET DEVIC MIS ADJUST	191
LAMICTAL XR TAB 300MG.....	51	LANCET MICRO MIS THIN 33G.....	191
LAMICTAL XR TAB 50MG	51	LANCETS MICR MIS THIN 33G	191
<i>lamivudine oral soln 10 mg/ml</i>	111	LANCETS MIS	191
<i>lamivudine tab 100 mg (hbv)</i>	115	LANCETS MIS 21G.....	191
<i>lamivudine tab 150 mg</i>	111	LANCETS MIS 21G COLR	191
<i>lamivudine tab 300 mg</i>	111	LANCETS MIS 28G	192
<i>lamivudine-zidovudine tab 150-300 mg</i> ...	111	LANCETS MIS 30G	192
<i>lamotrigine orally disintegrating tab 100 mg</i>		LANCETS MIS 33G	192
.....	51	LANCETS MIS ORANGE	192
<i>lamotrigine orally disintegrating tab 200 mg</i>		LANCETS MIS ORIGINAL	192
.....	51	LANCETS MIS THIN	192
<i>lamotrigine orally disintegrating tab 25 mg</i>		LANCETS MIS THIN 26G	192
.....	51	LANCETS MIS THIN 30G	192
<i>lamotrigine orally disintegrating tab 50 mg</i>		LANCETS SUPR MIS THIN 28G	192
.....	51	LANCET STAND MIS 21G	191
<i>lamotrigine tab 100 mg</i>	51	LANCETS THIN MIS	192
<i>lamotrigine tab 150 mg</i>	51	LANCETS THIN MIS 26G	192
<i>lamotrigine tab 200 mg</i>	51	LANCETS ULTR MIS THIN	192
<i>lamotrigine tab 25 mg</i>	51	LANCET SUPER MIS THIN 30G.....	191
<i>lamotrigine tab 25 mg (42) & 100 mg (7)</i>		LANCET ULTRA MIS 28G	191
<i>starter kit</i>	51	LANCET ULTRA MIS THIN 30G.....	191
<i>lamotrigine tab 35 x 25 mg starter kit</i>	51	LANCET WITH MIS EJECTOR	191
<i>lamotrigine tab 84 x 25 mg & 14 x 100 mg</i>		LANCING DEVI MIS	192
<i>starter kit</i>	51	LANCING DEVI MIS 25G.....	192
<i>lamotrigine tab chewable dispersible 25 mg</i>		LANCING DEVI MIS 30G.....	192
.....	52	LANCING MIS DEVICE	192

LANOXIN TAB 0.0625MG	122	levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)	45
lansoprazole cap delayed release 15 mg	235	levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)	45
lansoprazole cap delayed release 30 mg	235	levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)	45
lansoprazole tab delayed release orally disintegrating 15 mg	235	LEVBID TAB 0.375 ER	234
lansoprazole tab delayed release orally disintegrating 30 mg.....	235	LEVEMIR INJ.....	65
LANZO MIS LANCING.....	192	LEVEMIR INJ FLEXPEN	65
lapatinib ditosylate tab 250 mg (base equiv)	93	LEVEMIR INJ FLEXTOUC	65
LASIX TAB 20MG.....	159	levetiracetam oral soln 100 mg/ml	52
LASIX TAB 40MG	159	levetiracetam tab 1000 mg	52
LASIX TAB 80MG	159	levetiracetam tab 250 mg.....	52
latanoprost ophth soln 0.005%	219	levetiracetam tab 500 mg.....	52
LB LANCET MIS 28G.....	192	levetiracetam tab 750 mg.....	52
LB LANCING MIS DEVICE	192	levetiracetam tab er 24hr 500 mg	52
leflunomide tab 10 mg	21	levetiracetam tab er 24hr 750 mg	52
leflunomide tab 20 mg	21	LEVITRA TAB 10MG.....	124
lenalidomide cap 10 mg	207	LEVITRA TAB 20MG.....	124
lenalidomide cap 15 mg	207	levobunolol hcl ophth soln 0.5%	214
lenalidomide cap 25 mg.....	207	levocarnitine oral soln 1 gm/10ml (10%)..	164
lenalidomide cap 5 mg.....	207	levocarnitine tab 330 mg.....	164
LENVIMA CAP 10 MG	86	levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)	70
LENVIMA CAP 12MG	86	levofloxacin ophth soln 0.5%.....	216
LENVIMA CAP 14 MG	86	levofloxacin oral soln 25 mg/ml	169
LENVIMA CAP 18 MG	87	levofloxacin tab 250 mg	169
LENVIMA CAP 20 MG.....	87	levofloxacin tab 500 mg	170
LENVIMA CAP 24 MG.....	87	levofloxacin tab 750 mg	170
LENVIMA CAP 4MG.....	86	levonor-eth est tab 0.15-0.02/0.025/0.03 mg ð est 0.01 mg	130
LENVIMA CAP 8 MG.....	86	levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg.....	130
letrozole tab 2.5 mg	88	levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg.....	130
leucovorin calcium tab 10 mg.....	97	levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg.....	130
leucovorin calcium tab 15 mg.....	97	levonorgestrel-eth estra tab 0.05- 30/0.075-40/0.125-30mg-mcg	131
leucovorin calcium tab 25 mg	97	levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	131
leucovorin calcium tab 5 mg	97	levonorgestrel tab 1.5 mg	132
LEUKERAN TAB 2MG	85		
leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml).....	89		
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)	45		
levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)	45		

<i>levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)</i>	130	<i>lisinopril & hydrochlorothiazide tab 10-12.5 mg</i>	80
<i>levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)</i>	130	<i>lisinopril & hydrochlorothiazide tab 20-12.5 mg</i>	80
<i>levothyroxine sodium tab 100 mcg</i>	232	<i>lisinopril & hydrochlorothiazide tab 20-25 mg</i>	80
<i>levothyroxine sodium tab 112 mcg</i>	232	<i>lisinopril tab 10 mg</i>	75
<i>levothyroxine sodium tab 125 mcg</i>	232	<i>lisinopril tab 2.5 mg</i>	75
<i>levothyroxine sodium tab 137 mcg</i>	232	<i>lisinopril tab 20 mg</i>	75
<i>levothyroxine sodium tab 150 mcg</i>	232	<i>lisinopril tab 30 mg</i>	75
<i>levothyroxine sodium tab 175 mcg</i>	232	<i>lisinopril tab 40 mg</i>	75
<i>levothyroxine sodium tab 200 mcg</i>	232	<i>lisinopril tab 5 mg</i>	75
<i>levothyroxine sodium tab 25 mcg</i>	232	LITETOUCH MIS LANCETS	192
<i>levothyroxine sodium tab 300 mcg</i>	232	LITE TOUCH MIS LANCETS	192
<i>levothyroxine sodium tab 50 mcg</i>	232	LITE TOUCH MIS LANC PEN.....	192
<i>levothyroxine sodium tab 75 mcg</i>	232	LITFULO CAP 50MG	149
<i>levothyroxine sodium tab 88 mcg</i>	232	<i>lithium carbonate cap 150 mg</i>	101
LEVSIN/SL SUB 0.125MG	234	<i>lithium carbonate cap 300 mg</i>	101
LEVSIN TAB 0.125MG.....	234	<i>lithium carbonate cap 600 mg</i>	101
LEVULAN KERA SOL 20%.....	140	<i>lithium carbonate tab 300 mg</i>	101
<i>lidocaine hcl laryngotracheal soln 4%</i>	210	<i>lithium carbonate tab er 300 mg</i>	101
<i>lidocaine hcl soln 4%</i>	150	<i>lithium carbonate tab er 450 mg</i>	101
<i>lidocaine hcl urethral/mucosal gel 2%</i>	150	LITHIUM SOL 8MEQ/5ML.....	101
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	150	LITHOBID TAB 300MG CR.....	101
<i>lidocaine hcl viscous soln 2%</i>	210	LIVTENCITY TAB 200MG.....	114
<i>lidocaine oint 5%</i>	150	LOCOID LIPO CRE 0.1%.....	147
<i>lidocaine patch 5%</i>	150	LOCOID LOT 0.1%	147
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	150	LODOSYN TAB 25MG.....	97
LIDODERM DIS 5%.....	150	LOKELMA PAK 10GM	210
LIFESCAN MIS UNISTIK2.....	192	LOKELMA PAK 5GM	210
<i>lindane shampoo 1%</i>	151	LO LOESTRIN TAB 1-10-10	131
<i>linezolid for susp 100 mg/5ml</i>	37	LOMOTIL TAB 2.5MG.....	66
<i>linezolid tab 600 mg</i>	37	LONGS LANCET MIS STANDARD	192
LINZESS CAP 145MCG.....	172	LONGS LANCET MIS THIN.....	192
LINZESS CAP 290MCG.....	172	LONGS LANCET MIS ULTRA TH	192
LINZESS CAP 72MCG	172	LONSURF TAB 15-6.14	90
<i>liothyronine sodium tab 25 mcg</i>	233	LONSURF TAB 20-8.19.....	90
<i>liothyronine sodium tab 50 mcg</i>	233	LOPHLEX POW	154
<i>liothyronine sodium tab 5 mcg</i>	233	LOPID TAB 600MG	72
LIPOFEN CAP 150MG	72	<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	111
LIPOFEN CAP 50MG.....	72	<i>lopinavir-ritonavir tab 100-25 mg</i>	111
LIQUID HOPE LIQ	154	<i>lopinavir-ritonavir tab 200-50 mg</i>	111

LOPRESSOR TAB 100MG.....	118	LOVENOX INJ 60/0.6ML.....	47
LOPRESSOR TAB 50MG.....	118	LOVENOX INJ 80/0.8ML.....	47
LOPROX SHA 1%.....	139	<i>loxapine succinate cap 10 mg</i>	104
<i>lorazepam conc 2 mg/ml</i>	40	<i>loxapine succinate cap 25 mg</i>	104
<i>lorazepam tab 0.5 mg</i>	40	<i>loxapine succinate cap 50 mg</i>	104
<i>lorazepam tab 1 mg</i>	40	<i>loxapine succinate cap 5 mg</i>	104
<i>lorazepam tab 2 mg</i>	40	<i>lubiprostone cap 24 mcg</i>	170
LORBRENA TAB 100MG.....	93	<i>lubiprostone cap 8 mcg</i>	170
LORBRENA TAB 25MG.....	93	LUMAKRAS TAB 120MG.....	93
LORTAB ELX 10-300MG.....	32	LUMAKRAS TAB 320MG.....	93
<i>losartan potassium & hydrochlorothiazide</i>		LUMIGAN SOL 0.01%.....	219
<i>tab 100-12.5 mg</i>	80	<i>lurasidone hcl tab 120 mg</i>	101
<i>losartan potassium & hydrochlorothiazide</i>		<i>lurasidone hcl tab 20 mg</i>	101
<i>tab 100-25 mg</i>	80	<i>lurasidone hcl tab 40 mg</i>	101
<i>losartan potassium & hydrochlorothiazide</i>		<i>lurasidone hcl tab 60 mg</i>	101
<i>tab 50-12.5 mg</i>	80	<i>lurasidone hcl tab 80 mg</i>	101
<i>losartan potassium tab 100 mg</i>	77	LUXIQ AER 0.12%.....	147
<i>losartan potassium tab 25 mg</i>	77	LUZU CRE 1%.....	139
<i>losartan potassium tab 50 mg</i>	77	LYNPARZA TAB 100MG.....	94
LOTENSIN HCT TAB 10-12.5.....	80	LYNPARZA TAB 150MG.....	94
LOTENSIN HCT TAB 20-12.5.....	80	LYSODREN TAB 500MG.....	89
LOTENSIN HCT TAB 20-25MG.....	80	LYSTEDA TAB 650MG.....	178
LOTENSIN TAB 10MG.....	75	LYVISPAH GRA 10MG.....	212
LOTENSIN TAB 20MG.....	75	LYVISPAH GRA 20MG.....	212
LOTENSIN TAB 40MG.....	75	LYVISPAH GRA 5MG.....	212
<i>loteprednol etabonate ophth gel 0.5%</i>	217	M	
<i>loteprednol etabonate ophth susp 0.5%</i>	217	MACROBID CAP 100MG.....	37
LOTREL CAP 10-20MG.....	80	<i>mafenide acetate packet for topical soln</i>	
LOTREL CAP 10-40MG.....	80	5% (50 gm).....	145
LOTREL CAP 5-10MG.....	80	MALARONE TAB 250-100.....	83
LOTREL CAP 5-20MG.....	80	MALARONE TAB 62.5-25.....	83
LOTRONEX TAB 0.5MG.....	172	<i>malathion lotion 0.5%</i>	151
LOTRONEX TAB 1MG.....	172	<i>maprotiline hcl tab 25 mg</i>	57
<i>lovastatin tab 10 mg</i>	73	<i>maprotiline hcl tab 50 mg</i>	57
<i>lovastatin tab 20 mg</i>	73	<i>maprotiline hcl tab 75 mg</i>	57
<i>lovastatin tab 40 mg</i>	73	MAR-COF CG LIQ 225-7.5.....	135
LOVAZA CAP 1GM.....	71	MARINOL CAP 10MG.....	68
LOVENOX INJ 100MG/ML.....	48	MARINOL CAP 2.5MG.....	68
LOVENOX INJ 120/0.8.....	48	MARINOL CAP 5MG.....	68
LOVENOX INJ 150MG/ML.....	48	MARPLAN TAB 10MG.....	57
LOVENOX INJ 30/0.3ML.....	47	MATULANE CAP 50MG.....	97
LOVENOX INJ 300/3ML.....	48	MAVENCLAD PAK 10MG(10).....	226
LOVENOX INJ 40/0.4ML.....	47	MAVENCLAD PAK 10MG(4).....	226

MAVENCLAD PAK 10MG(5)	226	<i>mefenamic acid cap 250 mg</i>	20
MAVENCLAD PAK 10MG(6)	226	<i>mefloquine hcl tab 250 mg</i>	83
MAVENCLAD PAK 10MG(7)	226	<i>megestrol acetate susp 40 mg/ml</i>	89
MAVENCLAD PAK 10MG(8)	226	<i>megestrol acetate susp 625 mg/5ml</i>	221
MAVENCLAD PAK 10MG(9)	226	<i>megestrol acetate tab 20 mg</i>	89
MAXITROL OIN 0.1% OP	218	<i>megestrol acetate tab 40 mg</i>	89
MAXITROL SUS 0.1% OP	218	MEIJER LANCE MIS COLOR	193
MAXZIDE-25 TAB	159	MEIJER LANCE MIS UNIV 21G	193
MAXZIDE TAB 75-50.....	159	MEIJER LANCE MIS UNIV 30G	193
MAYZENT PAK STARTER	226	MEIJER LANCE MIS UNIVERSA.....	193
MAYZENT TAB 0.25MG	226	MEIJER MIS LANCETS.....	193
MAYZENT TAB 1MG.....	226	MEKINIST SOL 0.05/ML	94
MAYZENT TAB 2MG	226	MEKINIST TAB 0.5MG.....	94
MCT PRO-CAL PAK	154	MEKINIST TAB 2MG	94
<i>meclofenamate sodium cap 100 mg</i>	20	MEKTOVI TAB 15MG	94
<i>meclofenamate sodium cap 50 mg</i>	20	<i>meloxicam tab 15 mg</i>	20
MEDICHOICE MIS LANCET	192	<i>meloxicam tab 7.5 mg</i>	20
MEDISENSE LIQ GLUC/KET	192	<i>melfalan tab 2 mg</i>	85
MEDISENSE LIQ GLUC-KET	192	<i>memantine hcl cap er 24hr 14 mg</i>	223
MEDLANCE MIS 30G PLUS.....	192	<i>memantine hcl cap er 24hr 21 mg</i>	223
MEDLANCE MIS EXTR 21G.....	192	<i>memantine hcl cap er 24hr 28 mg</i>	223
MEDLANCE MIS LITE 25G.....	192	<i>memantine hcl cap er 24hr 7 mg</i>	223
MEDLANCE MIS PLUS	192	<i>memantine hcl oral solution 2 mg/ml</i>	223
MEDLANCE MIS PLUS 30G.....	192	<i>memantine hcl tab 10 mg</i>	223
MEDLANCE MIS UNV 21G	192	<i>memantine hcl tab 28 x 5 mg & 21 x 10 mg</i>	
MEDLANCE PLS MIS 0.8MM	193	<i>titration pack</i>	223
MEDLANCE PLS MIS EXTR 21G.....	193	<i>memantine hcl tab 5 mg</i>	223
MEDLANCE PLS MIS LITE 25G.....	193	MEMBRANEBLUE INJ 0.15%	218
MEDLANCE PLS MIS UNIV 21G	193	MENOPUR INJ 75UNIT	162
MEDROL TAB 16MG	133	MENOSTAR DIS 14MCG	169
MEDROL TAB 2MG.....	133	<i>meperidine hcl oral soln 50 mg/5ml</i>	26
MEDROL TAB 32MG.....	133	<i>meperidine hcl tab 50 mg</i>	26
MEDROL TAB 4MG.....	133	MEPHYTON TAB 5MG	239
MEDROL TAB 8MG.....	133	<i>meprobamate tab 200 mg</i>	39
<i>medroxyprogesterone acetate im susp 150</i>		<i>meprobamate tab 400 mg</i>	39
<i>mg/ml</i>	132	MEPRON SUS	36
<i>medroxyprogesterone acetate im susp</i>		<i>mercaptopurine tab 50 mg</i>	85
<i>prefilled syr 150 mg/ml</i>	132	<i>mesalamine cap dr 400 mg</i>	171
<i>medroxyprogesterone acetate tab 10 mg</i>		<i>mesalamine cap er 24hr 0.375 gm</i>	171
.....	221	<i>mesalamine cap er 500 mg</i>	171
<i>medroxyprogesterone acetate tab 2.5 mg</i>		<i>mesalamine enema 4 gm</i>	171
.....	221	<i>mesalamine rectal enema 4 gm & cleanser</i>	
<i>medroxyprogesterone acetate tab 5 mg</i> .221		<i>wipe kit</i>	171

<i>mesalamine suppos 1000 mg</i>	171	<i>methotrexate sodium inj pf 250 mg/10ml</i> (25 mg/ml)	86
<i>mesalamine tab delayed release 1.2 gm</i> ..	171	<i>methotrexate sodium inj pf 50 mg/2ml (25</i> <i>mg/ml)</i>	85
<i>mesalamine tab delayed release 800 mg</i>	171	<i>methotrexate sodium tab 2.5 mg (base</i> <i>equiv)</i>	86
MESNEX TAB 400MG.....	97	<i>methoxsalen rapid cap 10 mg</i>	142
MESTINON SOL 60MG/5ML.....	84	<i>methscopolamine bromide tab 2.5 mg</i> ...	234
MESTINON TAB 60MG	84	<i>methscopolamine bromide tab 5 mg</i>	234
MESTINON TAB TIMESPAN	84	<i>methyldopa & hydrochlorothiazide tab 250-</i> <i>15 mg</i>	80
<i>metaxalone tab 800 mg</i>	212	<i>methyldopa & hydrochlorothiazide tab 250-</i> <i>25 mg</i>	80
<i>metformin hcl oral soln 500 mg/5ml</i>	63	<i>methyldopa tab 250 mg</i>	77
<i>metformin hcl tab 1000 mg</i>	63	<i>methyldopa tab 500 mg</i>	78
<i>metformin hcl tab 500 mg</i>	63	<i>methylergonovine maleate tab 0.2 mg</i> ...	220
<i>metformin hcl tab 850 mg</i>	63	METHYLIN SOL 10MG/5ML.....	7
<i>metformin hcl tab er 24hr 500 mg</i>	63	METHYLIN SOL 5MG/5ML	7
<i>metformin hcl tab er 24hr 750 mg</i>	63	<i>methylphenidate hcl cap er 10 mg (cd)</i>	7
<i>methadone hcl conc 10 mg/ml</i>	26	<i>methylphenidate hcl cap er 20 mg (cd)</i>	7
<i>methadone hcl soln 10 mg/5ml</i>	26	<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	7
<i>methadone hcl soln 5 mg/5ml</i>	26	<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	7
<i>methadone hcl tab 10 mg</i>	26	<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	7
<i>methadone hcl tab 5 mg</i>	26	<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	7
<i>methadone hcl tab for oral susp 40 mg</i>	26	<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	7
METHADOSE CON 10MG/ML	26	<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	7
METHADOSE SF CON 10MG/ML.....	26	<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	8
<i>methamphetamine hcl tab 5 mg</i>	2	<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	8
<i>methazolamide tab 25 mg</i>	158	<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	8
<i>methazolamide tab 50 mg</i>	158	<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	8
<i>methenamine hippurate tab 1 gm</i>	37	<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	8
<i>methenamine-hyos-meth blue-sod phos-</i> <i>phen sal tab 81.6 mg</i>	36		
<i>methenamine mandelate tab 0.5 gm</i>	37		
<i>methenamine mandelate tab 1 gm</i>	37		
<i>methimazole tab 10 mg</i>	232		
<i>methimazole tab 5 mg</i>	232		
METHITEST TAB 10MG	34		
<i>methocarbamol tab 500 mg</i>	212		
<i>methocarbamol tab 750 mg</i>	212		
<i>methotrexate sodium for inj 1 gm</i>	85		
<i>methotrexate sodium inj 250 mg/10ml (25</i> <i>mg/ml)</i>	85		
<i>methotrexate sodium inj 50 mg/2ml (25</i> <i>mg/ml)</i>	85		
<i>methotrexate sodium inj pf 1000 mg/40ml</i> (25 mg/ml)	86		

