



Express Scripts Medicare (PDP) 2018 Formulary (List of Covered Drugs)

**PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION
ABOUT SOME OF THE DRUGS COVERED BY THIS PLAN**

Formulary ID Number: 18046, v6

This formulary was updated on 08/14/2017. For more recent information or other questions, please contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week. You can also visit us on the Web at **www.express-scripts.com**.

Note to current members: This formulary has changed since last year. Please review this document to understand your plan's drug coverage.

When this drug list (formulary) refers to "we," "us" or "our," it means *Medco Containment Life Insurance Company* or *Medco Containment Insurance Company of New York (for employer plans domiciled in New York)*. When it refers to "plan" or "our plan," it means *Express Scripts Medicare*.

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 14, 2017. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, premium and/or copayments/coinsurance may change on January 1, 2019. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

This information is available for free in other languages. Please call Express Scripts Medicare Customer Service at the numbers on the back of your member ID card for additional information. Customer Service is available 24 hours a day, 7 days a week.

Esta información está disponible sin cargo en otros idiomas. Llame al Servicio al cliente de Express Scripts Medicare a los números que figuran al dorso de su tarjeta de identificación de miembro para obtener información adicional. El Servicio al cliente está disponible las 24 horas del día, los 7 días de la semana.

This document is available in braille. Please contact Customer Service if you need plan information in another format.

What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the “formulary.” It contains a list of covered Medicare Part D drugs selected by Express Scripts Medicare in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. The formulary also includes information on requirements or limits for some covered drugs that are part of Express Scripts Medicare’s standard formulary rules. **Your specific plan may provide coverage of additional drugs that are not listed in this formulary, and your plan may have different plan rules and coverage.** For more information on your plan’s specific drug coverage, please review your other plan materials, visit us on the Web at www.express-scripts.com or contact Customer Service.

Express Scripts Medicare will cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at an Express Scripts Medicare network pharmacy and other plan rules are followed. For more information on how to fill your prescriptions, please review your other plan materials.

Can my drug coverage change?

Generally, if you are taking a drug covered by your plan in 2018, Express Scripts Medicare will not discontinue or reduce coverage of the drug during the 2018 coverage year, except when a new, less expensive generic drug becomes available or when new adverse information about the safety or effectiveness of a drug is released. Other types of formulary changes, such as removing a drug from our plan’s formulary, will not affect members who are currently taking the drug. It will remain available at the same copayment or coinsurance amount for those members taking it for the remainder of the coverage year. We feel it is important that you have continued access for the remainder of the coverage year to the drugs that were available when you chose our plan, except for cases in which you can save additional money or we can ensure your safety.

If Express Scripts Medicare removes drugs from your plan’s coverage, adds prior authorization, quantity limits, and/or step therapy restrictions on a drug, or moves a drug to a higher cost-sharing tier, we must notify affected members of the change at least 60 days before the change becomes effective. If the Food and Drug Administration (FDA) determines that a drug we cover is unsafe, or if the drug’s manufacturer removes the drug from the market, we will immediately stop covering the drug and provide notice to members who are taking the drug. This enclosed formulary is current as of the date indicated on the front cover. **To get updated information about the drugs covered, please visit us on the Web or contact our Customer Service department using the information provided on the front and back covers of this formulary.** If there are any additional changes made to this plan’s drug coverage that affect you and are not mentioned above, you will be notified in writing of these changes within a reasonable period of time after the changes take effect.

How do I use the formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 1. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category “Cardiovascular, Hypertension/Lipids.”

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 75. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the “Drug Name” column of the list.

What are generic drugs?

Both brand-name drugs and generic drugs are covered under this plan. A generic drug is approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** You or your doctor is required to get prior authorization for certain drugs. This means that you will need to get approval from the plan before you fill your prescriptions. If you don't get approval, the drugs may not be covered. These drugs are noted with “PA” next to them in the formulary.

Some drugs may be covered under Part B or under Part D, depending on your medical condition. Your doctor will need to get a prior authorization for these drugs as well, so your pharmacy can process your prescription correctly.

- **Quantity Limits:** For certain drugs, the amount of the drug that will be covered by the plan is limited. The plan may limit how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day. These drugs are noted with “QL” next to them in the formulary.
- **Step Therapy:** In some cases, you are required to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B. These drugs are noted with “ST” next to them in the formulary.

You may be able to find out if your drug has any additional requirements or limits by looking in the drug list that begins on page 1. Note: This drug list includes all possible restrictions and limits on coverage. **The requirements and limits may not apply to your plan's specific coverage.** To confirm whether a particular drug is covered, visit us on the Web at www.express-scripts.com or contact Customer Service.

You can ask us to make an exception to these restrictions or limits. See the section “How do I request an exception to the formulary?” on the following page for information about how to request an exception.

What if my drug is not on the formulary?

If your drug is not included in this list of covered drugs, you should first contact Customer Service and ask if your drug is covered.

If you learn that your drug is not covered, you have two options:

- You can ask our Customer Service department for a list of similar drugs that are covered. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is covered.
- You can ask us to make an exception and cover your drug. See below for information about how to request an exception.

You should talk to your doctor to decide if you should switch to an appropriate drug that the plan covers or request a formulary exception so that the plan will cover the drug you are taking.

How do I request an exception to the formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our formulary. If approved, the drug will be covered at a pre-determined cost-sharing level, and you will not be able to ask us to provide the drug at a lower cost-sharing level.
- You can ask us to cover a formulary drug at a lower cost-sharing level. If your drug is contained in our Non-Preferred Drug tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in our Preferred Brand Drug tier instead. If approved, this would lower the amount you must pay for your drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in our Specialty Drug tier.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, Express Scripts Medicare limits the amount of the drug it will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

You should contact us to ask for an initial coverage decision for a formulary, tiering or utilization restriction exception. **When you are requesting an exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

Generally, your request for an exception will only be approved if the alternative drugs that are included in the plan formulary, the lower-tiered drugs or the additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

How do I request an appeal?

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. To start an appeal, you, your doctor or your representative must contact us.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision.

For more information about the appeals process, you may contact Customer Service using the information provided on the front and back covers of this document.

Can I get a temporary transition supply while I wait for an exception decision?

As a new or continuing member in our plan, you may be taking drugs that are not covered from one year to the next. Or, you may be taking a drug that is covered but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, or while you wait for a coverage decision from us, we may cover a temporary transition supply of your drug in certain cases during the first 90 days that you are enrolled in the plan or at the start of a new coverage year.

For each of your drugs that is not on our formulary, or if your ability to get drugs is limited, we will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for at least 30 days, or less if your prescription is written for fewer days. In that case, you will be allowed multiple fills to provide up to a total of at least a 30-day supply of the medication.

If you are a resident of a long-term care facility, we will allow you to refill your prescription until we have provided you with a 98-day transition supply, consistent with the dispensing increment (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days you are a member of our plan. If you need a drug that is not on our formulary, or if your ability to get your drug is limited but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency transition supply of that drug (unless you have a prescription written for fewer days) while you pursue an exception.

Other times when we will cover at least a temporary 30-day transition supply (or less, if you have a prescription written for fewer days) include:

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility
- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

Express Scripts Medicare will send you a letter within 3 business days of your filling a temporary transition supply notifying you that this was a temporary supply and explaining your options.

Other coverage that your plan may provide

Your plan **may** also cover categories of “excluded” drugs that are not normally covered by a Medicare prescription drug plan and are not listed in the formulary. **Drugs in the following categories may be covered subject to the rules and limitations of your specific plan:**

- Prescription drugs when used for anorexia, weight loss or weight gain
- Prescription drugs when used to promote fertility
- Prescription drugs when used for cosmetic purposes or to promote hair growth
- Prescription drugs when used for the symptomatic relief of cough or colds
- Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations, which are considered Part D drugs)
- Drugs, such as CAVERJECT[®], CIALIS[®], EDEX[®], LEVITRA[®], MUSE[®] and VIAGRA[®], when used for the treatment of sexual or erectile dysfunction
- Over-the-counter (OTC) diabetic supplies
- Federal Legend Part B medications – for example, oral chemotherapy agents (e.g., TEMODAR[®], XELODA[®])
- Non-prescription drugs, also known as over-the-counter (OTC) drugs
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.

Please contact Customer Service for additional information about your plan’s specific drug coverage and your cost-sharing amount. **Please note:** Costs for excluded drugs not normally covered by a Medicare prescription drug plan will not count toward your Medicare prescription drug yearly deductible (if applicable), total drug costs or yearly out-of-pocket expenses.

Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 75.

The “Drug Name” column of the chart lists the drug name. Brand-name drugs are capitalized (e.g., CRESTOR[®]) and generic drugs are listed in lowercase italics (e.g., *atorvastatin*). The information in the “Requirements/Limits” column tells you if there are any special requirements for coverage of that particular drug.

If you are not sure whether your drug is covered, please visit our website or contact Customer Service using the information provided on the front and back covers of this formulary.

Your Costs

The amount you pay for a covered drug will depend on:

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.
- **The drug tier for your drug.** Each covered drug is in one of four drug tiers. Each tier may have a different cost-sharing amount. The “Drug Tiers” chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

Your other plan materials have more information about your plan’s coverage stages and list the specific cost-sharing amounts for each tier.

Drug Tiers

Tier	Includes	Helpful tips
Tier 1: Generic Drugs	This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.	Use Tier 1 drugs for the lowest cost-sharing amount.
Tier 2: Preferred Brand Drugs	This tier includes preferred brand-name drugs as well as some generic drugs.	Drugs in this tier will generally have lower cost-sharing amounts than non-preferred drugs.
Tier 3: Non-Preferred Drugs	This tier includes non-preferred brand-name drugs as well as some generic drugs.	Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.
Tier 4: Specialty Tier Drugs	This tier includes very high cost brand-name and generic drugs.	To learn more about medications in this tier, you may contact a pharmacist using the information provided on the front and back covers of this formulary.

If you qualify for Extra Help

If you qualify for Extra Help from Medicare to help pay for your prescription drugs, your cost-sharing amounts may be lower than your plan’s standard benefit. Members who qualify for Extra Help will receive a notice called “Important Information for Those Who Receive Extra Help Paying for Their Prescription Drugs” (“Low Income Rider” or “LIS Rider”). Please read it to find out what your costs are. You can also contact Customer Service with any questions using the information listed on the front and back covers of this formulary.

For more information

For more detailed information about your Medicare prescription drug coverage and your plan’s specific costs, please review your other plan materials.

If you need additional information on network pharmacies or if you have any other questions, please contact our Customer Service department using the information provided on the front and back covers of this formulary.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1.800.MEDICARE (1.800.633.4227), 24 hours a day, 7 days a week. TTY users should call 1.877.486.2048. Or visit <https://www.medicare.gov>.

Below is a list of abbreviations that may appear on the following pages in the “Requirements/Limits” column that tells you if there are any special requirements for coverage of your drug.

Note: The following drug list includes all possible restrictions and limitations. **Depending on your plan’s specific benefit, you may not experience every restriction or limit indicated in the list.** To confirm your plan’s specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.express-scripts.com.

List of abbreviations

LA: Limited Availability. This prescription drug may be available only at certain pharmacies. For more information, contact Customer Service using the information provided on the front and back covers of this formulary.

MO: Mail-Order Drug. This prescription drug is available through our home delivery service, as well as through our retail network pharmacies. Consider using home delivery for your long-term (maintenance) medications, such as high blood pressure medications. Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

PA: Prior Authorization. The plan requires you or your doctor to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescription. If you don’t get approval, we may not cover this drug.