<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i> .....8	<i>metoclopramide hcl tab 5 mg (base equivalent)</i> .....171
<i>methylphenidate hcl cap er 30 mg (cd)</i> .....8	METOCLOPRAMI TAB 10MG ODT .....170
<i>methylphenidate hcl cap er 40 mg (cd)</i> .....8	<i>metolazone tab 10 mg</i>.....160
<i>methylphenidate hcl cap er 50 mg (cd)</i> .....8	<i>metolazone tab 2.5 mg</i> .....160
<i>methylphenidate hcl cap er 60 mg (cd)</i> .....8	<i>metolazone tab 5 mg</i> .....160
<i>methylphenidate hcl chew tab 10 mg</i>.....8	<i>metoprolol & hydrochlorothiazide tab 100-25 mg</i> .....80
<i>methylphenidate hcl chew tab 2.5 mg</i> .....8	<i>metoprolol & hydrochlorothiazide tab 100-50 mg</i>.....81
<i>methylphenidate hcl chew tab 5 mg</i> .....8	<i>metoprolol & hydrochlorothiazide tab 50-25 mg</i> .....80
<i>methylphenidate hcl soln 10 mg/5ml</i> .....8	<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i> .....118
<i>methylphenidate hcl soln 5 mg/5ml</i>.....8	<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i> .....118
<i>methylphenidate hcl tab 10 mg</i> .....8	<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i> .....118
<i>methylphenidate hcl tab 20 mg</i> .....8	<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i> .....118
<i>methylphenidate hcl tab 5 mg</i>.....8	<i>metoprolol tartrate tab 100 mg</i> .....118
<i>methylphenidate hcl tab er 10 mg</i>.....9	<i>metoprolol tartrate tab 25 mg</i> .....118
<i>methylphenidate hcl tab er 20 mg</i> .....9	<i>metoprolol tartrate tab 37.5 mg</i> .....118
<i>methylphenidate hcl tab er 24hr 18 mg</i>.....9	<i>metoprolol tartrate tab 50 mg</i> .....118
<i>methylphenidate hcl tab er 24hr 27 mg</i> .....9	<i>metoprolol tartrate tab 75 mg</i> .....118
<i>methylphenidate hcl tab er 24hr 36 mg</i>.....9	METROCREAM CRE 0.75% .....151
<i>methylphenidate hcl tab er 24hr 54 mg</i>.....9	METROGEL GEL 1% .....151
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i> .....9	METROLOTION LOT 0.75% .....151
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i> .....9	<i>metronidazole cap 375 mg</i> .....35
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i> .....9	<i>metronidazole cream 0.75%</i> .....151
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i> .....9	<i>metronidazole gel 0.75%</i> .....151
METHYLPHENID TAB 72MG ER .....7	<i>metronidazole gel 1%</i> .....151
<i>methylprednisolone tab 16 mg</i> .....133	<i>metronidazole lotion 0.75%</i>.....151
<i>methylprednisolone tab 32 mg</i> .....133	<i>metronidazole tab 250 mg</i> .....35
<i>methylprednisolone tab 4 mg</i> .....133	<i>metronidazole tab 500 mg</i> .....35
<i>methylprednisolone tab 8 mg</i> .....133	<i>metronidazole vaginal gel 0.75%</i> .....237
<i>methylprednisolone tab therapy pack 4 mg (21)</i>.....133	<i>metyrosine cap 250 mg</i> .....76
<i>methyltestosterone cap 10 mg</i>.....34	<i>mexiletine hcl cap 150 mg</i> .....40
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>.....170	<i>mexiletine hcl cap 200 mg</i> .....40
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i> .....171	<i>mexiletine hcl cap 250 mg</i> .....40
<i>metoclopramide hcl tab 10 mg (base equivalent)</i> .....171	<i>miconazole nitrate vaginal suppos 200 mg</i>.....237

<i>miconazole-zinc oxide-white petrolatum</i>		<i>mirtazapine orally disintegrating tab 30 mg</i>	
<i>oint 0.25-15-81.35%</i>	139	.....	56
MICROCHAMBER MIS	203	<i>mirtazapine orally disintegrating tab 45 mg</i>	
MICRODOT CON SOL HIGH/LOW	193	.....	56
MICROLET MIS LANCETS	193	<i>mirtazapine tab 15 mg</i>	56
MICROLET MIS NEXT	193	<i>mirtazapine tab 30 mg</i>	56
MICRO THIN MIS LANC 33G	193	<i>mirtazapine tab 45 mg</i>	56
<i>midodrine hcl tab 10 mg</i>	239	<i>mirtazapine tab 7.5 mg</i>	56
<i>midodrine hcl tab 2.5 mg</i>	239	<i>misoprostol tab 100 mcg</i>	235
<i>midodrine hcl tab 5 mg</i>	239	<i>misoprostol tab 200 mcg</i>	235
MIFEPREX TAB 200MG	166	MITIGARE CAP 0.6MG.....	175
<i>mifepristone tab 200 mg</i>	166	MITOSOL KIT 0.2MG.....	216
<i>miglitol tab 100 mg</i>	61	MM LANCING MIS DEVICE	193
<i>miglitol tab 25 mg</i>	61	MM TWIST MIS LANCETS.....	193
<i>miglitol tab 50 mg</i>	61	MOBIC TAB 15MG.....	20
<i>miglustat cap 100 mg</i>	176	MOBIC TAB 7.5MG	20
MIGRANAL SPR 4MG/ML	204	MOBILE LANCE MIS 30G	193
MINI LANCING MIS DEVICE.....	193	<i>modafinil tab 100 mg</i>	9
MINIPRESS CAP 1MG	78	<i>modafinil tab 200 mg</i>	9
MINIPRESS CAP 2MG.....	78	<i>moexipril hcl tab 15 mg</i>	75
MINIPRESS CAP 5MG	78	<i>moexipril hcl tab 7.5 mg</i>	75
<i>minocycline hcl cap 100 mg</i>	231	<i>molindone hcl tab 10 mg</i>	105
<i>minocycline hcl cap 50 mg</i>	231	<i>molindone hcl tab 25 mg</i>	105
<i>minocycline hcl cap 75 mg</i>	231	<i>molindone hcl tab 5 mg</i>	105
<i>minocycline hcl tab 100 mg</i>	231	<i>mometasone furoate cream 0.1%</i>	147
<i>minocycline hcl tab 50 mg</i>	231	<i>mometasone furoate nasal susp 50</i>	
<i>minocycline hcl tab 75 mg</i>	231	<i>mcg/act</i>	213
<i>minoxidil tab 10 mg</i>	83	<i>mometasone furoate oint 0.1%</i>	147
<i>minoxidil tab 2.5 mg</i>	83	<i>mometasone furoate solution 0.1% (lotion)</i>	
MIRAPEX ER TAB 0.375MG.....	99	.....	147
MIRAPEX ER TAB 0.75MG.....	99	MONOLET MIS LANCETS.....	193
MIRAPEX ER TAB 1.5MG	99	MONOLET OPD MIS LANCETS	193
MIRAPEX ER TAB 2.25MG.....	99	MONOLETTOR MIS LANCETS.....	193
MIRAPEX ER TAB 3.75MG.....	99	<i>montelukast sodium chew tab 4 mg (base</i>	
MIRAPEX ER TAB 3MG	99	<i>equiv)</i>	42
MIRAPEX ER TAB 4.5MG	99	<i>montelukast sodium chew tab 5 mg (base</i>	
MIRAPEX TAB 0.125MG	99	<i>equiv)</i>	42
MIRAPEX TAB 0.5MG.....	99	<i>montelukast sodium oral granules packet 4</i>	
MIRAPEX TAB 0.75MG	99	<i>mg (base equiv)</i>	42
MIRAPEX TAB 1MG.....	99	<i>montelukast sodium tab 10 mg (base equiv)</i>	
MIRCETTE TAB 28 DAY	131	.....	42
<i>mirtazapine orally disintegrating tab 15 mg</i>		MONUROL PAK GRANULES.....	37
.....	56		

<i>morphine sulfate beads cap er 24hr 120 mg</i>.....27	<i>moxifloxacin hcl tab 400 mg (base equiv)</i> .....170
<i>morphine sulfate beads cap er 24hr 30 mg</i>.....26	MPD SFTY LAN MIS 21G.....193
<i>morphine sulfate beads cap er 24hr 45 mg</i>.....26	MPD SFTY LAN MIS 23G.....193
<i>morphine sulfate beads cap er 24hr 60 mg</i>.....26	MPD SFTY LAN MIS 28G.....193
<i>morphine sulfate beads cap er 24hr 75 mg</i>.....27	MPD SFTY LAN MIS 30G.....193
<i>morphine sulfate beads cap er 24hr 90 mg</i>.....27	MS CONTIN TAB 100MG ER.....28
<i>morphine sulfate cap er 24hr 100 mg</i>.....27	MS CONTIN TAB 15MG ER.....28
<i>morphine sulfate cap er 24hr 10 mg</i>.....27	MS CONTIN TAB 200MG ER.....28
<i>morphine sulfate cap er 24hr 20 mg</i>.....27	MS CONTIN TAB 30MG ER.....28
<i>morphine sulfate cap er 24hr 30 mg</i>.....27	MS CONTIN TAB 60MG ER.....28
<i>morphine sulfate cap er 24hr 40 mg</i>.....27	MULPLETA TAB 3MG.....177
<i>morphine sulfate cap er 24hr 50 mg</i>.....27	MULTAQ TAB 400MG.....41
<i>morphine sulfate cap er 24hr 60 mg</i>.....27	MULTI-LANCET KIT DEVICE.....193
<i>morphine sulfate cap er 24hr 80 mg</i>.....27	MULTI-LANCET MIS DEVICE.....193
<i>morphine sulfate oral soln 100 mg/5ml (20</i> <i>mg/ml)</i>.....27	<i>mupirocin oint 2%</i>.....138
<i>morphine sulfate oral soln 10 mg/5ml</i>.....27	MUSE SUP 1000MCG.....125
<i>morphine sulfate oral soln 20 mg/5ml</i>.....27	MUSE SUP 125MCG.....124
<i>morphine sulfate suppos 10 mg</i>.....27	MUSE SUP 250MCG.....124
<i>morphine sulfate suppos 20 mg</i>.....27	MUSE SUP 500MCG.....125
<i>morphine sulfate suppos 30 mg</i>.....27	MYALEPT INJ 11.3MG.....164
<i>morphine sulfate suppos 5 mg</i>.....27	MYAMBUTOL TAB 400MG.....84
<i>morphine sulfate tab 15 mg</i>.....28	MYCOBUTIN CAP 150MG.....84
<i>morphine sulfate tab 30 mg</i>.....28	<i>mycophenolate mofetil cap 250 mg</i>.....209
<i>morphine sulfate tab er 100 mg</i>.....28	<i>mycophenolate mofetil for oral susp 200</i> <i>mg/ml</i>.....209
<i>morphine sulfate tab er 15 mg</i>.....28	<i>mycophenolate mofetil tab 500 mg</i>.....209
<i>morphine sulfate tab er 200 mg</i>.....28	<i>mycophenolate sodium tab dr 180 mg</i> <i>(mycophenolic acid equiv)</i>.....209
<i>morphine sulfate tab er 30 mg</i>.....28	<i>mycophenolate sodium tab dr 360 mg</i> <i>(mycophenolic acid equiv)</i>.....209
<i>morphine sulfate tab er 60 mg</i>.....28	MYDAYIS CAP 12.5MG.....2
MOVANTIK TAB 12.5MG.....173	MYDAYIS CAP 25MG.....2
MOVANTIK TAB 25MG.....173	MYDAYIS CAP 37.5MG.....2
MOXEZA SOL 0.5%.....216	MYDAYIS CAP 50MG.....2
<i>moxifloxacin hcl ophth soln 0.5% (base eq)</i> <i>(2 times daily)</i>.....216	MYFORTIC TAB 180MG.....209
<i>moxifloxacin hcl ophth soln 0.5% (base</i> <i>equiv)</i>.....216	MYFORTIC TAB 360MG.....209
	MYGLUCOHEALT MIS LANC 30G.....193
	MYGLUCOHEALT SOL LO/NL/HI.....193
	MYLERAN TAB 2MG.....85
	MYRBETRIQ SUS 8MG/ML.....236
	MYRBETRIQ TAB 25MG.....236
	MYRBETRIQ TAB 50MG.....236

MYSOLINE TAB 250MG	52	<i>naproxen tab 375 mg</i>	20
MYSOLINE TAB 50MG	52	<i>naproxen tab 500 mg</i>	20
N		<i>naproxen tab ec 375 mg</i>	20
<i>nabumetone tab 500 mg</i>	20	<i>naproxen tab ec 500 mg</i>	20
<i>nabumetone tab 750 mg</i>	20	<i>naratriptan hcl tab 1 mg (base equiv)</i>	205
<i>nadolol tab 20 mg</i>	119	<i>naratriptan hcl tab 2.5 mg (base equiv)</i> ..	205
<i>nadolol tab 40 mg</i>	119	NARCAN SPR 4MG	67
<i>nadolol tab 80 mg</i>	119	NARDIL TAB 15MG	57
NAFRINSE DLY SOL /NEUTRAL	211	NASCOBAL SPR 500MCG	177
NAFRINSE SOL DAILY	211	NASONEX SPR 50MCG/AC	214
NAFRINSE WK SOL 0.2%	211	NATACYN SUS 5% OP	216
<i>naftifine hcl cream 1%</i>	139	NATAZIA TAB	131
<i>naftifine hcl cream 2%</i>	139	<i>nateglinide tab 120 mg</i>	65
<i>naftifine hcl gel 1%</i>	139	<i>nateglinide tab 60 mg</i>	65
NAFTIN GEL 1%	139	NATESTO GEL 5.5MG	34
NAFTIN GEL 2%	139	NATPARA INJ 100MCG	161
NALFON CAP 400MG	20	NATPARA INJ 25MCG	161
NALFON TAB 600MG	20	NATPARA INJ 50MCG	161
<i>naloxone hcl inj 0.4 mg/ml</i>	67	NATPARA INJ 75MCG	161
<i>naloxone hcl inj 4 mg/10ml</i>	67	NATROBA SUS 0.9%	151
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	67	NAYZILAM SPR 5MG	49
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	67	<i>nebivolol hcl tab 10 mg (base equivalent)</i> ..	118
<i>naloxone hcl soln prefilled syringe 2</i>		<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	
<i>mg/2ml</i>	67	.....	118
<i>naltrexone hcl tab 50 mg</i>	67	<i>nebivolol hcl tab 20 mg (base equivalent)</i>	
NAMENDA TAB 10MG	223	.....	119
NAMENDA TAB 5-10MG	223	<i>nebivolol hcl tab 5 mg (base equivalent)</i> ..	118
NAMENDA TAB 5MG	223	<i>nefazodone hcl tab 100 mg</i>	58
NAMENDA XR CAP 14MG	223	<i>nefazodone hcl tab 150 mg</i>	59
NAMENDA XR CAP 21MG	223	<i>nefazodone hcl tab 200 mg</i>	59
NAMENDA XR CAP 28MG	223	<i>nefazodone hcl tab 250 mg</i>	59
NAMENDA XR CAP 7MG	223	<i>nefazodone hcl tab 50 mg</i>	58
NAMENDA XR CAP TITRATIO	223	NEOCATE LIQ SPLASH	154
NAMZARIC CAP	223	NEOKE MCT70 POW	154
NAMZARIC CAP 14-10MG	223	<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i>	
NAMZARIC CAP 21-10MG	223	<i>400unt-10000unt op oin</i>	216
NAMZARIC CAP 28-10MG	223	<i>neomycin-polymy-gramicid op sol 1.75-</i>	
NAMZARIC CAP 7-10MG	223	<i>10000-0.025mg-unt-mg/ml</i>	216
NAPROSYN SUS 125/5ML	20	<i>neomycin-polymyxin-dexamethasone</i>	
NAPROSYN TAB 500MG	20	<i>ophth oint 0.1%</i>	218
<i>naproxen sodium tab 275 mg</i>	20	<i>neomycin-polymyxin-dexamethasone</i>	
<i>naproxen sodium tab 550 mg</i>	20	<i>ophth susp 0.1%</i>	218
<i>naproxen tab 250 mg</i>	20	<i>neomycin-polymyxin-hc ophth susp</i>	218

<i>neomycin-polymyxin-hc otic soln 1%</i>	219	NICORETTE GUM 2MG CINN	228
<i>neomycin-polymyxin-hc otic susp 3.5</i>		NICORETTE GUM 2MGFRUIT	228
<i>mg/ml-10000 unit/ml-1%</i>	220	NICORETTE GUM 2MG MINT	228
<i>neomycin sulfate tab 500 mg</i>	10	NICORETTE GUM 2MG ORIG	228
NEORAL CAP 100MG.....	209	NICORETTE GUM 4MG	228
NEORAL CAP 25MG.....	209	NICORETTE GUM 4MG CINN.....	228
NEORAL SOL 100MG/ML.....	209	NICORETTE GUM 4MGFRUIT.....	228
NEOTUSS PLUS LIQ	135	NICORETTE GUM 4MG MINT.....	228
NEPRO LIQ VANILLA	154	NICORETTE GUM 4MG ORIG.....	228
NERLYNX TAB 40MG.....	94	NICORETTE LOZ 2MG MINT	228
NEUPRO DIS 1MG/24HR.....	99	NICORETTE LOZ 4MG MINT	228
NEUPRO DIS 2MG/24HR	99	NICORETTE ST GUM 2MG MINT	228
NEUPRO DIS 3MG/24HR	99	NICORETTE ST GUM 2MG ORIG.....	229
NEUPRO DIS 4MG/24HR.....	99	NICORETTE ST GUM 4MG ORIG	229
NEUPRO DIS 6MG/24HR	99	<i>nicotine polacrilex gum 2 mg</i>	229
NEUPRO DIS 8MG/24HR.....	99	<i>nicotine polacrilex gum 4 mg</i>	229
NEURONTIN CAP 100MG	52	<i>nicotine polacrilex lozenge 2 mg</i>	229
NEURONTIN CAP 300MG.....	52	<i>nicotine polacrilex lozenge 4 mg</i>	229
NEURONTIN CAP 400MG.....	52	<i>nicotine td patch 24hr 14 mg/24hr</i>	229
NEURONTIN SOL 250/5ML.....	52	<i>nicotine td patch 24hr 21 mg/24hr</i>	229
NEURONTIN TAB 600MG	52	<i>nicotine td patch 24hr 7 mg/24hr</i>	229
NEURONTIN TAB 800MG	52	NICOTROL INH.....	229
NEUTEK 2TEK SOL CONTROL.....	193	NICOTROL NS SPR 10MG/ML	229
<i>nevirapine susp 50 mg/5ml</i>	111	<i>nifedipine cap 10 mg</i>	121
<i>nevirapine tab 200 mg</i>	111	<i>nifedipine cap 20 mg</i>	121
<i>nevirapine tab er 24hr 100 mg</i>	111	<i>nifedipine tab er 24hr 30 mg</i>	121
<i>nevirapine tab er 24hr 400 mg</i>	111	<i>nifedipine tab er 24hr 60 mg</i>	121
NEXAVAR TAB 200MG	94	<i>nifedipine tab er 24hr 90 mg</i>	121
NEXLETOL TAB 180MG.....	70	<i>nifedipine tab er 24hr osmotic release 30</i>	
NEXLIZET TAB 180/10MG.....	71	<i>mg</i>	121
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>		<i>nifedipine tab er 24hr osmotic release 60</i>	
.....	74	<i>mg</i>	121
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	74	<i>nifedipine tab er 24hr osmotic release 90</i>	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	74	<i>mg</i>	121
NIASPAN TAB 1000 ER	74	<i>nilutamide tab 150 mg</i>	89
NIASPAN TAB 500MG ER.....	74	<i>nimodipine cap 30 mg</i>	121
NIASPAN TAB 750MG ER	74	NINLARO CAP 2.3MG	94
<i>nicardipine hcl cap 20 mg</i>	121	NINLARO CAP 3MG.....	94
<i>nicardipine hcl cap 30 mg</i>	121	NINLARO CAP 4MG.....	94
NICODERM CQ DIS 14MG/24H	228	<i>nisoldipine tab er 24hr 17 mg</i>	121
NICODERM CQ DIS 21MG/24H.....	228	<i>nisoldipine tab er 24hr 20 mg</i>	121
NICODERM CQ DIS 7MG/24HR.....	228	<i>nisoldipine tab er 24hr 25.5 mg</i>	121
NICORETTE GUM 2MG	228	<i>nisoldipine tab er 24hr 30 mg</i>	121