QL: Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

ST: Step Therapy. In some cases, the plan requires you to first try a certain drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	4	PA; MO
AMBISOME	4	PA; MO
<i>amphotericin b</i>	1	PA; MO
CANCIDAS	4	PA; MO
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA INTRAVENOUS	4	
CRESEMBA ORAL	4	MO
<i>fluconazole</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	1	
<i>flucytosine</i>	4	MO
<i>griseofulvin microsize</i>	1	MO
<i>griseofulvin ultramicrosize</i>	1	MO
<i>itraconazole</i>	1	MO
<i>ketoconazole oral</i>	1	MO
MYCAMINE	4	MO
NOXAFIL ORAL	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>nystatin oral suspension</i>	1	MO
<i>nystatin oral tablet</i>	1	MO
ORAVIG	2	MO
SPORANOX ORAL SOLUTION	2	MO
<i>terbinafine hcl oral</i>	1	MO
<i>voriconazole intravenous</i>	1	MO
<i>voriconazole oral</i>	4	MO
ANTIVIRALS		
<i>abacavir</i>	1	MO
<i>abacavir-lamivudine</i>	4	MO
<i>abacavir-lamivudine-zidovudine</i>	4	MO
<i>acyclovir oral capsule</i>	1	MO
<i>acyclovir oral suspension 200 mg/5 ml</i>	1	MO
<i>acyclovir oral tablet</i>	1	MO
<i>acyclovir sodium intravenous solution</i>	1	PA; MO
<i>adefovir</i>	4	MO
<i>amantadine hcl</i>	1	MO
APTIVUS ORAL CAPSULE	4	MO
APTIVUS ORAL SOLUTION	4	
ATRIPLA	4	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
BARACLUDE ORAL SOLUTION	2	MO
<i>cidofovir</i>	4	PA; MO
COMPLERA	4	MO
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	2	MO
DESCOVY	4	MO
<i>didanosine oral capsule, delayed release(dr/ec) 125 mg</i>	1	
<i>didanosine oral capsule, delayed release(dr/ec) 200 mg, 250 mg, 400 mg</i>	1	MO
EDURANT	4	MO
EMTRIVA	2	MO
<i>entecavir</i>	4	MO
EPCLUSA	4	PA; MO; QL (28 per 28 days)
EPIVIR HBV ORAL SOLUTION	2	MO
EVOTAZ	4	MO
<i>famciclovir</i>	1	MO
FUZEON SUBCUTANEOUS RECON SOLN	4	MO
<i>ganciclovir sodium</i>	1	PA; MO
GENVOYA	4	MO
HARVONI	4	PA; MO; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
INTELENCE ORAL TABLET 100 MG, 200 MG	4	MO
INTELENCE ORAL TABLET 25 MG	2	MO
INVIRASE	4	MO
ISENTRESS ORAL POWDER IN PACKET	4	MO
ISENTRESS ORAL TABLET	4	MO
ISENTRESS ORAL TABLET, CHEWABLE 100 MG	4	MO
ISENTRESS ORAL TABLET, CHEWABLE 25 MG	2	MO
KALETRA ORAL TABLET 100-25 MG	2	MO
KALETRA ORAL TABLET 200-50 MG	4	MO
<i>lamivudine</i>	1	MO
<i>lamivudine-zidovudine</i>	1	MO
LEXIVA ORAL SUSPENSION	2	MO
LEXIVA ORAL TABLET	4	MO
<i>lopinavir-ritonavir</i>	1	MO
<i>moderiba</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>moderiba dose pack oral tablets,dose pack 200 mg (7)-400 mg (7), 400 mg (7)- 400 mg (7)</i>	1	MO
<i>moderiba dose pack oral tablets,dose pack 600 mg (7)-400 mg (7), 600 mg (7)- 600 mg (7)</i>	4	MO
<i>nevirapine</i>	1	MO
NORVIR	2	MO
ODEFSEY	4	MO
<i>oseltamivir</i>	1	MO
PREZCOBIX	4	MO
PREZISTA ORAL SUSPENSION	4	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	2	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	4	MO
REBETOL ORAL SOLUTION	2	MO
RELENZA DISKHALER	2	MO
RESCRIPTOR	2	MO
RETROVIR INTRAVENOUS	2	MO
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	4	MO

Drug Name	Drug Tier	Requirements /Limits
REYATAZ ORAL POWDER IN PACKET	4	MO
<i>ribasphere oral capsule</i>	1	MO
<i>ribasphere oral tablet 200 mg, 400 mg</i>	1	MO
<i>ribasphere oral tablet 600 mg</i>	4	MO
<i>ribasphere ribapak oral tablets,dose pack 200 mg (7)-400 mg (7)</i>	1	
<i>ribasphere ribapak oral tablets,dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	4	MO
<i>ribavirin oral capsule</i>	1	MO
<i>ribavirin oral tablet 200 mg</i>	1	MO
<i>rimantadine</i>	1	MO
SELZENTRY ORAL TABLET	2	MO
<i>stavudine oral capsule</i>	1	MO
STRIBILD	4	MO
SUSTIVA ORAL CAPSULE 200 MG	4	MO
SUSTIVA ORAL CAPSULE 50 MG	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
SUSTIVA ORAL TABLET	4	MO
SYNAGIS INTRAMUSCULAR SOLUTION 50 MG/0.5 ML	4	MO; LA
TAMIFLU ORAL SUSPENSION FOR RECONSTITUTION	2	MO
TIVICAY ORAL TABLET 10 MG	2	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	4	MO
TRIUMEQ	4	MO
TRUVADA	4	MO
<i>valacyclovir</i>	1	PA; MO; QL (30 per 30 days)
<i>valganciclovir</i>	4	MO
VEMLIDY	4	MO
VIDEX 2 GRAM PEDIATRIC	2	MO
VIRACEPT ORAL TABLET	4	MO
VIREAD	4	MO
ZEPATIER	4	PA; MO; QL (28 per 28 days)
ZERIT ORAL RECON SOLN	3	MO
ZIAGEN ORAL SOLUTION	2	MO

Drug Name	Drug Tier	Requirements /Limits
<i>zidovudine</i>	1	MO
CEPHALOSPORINS		
<i>cefactor oral capsule</i>	1	MO
<i>cefactor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	1	MO
<i>cefactor oral suspension for reconstitution 375 mg/5 ml</i>	1	
<i>cefactor oral tablet extended release 12 hr</i>	1	MO
<i>cefadroxil oral capsule</i>	1	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	MO
<i>cefadroxil oral tablet</i>	1	MO
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	1	MO
<i>cefazolin injection recon soln 10 gram</i>	1	
<i>cefdinir</i>	1	MO
<i>cefepime</i>	1	MO
<i>cefixime</i>	1	MO
<i>cefotaxime injection recon soln 1 gram, 2 gram, 500 mg</i>	1	
<i>cefotetan injection</i>	1	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	MO
<i>cefoxitin intravenous recon soln 10 gram</i>	1	
<i>cefepodoxime</i>	1	MO
<i>cefprozil</i>	1	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	MO
<i>ceftazidime injection recon soln 6 gram</i>	1	
<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>ceftriaxone injection recon soln 250 mg, 500 mg</i>	1	MO
<i>ceftriaxone intravenous</i>	1	MO
<i>cefuroxime axetil oral tablet</i>	1	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	MO
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	1	
<i>cephalexin</i>	1	MO
SUPRAX ORAL CAPSULE	3	MO

Drug Name	Drug Tier	Requirements /Limits
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	3	
SUPRAX ORAL TABLET,CHEWABLE	3	MO
TEFLARO	4	MO
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin</i>	1	MO
<i>clarithromycin</i>	1	MO
<i>e.e.s. 400 oral tablet</i>	1	MO
<i>ery-tab oral tablet,delayed release (dr/ec) 250 mg, 333 mg</i>	1	MO
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	2	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	MO
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	MO
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>erythromycin oral capsule, delayed release(dr/ec)</i>	1	MO
<i>erythromycin oral tablet</i>	1	MO
MISCELLANEOUS ANTIINFECTIVES		
ALBENZA	2	MO
ALINIA ORAL SUSPENSION FOR RECONSTITUTION	2	MO
ALINIA ORAL TABLET	4	MO
<i>amikacin injection solution 500 mg/2 ml</i>	1	MO
<i>atovaquone</i>	4	MO
<i>atovaquone-proguanil</i>	1	MO
<i>aztreonam injection recon soln 1 gram</i>	1	MO
<i>baciiim</i>	1	
<i>bacitracin intramuscular</i>	1	MO
BETHKIS	4	PA; MO; QL (224 per 28 days)
BILTRICIDE	2	MO
CAPASTAT	3	
CAYSTON	4	MO; LA; QL (84 per 28 days)
<i>chloramphenicol sod succinate</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>chloroquine phosphate</i>	1	MO
<i>clindamycin hcl</i>	1	MO
<i>clindamycin in 5 % dextrose</i>	1	MO
<i>clindamycin pediatric</i>	1	MO
<i>clindamycin phosphate injection</i>	1	MO
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	1	MO
COARTEM	2	MO
<i>colistin (colistimethate na)</i>	1	MO
<i>dapsone</i>	1	MO
<i>daptomycin</i>	4	MO
DARAPRIM	4	PA; MO
EMVERM	4	MO
<i>ethambutol</i>	1	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 80 mg/50 ml</i>	1	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 60 mg/50 ml, 80 mg/100 ml</i>	1	
<i>gentamicin injection solution 40 mg/ml</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>gentamicin sulfate (pf) intravenous solution 100 mg/10 ml</i>	1	MO
<i>hydroxychloroquine</i>	1	MO
<i>imipenem-cilastatin</i>	1	MO
INVANZ INJECTION	3	MO
<i>isoniazid injection</i>	1	
<i>isoniazid oral</i>	1	MO
<i>ivermectin</i>	1	MO
<i>lincomycin</i>	1	
<i>linezolid intravenous</i>	4	
<i>linezolid oral</i>	4	MO
<i>mefloquine</i>	1	MO
<i>meropenem intravenous recon soln 500 mg</i>	1	MO
<i>metronidazole in nacl (iso-os)</i>	1	MO
<i>metronidazole oral</i>	1	MO
NEBUPENT	2	PA; MO; QL (1 per 28 days)
<i>neomycin</i>	1	MO
<i>paromomycin</i>	1	MO
PASER	2	MO
PENTAM	3	MO
<i>polymyxin b sulfate</i>	1	MO
PRIFTIN	2	MO
PRIMAQUINE	2	MO
<i>pyrazinamide</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>quinine sulfate</i>	1	MO
<i>rifabutin</i>	1	MO
<i>rifampin</i>	1	MO
SIRTURO	4	MO; LA
SIVEXTRO INTRAVENOUS	4	
STREPTOMYCIN	2	MO
SYNERCID	4	
<i>tinidazole</i>	1	MO
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	4	MO; QL (224 per 28 days)
<i>tobramycin in 0.225 % nacl</i>	4	PA; MO; QL (280 per 28 days)
<i>tobramycin sulfate injection solution</i>	1	MO
TRECTOR	2	MO
TYGACIL	4	MO
XIFAXAN ORAL TABLET 200 MG	4	MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	MO; QL (60 per 30 days)
PENICILLINS		
<i>amoxicillin oral capsule</i>	1	MO
<i>amoxicillin oral suspension for reconstitution</i>	1	MO
<i>amoxicillin oral tablet</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO
<i>amoxicillin-pot clavulanate</i>	1	MO
<i>ampicillin</i>	1	MO
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	1	MO
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	MO
BICILLIN C-R	2	MO
BICILLIN L-A	2	MO
<i>dicloxacillin</i>	1	MO
<i>nafcillin injection recon soln 1 gram</i>	1	MO
<i>nafcillin injection recon soln 10 gram</i>	4	MO
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml</i>	4	MO
<i>oxacillin injection recon soln 10 gram</i>	4	
<i>oxacillin injection recon soln 2 gram</i>	1	MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML	2	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 3 MILLION UNIT/50 ML	2	MO
<i>penicillin g potassium injection recon soln 5 million unit</i>	1	MO
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	1	MO
<i>penicillin g sodium</i>	1	MO
<i>penicillin v potassium</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>piperacillin-tazobactam intravenous recon soln 3.375 gram, 4.5 gram, 40.5 gram</i>	1	MO

QUINOLONES

<i>ciprofloxacin</i>	1	
<i>ciprofloxacin (mixture)</i>	1	MO
<i>ciprofloxacin hcl oral</i>	1	MO
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	1	MO
<i>ciprofloxacin lactate intravenous solution 400 mg/40 ml</i>	1	
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	MO
<i>levofloxacin intravenous</i>	1	MO
<i>levofloxacin oral</i>	1	MO
<i>moxifloxacin oral</i>	1	MO
<i>ofloxacin oral tablet 300 mg</i>	1	
<i>ofloxacin oral tablet 400 mg</i>	1	MO