<i>nisoldipine tab er 24hr 34 mg</i>	121	NIVESTYM INJ 480MCG	177
<i>nisoldipine tab er 24hr 40 mg</i>	121	<i>nizatidine cap 150 mg</i>	234
<i>nisoldipine tab er 24hr 8.5 mg</i>	121	<i>nizatidine cap 300 mg</i>	234
<i>nitazoxanide tab 500 mg</i>	36	<i>nizatidine oral soln 15 mg/ml</i>	234
<i>nitisinone cap 10 mg</i>	164	NOCDURNA SUB 27.7MCG.....	166
<i>nitisinone cap 2 mg</i>	164	NOCDURNA SUB 55.3MCG	166
<i>nitisinone cap 5 mg</i>	164	NORDITROPIN INJ 10/1.5ML	163
NITRO-BID OIN 2%	38	NORDITROPIN INJ 15/1.5ML	163
NITRO-DUR DIS 0.1MG/HR	38	NORDITROPIN INJ 30/3ML	163
NITRO-DUR DIS 0.2MG/HR.....	38	NORDITROPIN INJ 5/1.5ML.....	163
NITRO-DUR DIS 0.3MG/HR.....	38	<i>norelgestromin-ethinyl estradiol td ptwk</i>	
NITRO-DUR DIS 0.4MG/HR.....	38	<i>150-35 mcg/24hr</i>	132
NITRO-DUR DIS 0.6MG/HR.....	38	<i>norethindrone & ethinyl estradiol-fe chew</i>	
NITRO-DUR DIS 0.8MG/HR.....	38	<i>tab 0.4 mg-35 mcg</i>	131
<i>nitrofurantoin macrocrystalline cap 100 mg</i>		<i>norethindrone & ethinyl estradiol-fe chew</i>	
.....	37	<i>tab 0.8 mg-25 mcg</i>	131
<i>nitrofurantoin macrocrystalline cap 25 mg</i>		<i>norethindrone & ethinyl estradiol tab 0.4</i>	
.....	37	<i>mg-35 mcg</i>	131
<i>nitrofurantoin macrocrystalline cap 50 mg</i>		<i>norethindrone & ethinyl estradiol tab 0.5</i>	
.....	37	<i>mg-35 mcg</i>	131
<i>nitrofurantoin monohydrate</i>		<i>norethindrone & ethinyl estradiol tab 1 mg-</i>	
<i>macrocrystalline cap 100 mg</i>	37	<i>35 mcg</i>	131
<i>nitrofurantoin susp 25 mg/5ml</i>	37	<i>norethindrone ace & ethinyl estradiol-fe tab</i>	
<i>nitroglycerin sl tab 0.3 mg</i>	38	<i>1.5 mg-30 mcg</i>	131
<i>nitroglycerin sl tab 0.4 mg</i>	38	<i>norethindrone ace & ethinyl estradiol-fe tab</i>	
<i>nitroglycerin sl tab 0.6 mg</i>	38	<i>1 mg-20 mcg</i>	131
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	38	<i>norethindrone ace & ethinyl estradiol tab 1.5</i>	
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	38	<i>mg-30 mcg</i>	131
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	38	<i>norethindrone ace & ethinyl estradiol tab 1</i>	
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	38	<i>mg-20 mcg</i>	131
<i>nitroglycerin tl soln 0.4 mg/spray (400</i>		<i>norethindrone ace-eth estradiol-fe chew</i>	
<i>mcg/spray)</i>	38	<i>tab 1 mg-20 mcg (24)</i>	131
NITROLINGUAL SPR PUMPSPRA.....	38	<i>norethindrone ace-ethinyl estradiol-fe cap 1</i>	
NITROMIST AER 400MCG.....	38	<i>mg-20 mcg (24)</i>	131
NITROSTAT SUB 0.3MG	38	<i>norethindrone ace-ethinyl estradiol-fe tab 1</i>	
NITROSTAT SUB 0.4MG	38	<i>mg-20 mcg (24)</i>	131
NITROSTAT SUB 0.6MG	38	<i>norethindrone acetate-ethinyl estradiol tab</i>	
NITYR TAB 10MG.....	164	<i>0.5 mg-2.5 mcg</i>	167
NITYR TAB 2MG	164	<i>norethindrone acetate-ethinyl estradiol tab</i>	
NITYR TAB 5MG	164	<i>1 mg-5 mcg</i>	167
NIVESTYM INJ 300/0.5	177	<i>norethindrone acetate tab 5 mg</i>	221
NIVESTYM INJ 300MCG	177	<i>norethindrone ac-ethinyl estrad-fe tab 1-</i>	
NIVESTYM INJ 480/0.8.....	177	<i>20/1-30/1-35 mg-mcg</i>	131

<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	131	NOZIN NASAL MIS SANITIZE.....	213
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	132	NP THYROID TAB 120MG	233
<i>norethindrone tab 0.35 mg</i>	132	NP THYROID TAB 15MG	233
<i>norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg</i>	132	NP THYROID TAB 30MG.....	233
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	132	NP THYROID TAB 60MG	233
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	132	NP THYROID TAB 90MG	233
<i>norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg</i>	132	NUBEQA TAB 300MG	89
NORPACE CAP 100MG CR.....	40	NUCALA INJ 100MG/ML	42
NORPACE CAP 150MG CR.....	40	NUCALA INJ 40MG/0.4	41
NORPRAMIN TAB 10MG.....	61	NUCYNTA ER TAB 100MG.....	28
NORPRAMIN TAB 25MG	61	NUCYNTA ER TAB 150MG	28
<i>nortriptyline hcl cap 10 mg</i>	61	NUCYNTA ER TAB 200MG	28
<i>nortriptyline hcl cap 25 mg</i>	61	NUCYNTA ER TAB 250MG	28
<i>nortriptyline hcl cap 50 mg</i>	61	NUCYNTA ER TAB 50MG.....	28
<i>nortriptyline hcl cap 75 mg</i>	61	NUCYNTA TAB 100MG.....	28
<i>nortriptyline hcl soln 10 mg/5ml</i>	61	NUCYNTA TAB 50MG	28
NORVIR POW 100MG.....	111	NUCYNTA TAB 75MG	28
NORVIR SOL 80MG/ML.....	111	NUEDEXTA CAP 20-10MG.....	228
NORVIR TAB 100MG.....	111	NULYTELY SOL LMN/LIME	180
NOVA MAX GLU LIQ /KET CON	193	NUPLAZID CAP 34MG.....	101
NOVA MAX PLS TES KETONE	152	NUPLAZID TAB 10MG	102
NOVA SAFETY MIS LANC 23G	193	NURTEC TAB 75MG ODT	204
NOVA SAFETY MIS LANC 28G	193	NUTRAMINE PAK	154
NOVASOURCE LIQ RENAL.....	154	NUTREN 1.0 LIQ UNFLAVOR.....	155
NOVA SUREFLX MIS LANC DEV	193	NUTREN 1.5 LIQ FIBER.....	155
NOVA SURE MIS LANCETS.....	193	NUTREN 2.0 LIQ VANILLA	155
NOVOLIN INJ 70/30.....	65	NUTREN JR LIQ	155
NOVOLIN INJ 70/30 FP	65	NUTREN LIQ JUNIOR.....	155
NOVOLIN N INJ 100 UNIT	65	NUTREN RENAL LIQ.....	155
NOVOLIN N INJ U-100	65	NUTRIRENAL LIQ.....	155
NOVOLIN R INJ 100 UNIT	65	NUZYRA TAB 150MG	231
NOVOLIN R INJ U-100.....	65	NYMALIZE SOL.....	121
NOVOLOG INJ 100/ML	65	<i>nystatin cream 100000 unit/gm</i>	139
NOVOLOG INJ FLEXPEN	65	<i>nystatin oint 100000 unit/gm</i>	139
NOVOLOG INJ PENFILL.....	65	<i>nystatin oral powder</i>	69
NOVOLOG MIX INJ 70/30.....	65	<i>nystatin susp 100000 unit/ml</i>	210
NOVOLOG MIX INJ FLEXPEN	65	<i>nystatin tab 500000 unit</i>	69
		<i>nystatin topical powder 100000 unit/gm</i>	139
		<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	139
		<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	139
		NYVEPRIA INJ 6/0.6ML	178

○		
OCALIVA TAB 10MG	170	
OCALIVA TAB 5MG.....	170	
octreotide acetate inj 1000 mcg/ml (1 mg/ml)	166	
octreotide acetate inj 100 mcg/ml (0.1 mg/ml)	166	
octreotide acetate inj 200 mcg/ml (0.2 mg/ml)	166	
octreotide acetate inj 500 mcg/ml (0.5 mg/ml)	166	
octreotide acetate inj 50 mcg/ml (0.05 mg/ml)	166	
OCUFLOX DRO 0.3% OP	216	
ODEFSEY TAB.....	111	
ODOMZO CAP 200MG.....	88	
OFEV CAP 100MG.....	230	
OFEV CAP 150MG.....	230	
ofloxacin ophth soln 0.3%	216	
ofloxacin otic soln 0.3%.....	219	
ofloxacin tab 300 mg	170	
ofloxacin tab 400 mg	170	
olanzapine-fluoxetine hcl cap 12-25 mg	224	
olanzapine-fluoxetine hcl cap 12-50 mg	224	
olanzapine-fluoxetine hcl cap 3-25 mg.....	224	
olanzapine-fluoxetine hcl cap 6-25 mg	224	
olanzapine-fluoxetine hcl cap 6-50 mg	224	
olanzapine for im inj 10 mg.....	104	
olanzapine orally disintegrating tab 10 mg	104	
olanzapine orally disintegrating tab 15 mg	104	
olanzapine orally disintegrating tab 20 mg	104	
olanzapine orally disintegrating tab 5 mg	104	
olanzapine tab 10 mg	104	
olanzapine tab 15 mg	104	
olanzapine tab 2.5 mg.....	104	
olanzapine tab 20 mg	104	
olanzapine tab 5 mg.....	104	
olanzapine tab 7.5 mg.....	104	
olmesartan-amlodipine- hydrochlorothiazide tab 20-5-12.5 mg...	81	
olmesartan-amlodipine- hydrochlorothiazide tab 40-10-12.5 mg	81	
olmesartan-amlodipine- hydrochlorothiazide tab 40-10-25 mg	81	
olmesartan-amlodipine- hydrochlorothiazide tab 40-5-12.5 mg.....	81	
olmesartan-amlodipine- hydrochlorothiazide tab 40-5-25 mg	81	
olmesartan medoxomil- hydrochlorothiazide tab 20-12.5 mg.....	81	
olmesartan medoxomil- hydrochlorothiazide tab 40-12.5 mg	81	
olmesartan medoxomil- hydrochlorothiazide tab 40-25 mg	81	
olmesartan medoxomil tab 20 mg	77	
olmesartan medoxomil tab 40 mg	77	
olmesartan medoxomil tab 5 mg	77	
olopatadine hcl nasal soln 0.6%	213	
OLUX AER 0.05%	147	
OMECLAMOX- MIS PAK.....	235	
omega-3-acid ethyl esters cap 1 gm	71	
omeprazole cap delayed release 10 mg	235	
omeprazole cap delayed release 20 mg.....	235	
omeprazole cap delayed release 40 mg	235	
OMNIFLEX DPR	182	
OMNIPOD 5 G6 KIT INTRO	193	
OMNIPOD 5 G6 MIS PODS	194	
OMNIPOD DASH KIT PDM	194	
OMNIPOD MIS CLASSIC	194	
OMNIPOD PDM KIT CLASSIC	194	
ondansetron hcl oral soln 4 mg/5ml.....	67	
ondansetron hcl tab 24 mg	67	
ondansetron hcl tab 4 mg	67	
ondansetron hcl tab 8 mg	67	
ondansetron orally disintegrating tab 4 mg	68	
ondansetron orally disintegrating tab 8 mg	68	
ONETOUCH DEL MIS LANC DEV	194	
ONETOUCH DEL MIS PLUS 30G	194	
ONETOUCH DEL MIS PLUS 33G	194	

ONETOUCH FP MIS LANCETS	194	ORFADIN CAP 2MG	164
ONETOUCH KIT ULTRA 2	194	ORFADIN CAP 5MG	164
ONETOUCH KIT VERIO FL	194	ORFADIN SUS 4MG/ML	164
ONETOUCH KIT VERIO RE	194	ORIAHNN CAP	168
ONETOUCH LIQ ULT CONT	194	ORLISSA TAB 150MG	162
ONETOUCH LIQ VERIO	194	ORLISSA TAB 200MG	162
ONETOUCH LIQ VERIO 4	194	ORKAMBI GRA 100-125	230
ONETOUCH MIS 30G	194	ORKAMBI GRA 150-188	230
ONETOUCH MIS LANC DEV	194	ORKAMBI GRA 75-94MG	230
ONETOUCH MIS LANCETS	194	ORKAMBI TAB 100-125	230
ONETOUCH SOL KIT COMPLETE	194	ORKAMBI TAB 200-125	230
ONETOUCH SOL KIT FIT	194	ORLADEYO CAP 110MG	176
ONETOUCH SOL KIT REFILL	194	ORLADEYO CAP 150MG	176
ONETOUCH TES ULTRA	152	<i>orlistat cap 120 mg</i>	4
ONETOUCH TES VERIO	152	<i>orphenadrine citrate tab er 12hr 100 mg</i> ..	212
ONETOUCH US MIS LANCETS	194	ORTHO MICRON TAB 0.35MG	132
ONEXTON GEL 1.2-3.75	137	<i>oseltamivir phosphate cap 30 mg (base</i>	
ON-THE-GO MIS LANC 30G	194	<i>equiv)</i>	117
ONUREG TAB 200MG	86	<i>oseltamivir phosphate cap 45 mg (base</i>	
ONUREG TAB 300MG	86	<i>equiv)</i>	117
ONZETRA XSAI MIS 11MG	205	<i>oseltamivir phosphate cap 75 mg (base</i>	
OPSUMIT TAB 10MG	127	<i>equiv)</i>	117
OPTICHAMBER MIS DIA MD	203	<i>oseltamivir phosphate for susp 6 mg/ml</i>	
OPTICHAMBER MIS DIAMOND	203	<i>(base equiv)</i>	117
OPTICHAMBER MIS DIA SM	203	OSMOLITE 1.2 LIQ CAL	155
OPTIMENTAL LIQ	155	OSMOLITE 1.5 LIQ CAL	155
ORACEA CAP 40MG	151	OSMOLITE 1 LIQ CAL	155
ORACIT SOL	174	OSMOLITE HN LIQ	155
ORAFATE PST 10%	211	OSMOLITE LIQ	155
ORAPRED ODT TAB 10MG	133	OTEZLA TAB 10/20/30	21
ORAPRED ODT TAB 15MG	133	OTEZLA TAB 30MG	21
ORAPRED ODT TAB 30MG	134	OVIDE LOT 0.5%	151
ORAVIG TAB 50MG	211	OVIDREL INJ	162
ORENITRAM TAB 0.125MG	126	<i>oxandrolone tab 10 mg</i>	33
ORENITRAM TAB 0.25MG	126	<i>oxandrolone tab 2.5 mg</i>	33
ORENITRAM TAB 1MG	126	<i>oxaprozin tab 600 mg</i>	20
ORENITRAM TAB 2.5MG	126	<i>oxazepam cap 10 mg</i>	40
ORENITRAM TAB 5MG	126	<i>oxazepam cap 15 mg</i>	40
ORENITRAM TAB MONTH 1	126	<i>oxazepam cap 30 mg</i>	40
ORENITRAM TAB MONTH 2	126	<i>oxcarbazepine susp 300 mg/5ml (60</i>	
ORENITRAM TAB MONTH 3	126	<i>mg/ml)</i>	52
ORFADIN CAP 10MG	164	<i>oxcarbazepine tab 150 mg</i>	52
ORFADIN CAP 20MG	164	<i>oxcarbazepine tab 300 mg</i>	52

<i>oxcarbazepine tab 600 mg</i>	52	OZEMPIC INJ 2/1.5ML	64
OXEPA 1.5 LIQ	155	OZEMPIC INJ 2MG/3ML.....	64
OXEPA LIQ.....	155	OZEMPIC INJ 4MG/3ML.....	64
OXERVATE SOL 20MCG/ML	217	OZEMPIC INJ 8MG/3ML.....	64
<i>oxiconazole nitrate cream 1%</i>	140	P	
OXISTAT CRE 1%.....	140	<i>paliperidone tab er 24hr 1.5 mg</i>	102
OXISTAT LOT 1%.....	140	<i>paliperidone tab er 24hr 3 mg</i>	102
OXSORALEN-UL CAP 10MG	142	<i>paliperidone tab er 24hr 6 mg</i>	102
OXTELLAR XR TAB 150MG.....	52	<i>paliperidone tab er 24hr 9 mg</i>	102
OXTELLAR XR TAB 300MG.....	52	PAMELOR CAP 10MG	61
OXTELLAR XR TAB 600MG.....	53	PAMELOR CAP 25MG.....	61
<i>oxybutynin chloride solution 5 mg/5ml</i> ..	236	PAMELOR CAP 50MG.....	61
<i>oxybutynin chloride tab 5 mg</i>	236	PAMELOR CAP 75MG.....	61
<i>oxybutynin chloride tab er 24hr 10 mg</i>	236	PANCREAZE CAP 10500UNT	158
<i>oxybutynin chloride tab er 24hr 15 mg</i>	236	PANCREAZE CAP 16800UNT	158
<i>oxybutynin chloride tab er 24hr 5 mg</i>	236	PANCREAZE CAP 21000UNT	158
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	32	PANCREAZE CAP 2600UNIT	157
<i>oxycodone hcl cap 5 mg</i>	28	PANCREAZE CAP 37000	158
<i>oxycodone hcl conc 100 mg/5ml (20</i> <i>mg/ml)</i>	29	PANCREAZE CAP 4200UNIT	158
<i>oxycodone hcl soln 5 mg/5ml</i>	29	PANDEL CRE 0.1%	147
<i>oxycodone hcl tab 10 mg</i>	29	PANRETIN GEL 0.1%.....	140
<i>oxycodone hcl tab 15 mg</i>	29	<i>pantoprazole sodium ec tab 20 mg (base</i> <i>equiv)</i>	235
<i>oxycodone hcl tab 20 mg</i>	29	<i>pantoprazole sodium ec tab 40 mg (base</i> <i>equiv)</i>	235
<i>oxycodone hcl tab 30 mg</i>	29	<i>pantoprazole sodium for iv soln 40 mg</i> <i>(base equiv)</i>	235
<i>oxycodone hcl tab 5 mg</i>	29	<i>paricalcitol cap 1 mcg</i>	164
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	29	<i>paricalcitol cap 2 mcg</i>	164
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	29	<i>paricalcitol cap 4 mcg</i>	164
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	29	PARLODEL CAP 5MG.....	99
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	29	PARLODEL TAB 2.5MG	99
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	29	PARNATE TAB 10MG.....	57
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	29	<i>paromomycin sulfate cap 250 mg</i>	10
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	29	<i>paroxetine hcl tab 10 mg</i>	58
<i>oxycodone w/ acetaminophen tab 10-325</i> <i>mg</i>	32	<i>paroxetine hcl tab 20 mg</i>	58
<i>oxycodone w/ acetaminophen tab 2.5-325</i> <i>mg</i>	32	<i>paroxetine hcl tab 30 mg</i>	58
<i>oxycodone w/ acetaminophen tab 5-325</i> <i>mg</i>	32	<i>paroxetine hcl tab 40 mg</i>	58
<i>oxycodone w/ acetaminophen tab 7.5-325</i> <i>mg</i>	32	<i>paroxetine hcl tab er 24hr 12.5 mg</i>	58
<i>oxymorphone hcl tab 10 mg</i>	29	<i>paroxetine hcl tab er 24hr 25 mg</i>	58
<i>oxymorphone hcl tab 5 mg</i>	29	<i>paroxetine hcl tab er 24hr 37.5 mg</i>	58
		PASER GRA 4GM	84
		PATANASE SPR 0.6%	213