SULFA'S / RELATED AGENTS

<i>sulfadiazine</i>	1	MO
---------------------	---	----

Drug Name	Drug Tier	Requirements /Limits
<i>sulfamethoxazole-trimethoprim</i>	1	MO

TETRACYCLINES

<i>demeclocycline</i>	1	MO
<i>doxy-100</i>	1	MO
<i>doxycycline hyclate oral capsule</i>	1	MO
<i>doxycycline hyclate oral tablet 100 mg, 20 mg</i>	1	MO
<i>doxycycline hyclate oral tablet, delayed release (dr/ec)</i>	1	MO
<i>doxycycline monohydrate oral capsule</i>	1	MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO
<i>doxycycline monohydrate oral tablet</i>	1	MO
<i>minocycline</i>	1	MO
<i>morgidox oral capsule 50 mg</i>	1	
<i>tetracycline</i>	1	MO
VIBRAMYCIN ORAL SYRUP	2	MO

URINARY TRACT AGENTS

<i>methenamine hippurate</i>	1	MO
<i>nitrofurantoin</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>nitrofurantoin macrocrystal</i>	1	MO
<i>nitrofurantoin monohyd/m-cryst</i>	1	MO
PRIMSOL	3	MO
<i>trimethoprim</i>	1	MO
VANCOMYCIN		
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg</i>	1	MO
<i>vancomycin oral capsule</i>	4	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>dexrazoxane hcl intravenous recon soln 250 mg</i>	4	
ELITEK	4	MO
KEPIVANCE	4	MO
<i>leucovorin calcium injection recon soln 100 mg, 350 mg</i>	1	MO
<i>leucovorin calcium oral</i>	1	MO
<i>levoleucovorin intravenous solution</i>	4	
<i>mesna</i>	1	MO
MESNEX ORAL	4	MO
XGEVA	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ABRAXANE	4	PA; MO
<i>adriamycin intravenous solution 20 mg/10 ml</i>	1	PA
<i>adrucil intravenous solution 500 mg/10 ml</i>	1	PA; MO
AFINITOR DISPERZ	4	PA; MO
AFINITOR ORAL TABLET 10 MG	4	PA; MO; QL (60 per 30 days)
AFINITOR ORAL TABLET 2.5 MG, 5 MG, 7.5 MG	4	PA; MO
ALECENSA	4	PA; MO; QL (240 per 30 days)
ALIMTA INTRAVENOUS RECON SOLN 500 MG	4	PA; MO
ALUNBRIG	4	PA; MO; QL (180 per 30 days)
<i>anastrozole</i>	1	MO
ARRANON	4	PA
AVASTIN	4	PA; MO
<i>azacitidine</i>	4	PA; MO
<i>azathioprine</i>	1	PA; MO
<i>azathioprine sodium</i>	1	PA
BAVENCIO	4	PA; MO; LA