PAXLOVID TAB 150-100.....	114	<i>permethrin cream 5%</i>	151
PAXLOVID TAB 300-100.....	114	<i>perphenazine-amitriptyline tab 2-10 mg.</i>	224
PC LANCETS MIS 30G.....	194	<i>perphenazine-amitriptyline tab 2-25 mg</i>	224
PEDIAPRED SOL 5MG/5ML.....	134	<i>perphenazine-amitriptyline tab 4-10 mg</i>	224
PEDIASURE EN LIQ /FIBER	155	<i>perphenazine-amitriptyline tab 4-25 mg</i>	224
PEDIASURE LIQ PEPTIDE	155	<i>perphenazine-amitriptyline tab 4-50 mg</i>	224
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	180	<i>perphenazine tab 16 mg</i>	106
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm</i>	180	<i>perphenazine tab 2 mg</i>	106
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	180	<i>perphenazine tab 4 mg</i>	106
PEGINTRON KIT 50MCG.....	116	<i>perphenazine tab 8 mg</i>	106
PEG-PREP KIT.....	180	PERSERIS INJ 120MG	102
<i>peniclovir cream 1%</i>	145	PERSERIS INJ 90MG.....	102
<i>penicillamine cap 250 mg</i>	207	PERTZYE CAP 16000U.....	158
<i>penicillamine tab 250 mg</i>	207	PERTZYE CAP 24000U	158
<i>penicillin v potassium for soln 125 mg/5ml</i>	220	PERTZYE CAP 4000UNIT	158
<i>penicillin v potassium for soln 250 mg/5ml</i>	220	PERTZYE CAP 8000UNIT	158
<i>penicillin v potassium tab 250 mg</i>	220	PHARMACY COU MIS LANCETS	194
<i>penicillin v potassium tab 500 mg</i>	220	PHEBURANE MIS 483/GM.....	164
PENLET II KIT BLOOD	194	PHENACTIN AA LIQ PLUS.....	156
PENLET II MIS REPL CAP	194	<i>phenazopyridine hcl tab 200 mg</i>	174
PENTASA CAP 250MG CR.....	171	PHENDIMETRAZ CAP 105MG ER.....	4
PENTASA CAP 500MG CR	171	<i>phendimetrazine tartrate tab 35 mg</i>	4
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	33	<i>phenelzine sulfate tab 15 mg</i>	57
<i>pentoxifylline tab er 400 mg</i>	176	<i>phenobarbital elixir 20 mg/5ml</i>	178
PEPCID TAB 40MG.....	234	<i>phenobarbital tab 100 mg</i>	179
PEPTAMEN LIQ PREBIO1.....	155	<i>phenobarbital tab 15 mg</i>	178
PEPTAMEN LIQ UNFLAVOR	156	<i>phenobarbital tab 16.2 mg</i>	178
PEPTINEX DT LIQ	156	<i>phenobarbital tab 30 mg</i>	178
PEPTINEX DT LIQ VANILLA	156	<i>phenobarbital tab 32.4 mg</i>	179
PERATIVE LIQ	156	<i>phenobarbital tab 60 mg</i>	179
PERFECT 28G MIS LANCETS	194	<i>phenobarbital tab 64.8 mg</i>	179
PERFECT 30G MIS LANCETS	194	<i>phenobarbital tab 97.2 mg</i>	179
PERFOROMIST NEB 20MCG.....	45	<i>phenoxybenzamine hcl cap 10 mg</i>	76
PERIDEX SOL 0.12%.....	211	<i>phentermine hcl cap 15 mg</i>	4
<i>perindopril erbumine tab 2 mg</i>	75	<i>phentermine hcl cap 30 mg</i>	4
<i>perindopril erbumine tab 4 mg</i>	75	<i>phentermine hcl cap 37.5 mg</i>	4
<i>perindopril erbumine tab 8 mg</i>	75	<i>phentermine hcl tab 37.5 mg</i>	4
		<i>phenylephrine hcl ophth soln 10%</i>	215
		<i>phenylephrine hcl ophth soln 2.5%</i>	215
		<i>phenytoin chew tab 50 mg</i>	55
		<i>phenytoin sodium extended cap 100 mg</i> .	55
		<i>phenytoin sodium extended cap 200 mg</i> .	55
		<i>phenytoin sodium extended cap 300 mg</i> .	55

<i>phenytoin susp 125 mg/5ml</i>	55	POCKETCHEM SOL EZ	194
PHLEXY-10 POW	156	POCKET SPACE MIS	203
PHOSLYRA SOL	173	<i>podofilox soln 0.5%</i>	150
PHOSPHOLINE SOL 0.125%OP	215	<i>polymyxin b-trimethoprim ophth soln</i>	
<i>phytonadione tab 5 mg</i>	239	10000 unit/ml-0.1%	216
PICATO GEL 0.015%	140	POLYTRIM SOL OP	216
PICATO GEL 0.05%	140	POMALYST CAP 1MG	89
<i>pilocarpine hcl ophth soln 1%</i>	215	POMALYST CAP 2MG	89
<i>pilocarpine hcl ophth soln 2%</i>	215	POMALYST CAP 3MG	89
<i>pilocarpine hcl ophth soln 4%</i>	215	POMALYST CAP 4MG	89
<i>pilocarpine hcl tab 5 mg</i>	211	<i>posaconazole susp 40 mg/ml</i>	69
<i>pilocarpine hcl tab 7.5 mg</i>	211	<i>pot & sod citrates w/ cit ac soln 550-500-</i>	
<i>pimecrolimus cream 1%</i>	149	334 mg/5ml	174
<i>pimozide tab 1 mg</i>	228	<i>potassium chloride cap er 10 meq</i>	207
<i>pimozide tab 2 mg</i>	228	<i>potassium chloride cap er 8 meq</i>	207
<i>pindolol tab 10 mg</i>	119	<i>potassium chloride microencapsulated crys</i>	
<i>pindolol tab 5 mg</i>	119	er tab 10 meq	207
<i>pioglitazone hcl-glimepiride tab 30-2 mg</i>	62	<i>potassium chloride microencapsulated crys</i>	
<i>pioglitazone hcl-glimepiride tab 30-4 mg</i>	62	er tab 15 meq	207
<i>pioglitazone hcl-metformin hcl tab 15-500</i>		<i>potassium chloride microencapsulated crys</i>	
<i>mg</i>	62	er tab 20 meq	207
<i>pioglitazone hcl-metformin hcl tab 15-850</i>		<i>potassium chloride oral soln 10% (20</i>	
<i>mg</i>	62	meq/15ml)	207
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	65	<i>potassium chloride oral soln 20% (40</i>	
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	65	meq/15ml)	207
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	65	<i>potassium chloride powder packet 20 meq</i>	
PIP LANCETS MIS 28G	194	.....	207
PIP LANCETS MIS 30G	194	<i>potassium chloride tab er 10 meq</i>	207
PIQRAY 200MG TAB DOSE	94	<i>potassium chloride tab er 20 meq (1500</i>	
PIQRAY 250MG TAB DOSE	94	mg)	207
PIQRAY 300MG TAB DOSE	94	<i>potassium chloride tab er 8 meq (600 mg)</i>	
<i>pirfenidone tab 267 mg</i>	231	.....	207
<i>pirfenidone tab 801 mg</i>	231	<i>potassium citrate & citric acid powder pack</i>	
<i>piroxicam cap 10 mg</i>	20	3300-1002 mg	174
<i>piroxicam cap 20 mg</i>	20	<i>potassium citrate & citric acid soln 1100-</i>	
PIVOT LIQ 1.5 CAL	156	334 mg/5ml	174
PKU EXPLORE5 POW UNFLAVOR	156	<i>potassium citrate tab er 10 meq (1080 mg)</i>	
PLAQUENIL TAB 200MG	83	.....	174
PLEGRIDY INJ	226	<i>potassium citrate tab er 15 meq (1620 mg)</i>	
PLEGRIDY INJ PEN	227	.....	174
PLEGRIDY INJ STARTER	227	<i>potassium citrate tab er 5 meq (540 mg)</i>	174
PLEGRIDY PEN INJ STARTER	227	POTASSIUM POW CHLORIDE	207
POCKET CHAMB MIS	203	POVIDONE IOD SOL 5%	216

PPA/MMA POW EXPRESS.....	156	PRECOSE TAB 25MG	61
<i>pramipexole dihydrochloride tab 0.125 mg</i>		PRECOSE TAB 50MG	61
.....	99	PRED-G S.O.P OIN OP	218
<i>pramipexole dihydrochloride tab 0.25 mg</i>		PRED-G SUS OP	218
.....	99	<i>prednicarbate cream 0.1%</i>	148
<i>pramipexole dihydrochloride tab 0.5 mg</i>	99	<i>prednicarbate oint 0.1%</i>	148
<i>pramipexole dihydrochloride tab 0.75 mg</i>		<i>prednisolone acetate ophth susp 1%</i>	218
.....	99	<i>prednisolone sodium phosphate oral soln</i>	
<i>pramipexole dihydrochloride tab 1.5 mg</i>	99	<i>25 mg/5ml (base eq)</i>	134
<i>pramipexole dihydrochloride tab 1 mg</i>	99	<i>prednisolone sod phos orally disintegr tab</i>	
<i>pramipexole dihydrochloride tab er 24hr</i>		<i>10 mg (base eq)</i>	134
<i>0.375 mg</i>	100	<i>prednisolone sod phos orally disintegr tab</i>	
<i>pramipexole dihydrochloride tab er 24hr</i>		<i>15 mg (base eq)</i>	134
<i>0.75 mg</i>	100	<i>prednisolone sod phos orally disintegr tab</i>	
<i>pramipexole dihydrochloride tab er 24hr 1.5</i>		<i>30 mg (base eq)</i>	134
<i>mg</i>	100	<i>prednisolone sod phosphate oral soln 15</i>	
<i>pramipexole dihydrochloride tab er 24hr</i>		<i>mg/5ml (base equiv)</i>	134
<i>2.25 mg</i>	100	<i>prednisolone sod phosph oral soln 6.7</i>	
<i>pramipexole dihydrochloride tab er 24hr</i>		<i>mg/5ml (5 mg/5ml base)</i>	134
<i>3.75 mg</i>	100	<i>prednisolone soln 15 mg/5ml</i>	134
<i>pramipexole dihydrochloride tab er 24hr 3</i>		PREDNISOLONE SUS 1%.....	218
<i>mg</i>	100	PREDNISONONE CON 5MG/ML.....	134
<i>pramipexole dihydrochloride tab er 24hr</i>		<i>prednisone oral soln 5 mg/5ml</i>	134
<i>4.5 mg</i>	100	<i>prednisone tab 10 mg</i>	134
PRAMOSONE CRE 1-1%	148	<i>prednisone tab 1 mg</i>	134
PRAMOSONE LOT 1%.....	148	<i>prednisone tab 2.5 mg</i>	134
PRAMOSONE LOT 2.5%.....	148	<i>prednisone tab 20 mg</i>	134
<i>prasugrel hcl tab 10 mg (base equiv)</i>	176	<i>prednisone tab 50 mg</i>	134
<i>prasugrel hcl tab 5 mg (base equiv)</i>	176	<i>prednisone tab 5 mg</i>	134
<i>pravastatin sodium tab 10 mg</i>	73	<i>prednisone tab therapy pack 10 mg (21)</i> .	134
<i>pravastatin sodium tab 20 mg</i>	73	<i>prednisone tab therapy pack 10 mg (48)</i>	134
<i>pravastatin sodium tab 40 mg</i>	73	<i>prednisone tab therapy pack 5 mg (21)</i> ...	134
<i>pravastatin sodium tab 80 mg</i>	73	<i>prednisone tab therapy pack 5 mg (48)</i> ..	134
<i>praziquantel tab 600 mg</i>	35	PRED SOD PHO SOL 1% OP	218
<i>prazosin hcl cap 1 mg</i>	78	PREFEST TAB.....	168
<i>prazosin hcl cap 2 mg</i>	78	<i>pregabalin cap 100 mg</i>	53
<i>prazosin hcl cap 5 mg</i>	78	<i>pregabalin cap 150 mg</i>	53
PR BENZOYL LIQ 7% WASH	137	<i>pregabalin cap 200 mg</i>	53
PRECISION LIQ CONTROL.....	194	<i>pregabalin cap 225 mg</i>	53
PRECISION LIQ GLUC/KET	194	<i>pregabalin cap 25 mg</i>	53
PRECISION LIQ NRML/MID	195	<i>pregabalin cap 300 mg</i>	53
PRECISN XTRA TES KETONE	152	<i>pregabalin cap 50 mg</i>	53
PRECOSE TAB 100MG.....	62	<i>pregabalin cap 75 mg</i>	53

<i>pregabalin soln 20 mg/ml</i>	53	<i>probenecid tab 500 mg</i>	175
<i>pregabalin tab er 24hr 165 mg</i>	228	PROCARDIA CAP 10MG	121
<i>pregabalin tab er 24hr 330 mg</i>	228	PROCARDIA XL TAB 30MG CR	121
<i>pregabalin tab er 24hr 82.5 mg</i>	228	PROCARDIA XL TAB 60MG CR.....	121
PREMARIN INJ 25MG.....	169	PROCARDIA XL TAB 90MG CR.....	121
PREMPHASE TAB.....	168	<i>prochlorperazine edisylate inj 10 mg/2ml</i>	
PREMPRO TAB	168	.....	106
PREMPRO TAB 0.3-1.5	168	<i>prochlorperazine edisylate inj 50 mg/10ml</i>	
PREMPRO TAB 0.45-1.5	168	.....	106
PREMPRO TAB 0.625-5	168	<i>prochlorperazine maleate tab 10 mg (base</i>	
<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1</i>		<i>equivalent)</i>	106
<i>mg</i>	211	<i>prochlorperazine maleate tab 5 mg (base</i>	
<i>prenatal vit w/ fe fumarate-fa chew tab 29-1</i>		<i>equivalent)</i>	106
<i>mg</i>	212	<i>prochlorperazine suppos 25 mg</i>	106
<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>		PRO COMFORT MIS 31G	195
.....	212	PRO COMFORT MIS LANCETS.....	195
<i>prenatal vit w/ fe fum-methylfolate-fa tab</i>		PRO COMFORT PAD ALCOHOL	201
<i>27-0.6-0.4 mg</i>	212	PROCORT CRE	34
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>		PROCTOCORT CRE 1%	35
.....	212	PROCTOCORT SUP 30MG	35
<i>prenat w/o a w/fefum-methfol-fa-dha cap</i>		PROCTOFOAM AER HC 1%	34
<i>27-0.6-0.4-300 mg</i>	211	PRODIGY MIS 26G	195
PREPIDIL GEL 0.5MG/3G	220	PRODIGY MIS 28G	195
PREP PADS PAD.....	201	PRODIGY MIS LANC DEV	195
PRESSURE ACT MIS LANCET	195	PRODIGY SOL HIGH.....	195
PRESSURE ACT MIS LANCETS	195	PRODIGY SOL LOW	195
PRETOMANID TAB 200MG.....	84	<i>progesterone cap 100 mg</i>	221
PREVYMIS TAB 240MG.....	114	<i>progesterone cap 200 mg</i>	221
PREVYMIS TAB 480MG	114	<i>progesterone im in oil 50 mg/ml</i>	221
PREZCOBIX TAB 800-150.....	111	PROGLYCEM SUS 50MG/ML.....	63
PREZISTA SUS 100MG/ML	111	PROGRAF CAP 0.5MG.....	209
PREZISTA TAB 150MG.....	112	PROGRAF CAP 1MG	209
PREZISTA TAB 600MG.....	112	PROGRAF CAP 5MG	209
PREZISTA TAB 75MG	111	PROGRAF GRA 0.2MG.....	209
PREZISTA TAB 800MG.....	112	PROGRAF GRA 1MG	209
PRIFTIN TAB 150MG.....	84	PROLENSA SOL 0.07%	219
<i>primaquine phosphate tab 26.3 mg (15 mg</i>		PROMACTIN AA SUS PLUS.....	156
<i>base)</i>	83	<i>promethazine & phenylephrine syrup 6.25-</i>	
PRIMAQUINE TAB 26.3MG.....	83	<i>5 mg/5ml</i>	135
<i>primidone tab 250 mg</i>	53	<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	
<i>primidone tab 50 mg</i>	53	.....	135
PRIMSOL SOL 50MG/5ML	35	<i>promethazine hcl suppos 12.5 mg</i>	70
PRINIVIL TAB 20MG	75	<i>promethazine hcl suppos 25 mg</i>	70

<i>promethazine hcl suppos 50 mg</i>	70	PROTOPIC OIN 0.03%.....	149
<i>promethazine hcl syrup 6.25 mg/5ml</i>	70	PROTOPIC OIN 0.1%.....	149
<i>promethazine hcl tab 12.5 mg</i>	70	<i>protriptyline hcl tab 10 mg</i>	61
<i>promethazine hcl tab 25 mg</i>	70	<i>protriptyline hcl tab 5 mg</i>	61
<i>promethazine hcl tab 50 mg</i>	70	PROVERA TAB 10MG.....	222
<i>promethazine-phenylephrine-codeine</i>		PROVERA TAB 2.5MG	222
<i>syrup 6.25-5-10 mg/5ml</i>	135	PROVERA TAB 5MG	222
<i>promethazine w/ codeine syrup 6.25-10</i>		PRUDOXIN CRE 5%	140
<i>mg/5ml</i>	135	<i>pseudoephed-bromphen-dm syrup 30-2-10</i>	
PROMOTE/ LIQ FIBER	156	<i>mg/5ml</i>	135
PROMOTE 1.0 LIQ W/ FIBER.....	156	PSS SAFE LAN MIS.....	195
PROMOTE LIQ VANILLA.....	156	PSS SEL LANC MIS.....	195
PROMOTE W/FB LIQ VANILLA	156	PSS SEL PLAT MIS	195
PROMOTE W/ LIQ FIBER.....	156	PTS PANELS TES KETONE	152
<i>propafenone hcl cap er 12hr 225 mg</i>	41	PULMICORT INH 180MCG.....	43
<i>propafenone hcl cap er 12hr 325 mg</i>	41	PULMICORT INH 90MCG	43
<i>propafenone hcl cap er 12hr 425 mg</i>	41	PULMICORT SUS 0.25MG/2	43
<i>propafenone hcl tab 150 mg</i>	41	PULMICORT SUS 0.5MG/2.....	43
<i>propafenone hcl tab 225 mg</i>	41	PULMICORT SUS 1MG/2ML	43
<i>propafenone hcl tab 300 mg</i>	41	PULMOZYME SOL 1MG/ML	230
<i>proparacaine hcl ophth soln 0.5%</i>	217	PURE COMFORT PAD.....	201
PRO-PHREE POW	156	PURIXAN SUS 20MG/ML.....	86
<i>propranolol & hydrochlorothiazide tab 40-</i>		PX LANCETS MIS 28G	195
<i>25 mg</i>	81	PX LANCETS MIS ULT THIN	195
<i>propranolol & hydrochlorothiazide tab 80-</i>		PYLERA CAP.....	235
<i>25 mg</i>	81	<i>pyrazinamide tab 500 mg</i>	84
<i>propranolol hcl cap er 24hr 120 mg</i>	119	<i>pyridostigmine bromide oral soln 60</i>	
<i>propranolol hcl cap er 24hr 160 mg</i>	119	<i>mg/5ml</i>	84
<i>propranolol hcl cap er 24hr 60 mg</i>	119	<i>pyridostigmine bromide tab 60 mg</i>	84
<i>propranolol hcl cap er 24hr 80 mg</i>	119	<i>pyridostigmine bromide tab er 180 mg</i>	84
<i>propranolol hcl oral soln 20 mg/5ml</i>	119	<i>pyrimethamine tab 25 mg</i>	83
<i>propranolol hcl oral soln 40 mg/5ml</i>	119	PYROGALL ACD OIN	150
<i>propranolol hcl tab 10 mg</i>	119	Q	
<i>propranolol hcl tab 20 mg</i>	119	QBRELIS SOL 1MG/ML.....	75
<i>propranolol hcl tab 40 mg</i>	119	QBREXZA PAD 2.4%.....	150
<i>propranolol hcl tab 60 mg</i>	119	QC ALCOHOL PAD SWABS	201
<i>propranolol hcl tab 80 mg</i>	119	QC LANCETS MIS 28G.....	195
<i>propylthiouracil tab 50 mg</i>	232	QC LANCETS MIS 30G	195
PROSCAR TAB 5MG	174	QC LANCING MIS DEVICE	195
PROSOURCE LIQ TF.....	156	QSYMIA CAP 11.25-69	4
PROSTIN E2 SUP 20MG.....	220	QSYMIA CAP 15-92MG.....	5
PROTHELIAL PST 10%.....	211	QSYMIA CAP 3.75-23	4
PROTONIX INJ 40MG	235	QSYMIA CAP 7.5-46MG.....	4