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
BELEODAQ	4	PA; MO
<i>bexarotene</i>	4	MO
<i>bicalutamide</i>	1	MO
BICNU	4	PA; MO
<i>bleomycin injection recon soln 30 unit</i>	1	PA; MO
BOSULIF ORAL TABLET 100 MG	4	PA; MO
BOSULIF ORAL TABLET 500 MG	4	PA; MO; QL (30 per 30 days)
<i>busulfan</i>	4	PA
BUSULFEX	4	PA
CABOMETYX	4	PA; MO; LA
CAPRELSA ORAL TABLET 100 MG	4	PA; MO; LA; QL (90 per 30 days)
CAPRELSA ORAL TABLET 300 MG	4	PA; MO; LA; QL (30 per 30 days)
<i>carboplatin intravenous solution</i>	1	PA; MO
CELLCEPT INTRAVENOUS	2	PA; MO
<i>cisplatin</i>	1	PA; MO
<i>cladribine</i>	4	PA; MO
<i>clofarabine</i>	4	PA
CLOLAR	4	PA
COMETRIQ	4	PA; MO
COSMEGEN	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
COTELLIC	4	PA; MO; LA; QL (63 per 28 days)
CYCLOPHOSPHAMIDE ORAL CAPSULE	2	PA; MO
<i>cyclosporine intravenous</i>	1	PA
<i>cyclosporine modified</i>	1	PA; MO
<i>cyclosporine oral capsule</i>	1	PA; MO
CYRAMZA	4	PA; MO
<i>cytarabine</i>	1	PA; MO
<i>cytarabine (pf) injection solution 2 gram/20 ml (100 mg/ml)</i>	1	PA; MO
<i>dacarbazine intravenous recon soln 200 mg</i>	1	PA; MO
DARZALEX	4	PA; MO; LA
<i>daunorubicin intravenous solution</i>	1	PA
<i>decitabine</i>	4	PA; MO
<i>docetaxel intravenous solution 80 mg/4 ml (20 mg/ml), 80 mg/8 ml (10 mg/ml)</i>	4	PA; MO
<i>doxorubicin intravenous solution 50 mg/25 ml</i>	1	PA; MO
<i>doxorubicin, peg-liposomal</i>	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
DROXIA	2	MO
EMCYT	2	MO
EMPLICITI	4	PA; MO
<i>epirubicin intravenous solution 200 mg/100 ml</i>	1	PA; MO
ERBITUX INTRAVENOUS SOLUTION 100 MG/50 ML	4	PA; MO
ERIVEDGE	4	PA; MO; QL (30 per 30 days)
ERWINAZE	4	PA; MO
ETOPOPHOS	3	PA; MO
<i>etoposide intravenous</i>	1	PA; MO
<i>exemestane</i>	1	MO
FARESTON	4	MO
FARYDAK ORAL CAPSULE 10 MG	4	PA; MO; QL (12 per 21 days)
FARYDAK ORAL CAPSULE 15 MG, 20 MG	4	PA; MO; QL (6 per 21 days)
FASLODEX	4	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	2	PA; MO
<i>fludarabine intravenous recon soln</i>	1	PA; MO
<i>fluorouracil intravenous solution 2.5 gram/50 ml</i>	1	PA; MO
<i>flutamide</i>	1	MO
FOLOTYN INTRAVENOUS SOLUTION 40 MG/2 ML (20 MG/ML)	4	PA; MO
<i>gemcitabine intravenous recon soln 1 gram</i>	1	PA; MO
<i>gengraf</i>	1	PA; MO
GILOTRIF ORAL TABLET 20 MG	4	PA; MO; QL (60 per 30 days)
GILOTRIF ORAL TABLET 30 MG	4	PA; MO; QL (40 per 30 days)
GILOTRIF ORAL TABLET 40 MG	4	PA; MO; QL (30 per 30 days)
GLEOSTINE	2	MO
HALAVEN	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
HERCEPTIN INTRAVENOUS RECON SOLN 440 MG	4	PA; MO
HEXALEN	4	MO
<i>hydroxyurea</i>	1	MO
IBRANCE	4	PA; MO; QL (21 per 28 days)
ICLUSIG ORAL TABLET 15 MG	4	PA; QL (90 per 30 days)
ICLUSIG ORAL TABLET 45 MG	4	PA; MO; QL (30 per 30 days)
<i>idarubicin</i>	1	PA
<i>ifosfamide intravenous recon soln 1 gram</i>	1	PA; MO
<i>imatinib oral tablet 100 mg</i>	4	PA; MO
<i>imatinib oral tablet 400 mg</i>	4	PA; MO; QL (60 per 30 days)
IMBRUVICA	4	PA; MO; QL (120 per 30 days)
IMFINZI	4	PA; MO; LA
INLYTA ORAL TABLET 1 MG	4	PA; MO
INLYTA ORAL TABLET 5 MG	4	PA; MO; QL (120 per 30 days)
IRESSA	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>irinotecan intravenous solution 100 mg/5 ml</i>	1	PA; MO
ISTODAX	4	PA; MO
JAKAFI ORAL TABLET 10 MG, 15 MG, 20 MG, 5 MG	4	PA; MO
JAKAFI ORAL TABLET 25 MG	4	PA; MO; QL (60 per 30 days)
JEVTANA	4	PA; MO
KADCYLA INTRAVENOUS RECON SOLN 100 MG	4	PA; MO
KEYTRUDA	4	PA; MO
KISQALI	4	PA; MO
KISQALI FEMARA CO-PACK	4	PA; MO
KYPROLIS	4	PA; MO
LARTRUVO	4	PA; MO; LA
LENVIMA	4	PA; MO
<i>letrozole</i>	1	MO
LEUKERAN	2	MO
<i>leuprolide subcutaneous kit</i>	1	PA; MO
LONSURF	4	PA; MO
LUPRON DEPOT	4	PA; MO
LUPRON DEPOT (3 MONTH)	4	PA; MO
LUPRON DEPOT (4 MONTH)	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
LUPRON DEPOT (6 MONTH)	4	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR KIT 11.25 MG, 15 MG	4	PA; MO
LYNPARZA	4	PA; MO
LYSODREN	2	MO
MATULANE	4	MO
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	1	PA; MO
<i>megestrol oral tablet</i>	1	PA; MO
MEKINIST ORAL TABLET 0.5 MG	4	PA; MO; QL (120 per 30 days)
MEKINIST ORAL TABLET 2 MG	4	PA; MO; QL (30 per 30 days)
<i>melphalan hcl</i>	4	PA
<i>mercaptopurine</i>	1	MO
<i>methotrexate sodium</i>	1	PA; MO
<i>methotrexate sodium (pf) injection recon soln</i>	1	PA
<i>methotrexate sodium (pf) injection solution</i>	1	PA; MO
<i>mitomycin intravenous recon soln 20 mg, 5 mg</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>mitomycin intravenous recon soln 40 mg</i>	4	PA; MO
<i>mitoxantrone</i>	1	PA; MO
MUSTARGEN	3	PA; MO
<i>mycophenolate mofetil hcl</i>	1	PA
<i>mycophenolate mofetil oral capsule</i>	1	PA; MO
<i>mycophenolate mofetil oral suspension for reconstitution</i>	4	PA; MO
<i>mycophenolate mofetil oral tablet</i>	1	PA; MO
<i>mycophenolate sodium</i>	1	PA; MO
NEXAVAR	4	PA; MO; LA; QL (120 per 30 days)
<i>nilutamide</i>	4	MO
NINLARO ORAL CAPSULE 2.3 MG	4	PA; MO; QL (6 per 28 days)
NINLARO ORAL CAPSULE 3 MG	4	PA; MO; QL (4 per 28 days)
NINLARO ORAL CAPSULE 4 MG	4	PA; MO; QL (3 per 28 days)
NULOJIX	4	PA; MO
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	4	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	1	MO
ODOMZO	4	PA; MO; LA; QL (30 per 30 days)
OPDIVO INTRAVENOUS SOLUTION 40 MG/4 ML	4	PA; MO
<i>oxaliplatin intravenous solution 100 mg/20 ml</i>	1	PA; MO
<i>paclitaxel</i>	1	PA; MO
PERJETA	4	PA; MO
POMALYST	4	MO; LA
PROGRAF INTRAVENOUS	2	PA; MO
PURIXAN	4	MO
RAPAMUNE ORAL SOLUTION	4	PA; MO
REVLIMID	4	PA; MO; LA
RITUXAN	4	PA; MO
RUBRACA ORAL TABLET 200 MG	4	PA; MO; LA; QL (180 per 30 days)
RUBRACA ORAL TABLET 300 MG	4	PA; MO; LA; QL (120 per 30 days)
RYDAPT	4	PA; MO
SANDIMMUNE ORAL SOLUTION	2	PA; MO