QUALAQUIN CAP 324MG.....	83	QVAR REDIHAL AER 40MCG	43
QUDEXY XR CAP 100/24HR.....	53	R	
QUDEXY XR CAP 150/24HR	53	RABEPRAZOLE CAP 10MG DR.....	235
QUDEXY XR CAP 200/24HR	53	<i>rabeprazole sodium ec tab 20 mg</i>	235
QUDEXY XR CAP 25/24HR.....	53	RADICAVA ORS SUS 105/5ML	214
QUDEXY XR CAP 50/24HR	53	RADICAVA ORS SUS STARTER	214
QUESTRAN POW 4GM.....	71	RADIOGARDASE CAP 0.5GM	67
QUESTRAN POW 4GM LITE	71	RA E-ZJECT MIS 28G	195
<i>quetiapine fumarate tab 100 mg</i>	104	RA E-ZJECT MIS THIN 26G.....	195
<i>quetiapine fumarate tab 200 mg</i>	104	RA E-ZJECT MIS THIN 28G.....	195
<i>quetiapine fumarate tab 25 mg</i>	104	RA E-ZJECT MIS ULT THIN	195
<i>quetiapine fumarate tab 300 mg</i>	104	RAGWITEK SUB	10
<i>quetiapine fumarate tab 400 mg</i>	104	<i>raloxifene hcl tab 60 mg</i>	163
<i>quetiapine fumarate tab 50 mg</i>	104	<i>ramelteon tab 8 mg</i>	180
<i>quetiapine fumarate tab er 24hr 150 mg</i>	105	<i>ramipril cap 1.25 mg</i>	76
<i>quetiapine fumarate tab er 24hr 200 mg</i>	105	<i>ramipril cap 10 mg</i>	76
<i>quetiapine fumarate tab er 24hr 300 mg</i>	105	<i>ramipril cap 2.5 mg</i>	76
<i>quetiapine fumarate tab er 24hr 400 mg</i>	105	<i>ramipril cap 5 mg</i>	76
<i>quetiapine fumarate tab er 24hr 50 mg</i> ..	105	RANEXA TAB 1000MG	37
QUICKTEK LIQ SOLUTION	195	RANEXA TAB 500MG.....	37
QUILLICHEW CHW 20MG ER.....	9	<i>ranolazine tab er 12hr 1000 mg</i>	37
QUILLICHEW CHW 30MG ER.....	9	<i>ranolazine tab er 12hr 500 mg</i>	37
QUILLICHEW CHW 40MG ER.....	9	RAPAMUNE SOL 1MG/ML.....	209
QUILLIVANT SUS 25MG/5ML	9	RAPAMUNE TAB 0.5MG.....	209
<i>quinapril hcl tab 10 mg</i>	76	RAPAMUNE TAB 1MG	209
<i>quinapril hcl tab 20 mg</i>	76	RAPAMUNE TAB 2MG	209
<i>quinapril hcl tab 40 mg</i>	76	RAPID-SAFE MIS LANCING	195
<i>quinapril hcl tab 5 mg</i>	75	<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	101
<i>quinapril-hydrochlorothiazide tab 10-12.5</i> <i>mg</i>	81	<i>rasagiline mesylate tab 1 mg (base equiv)</i>	101
<i>quinapril-hydrochlorothiazide tab 20-12.5</i> <i>mg</i>	81	RAZADYNE ER CAP 16MG	223
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i>	81	RAZADYNE ER CAP 24MG	223
<i>quinidine gluconate tab er 324 mg</i>	40	RAZADYNE ER CAP 8MG.....	223
<i>quinidine sulfate tab 200 mg</i>	40	READYLANCE MIS 21G	195
<i>quinidine sulfate tab 300 mg</i>	40	READYLANCE MIS 23G	195
<i>quinine sulfate cap 324 mg</i>	83	READYLANCE MIS 26G	195
QUINTET CONT SOL HGH/NORM	195	READYLANCE MIS 28G	195
QULIPTA TAB 10MG.....	204	READYLANCE MIS 30G	195
QULIPTA TAB 30MG	204	REALITY MIS LANCETS	195
QULIPTA TAB 60MG.....	204	REALITY SWAB PAD	201
QVAR REDIHA AER 80MCG	43	REALITY TRIG MIS LANCETS	195
		REBIF INJ 22/0.5.....	227

REBIF INJ 44/0.5	227	RESTASIS MUL EMU 0.05% OP	217
REBIF REBIDO INJ 22/0.5.....	227	RESTORA RX CAP 60-1.25.....	66
REBIF REBIDO INJ 44/0.5.....	227	RESTORIL CAP 15MG.....	179
REBIF REBIDO INJ TITRATN.....	227	RESTORIL CAP 22.5MG.....	179
REBIF TITRTN INJ PACK.....	227	RESTORIL CAP 30MG.....	179
RECTIV OIN 0.4%.....	35	RESTORIL CAP 7.5MG	179
REFUAH PLUS SOL CONTROL	195	RETACRIT INJ 10000UNT	178
REGLAN TAB 10MG.....	171	RETACRIT INJ 20000UNI.....	178
REGLAN TAB 5MG	171	RETACRIT INJ 2000UNIT	178
REGRANEX GEL 0.01%.....	151	RETACRIT INJ 3000UNIT	178
RELENZA MIS DISKHALE	117	RETACRIT INJ 40000UNT	178
RELION KIT LANCING.....	195	RETACRIT INJ 4000UNIT	178
RELION LANCE MIS THIN 26G	195	RETIN-A CRE 0.025%	137
RELION LANCE MIS THIN 30G.....	196	RETIN-A CRE 0.05%	137
RELION LANCI MIS DEVICE	196	RETIN-A CRE 0.1%.....	137
RELION MICRO MIS THIN 33G	196	RETIN-A GEL 0.01%	137
RELION TES KETONE.....	152	RETIN-A GEL 0.025%	137
RELION ULTRA MIS THIN 30G	196	RETIN-A MICR GEL 0.04%.....	137
RELION ULTRA MIS THIN PLS.....	196	RETIN-A MICR GEL 0.04%PMP	137
RELISTOR INJ 12/0.6ML.....	173	RETIN-A MICR GEL 0.06%.....	138
RELISTOR INJ 8/0.4ML	173	RETIN-A MICR GEL 0.08%.....	138
RELISTOR TAB 150MG.....	173	RETIN-A MICR GEL 0.1%	137
RELPAK TAB 20MG.....	205	RETIN-A MICR GEL 0.1%PUMP	137
RELPAK TAB 40MG.....	205	RETROVIR CAP 100MG	112
REMERON SLTB TAB 15MG	56	RETROVIR SYP 50MG/5ML.....	112
REMERON SLTB TAB 30MG.....	56	REVCovi INJ 1.6MG/ML	164
REMERON SLTB TAB 45MG.....	56	REVLIMID CAP 10MG	208
REMERON TAB 15MG.....	56	REVLIMID CAP 15MG	208
REMERON TAB 30MG.....	56	REVLIMID CAP 2.5MG	207
RENAGEL TAB 800MG	173	REVLIMID CAP 20MG	208
REVELA POW 0.8GM	173	REVLIMID CAP 25MG	208
REVELA POW 2.4GM.....	173	REVLIMID CAP 5MG.....	208
REVELA TAB 800MG.....	173	REXULTI TAB 0.25MG.....	107
<i>repaglinide tab 0.5 mg</i>	65	REXULTI TAB 0.5MG.....	107
<i>repaglinide tab 1 mg</i>	65	REXULTI TAB 1MG.....	107
<i>repaglinide tab 2 mg</i>	65	REXULTI TAB 2MG	107
REPATHA INJ 140MG/ML	74	REXULTI TAB 3MG	107
REPATHA PUSH INJ 420/3.5.....	74	REXULTI TAB 4MG	107
REPATHA SURE INJ 140MG/ML.....	74	REYATAZ CAP 150MG	112
REPLETE FIBE LIQ 1 CAL	156	REYATAZ CAP 200MG	112
REPLETE LIQ ULTRAPAK	157	REYATAZ CAP 300MG	112
RESOURCE DIA LIQ TF.....	157	REYATAZ POW 50MG	112
RESTASIS EMU 0.05% OP.....	217	REYVOW TAB 100MG	205

REYVOW TAB 50MG.....	205	<i>risperidone orally disintegrating tab 1 mg</i>	103
RHOFADE CRE 1%.....	151	<i>risperidone orally disintegrating tab 2 mg</i>	103
RHOPRESSA SOL 0.02%.....	217	<i>risperidone orally disintegrating tab 3 mg</i>	103
RIAX AER 5.5%	138	<i>risperidone orally disintegrating tab 4 mg</i>	103
RIAX AER 9.5%	138	<i>risperidone soln 1 mg/ml</i>	103
<i>ribavirin cap 200 mg</i>	116	<i>risperidone tab 0.25 mg</i>	103
<i>ribavirin tab 200 mg</i>	116	<i>risperidone tab 0.5 mg</i>	103
RIDAURA CAP 3MG.....	18	<i>risperidone tab 1 mg</i>	103
<i>rifabutin cap 150 mg</i>	84	<i>risperidone tab 2 mg</i>	103
<i>rifampin cap 150 mg</i>	84	<i>risperidone tab 3 mg</i>	103
<i>rifampin cap 300 mg</i>	84	<i>risperidone tab 4 mg</i>	103
RIGHTEST ALT MIS ADAPTOR.....	196	RITALIN LA CAP 10MG	9
RIGHTEST LIQ HIGH CON	196	RITALIN LA CAP 20MG	9
RIGHTEST LIQ NORM CON.....	196	RITALIN LA CAP 30MG	9
RIGHTEST MIS GD500.....	196	RITALIN LA CAP 40MG	9
RIGHTEST MIS GL300	196	RITALIN TAB 10MG	10
RILUTEK TAB 50MG.....	214	RITALIN TAB 20MG.....	10
<i>riluzole tab 50 mg</i>	214	RITALIN TAB 5MG.....	9
<i>rimantadine hydrochloride tab 100 mg</i>	117	RITEFLO MIS.....	203
RINVOQ TAB 15MG ER.....	15	<i>ritonavir tab 100 mg</i>	112
RINVOQ TAB 30MG ER.....	16	<i>rivastigmine tartrate cap 1.5 mg (base</i>	
RINVOQ TAB 45MG ER.....	16	<i>equivalent)</i>	223
<i>risedronate sodium tab 150 mg</i>	161	<i>rivastigmine tartrate cap 3 mg (base</i>	
<i>risedronate sodium tab 30 mg</i>	161	<i>equivalent)</i>	223
<i>risedronate sodium tab 35 mg</i>	161	<i>rivastigmine tartrate cap 4.5 mg (base</i>	
<i>risedronate sodium tab 5 mg</i>	161	<i>equivalent)</i>	223
<i>risedronate sodium tab delayed release 35</i>		<i>rivastigmine tartrate cap 6 mg (base</i>	
<i>mg</i>	161	<i>equivalent)</i>	223
RISPERDAL INJ 12.5MG.....	102	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	223
RISPERDAL INJ 25MG	102	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	223
RISPERDAL INJ 37.5MG.....	102	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	223
RISPERDAL INJ 50MG.....	102	<i>rizatriptan benzoate oral disintegrating tab</i>	
RISPERDAL SOL 1MG/ML	102	<i>10 mg (base eq)</i>	205
RISPERDAL TAB 0.5MG	102	<i>rizatriptan benzoate oral disintegrating tab</i>	
RISPERDAL TAB 1MG.....	103	<i>5 mg (base eq)</i>	205
RISPERDAL TAB 2MG.....	103	<i>rizatriptan benzoate tab 10 mg (base</i>	
RISPERDAL TAB 3MG.....	103	<i>equivalent)</i>	205
RISPERDAL TAB 4MG.....	103	<i>rizatriptan benzoate tab 5 mg (base</i>	
<i>risperidone orally disintegrating tab 0.25</i>		<i>equivalent)</i>	205
<i>mg</i>	103		
<i>risperidone orally disintegrating tab 0.5 mg</i>			
.....	103		

ROCALTROL CAP 0.25MCG	164	RYTHMOL SR CAP 325MG.....	41
ROCALTROL CAP 0.5MCG	164	RYTHMOL SR CAP 425MG	41
ROCALTROL SOL 1MCG/ML	164	S	
ROCKLATAN DRO	217	S.O.S. 20 POW	157
<i>ropinirole hydrochloride tab 0.25 mg</i>	100	S.O.S. 25 POW.....	157
<i>ropinirole hydrochloride tab 0.5 mg</i>	100	SAFE-T-LANCE MIS 21G.....	196
<i>ropinirole hydrochloride tab 1 mg</i>	100	SAFE-T-LANCE MIS 25G	196
<i>ropinirole hydrochloride tab 2 mg</i>	100	SAFE-T-LANCE MIS HI FLOW	196
<i>ropinirole hydrochloride tab 3 mg</i>	100	SAFE-T-LANCE MIS LOW FLOW	196
<i>ropinirole hydrochloride tab 4 mg</i>	100	SAFE-T-LANCE MIS NOR FLOW	196
<i>ropinirole hydrochloride tab 5 mg</i>	100	SAFE-T-PRO MIS LANCETS.....	196
<i>ropinirole hydrochloride tab er 24hr 12 mg</i> <i>(base equivalent)</i>	100	SAFE-T-PRO MIS PLUS	196
<i>ropinirole hydrochloride tab er 24hr 2 mg</i> <i>(base equivalent)</i>	100	SAFETY 21G MIS LANCETS.....	196
<i>ropinirole hydrochloride tab er 24hr 4 mg</i> <i>(base equivalent)</i>	100	SAFETY 23G MIS LANCETS	196
<i>ropinirole hydrochloride tab er 24hr 6 mg</i> <i>(base equivalent)</i>	100	SAFETY 28G MIS LANCETS	196
<i>ropinirole hydrochloride tab er 24hr 8 mg</i> <i>(base equivalent)</i>	100	SAFETY 30G MIS LANCETS.....	196
<i>rosuvastatin calcium tab 10 mg</i>	73	SAFETY MIS LANCETS	196
<i>rosuvastatin calcium tab 20 mg</i>	73	SAFYRAL TAB	132
<i>rosuvastatin calcium tab 40 mg</i>	73	SALAGEN TAB 5MG.....	211
<i>rosuvastatin calcium tab 5 mg</i>	73	SALAGEN TAB 7.5MG.....	211
ROWASA KIT 4GM	171	SALIMEZ FORT CRE 10%	150
ROXICODONE TAB 15MG	29	<i>salsalate tab 500 mg</i>	23
ROXICODONE TAB 30MG	30	<i>salsalate tab 750 mg</i>	23
ROXICODONE TAB 5MG.....	29	SAMSCA TAB 15MG	167
ROZLYTREK CAP 100MG.....	94	SAMSCA TAB 30MG	167
ROZLYTREK CAP 200MG.....	94	SANCUSO DIS 3.1MG	68
RUBRACA TAB 200MG	94	SANDIMMUNE CAP 100MG.....	209
RUBRACA TAB 250MG	94	SANDIMMUNE CAP 25MG.....	209
RUBRACA TAB 300MG	95	SANDIMMUNE SOL 100MG/ML.....	209
RUCONEST INJ 2100UNIT	175	SANDOSTATIN INJ 100MCG.....	166
<i>rufinamide susp 40 mg/ml</i>	53	SANDOSTATIN INJ 500MCG	166
RUKOBIA TAB 600MG ER	112	SANDOSTATIN INJ 50MCG/ML	166
RUZURGI TAB 10MG	84	SANTYL OIN 250/GM	149
RYBELSUS TAB 14MG	64	SAPHRIS SUB 10MG.....	105
RYBELSUS TAB 3MG.....	64	SAPHRIS SUB 2.5MG	105
RYBELSUS TAB 7MG	64	SAPHRIS SUB 5MG	105
RYDAPT CAP 25MG	95	<i>sapropterin dihydrochloride powder packet</i> <i>100 mg</i>	164
RYTHMOL SR CAP 225MG.....	41	<i>sapropterin dihydrochloride powder packet</i> <i>500 mg</i>	164
		<i>sapropterin dihydrochloride tab 100 mg</i>	164
		SAPSCARE MIS TWIST	196
		SAPS CARE PAD ALCOHOL	201

SAPS HEALTH MIS TWIST	196	<i>sevelamer carbonate packet 0.8 gm</i>	173
SAPS HEALTH PAD ALCOHOL.....	201	<i>sevelamer carbonate packet 2.4 gm</i>	173
SAPS TWIST MIS 30G.....	196	<i>sevelamer carbonate tab 800 mg</i>	173
SAVELLA MIS TITR PAK.....	224	<i>sevelamer hcl tab 400 mg</i>	173
SAVELLA TAB 100MG	224	<i>sevelamer hcl tab 800 mg</i>	173
SAVELLA TAB 12.5MG.....	224	SFROWASA ENE 4GM	171
SAVELLA TAB 25MG	224	SHOPKO LANC MIS DEVICE.....	196
SAVELLA TAB 50MG.....	224	SHUR-SEAL GEL 2%.....	237
SAXENDA INJ 18MG/3ML.....	4	SIDE BUTTON MIS SAFETY.....	196
SB ALCOHOL PAD PREP	201	SIGNIFOR INJ 0.3MG/ML	166
SB LANCETS MIS THIN.....	196	SIGNIFOR INJ 0.6MG/ML	166
SB LANCETS MIS ULTR THN	196	SIGNIFOR INJ 0.9MG/ML	166
<i>scopolamine td patch 72hr 1 mg/3days</i>	68	SIKLOS TAB 1000MG	177
SELECT-LITE KIT DEV/LANC	196	SIKLOS TAB 100MG	177
SELECT-LITE MIS LANC DEV	196	<i>sildenafil citrate for suspension 10 mg/ml</i>	
<i>selegiline hcl cap 5 mg</i>	101	.....	127
<i>selegiline hcl tab 5 mg</i>	101	<i>sildenafil citrate tab 100 mg</i>	125
<i>selenium sulfide lotion 2.5%</i>	144	<i>sildenafil citrate tab 20 mg</i>	127
SELZENTRY SOL 20MG/ML	112	<i>sildenafil citrate tab 25 mg</i>	125
SELZENTRY TAB 150MG	112	<i>sildenafil citrate tab 50 mg</i>	125
SELZENTRY TAB 25MG	112	<i>silodosin cap 4 mg</i>	174
SELZENTRY TAB 300MG	112	<i>silodosin cap 8 mg</i>	174
SELZENTRY TAB 75MG	112	SILVADENE CRE 1%	145
SENSIPAR TAB 30MG.....	165	<i>silver sulfadiazine cream 1%</i>	145
SENSIPAR TAB 60MG.....	165	SIMBRINZA SUS 1-0.2%	216
SENSIPAR TAB 90MG.....	165	SIMPLE DIAG MIS LANCING.....	196
SEREVENT DIS AER 50MCG	45	<i>simvastatin tab 10 mg</i>	73
SERNIVO SPR.....	148	<i>simvastatin tab 20 mg</i>	73
SERNIVO SPR 0.05%	148	<i>simvastatin tab 40 mg</i>	73
SEROQUEL TAB 100MG	105	<i>simvastatin tab 5 mg</i>	73
SEROQUEL TAB 200MG.....	105	<i>simvastatin tab 80 mg</i>	73
SEROQUEL TAB 25MG	105	SINEMET TAB 10-100MG	100
SEROQUEL TAB 300MG.....	105	SINEMET TAB 25-100MG.....	100
SEROQUEL TAB 400MG.....	105	SINGLE-LET MIS 23G.....	196
SEROQUEL TAB 50MG	105	<i>sirolimus oral soln 1 mg/ml</i>	209
SEROSTIM INJ 4MG.....	163	<i>sirolimus tab 0.5 mg</i>	210
SEROSTIM INJ 5MG.....	163	<i>sirolimus tab 1 mg</i>	210
SEROSTIM INJ 6MG.....	163	<i>sirolimus tab 2 mg</i>	210
<i>sertraline hcl oral concentrate for solution</i>		SIRTURO TAB 100MG.....	84
<i>20 mg/ml</i>	58	SIRTURO TAB 20MG	84
<i>sertraline hcl tab 100 mg</i>	58	SITAVIG TAB 50MG	116
<i>sertraline hcl tab 25 mg</i>	58	SIVEXTRO TAB 200MG	37
<i>sertraline hcl tab 50 mg</i>	58	SKELAXIN TAB 800MG.....	212