Drug Name	Drug Tier	Requirements /Limits
SANDOSTATIN LAR DEPOT INTRAMUSCULAR SUSPENSION,EXTENDED RELEASE RECON	4	MO
SIGNIFOR	4	MO
SIMULECT INTRAVENOUS RECON SOLN 20 MG	2	PA; MO
<i>sirolimus oral tablet 0.5 mg, 1 mg</i>	1	PA; MO
<i>sirolimus oral tablet 2 mg</i>	4	PA; MO
SOLTAMOX	2	MO
SOMATULINE DEPOT	4	MO
SPRYCEL ORAL TABLET 100 MG, 20 MG, 50 MG, 80 MG	4	PA; MO
SPRYCEL ORAL TABLET 140 MG	4	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 70 MG	4	PA; MO; QL (60 per 30 days)
STIVARGA	4	PA; MO; QL (84 per 28 days)
SUTENT ORAL CAPSULE 12.5 MG	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
SUTENT ORAL CAPSULE 25 MG, 37.5 MG	4	PA; MO; QL (60 per 30 days)
SUTENT ORAL CAPSULE 50 MG	4	PA; MO; QL (30 per 30 days)
SYLVANT INTRAVENOUS RECON SOLN 100 MG	4	PA; MO
SYNRIBO	4	PA; MO
TABLOID	2	MO
<i>tacrolimus oral</i>	1	PA; MO
TAFINLAR ORAL CAPSULE 50 MG	4	PA; MO; QL (180 per 30 days)
TAFINLAR ORAL CAPSULE 75 MG	4	PA; MO; QL (120 per 30 days)
TAGRISSE ORAL TABLET 40 MG	4	PA; MO; LA; QL (60 per 30 days)
TAGRISSE ORAL TABLET 80 MG	4	PA; MO; LA; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO
TARCEVA ORAL TABLET 100 MG, 25 MG	4	PA; MO
TARCEVA ORAL TABLET 150 MG	4	PA; MO; QL (30 per 30 days)
TARGRETIN TOPICAL	4	MO

Drug Name	Drug Tier	Requirements /Limits
TASIGNA ORAL CAPSULE 150 MG	4	PA; MO
TASIGNA ORAL CAPSULE 200 MG	4	PA; MO; QL (112 per 28 days)
TECENTRIQ	4	PA; MO; LA
THALOMID	4	PA; MO
<i>thiotepa</i>	4	PA; MO
<i>toposar</i>	1	PA; MO
<i>topotecan intravenous recon soln</i>	4	PA
TORISEL	4	PA; MO
TREANDA INTRAVENOUS RECON SOLN 100 MG	4	PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 11.25 MG, 3.75 MG	4	PA; MO
TRELSTAR INTRAMUSCULAR SYRINGE	4	PA; MO
<i>tretinoin (chemotherapy)</i>	4	MO
TRISENOX	4	PA; MO
TYKERB	4	PA; MO; LA; QL (180 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
VECTIBIX INTRAVENOUS SOLUTION 100 MG/5 ML (20 MG/ML)	4	PA; MO
VELCADE	4	PA; MO
VENCLEXTA ORAL TABLET 10 MG, 50 MG	2	PA; MO; LA
VENCLEXTA ORAL TABLET 100 MG	4	PA; MO; LA
VENCLEXTA STARTING PACK	4	PA; MO; LA; QL (42 per 180 days)
<i>vinblastine intravenous solution</i>	1	PA; MO
<i>vincasar pfs intravenous solution 1 mg/ml</i>	1	PA
<i>vincristine intravenous solution 1 mg/ml</i>	1	PA; MO
<i>vinorelbine intravenous solution 50 mg/5 ml</i>	1	PA; MO
VOTRIENT	4	PA; MO; QL (120 per 30 days)
XALKORI ORAL CAPSULE 200 MG	4	PA; MO
XALKORI ORAL CAPSULE 250 MG	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
XERMELO	4	PA; MO; LA; QL (90 per 30 days)
XTANDI	4	PA; MO; QL (120 per 30 days)
YERVOY INTRAVENOUS SOLUTION 50 MG/10 ML (5 MG/ML)	4	PA; MO
YONDELIS	4	PA; MO
ZALTRAP INTRAVENOUS SOLUTION 100 MG/4 ML (25 MG/ML)	4	PA; MO
ZANOSAR	3	PA; MO
ZEJULA	4	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	4	PA; MO; QL (240 per 30 days)
ZOLINZA	4	MO
ZORTRESS	4	PA; MO
ZYDELIG	4	PA; MO; QL (90 per 30 days)
ZYKADIA	4	PA; MO; QL (150 per 30 days)
ZYTIGA ORAL TABLET 250 MG	4	PA; MO; QL (120 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	3	MO
APTIOM ORAL TABLET 600 MG	4	MO
BANZEL ORAL SUSPENSION	2	MO
BANZEL ORAL TABLET 200 MG	2	MO
BANZEL ORAL TABLET 400 MG	4	MO
BRIVIACT INTRAVENOUS	3	
BRIVIACT ORAL	4	MO
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	MO
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	MO
<i>carbamazepine oral tablet</i>	1	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	1	MO
<i>carbamazepine oral tablet, chewable</i>	1	MO
CELONTIN ORAL CAPSULE 300 MG	2	MO
<i>clonazepam</i>	1	PA; MO
DIASTAT	3	MO