SKYRIZI INJ 150DOSE.....	143	SOLU-CORTEF INJ 250MG.....	134
SKYRIZI INJ 150MG/ML	143	SOLU-CORTEF INJ 500MG.....	134
SKYRIZI INJ 180/1.2.....	172	SOLUS V2 MIS LANC 28G	197
SKYRIZI INJ 360/2.4	172	SOLUS V2 MIS LANC 30G	197
SKYRIZI PEN INJ 150MG/ML.....	143	SOLUS V2 MIS LANC DEV	197
SM ALCOHOL PAD PREP	201	SOLUS V2 SOL HIGH.....	197
SMARTEST MIS LANCETS	197	SOLUS V2 SOL LOW	197
SMARTEST SOL CONTROL.....	197	SOMA TAB 250MG.....	212
SMART SENSE MIS LANC 21G.....	197	SOMA TAB 350MG.....	212
SMART SENSE MIS LANC 26G.....	197	SOOLANTRA CRE 1%	151
SMART SENSE MIS LANC 30G.....	197	<i>sorafenib tosylate tab 200 mg (base</i>	
SMART SENSE MIS LANC 33G.....	197	<i>equivalent)</i>	95
SM LANCETS MIS 33G	196	SORIATANE CAP 10MG	143
SM TRUEDRAW MIS LANC DEV.....	196	SORIATANE CAP 25MG	143
<i>sodium chloride soln nebu 0.9%.....</i>	135	<i>sotalol hcl (afib/afl) tab 120 mg</i>	119
<i>sodium chloride soln nebu 10%.....</i>	136	<i>sotalol hcl (afib/afl) tab 160 mg.....</i>	119
<i>sodium chloride soln nebu 3%</i>	135	<i>sotalol hcl (afib/afl) tab 80 mg</i>	119
<i>sodium chloride soln nebu 7%</i>	135	<i>sotalol hcl tab 120 mg</i>	119
<i>sodium citrate & citric acid soln 500-334</i>		<i>sotalol hcl tab 160 mg</i>	119
<i>mg/5ml.....</i>	174	<i>sotalol hcl tab 240 mg</i>	119
<i>sodium fluoride gel 1.1% (0.5% f).....</i>	211	<i>sotalol hcl tab 80 mg.....</i>	119
<i>sodium phenylbutyrate oral powder 3</i>		SOTYLIZE SOL 5MG/ML	119
<i>gm/teaspoonful</i>	165	SOVALDI PAK 150MG.....	116
<i>sodium phenylbutyrate tab 500 mg</i>	165	SOVALDI PAK 200MG	116
<i>sodium polystyrene sulfonate oral susp 15</i>		SOVALDI TAB 200MG	116
<i>gm/60ml.....</i>	210	SOVALDI TAB 400MG	116
<i>sodium polystyrene sulfonate powder</i>	210	<i>spinosad susp 0.9%.....</i>	151
SODIUM SULFA LIQ 10% WASH	145	SPIRIVA AER 1.25MCG	42
SOD OXYBATE SOL 500MG/ML	222	SPIRIVA CAP HANDIHLR.....	42
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-</i>		SPIRIVA SPR 2.5MCG.....	42
<i>3.13-1.6 gm/177ml.....</i>	180	<i>spironolactone & hydrochlorothiazide tab</i>	
SOFTCLIX MIS LANCETS	197	<i>25-25 mg.....</i>	159
<i>solifenacin succinate tab 10 mg.....</i>	236	<i>spironolactone tab 100 mg.....</i>	160
<i>solifenacin succinate tab 5 mg</i>	236	<i>spironolactone tab 25 mg.....</i>	159
SOLIQUA INJ 100/33.....	62	<i>spironolactone tab 50 mg</i>	160
SOLODYN TAB 105MG	231	SPORANOX CAP 100MG	69
SOLODYN TAB 115MG	231	SPORANOX CAP PULSEPAK	69
SOLODYN TAB 55MG	231	SPORANOX SOL 10MG/ML.....	69
SOLODYN TAB 65MG	231	SPRAVATO SOL 56MG DOS.....	57
SOLODYN TAB 80MG.....	231	SPRAVATO SOL 84MG DOS.....	57
SOLTAMOX SOL 10MG/5ML	89	SPRYCEL TAB 100MG	95
SOLU-CORTEF INJ 1000MG.....	134	SPRYCEL TAB 140MG	95
SOLU-CORTEF INJ 100MG	134	SPRYCEL TAB 20MG.....	95

SPRYCEL TAB 50MG.....	95	<i>sulconazole nitrate solution 1%</i>	140
SPRYCEL TAB 70MG.....	95	<i>sulfacetamide sodium lotion 10% (acne)</i>	138
SPRYCEL TAB 80MG.....	95	<i>sulfacetamide sodium ophth oint 10%</i>	216
STALEVO 100 TAB	100	<i>sulfacetamide sodium ophth soln 10%....</i>	216
STALEVO 125 TAB.....	100	<i>sulfacetamide sodium-prednisolone ophth</i>	
STALEVO 150 TAB.....	100	<i>soln 10-0.23(0.25)%</i>	218
STALEVO 200 TAB.....	100	<i>sulfacetamide sodium w/ sulfur cleansing</i>	
STALEVO 50 TAB	100	<i>pad 10-4%</i>	138
STALEVO 75 TAB	100	<i>sulfacetamide sodium w/ sulfur emulsion</i>	
STARLIX TAB 120MG.....	65	<i>10-1%</i>	138
<i>stavudine cap 15 mg</i>	112	<i>sulfadiazine tab 500 mg</i>	231
<i>stavudine cap 20 mg.....</i>	112	<i>sulfamethoxazole-trimethoprim susp 200-</i>	
<i>stavudine cap 30 mg.....</i>	113	<i>40 mg/5ml</i>	36
<i>stavudine cap 40 mg</i>	113	<i>sulfamethoxazole-trimethoprim tab 400-80</i>	
STAXYN TAB 10MG.....	125	<i>mg</i>	36
STELARA INJ 45MG/0.5	143, 144	<i>sulfamethoxazole-trimethoprim tab 800-</i>	
STELARA INJ 90MG/ML	144	<i>160 mg</i>	36
STERILANCE MIS 1.8MM	197	SULFAMYLON CRE 85MG/GM	145
STERILANCE MIS TL 28G.....	197	SULFAMYLON PAK 5%	145
STERILANCE MIS TL 30G.....	197	<i>sulfasalazine tab 500 mg.....</i>	172
STERILANCE MIS TL 32G	197	<i>sulfasalazine tab delayed release 500 mg</i>	
STIMATE SOL 1.5MG/ML	166	<i>.....</i>	172
STIOLTO AER 2.5-2.5	45	SULF LIME SOL.....	151
STIVARGA TAB 40MG.....	95	<i>sulindac tab 150 mg.....</i>	20
STRATTERA CAP 100MG.....	6	<i>sulindac tab 200 mg.....</i>	20
STRATTERA CAP 10MG	5	<i>sumatriptan nasal spray 20 mg/act</i>	205
STRATTERA CAP 18MG.....	5	<i>sumatriptan nasal spray 5 mg/act.....</i>	205
STRATTERA CAP 25MG.....	5	<i>sumatriptan succinate inj 6 mg/0.5ml....</i>	205
STRATTERA CAP 40MG.....	5	<i>sumatriptan succinate solution auto-</i>	
STRATTERA CAP 60MG.....	5	<i>injector 4 mg/0.5ml.....</i>	206
STRATTERA CAP 80MG.....	5	<i>sumatriptan succinate solution auto-</i>	
STRENSIQ INJ 18/0.45	165	<i>injector 6 mg/0.5ml.....</i>	206
STRENSIQ INJ 28/0.7ML	165	<i>sumatriptan succinate solution cartridge 4</i>	
STRENSIQ INJ 40MG/ML	165	<i>mg/0.5ml</i>	206
STRENSIQ INJ 80/0.8ML	165	<i>sumatriptan succinate solution cartridge 6</i>	
STRIVERDI AER 2.5MCG.....	45	<i>mg/0.5ml</i>	206
STROMECTOL TAB 3MG	35	<i>sumatriptan succinate solution prefilled</i>	
SUCRAID SOL 8500/ML.....	158	<i>syringe 6 mg/0.5ml</i>	206
<i>sucrafate tab 1 gm.....</i>	234	<i>sumatriptan succinate tab 100 mg</i>	206
SULAR TAB 17MG.....	121	<i>sumatriptan succinate tab 25 mg.....</i>	206
SULAR TAB 34MG.....	121	<i>sumatriptan succinate tab 50 mg.....</i>	206
SULAR TAB 8.5MG.....	121	<i>sunitinib malate cap 12.5 mg (base</i>	
<i>sulconazole nitrate cream 1%.....</i>	140	<i>equivalent)</i>	95

<i>sunitinib malate cap 25 mg (base equivalent)</i>	95	SYMAX DUOTAB TAB	234
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	95	SYMBICORT AER 160-4.5	45
<i>sunitinib malate cap 50 mg (base equivalent)</i>	95	SYMBICORT AER 80-4.5	45
SUNOSI TAB 150MG	6	SYMBYAX CAP 12-50MG	224
SUNOSI TAB 75MG	6	SYMBYAX CAP 3-25MG	224
SUPER THIN MIS LANC 28G	197	SYMBYAX CAP 6-25MG	224
SUPER THIN MIS LANCETS	197	SYMBYAX CAP 6-50MG	224
SUPLENA LIQ VANILLA	157	SYMDEKO TAB 100-150	230
SUPRAX CAP 400MG	129	SYMDEKO TAB 50-75MG	230
SUPRAX CHW 100MG	129	SYMFI LO TAB	113
SUPRAX CHW 200MG	130	SYMFI TAB	113
SUPRAX SUS 100/5ML	130	SYMLINPEN 60 INJ 1000MCG	62
SUPRAX SUS 200/5ML	130	SYMLNPEN 120 INJ 1000MCG	62
SUPRAX SUS 500/5ML	130	SYMPROIC TAB 0.2MG	173
SUPREME II LIQ HIGH/LOW	197	SYMTUZA TAB	113
SURE COMFORT MIS LANC 18G	197	SYNALAR CRE 0.025%	148
SURE COMFORT MIS LANC 21G	197	SYNALAR OIN 0.025%	148
SURE COMFORT MIS LANC 23G	197	SYNALAR SOL 0.01%	148
SURE COMFORT MIS LANC 30G	197	SYNAREL SOL 2MG/ML	163
SURE COMFORT MIS LANCETS	197	SYNERA DIS 70-70MG	150
SURE COMFORT MIS LANC PEN	197	SYNJARDY TAB	62
SUREFLEX MIS LANCETS	197	SYNJARDY TAB 12.5-500	62
SURE-LANCE MIS 26G	197	SYNJARDY TAB 5-1000MG	62
SURE-LANCE MIS LANCETS	197	SYNJARDY TAB 5-500MG	62
SURELITE MIS LANCETS	197	SYNJARDY XR TAB	62
SURE-PEN MIS	197	SYNJARDY XR TAB 10-1000	62
SURESTEP GLU SOL	197	SYNJARDY XR TAB 25-1000	63
SURESTEP GLU SOL HIGH/LOW	197	SYNJARDY XR TAB 5-1000MG	62
SURESTEP PRO TES HIGH CON	197	SYNTHROID TAB 100MCG	233
SURESTEP PRO TES LOW CON	197	SYNTHROID TAB 112MCG	233
SURESTEP PRO TES NORM CON	198	SYNTHROID TAB 125MCG	233
SURESTEP SOL CONTROL	198	SYNTHROID TAB 137MCG	233
SURE-TOUCH MIS UNV LANC	197	SYNTHROID TAB 150MCG	233
SUSTIVA CAP 200MG	113	SYNTHROID TAB 175MCG	233
SUSTIVA CAP 50MG	113	SYNTHROID TAB 200MCG	233
SUSTIVA TAB 600MG	113	SYNTHROID TAB 25MCG	233
SUTENT CAP 12.5MG	95	SYNTHROID TAB 300MCG	233
SUTENT CAP 25MG	95	SYNTHROID TAB 50MCG	233
SUTENT CAP 37.5MG	95	SYNTHROID TAB 75MCG	233
SUTENT CAP 50MG	95	SYNTHROID TAB 88MCG	233
		T	
		TABLOID TAB 40MG	86
		TACHOSIL PAD 4.8X4.8	178

TACHOSIL PAD 9.5X4.8	178	TAVALISSE TAB 100MG	175
TACLONEX OIN	148	TAVALISSE TAB 150MG	176
TACLONEX SUS	148	<i>tazarotene cream 0.1%</i>	144
<i>tacrolimus cap 0.5 mg</i>	210	TECHLITE AST MIS LANCETS	198
<i>tacrolimus cap 1 mg</i>	210	TECHLITE MIS LANC 30G	198
<i>tacrolimus cap 5 mg</i>	210	TECHLITE MIS LANCETS	198
<i>tacrolimus oint 0.03%</i>	149	TEGRETOL SUS 100/5ML	53
<i>tacrolimus oint 0.1%</i>	149	TEGRETOL TAB 200MG	53
<i>tadalafil tab 10 mg</i>	125	TEGRETOL-XR TAB 100MG	53
<i>tadalafil tab 2.5 mg</i>	125	TEGRETOL-XR TAB 200MG	53
<i>tadalafil tab 20 mg</i>	125	TEGRETOL-XR TAB 400MG	53
<i>tadalafil tab 20 mg (pah)</i>	127	TEGSEDI INJ 284/1.5	229
<i>tadalafil tab 5 mg</i>	125	TEKTURNA HCT TAB 150-12.5	81
TAFINLAR CAP 50MG	96	TEKTURNA HCT TAB 150-25MG	81
TAFINLAR CAP 75MG	96	TEKTURNA HCT TAB 300-12.5	81
TAFINLAR TAB 10MG	96	TEKTURNA HCT TAB 300-25MG	81
<i>tafluprost preservative free (pf) ophth soln</i> <i>0.0015%</i>	219	TEKTURNA TAB 150MG	82
TAGRISSE TAB 40MG	88	TEKTURNA TAB 300MG	82
TAGRISSE TAB 80MG	88	<i>telmisartan-amlodipine tab 40-10 mg</i>	81
TAI DOC SOL NORM CON	198	<i>telmisartan-amlodipine tab 40-5 mg</i>	81
TALICIA CAP	235	<i>telmisartan-amlodipine tab 80-10 mg</i>	81
TAMIFLU CAP 30MG	117	<i>telmisartan-amlodipine tab 80-5 mg</i>	81
TAMIFLU CAP 45MG	117	<i>telmisartan-hydrochlorothiazide tab 40-</i> <i>12.5 mg</i>	82
TAMIFLU CAP 75MG	117	<i>telmisartan-hydrochlorothiazide tab 80-12.5</i> <i>mg</i>	82
TAMIFLU SUS 6MG/ML	117	<i>telmisartan-hydrochlorothiazide tab 80-25</i> <i>mg</i>	82
<i>tamoxifen citrate tab 10 mg (base</i> <i>equivalent)</i>	89	<i>telmisartan tab 20 mg</i>	77
<i>tamoxifen citrate tab 20 mg (base</i> <i>equivalent)</i>	89	<i>telmisartan tab 40 mg</i>	77
<i>tamsulosin hcl cap 0.4 mg</i>	174	<i>telmisartan tab 80 mg</i>	77
TAPAZOLE TAB 10MG	232	<i>temazepam cap 15 mg</i>	179
TAPAZOLE TAB 5MG	232	<i>temazepam cap 22.5 mg</i>	179
TARCEVA TAB 100MG	88	<i>temazepam cap 30 mg</i>	179
TARCEVA TAB 150MG	88	<i>temazepam cap 7.5 mg</i>	179
TARCEVA TAB 25MG	88	TEMBEXA SUS 10MG/ML	117
TARGRETIN CAP 75MG	97	TEMBEXA TAB 100MG	117
TARGRETIN GEL 1%	140	TEMIXYS TAB 300-300	113
TARKA TAB 2-180 CR	81	TEMODAR CAP 100MG	85
TARKA TAB 2-240 CR	81	TEMODAR CAP 140MG	85
TARKA TAB 4-240 CR	81	TEMODAR CAP 180MG	85
<i>tasimelteon capsule 20 mg</i>	180	TEMODAR CAP 250MG	85
TASMAR TAB 100MG	98	TEMOVATE CRE 0.05%	148

TEMOVATE OIN 0.05%	148	<i>testosterone td soln 30 mg/act</i>	34
<i>temozolomide cap 100 mg</i>	85	<i>tetrabenazine tab 12.5 mg</i>	225
<i>temozolomide cap 140 mg</i>	85	<i>tetrabenazine tab 25 mg</i>	225
<i>temozolomide cap 180 mg</i>	85	<i>tetracaine hcl ophth soln 0.5%</i>	217
<i>temozolomide cap 20 mg</i>	85	<i>tetracycline hcl cap 250 mg</i>	232
<i>temozolomide cap 250 mg</i>	85	<i>tetracycline hcl cap 500 mg</i>	232
<i>temozolomide cap 5 mg</i>	85	TEXACORT SOL 2.5%.....	148
<i>tenofovir disoproxil fumarate tab 300 mg</i>	113	TGT LANCET MIS 26G	198
TENORETIC TAB 100	82	TGT LANCET MIS 30G	198
TENORETIC TAB 50.....	82	TGT LANCET MIS 33G	198
TENORMIN TAB 100MG.....	119	TGT LANCING MIS DEVICE.....	198
TENORMIN TAB 25MG.....	119	THALOMID CAP 100MG	208
TENORMIN TAB 50MG.....	119	THALOMID CAP 150MG	208
<i>terazosin hcl cap 10 mg (base equivalent)</i> 78		THALOMID CAP 200MG	208
<i>terazosin hcl cap 1 mg (base equivalent)</i> ..78		THALOMID CAP 50MG.....	208
<i>terazosin hcl cap 2 mg (base equivalent)</i> .78		<i>theophylline elixir 80 mg/15ml</i>	46
<i>terazosin hcl cap 5 mg (base equivalent)</i> .78		<i>theophylline tab er 12hr 300 mg</i>	46
<i>terbinafine hcl tab 250 mg</i>	69	<i>theophylline tab er 12hr 450 mg</i>	46
<i>terbutaline sulfate tab 2.5 mg</i>	45	<i>theophylline tab er 24hr 400 mg</i>	46
<i>terbutaline sulfate tab 5 mg</i>	45	<i>theophylline tab er 24hr 600 mg</i>	46
<i>terconazole vaginal cream 0.4%</i>	237	THIN LANCETS MIS	198
<i>terconazole vaginal cream 0.8%</i>	237	THIN LANCETS MIS 26G	198
<i>terconazole vaginal suppos 80 mg</i>	237	THIN LANCETS MIS 30G	198
<i>teriflunomide tab 14 mg</i>	227	THINLETS GP MIS 26G	198
<i>teriflunomide tab 7 mg</i>	227	<i>thioridazine hcl tab 100 mg</i>	106
TESSALON PER CAP 100MG	135	<i>thioridazine hcl tab 10 mg</i>	106
TESTOST CYP INJ 200MG/ML.....	34	<i>thioridazine hcl tab 25 mg</i>	106
<i>testosterone cypionate im inj in oil 100</i> <i>mg/ml</i>	34	<i>thioridazine hcl tab 50 mg</i>	106
<i>testosterone cypionate im inj in oil 200</i> <i>mg/ml</i>	34	<i>thiothixene cap 10 mg</i>	107
<i>testosterone enanthate im inj in oil 200</i> <i>mg/ml</i>	34	<i>thiothixene cap 1 mg</i>	107
<i>testosterone td gel 10mg/act (2%)</i>	34	<i>thiothixene cap 2 mg</i>	107
<i>testosterone td gel 12.5 mg/act (1%)</i>	34	<i>thiothixene cap 5 mg</i>	107
<i>testosterone td gel 20.25 mg/1.25gm</i> <i>(1.62%)</i>	34	<i>tiagabine hcl tab 12 mg</i>	55
<i>testosterone td gel 20.25 mg/act (1.62%)</i> 34		<i>tiagabine hcl tab 16 mg</i>	55
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	34	<i>tiagabine hcl tab 2 mg</i>	55
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	34	<i>tiagabine hcl tab 4 mg</i>	55
<i>testosterone td gel 50 mg/5gm (1%)</i>	34	TIAZAC CAP 120MG/24	121
		TIAZAC CAP 180MG/24.....	122
		TIAZAC CAP 240MG/24.....	122
		TIAZAC CAP 300MG/24.....	122
		TIAZAC CAP 360MG/24.....	122
		TIAZAC CAP 420MG/24.....	122
		TIBSOVO TAB 250MG.....	96

TIGAN CAP 300MG	68	TOBRADEX SUS 0.3-0.1%	218
TIKOSYN CAP 125MCG	41	<i>tobramycin-dexamethasone ophth susp</i>	
TIKOSYN CAP 250MCG.....	41	0.3-0.1%.....	218
TIKOSYN CAP 500MCG	41	<i>tobramycin nebu soln 300 mg/4ml</i>	10
<i>timolol maleate ophth gel forming soln</i>		<i>tobramycin nebu soln 300 mg/5ml</i>	10
0.25%	215	<i>tobramycin ophth soln 0.3%</i>	217
<i>timolol maleate ophth gel forming soln</i>		TOBEX OIN 0.3% OP	217
0.5%	214	TOBEX SOL 0.3% OP	217
<i>timolol maleate ophth soln 0.25%</i>	215	TODAY SPONGE MIS.....	237
<i>timolol maleate ophth soln 0.5%</i>	215	<i>tolbutamide tab 500 mg</i>	66
<i>timolol maleate ophth soln 0.5% (once-</i>		<i>tolcapone tab 100 mg</i>	98
<i>daily)</i>	215	TOLEREX POW.....	157
<i>timolol maleate preservative free ophth soln</i>		<i>tolmetin sodium cap 400 mg</i>	20
0.5%	215	<i>tolmetin sodium tab 600 mg</i>	20
<i>timolol maleate tab 10 mg</i>	119	<i>tolterodine tartrate cap er 24hr 2 mg</i>	236
<i>timolol maleate tab 20 mg</i>	120	<i>tolterodine tartrate cap er 24hr 4 mg</i>	236
<i>timolol maleate tab 5 mg</i>	119	<i>tolterodine tartrate tab 1 mg</i>	236
TIMOPTIC SOL 0.25% OP	215	<i>tolterodine tartrate tab 2 mg</i>	236
TIMOPTIC SOL 0.5% OP	215	<i>tolvaptan tab 30 mg</i>	167
TIMOPTIC-XE SOL 0.25% OP	215	TOPAMAX SPR CAP 15MG	53
TIMOPTIC-XE SOL 0.5% OP	215	TOPAMAX SPR CAP 25MG	53
<i>tinidazole tab 250 mg</i>	35	TOPAMAX TAB 100MG	54
<i>tinidazole tab 500 mg</i>	35	TOPAMAX TAB 200MG	54
<i>tiopronin tab 100 mg</i>	175	TOPAMAX TAB 25MG.....	53
TISSEEL KIT 10ML.....	178	TOPAMAX TAB 50MG.....	53
TISSEEL KIT 2ML	178	TOPCARE MIS LANC 33G	198
TISSEEL KIT 4ML	178	TOPICORT CRE 0.05%	148
TISSEEL SOL 10ML	178	TOPICORT CRE 0.25%	148
TISSEEL SOL 2ML.....	178	TOPICORT GEL 0.05%	148
TISSEEL SOL 4ML.....	178	TOPICORT OIN 0.05%.....	148
TIVICAY PD TAB 5MG.....	113	TOPICORT OIN 0.25%	148
TIVICAY TAB 10MG	113	TOPICORT SPR 0.25%	148
TIVICAY TAB 25MG.....	113	<i>topiramate cap er 24hr 200 mg</i>	54
TIVICAY TAB 50MG	113	<i>topiramate sprinkle cap 15 mg</i>	54
<i>tizanidine hcl cap 2 mg (base equivalent)</i>		<i>topiramate sprinkle cap 25 mg</i>	54
.....	212	<i>topiramate tab 100 mg</i>	54
<i>tizanidine hcl cap 4 mg (base equivalent)</i>		<i>topiramate tab 200 mg</i>	54
.....	212	<i>topiramate tab 25 mg</i>	54
<i>tizanidine hcl cap 6 mg (base equivalent)</i>		<i>topiramate tab 50 mg</i>	54
.....	212	<i>toremifene citrate tab 60 mg (base</i>	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	212	<i>equivalent)</i>	89
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	212	<i>toremide tab 100 mg</i>	159
TOBRADEX OIN 0.3-0.1%.....	218	<i>toremide tab 10 mg</i>	159

<i>torseamide tab 20 mg</i>	159	TREMFYA INJ 100MG/ML.....	144
<i>torseamide tab 5 mg</i>	159	TRESIBA FLEX INJ 100UNIT.....	65
TOUJEO MAX INJ 300IU/ML.....	65	TRESIBA FLEX INJ 200UNIT.....	65
TOUJEO SOLO INJ 300IU/ML.....	65	TRESIBA INJ 100UNIT.....	65
TPOXX CAP 200MG.....	117	<i>tretinoin cap 10 mg</i>	97
TPOXX INJ.....	117	<i>tretinoin cream 0.025%</i>	138
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	32	<i>tretinoin cream 0.05%</i>	138
<i>tramadol hcl tab 50 mg</i>	30	<i>tretinoin cream 0.1%</i>	138
<i>tramadol hcl tab er 24hr 100 mg</i>	30	<i>tretinoin gel 0.01%</i>	138
<i>tramadol hcl tab er 24hr 200 mg</i>	30	<i>tretinoin gel 0.025%</i>	138
<i>tramadol hcl tab er 24hr 300 mg</i>	30	<i>tretinoin gel 0.05%</i>	138
<i>tramadol hcl tab er 24hr biphasic release</i> <i>100 mg</i>	30	<i>tretinoin microsphere gel 0.04%</i>	138
<i>tramadol hcl tab er 24hr biphasic release</i> <i>200 mg</i>	30	<i>tretinoin microsphere gel 0.1%</i>	138
<i>tramadol hcl tab er 24hr biphasic release</i> <i>300 mg</i>	30	TREXALL TAB 10MG.....	86
<i>trandolapril tab 1 mg</i>	76	TREXALL TAB 15MG.....	86
<i>trandolapril tab 2 mg</i>	76	TREXALL TAB 5MG.....	86
<i>trandolapril tab 4 mg</i>	76	TREXALL TAB 7.5MG.....	86
<i>trandolapril-verapamil hcl tab er 1-240 mg</i>	82	<i>triamcinolone acetone cream 0.025%</i>	148
<i>trandolapril-verapamil hcl tab er 2-180 mg</i>	82	<i>triamcinolone acetone cream 0.1%</i>	148
<i>trandolapril-verapamil hcl tab er 2-240 mg</i>	82	<i>triamcinolone acetone cream 0.5%</i>	148
<i>trandolapril-verapamil hcl tab er 4-240 mg</i>	82	<i>triamcinolone acetone dental paste 0.1%</i>	211
<i>tranexamic acid tab 650 mg</i>	178	<i>triamcinolone acetone lotion 0.025%</i>	148
TRANXENE T TAB 7.5MG.....	40	<i>triamcinolone acetone lotion 0.1%</i>	148
<i>tranylcypromine sulfate tab 10 mg</i>	57	<i>triamcinolone acetone oint 0.025%</i>	148
TRAVEL LANCE MIS 30G.....	198	<i>triamcinolone acetone oint 0.1%</i>	148
TRAVEL LANCE MIS ADV 28G.....	198	<i>triamcinolone acetone oint 0.5%</i>	148
<i>travoprost ophth soln 0.004%</i> <i>(benzalkonium free) (bak free)</i>	219	<i>triamterene & hydrochlorothiazide cap</i> <i>37.5-25 mg</i>	159
<i>trazodone hcl tab 100 mg</i>	59	<i>triamterene & hydrochlorothiazide tab 37.5-</i> <i>25 mg</i>	159
<i>trazodone hcl tab 150 mg</i>	59	<i>triamterene & hydrochlorothiazide tab 75-</i> <i>50 mg</i>	159
<i>trazodone hcl tab 300 mg</i>	59	<i>triamterene cap 100 mg</i>	160
<i>trazodone hcl tab 50 mg</i>	59	<i>triamterene cap 50 mg</i>	160
TRECTOR TAB 250MG.....	84	<i>triazolam tab 0.125 mg</i>	179
TRELEGY AER 100MCG.....	45	<i>triazolam tab 0.25 mg</i>	179
TRELEGY AER 200MCG.....	45	TRIBENZOR20- TAB 5-12.5MG.....	82
		TRIBENZOR40- TAB 10-12.5.....	82
		TRIBENZOR40- TAB 10-25MG.....	82
		TRIBENZOR40- TAB 5-12.5MG.....	82
		TRIBENZOR40- TAB 5-25MG.....	82
		TRIDESILON CRE 0.05%.....	148

<i>trientine hcl cap 250 mg</i>	207	TRULANCE TAB 3MG	170
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	106	TRULICITY INJ 0.75/0.5	64
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	106	TRULICITY INJ 1.5/0.5	64
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	106	TRULICITY INJ 3/0.5	64
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	106	TRULICITY INJ 4.5/0.5	64
<i>trifluridine ophth soln 1%</i>	217	TRUPLUS LANC MIS 26G	198
<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i> ...	98	TRUPLUS LANC MIS 28G	198
<i>trihexyphenidyl hcl tab 2 mg</i>	98	TRUPLUS LANC MIS 30G	198
<i>trihexyphenidyl hcl tab 5 mg</i>	98	TRUPLUS LANC MIS 33G	198
TRIJARDY XR TAB	63	TRUSOPT SOL 2% OP	219
TRIKAFTA PAK 59.5MG	230	TRUZONE PEAK MIS FLOW MTR	203
TRIKAFTA PAK 75MG	230	TUKYSA TAB 150MG	87
TRIKAFTA TAB	230	TUKYSA TAB 50MG	87
TRILEPTAL SUS 300MG/5M	54	TURPENTINE SOL SPIRITS	150
TRILEPTAL TAB 150MG	54	TUSSICAPS CAP 10-8MG	135
TRILEPTAL TAB 300MG	54	TUZISTRA XR SUS	135
TRILEPTAL TAB 600MG	54	TWIST LANCET MIS 30G MULT	198
TRILIPIX CAP 135MG	72	TWOCAL HN LIQ	157
TRILIPIX CAP 45MG	72	TWYNSTA TAB 40-10MG	82
<i>trimethobenzamide hcl cap 300 mg</i>	68	TWYNSTA TAB 40-5MG	82
<i>trimethoprim tab 100 mg</i>	35	TWYNSTA TAB 80-10MG	82
<i>trimipramine maleate cap 100 mg</i>	61	TWYNSTA TAB 80-5MG	82
<i>trimipramine maleate cap 25 mg</i>	61	TYBOST TAB 150MG	113
<i>trimipramine maleate cap 50 mg</i>	61	TYKERB TAB 250MG	96
TRIUMEQ PD TAB	113	TYLACTIN POW BLD 20PE	157
TRIUMEQ TAB	113	TYMLOS INJ	161
TRIZIVIR TAB	113	TYVASO DPI POW 16-32-48	126
TROKENDI XR CAP 100MG	54	TYVASO DPI POW 16-32MCG	126
TROKENDI XR CAP 200MG	54	TYVASO DPI POW 16MCG	126
TROKENDI XR CAP 25MG	54	TYVASO DPI POW 32-48MCG	126
TROKENDI XR CAP 50MG	54	TYVASO DPI POW 32MCG	126
<i>tropium chloride cap er 24hr 60 mg</i>	236	TYVASO DPI POW 48MCG	126
<i>tropium chloride tab 20 mg</i>	236	TYVASO DPI POW 64MCG	126
TRUECONTROL LIQ LEVEL 0	198	TYVASO REFIL SOL 0.6MG/ML	126
TRUECONTROL LIQ LEVEL 1	198	TYVASO SOL 0.6MG/ML	126
TRUEDRAW MIS LANC DEV	198	TYVASO START SOL 0.6MG/ML	127
TRUE METRIX SOL LEVEL 1	198	U	
TRUE METRIX SOL LEVEL 2	198	UBRELVY TAB 100MG	204
TRUE METRIX SOL LEVEL 3	198	UBRELVY TAB 50MG	204
		UCERIS AER 2MG/ACT	34
		UCERIS TAB 9MG	134
		ULTICARE PAD ALCOHOL	202
		ULTI-LANCE MIS CLR TIP	198

ULTILET MIS 26G.....	198	UNISTIK 2 MIS 2.4MM	199
ULTILET MIS 28G.....	198	UNISTIK 2 MIS COMFORT	199
ULTILET MIS 30G	198	UNISTIK 2 MIS EXTRA.....	199
ULTILET MIS 33G.....	198	UNISTIK 2 MIS NEONATAL	199
ULTILET MIS LANCETS.....	198	UNISTIK 2 MIS NORMAL	200
ULTILET MIS SAFETY	198	UNISTIK 2 MIS SUPER.....	200
ULTILET PAD ALCOHOL.....	202	UNISTIK 3 MIS 1.8MM	200
ULTILET SAFE MIS 21G	199	UNISTIK 3 MIS COMFORT	200
ULTRACAL HN LIQ PLUS.....	157	UNISTIK 3 MIS EXTRA.....	200
ULTRACAL LIQ.....	157	UNISTIK 3 MIS GENT 30G	200
ULTRACET TAB 37.5-325	32	UNISTIK 3 MIS NEONATAL	200
ULTRAM TAB 50MG.....	30	UNISTIK 3 MIS NORMAL	200
ULTRA THIN MIS 28G	199	UNISTIK 3 MIS XTR 21G	200
ULTRA THIN MIS 30G.....	199	UNISTIK CZT MIS COMFORT	200
ULTRA THIN MIS 31G.....	199	UNISTIK CZT MIS NORMAL	200
ULTRA THIN MIS 33G	199	UNISTIK II MIS LANCETS.....	200
ULTRA THIN MIS LAN 31G	199	UNISTIK PRO MIS LANC 21G	200
ULTRA THIN MIS LANC 28G.....	199	UNISTIK PRO MIS LANC 28G	200
ULTRA THIN MIS LANC 30G.....	199	UNISTIK SAFE MIS LANC 28G	200
ULTRA THIN MIS LANCETS	199	UNISTIK SAFE MIS LANC 30G.....	200
ULTRIENT 1.5 LIQ SAFE-T.....	157	UNISTIK TOUC MIS LANC 21G.....	200
UNILET CMFR MIS TCH 28G.....	199	UNISTIK TOUC MIS LANC 23G.....	200
UNILET CMFR MIS TCH 30G	199	UNISTIK TOUC MIS LANC 28G.....	200
UNILET EXCEL MIS 23G	199	UNISTIK TOUC MIS LANC 30G.....	200
UNILET EX II MIS 28G.....	199	UNITSTIK PRO MIS LANC 25G	200
UNILET G.P. MIS 21G.....	199	UNIVERSAL 1 MIS 33G	200
UNILET G.P MIS SUPR 23G	199	UNIVERSAL 1 MIS LANC 26G.....	200
UNILET GP 28 MIS ULT THIN	199	UNIVERSAL 1 MIS LANC 30G.....	200
UNILET LANCE MIS 21G	199	UPTRAVI PACK TAB 200/800	127
UNILET LANCE MIS 28G.....	199	UPTRAVI TAB 1000MCG	128
UNILET LANCE MIS 33G.....	199	UPTRAVI TAB 1200MCG.....	128
UNILET LANC MIS 33G.....	199	UPTRAVI TAB 1400MCG	128
UNILET LANCT MIS 28G.....	199	UPTRAVI TAB 1600MCG	128
UNILET LANCT MIS 30G	199	UPTRAVI TAB 200MCG	127
UNILET LANCT MIS 33G.....	199	UPTRAVI TAB 400MCG.....	127
UNILET MICRO MIS 33G.....	199	UPTRAVI TAB 600MCG.....	127
UNILET MIS 21G	199	UPTRAVI TAB 800MCG	127
UNILET SUPER MIS 23G	199	<i>urea cream 39%</i>	149
UNILET SUPER MIS G.P. 23G	199	<i>urea lotion 40%</i>	149
UNISTIK 1 MIS 2.4MM	199	UROCIT-K 10 TAB	174
UNISTIK 1 MIS 3.0MM.....	199	UROCIT-K 15 TAB	174
UNISTIK 2 MIS.....	199	UROCIT-K 5 TAB.....	174
UNISTIK 2 MIS 1.8MM	199	URSO 250 TAB 250MG.....	170

<i>ursodiol cap 300 mg</i>	170	<i>vancomycin hcl for oral soln 50 mg/ml</i>	
<i>ursodiol tab 250 mg</i>	170	<i>(base equivalent)</i>	36
<i>ursodiol tab 500 mg</i>	170	VANDAZOLE GEL 0.75%	237
URSO FORTE TAB 500MG	170	VANOS CRE 0.1%	148
V		VANTAGE LANC MIS DEVICE	200
VAGIFEM TAB 10MCG	238	<i>varденаfil hcl orally disintegrating tab 10</i>	
<i>valacyclovir hcl tab 1 gm</i>	116	<i>mg</i>	125
<i>valacyclovir hcl tab 500 mg</i>	116	<i>varденаfil hcl tab 10 mg</i>	126
VALCHLOR GEL 0.016%	140	<i>varденаfil hcl tab 2.5 mg</i>	125
<i>valganciclovir hcl for soln 50 mg/ml (base</i>		<i>varденаfil hcl tab 20 mg</i>	126
<i>equiv)</i>	114	<i>varденаfil hcl tab 5 mg</i>	126
<i>valganciclovir hcl tab 450 mg (base</i>		VARUBI TAB 90MG	68
<i>equivalent)</i>	114	VASCEPA CAP 0.5GM	71
VALIUM TAB 10MG	40	VASCEPA CAP 1GM	71
VALIUM TAB 2MG	40	VASERETIC TAB 10-25MG	82
VALIUM TAB 5MG	40	VASOTEC TAB 10MG	76
<i>valproate sodium oral soln 250 mg/5ml</i>		VASOTEC TAB 2.5MG	76
<i>(base equiv)</i>	56	VASOTEC TAB 20MG	76
<i>valproic acid cap 250 mg</i>	56	VASOTEC TAB 5MG	76
<i>valsartan-hydrochlorothiazide tab 160-12.5</i>		VCF VAGINAL AER CONTRACP	237
<i>mg</i>	82	VCF VAGINAL GEL CONTRACE	237
<i>valsartan-hydrochlorothiazide tab 160-25</i>		VCF VAGINAL MIS CONTRACP	237
<i>mg</i>	82	VECAMYL TAB 2.5MG	82
<i>valsartan-hydrochlorothiazide tab 320-12.5</i>		VELPHORO CHW 500MG	173
<i>mg</i>	82	VELTASSA POW 16.8GM	210
<i>valsartan-hydrochlorothiazide tab 320-25</i>		VELTASSA POW 25.2GM	210
<i>mg</i>	82	VELTASSA POW 8.4GM	210
<i>valsartan-hydrochlorothiazide tab 80-12.5</i>		VEMLIDY TAB 25MG	116
<i>mg</i>	82	VENCLEXTA TAB 100MG	87
<i>valsartan tab 160 mg</i>	77	VENCLEXTA TAB 10MG	87
<i>valsartan tab 320 mg</i>	77	VENCLEXTA TAB 50MG	87
<i>valsartan tab 40 mg</i>	77	VENCLEXTA TAB START PK	87
<i>valsartan tab 80 mg</i>	77	<i>venlafaxine hcl cap er 24hr 150 mg (base</i>	
VALTOCO SPR 10MG	49	<i>equivalent)</i>	59
VALTOCO SPR 15MG	49	<i>venlafaxine hcl cap er 24hr 37.5 mg (base</i>	
VALTOCO SPR 20MG	49	<i>equivalent)</i>	59
VALTOCO SPR 5MG	49	<i>venlafaxine hcl cap er 24hr 75 mg (base</i>	
VANCOCIN CAP 125MG	36	<i>equivalent)</i>	59
VANCOCIN CAP 250MG	36	<i>venlafaxine hcl tab 100 mg (base</i>	
<i>vancomycin hcl cap 125 mg (base</i>		<i>equivalent)</i>	60
<i>equivalent)</i>	36	<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	
<i>vancomycin hcl cap 250 mg (base</i>		.....	60
<i>equivalent)</i>	36		

<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	60	VFEND SUS 40MG/ML.....	69
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	60	VFEND TAB 200MG.....	70
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	60	VFEND TAB 50MG	69
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	60	V-GO 20 KIT	200
VENTAVIS SOL 10MCG/ML	127	V-GO 30 KIT	200
VENTAVIS SOL 20MCG/ML.....	127	V-GO 40 KIT	200
<i>verapamil hcl cap er 24hr 100 mg</i>	122	VIBERZI TAB 100MG.....	172
<i>verapamil hcl cap er 24hr 120 mg</i>	122	VIBERZI TAB 75MG	172
<i>verapamil hcl cap er 24hr 180 mg</i>	122	VIBRAMYCIN CAP 100MG.....	232
<i>verapamil hcl cap er 24hr 200 mg</i>	122	VIBRAMYCIN SUS 25MG/5ML	232
<i>verapamil hcl cap er 24hr 240 mg</i>	122	VIBRAMYCIN SYP 50MG/5ML	232
<i>verapamil hcl cap er 24hr 300 mg</i>	122	VICTOZA INJ 18MG/3ML.....	64
<i>verapamil hcl cap er 24hr 360 mg</i>	122	VIDAZA INJ 100MG.....	86
<i>verapamil hcl tab 120 mg</i>	122	<i>vigabatrin powd pack 500 mg</i>	55
<i>verapamil hcl tab 40 mg</i>	122	<i>vigabatrin tab 500 mg</i>	55
<i>verapamil hcl tab 80 mg</i>	122	VIGAMOX DRO 0.5%	217
<i>verapamil hcl tab er 120 mg</i>	122	VILACTIN AA LIQ PLUS	157
<i>verapamil hcl tab er 180 mg</i>	122	VIMOVO TAB 375-20MG.....	20
<i>verapamil hcl tab er 240 mg</i>	122	VIMOVO TAB 500-20MG.....	20
VERASENS LIQ LEVEL 1.....	200	VIMPAT SOL 10MG/ML.....	54
VERDESO AER 0.05%.....	148	VIMPAT TAB 100MG	54
VERELAN CAP 120MG SR.....	122	VIMPAT TAB 150MG.....	54
VERELAN CAP 180MG SR	122	VIMPAT TAB 200MG.....	54
VERELAN CAP 240MG SR.....	122	VIMPAT TAB 50MG	54
VERELAN CAP 360MG SR.....	122	VIOKACE TAB 10440	158
VERELAN PM CAP 100MG ER	122	VIOKACE TAB 20880	158
VERELAN PM CAP 200MG ER.....	122	VIRAMUNE SUS 50MG/5ML	114
VERELAN PM CAP 300MG ER.....	122	VIRAMUNE XR TAB 400MG	114
VERQUVO TAB 10MG.....	128	VIREAD POW 40MG/GM	114
VERQUVO TAB 2.5MG	128	VIREAD TAB 150MG.....	114
VERQUVO TAB 5MG	128	VIREAD TAB 200MG.....	114
VERSACLOZ SUS 50MG/ML	105	VIREAD TAB 250MG.....	114
VERZENIO TAB 100MG	96	VIREAD TAB 300MG.....	114
VERZENIO TAB 150MG	96	VISIONBLUE INJ 0.06%.....	218
VERZENIO TAB 200MG.....	96	VISTARIL CAP 25MG	39
VERZENIO TAB 50MG	96	VISTARIL CAP 50MG.....	39
VESICARE LS SUS 5MG/5ML.....	236	VISTOGARD PAK 10GM	67
VESICARE TAB 10MG	236	VITAL HN POW	157
VESICARE TAB 5MG.....	236	VITRAKVI CAP 100MG	96
		VITRAKVI CAP 25MG	96
		VITRAKVI SOL 20MG/ML	96
		VIVAGUARD LIQ CONTROL.....	200
		VIVAGUARD MIS 28G	200

VIVAGUARD MIS 30G	200
VIVAGUARD MIS LANCING	200
VIVJOA CAP 150MG	70
VIVONEX RTF LIQ	157
VONJO CAP 100MG	96
VOQUEZNA PAK DUAL PAK.....	235
VOQUEZNA PAK TRIP PK	236
<i>voriconazole for susp 40 mg/ml</i>	70
<i>voriconazole tab 200 mg</i>	70
<i>voriconazole tab 50 mg</i>	70
VOSEVI TAB	116
VOTRIENT TAB 200MG	96
VOWST CAP	172
VOXZOGO INJ 0.4MG.....	165
VOXZOGO INJ 0.56MG	165
VOXZOGO INJ 1.2MG.....	165
VRAYLAR CAP 1.5-3MG	102
VRAYLAR CAP 1.5MG	102
VRAYLAR CAP 3MG.....	102
VRAYLAR CAP 4.5MG	102
VRAYLAR CAP 6MG.....	102
VUMERITY CAP 231MG.....	227
VUSION OIN	140
VYNDAMAX CAP 61MG	128
VYTORIN TAB 10-10MG	71
VYTORIN TAB 10-20MG	71
VYTORIN TAB 10-40MG	71
VYTORIN TAB 10-80MG	71
VYVANSE CAP 10MG.....	3
VYVANSE CAP 20MG	3
VYVANSE CAP 30MG	3
VYVANSE CAP 40MG.....	3
VYVANSE CAP 50MG	3
VYVANSE CAP 60MG.....	3
VYVANSE CAP 70MG	3
VYVANSE CHW 10MG	3
VYVANSE CHW 20MG.....	3
VYVANSE CHW 30MG	3
VYVANSE CHW 40MG	3
VYVANSE CHW 50MG	3
VYVANSE CHW 60MG	3
VYZULTA SOL 0.024%	219

W

WAKIX TAB 17.8MG	6
WAKIX TAB 4.45MG	6
<i>warfarin sodium tab 10 mg</i>	46
<i>warfarin sodium tab 1 mg</i>	46
<i>warfarin sodium tab 2.5 mg</i>	46
<i>warfarin sodium tab 2 mg</i>	46
<i>warfarin sodium tab 3 mg</i>	46
<i>warfarin sodium tab 4 mg</i>	46
<i>warfarin sodium tab 5 mg</i>	46
<i>warfarin sodium tab 6 mg</i>	46
<i>warfarin sodium tab 7.5 mg</i>	46
WEBCOL PREP PAD LARGE.....	202
WEBCOL PREP PAD MEDIUM	202
WEGOVY INJ 0.25MG	3
WEGOVY INJ 0.5MG.....	3
WEGOVY INJ 1.7MG.....	3
WEGOVY INJ 1MG.....	3
WEGOVY INJ 2.4MG.....	3
WELCHOL PAK 3.75GM	71
WELCHOL TAB 625MG.....	71
WELLBUTRIN TAB 100MG SR	57
WELLBUTRIN TAB 150MG SR	57
WELLBUTRIN TAB 200MG SR	57
WIDE-SEAL DPR KIT 60.....	182
WIDE-SEAL DPR KIT 65.....	182
WIDE-SEAL DPR KIT 70.....	182
WIDE-SEAL DPR KIT 75.....	182
WIDE-SEAL DPR KIT 80.....	182
WIDE-SEAL DPR KIT 85.....	182
WIDE-SEAL DPR KIT 90.....	182
WIDE-SEAL DPR KIT 95.....	182

X

XACIATO GEL 2%	237
XALATAN SOL 0.005%	219
XARELTO STAR TAB 15/20MG	46
XARELTO TAB 10MG	46
XARELTO TAB 15MG	46
XARELTO TAB 2.5MG.....	46
XARELTO TAB 20MG	46
XATMEP SOL 2.5MG/ML.....	86
XCOPRI PAK 100-150	55
XCOPRI PAK 12.5-25	54

XCOPRI PAK 150-200	55	XYOSTED INJ 100/0.5.....	34
XCOPRI PAK 50-100MG	54	XYOSTED INJ 50/0.5	34
XCOPRI PAK 50-200MG.....	54	XYOSTED INJ 75/0.5.....	34
XCOPRI TAB 100MG.....	55	XYWAV SOL 0.5GM/ML	222
XCOPRI TAB 150MG	55	Y	
XCOPRI TAB 200MG	55	YONSA TAB 125MG	89
XCOPRI TAB 50MG	55	YUPELRI SOL	42
XELJANZ SOL 1MG/ML	16	Z	
XELJANZ TAB 10MG.....	17	ZACLIR LOT 8%	138
XELJANZ TAB 5MG	17	<i>zafirlukast tab 10 mg</i>	42
XELJANZ XR TAB 11MG.....	17	<i>zafirlukast tab 20 mg</i>	42
XELJANZ XR TAB 22MG	18	<i>zaleplon cap 10 mg</i>	180
XELODA TAB 150MG.....	86	<i>zaleplon cap 5 mg</i>	179
XELODA TAB 500MG	86	ZANAFLEX CAP 2MG	212
XENLETA TAB 600MG	37	ZANAFLEX CAP 4MG	212
XEPI CRE 1%.....	138	ZANAFLEX CAP 6MG	212
XERAC-AC SOL 6.25%	150	ZANAFLEX TAB 4MG	212
XERESE CRE 5-1%	145	ZARONTIN CAP 250MG.....	56
XERMELO TAB 250MG	173	ZARONTIN SOL 250/5ML.....	56
XHANCE MIS 93MCG	214	ZAVESCA CAP 100MG	177
XIFAXAN TAB 200MG	35	ZEJULA CAP 100MG.....	96
XIFAXAN TAB 550MG	35	ZEJULA TAB 100MG	96
XIGDUO XR TAB 10-1000	63	ZEJULA TAB 200MG	96
XIGDUO XR TAB 10-500MG	63	ZEJULA TAB 300MG	97
XIGDUO XR TAB 2.5-1000	63	ZELAPAR TAB 1.25MG.....	101
XIGDUO XR TAB 5-1000MG	63	ZELBORAF TAB 240MG	97
XIGDUO XR TAB 5-500MG.....	63	ZEMBRACE SYM INJ 3/0.5ML.....	206
XIIDRA DRO 5%	217	ZEMPLAR CAP 1MCG	165
XOPENEX CONC NEB 1.25/0.5	45	ZEMPLAR CAP 2MCG.....	165
XOPENEX NEB 0.31MG	45	ZENPEP CAP 10000UNT	158
XOPENEX NEB 0.63MG	45	ZENPEP CAP 15000UNT	158
XOPENEX NEB 1.25/3ML	45	ZENPEP CAP 20000UNT	158
XOSPATA TAB 40MG.....	96	ZENPEP CAP 25000UNT.....	158
XTAMPZA ER CAP 13.5MG.....	30	ZENPEP CAP 3000UNIT	158
XTAMPZA ER CAP 18MG	30	ZENPEP CAP 40000UNT	158
XTAMPZA ER CAP 27MG.....	30	ZENPEP CAP 5000UNIT	158
XTAMPZA ER CAP 36MG	30	ZEPOSIA 7DAY CAP STR PACK.....	227
XTAMPZA ER CAP 9MG.....	30	ZEPOSIA CAP .92MG.....	227
XTANDI CAP 40MG	89	ZEPOSIA CAP STR KIT	227
XTANDI TAB 40MG	89	ZESTRIL TAB 10MG.....	76
XTANDI TAB 80MG	89	ZESTRIL TAB 2.5MG	76
XULTOPHY INJ 100/3.6	63	ZESTRIL TAB 20MG.....	76
XURIDEN POW 2GM	165	ZESTRIL TAB 30MG	76

ZESTRIL TAB 40MG.....	76	<i>zolpidem tartrate tab 10 mg</i>	180
ZESTRIL TAB 5MG.....	76	<i>zolpidem tartrate tab 5 mg</i>	180
ZIAC TAB 10/6.25.....	82	<i>zolpidem tartrate tab er 12.5 mg</i>	180
ZIAC TAB 2.5/6.25.....	82	<i>zolpidem tartrate tab er 6.25 mg</i>	180
ZIAC TAB 5-6.25MG.....	82	ZOMIG SPR 2.5MG.....	206
ZIAGEN SOL 20MG/ML.....	114	ZOMIG SPR 5MG.....	206
ZIAGEN TAB 300MG.....	114	ZOMIG TAB 2.5MG.....	206
<i>zidovudine cap 100 mg</i>	114	ZOMIG TAB 5MG.....	206
<i>zidovudine syrup 10 mg/ml</i>	114	ZOMIG ZMT TAB 2.5 MG.....	206
<i>zidovudine tab 300 mg</i>	114	ZOMIG ZMT TAB 5MG ODT.....	206
ZIOPTAN DRO 0.0015%.....	219	ZONALON CRE 5%.....	140
<i>ziprasidone hcl cap 20 mg</i>	102	<i>zonisamide cap 100 mg</i>	54
<i>ziprasidone hcl cap 40 mg</i>	102	<i>zonisamide cap 25 mg</i>	54
<i>ziprasidone hcl cap 60 mg</i>	102	<i>zonisamide cap 50 mg</i>	54
<i>ziprasidone hcl cap 80 mg</i>	102	ZORBTIVE INJ 8.8MG.....	163
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	102	ZORTRESS TAB 0.25MG.....	210
ZIPSOR CAP 25MG.....	20	ZORTRESS TAB 0.5MG.....	210
ZITHROMAX POW 1GM PAK.....	181	ZORTRESS TAB 0.75MG.....	210
ZITHROMAX SUS 100/5ML.....	181	ZORTRESS TAB 1MG.....	210
ZITHROMAX SUS 200/5ML.....	181	ZOVIRAX CRE 5%.....	145
ZITHROMAX TAB 250MG.....	181	ZOVIRAX OIN 5%.....	145
ZITHROMAX TAB 500MG.....	181	ZOVIRAX SUS 200/5ML.....	116
ZITHROMAX TAB TRI-PAK.....	181	ZUBSOLV SUB 0.7-0.18.....	33
ZITHROMAX TAB Z-PAK.....	181	ZUBSOLV SUB 1.4-0.36.....	33
ZOCOR TAB 10MG.....	73	ZUBSOLV SUB 11.4-2.9.....	33
ZOCOR TAB 20MG.....	73	ZUBSOLV SUB 2.9-0.71.....	33
ZOCOR TAB 40MG.....	73	ZUBSOLV SUB 5.7-1.4.....	33
ZOCOR TAB 80MG.....	74	ZUBSOLV SUB 8.6-2.1.....	33
ZOFRAN TAB 4MG.....	68	ZYCLARA CRE 3.75%.....	149
ZOKINVY CAP 50MG.....	210	ZYCLARA PUMP CRE 2.5%.....	149
ZOKINVY CAP 75MG.....	210	ZYCLARA PUMP CRE 3.75%.....	149
ZOLINZA CAP 100MG.....	97	ZYFLO TAB 600MG.....	42
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>	206	ZYKADIA TAB 150MG.....	97
<i>zolmitriptan nasal spray 5 mg/spray unit</i>	206	ZYLOPRIM TAB 100MG.....	175
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>	206	ZYLOPRIM TAB 300MG.....	175
<i>zolmitriptan orally disintegrating tab 5 mg</i>	206	ZYMAXID SOL 0.5%.....	217
<i>zolmitriptan tab 2.5 mg</i>	206	ZYPREXA INJ 10MG.....	105
<i>zolmitriptan tab 5 mg</i>	206	ZYPREXA RELP INJ 210MG.....	105
		ZYPREXA RELP INJ 300MG.....	105
		ZYPREXA RELP INJ 405MG.....	105
		ZYPREXA TAB 10MG.....	105
		ZYPREXA TAB 15MG.....	105
		ZYPREXA TAB 2.5MG.....	105

ZYPREXA TAB 20MG	105	ZYPREXA ZYDI TAB 20MG.....	105
ZYPREXA TAB 5MG	105	ZYPREXA ZYDI TAB 5MG.....	105
ZYPREXA TAB 7.5MG	105	ZYVOX SUS 100MG/5M	37
ZYPREXA ZYDI TAB 10MG	105	ZYVOX TAB 600MG.....	37
ZYPREXA ZYDI TAB 15MG	105		

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **[carefirst.com/fedhmo](https://www.carefirst.com/fedhmo)**.



10455 Mill Run Circle
Owings Mills, MD 21117

[carefirst.com/fedhmo](https://www.carefirst.com/fedhmo)

CareFirst BlueChoice, Inc. is an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SUM5463-1S (12/23)

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

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

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

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

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address P.O. Box 8894
 Baltimore, Maryland 21224

Email Address civilrightscoordinator@carefirst.com

Telephone Number 410-528-7820

Fax Number 410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Foreign Language Assistance

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

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

Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déèti pàtó o sì le ní láti gbé igbésé ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèé. Àwọn omọ-egbé gbòdò pe nómà fòdùn tò wà lèyìn kààdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasẹ̀ ijíròrò tí tí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pò mó ògbufò kan.

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

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

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

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

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

Bàsòò-wùdù (Bassa) Tò Dùù Cáo! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiǐn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ kè dε wa ḿ m̄ kè nyuεε nyu hwè b́é wé b́éa kè zi. Ǿ m̀ò nì kpé b́é m̄ kè bǎ nìà kè kè gbo-kpá-kpá m̄ ḿεε dyé dé nì bídí-wùdù mú b́é m̄ kè se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò d́éin nyε. Nyò t̀òò séin m̄ dá nòbà nìà kè: 855-258-6518, kè m̄ m̄ f̀ò tee b́é wa ḱε m̄ gbo ćé b́é m̄ kè nòbà m̀òà 0 ḱε dyi pàd̀àn hwè. Ǿ j̀ú kè nyò d̀ò dyi m̄ g̀ǎ j̀ùǐn, po wuqu m̄ ḿ poε dyie, kè nyò d̀ò mu bó nìin b́é Ǿ kè nì wuquò mú zà.

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

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

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

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

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

Igbo (Igbo) Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

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

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

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

Diné Bizaad (Navajo) Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íiyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'aa'ahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowól t'áa nínizaad bee t'áa jii'k'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nit'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náána'á' éí kójjí' dahóoolnih 855-258-6518 dóo yíi dii'łts'ííł yałtí'ígíí t'áa níléj'í' áádóo éí bikéé'dóo naasbaqas bił adidiilchíł. Áká'ánidaalwó'ígíí neidiitáágo, saad bee yáníłt'í'ígíí yíi diikił dóo ata' halne'é lá níká'ádoowól.