Drug Name	Drug Tier	Requirements /Limits
DIASTAT ACUDIAL	3	MO
DILANTIN 30 MG <i>divalproex</i>	2	MO
<i>epitol</i>	1	MO
<i>ethosuximide</i>	1	MO
<i>felbamate oral suspension</i>	4	MO
<i>felbamate oral tablet</i>	1	MO
<i>fosphenytoin injection solution 100 mg pe/2 ml</i>	1	MO
FYCOMPA ORAL SUSPENSION	4	MO
FYCOMPA ORAL TABLET	2	MO
<i>gabapentin oral capsule 100 mg</i>	1	MO; QL (1080 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	MO; QL (360 per 30 days)
<i>gabapentin oral capsule 400 mg</i>	1	MO; QL (270 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	1	MO; QL (2160 per 30 days)
<i>gabapentin oral tablet 600 mg</i>	1	MO; QL (180 per 30 days)
<i>gabapentin oral tablet 800 mg</i>	1	MO; QL (135 per 30 days)
GABITRIL ORAL TABLET 12 MG, 16 MG	2	MO
GRALISE 30-DAY STARTER PACK	2	PA; MO; QL (78 per 180 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	PA; MO; QL (30 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	2	PA; MO; QL (90 per 30 days)
<i>lamotrigine oral tablet</i>	1	MO
<i>lamotrigine oral tablet extended release 24hr</i>	1	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	1	MO
<i>lamotrigine oral tablet, disintegrating</i>	1	MO
<i>levetiracetam in nacl (iso-os) intravenous piggyback 1,000 mg/100 ml, 1,500 mg/100 ml</i>	1	
<i>levetiracetam in nacl (iso-os) intravenous piggyback 500 mg/100 ml</i>	1	MO
<i>levetiracetam intravenous</i>	1	MO
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO
<i>levetiracetam oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO
LYRICA ORAL CAPSULE 100 MG	2	PA; MO; QL (180 per 30 days)
LYRICA ORAL CAPSULE 150 MG	2	PA; MO; QL (120 per 30 days)
LYRICA ORAL CAPSULE 200 MG	2	PA; MO; QL (90 per 30 days)
LYRICA ORAL CAPSULE 225 MG	2	PA; MO; QL (81 per 30 days)
LYRICA ORAL CAPSULE 25 MG	2	PA; MO; QL (720 per 30 days)
LYRICA ORAL CAPSULE 300 MG	2	PA; MO; QL (60 per 30 days)
LYRICA ORAL CAPSULE 50 MG	2	PA; MO; QL (360 per 30 days)
LYRICA ORAL CAPSULE 75 MG	2	PA; MO; QL (240 per 30 days)
LYRICA ORAL SOLUTION	2	PA; MO; QL (900 per 30 days)
ONFI ORAL SUSPENSION	2	PA; MO
ONFI ORAL TABLET 10 MG, 20 MG	2	PA; MO
<i>oxcarbazepine</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
PEGANONE	2	MO
<i>phenobarbital</i>	1	PA; MO
<i>phenytoin oral suspension 125 mg/5 ml</i>	1	MO
<i>phenytoin oral tablet, chewable</i>	1	MO
<i>phenytoin sodium extended</i>	1	MO
<i>phenytoin sodium intravenous solution</i>	1	MO
<i>primidone</i>	1	MO
<i>roweepra oral tablet 1,000 mg, 750 mg</i>	1	
<i>roweepra oral tablet 500 mg</i>	1	MO
SABRIL	4	MO; LA
SPRITAM	3	MO
<i>tiagabine</i>	1	MO
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO
<i>topiramate oral tablet</i>	1	PA; MO
<i>valproate sodium</i>	1	MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
VIMPAT INTRAVENOUS	2	
VIMPAT ORAL SOLUTION	2	MO

Drug Name	Drug Tier	Requirements /Limits
VIMPAT ORAL TABLET	2	MO
<i>zonisamide</i>	1	PA; MO
ANTIPARKINSONISM AGENTS		
APOKYN	4	MO; LA
<i>benztropine injection</i>	1	MO
<i>benztropine oral</i>	1	PA; MO
<i>bromocriptine</i>	1	MO
<i>carbidopa</i>	1	MO
<i>carbidopa-levodopa</i>	1	MO
<i>carbidopa-levodopa-entacapone</i>	1	MO
<i>entacapone</i>	1	MO
NEUPRO	2	MO
<i>pramipexole</i>	1	MO
<i>rasagiline</i>	1	MO
<i>ropinirole</i>	1	MO
<i>selegiline hcl</i>	1	MO
<i>tolcapone</i>	4	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
<i>almotriptan malate oral tablet 12.5 mg</i>	1	MO; QL (24 per 28 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	1	MO; QL (18 per 28 days)
<i>dihydroergotamine injection</i>	1	MO
<i>dihydroergotamine nasal</i>	1	MO; QL (8 per 28 days)
<i>ergotamine-caffeine</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>frovatriptan</i>	1	MO; QL (27 per 28 days)
<i>migergot</i>	1	MO
<i>naratriptan</i>	1	MO; QL (18 per 28 days)
<i>rizatriptan</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 20 mg/actuation</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan succinate oral</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan succinate subcutaneous cartridge</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml</i>	1	MO; QL (8 per 28 days)
<i>zolmitriptan</i>	1	MO; QL (18 per 28 days)

MISCELLANEOUS NEUROLOGICAL THERAPY

Drug Name	Drug Tier	Requirements /Limits
AMPYRA	4	PA; MO; LA
AUBAGIO	4	PA; MO
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	4	PA; MO; QL (12 per 28 days)
<i>donepezil</i>	1	MO
<i>galantamine</i>	1	MO
GILENYA	4	PA; MO
<i>glatopa</i>	4	PA; MO; QL (30 per 30 days)
<i>memantine oral solution</i>	1	PA; MO
<i>memantine oral tablet</i>	1	PA; MO
NAMENDA XR	2	PA; MO
NAMZARIC	2	PA; MO
NUEDEXTA	2	MO
<i>rivastigmine</i>	1	MO
<i>rivastigmine tartrate</i>	1	MO
TECFIDERA	4	PA; MO; LA
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA; MO; QL (240 per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	4	PA; MO; QL (120 per 30 days)
TYSABRI	4	PA; MO; LA

MUSCLE RELAXANTS / ANTISPASMODIC THERAPY

<i>baclofen</i>	1	MO
-----------------	---	----

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>cyclobenzaprine oral tablet</i>	1	PA; MO
<i>dantrolene</i>	1	MO
LIORESAL INTRATHECAL SOLUTION 2,000 MCG/ML, 500 MCG/ML	2	PA; MO
LIORESAL INTRATHECAL SOLUTION 50 MCG/ML	2	PA
MESTINON ORAL SYRUP	4	MO
<i>pyridostigmine bromide</i>	1	MO
<i>tizanidine</i>	1	MO
NARCOTIC ANALGESICS		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	1	PA; MO; QL (4500 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>buprenorphine hcl injection solution</i>	1	MO; QL (266 per 30 days)
<i>buprenorphine hcl injection syringe</i>	1	QL (266 per 30 days)
<i>buprenorphine hcl sublingual tablet 2 mg</i>	1	MO; QL (100 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>buprenorphine hcl sublingual tablet 8 mg</i>	1	MO; QL (25 per 30 days)
BUTRANS	2	PA; MO; QL (4 per 28 days)
<i>codeine sulfate oral tablet</i>	1	PA; MO; QL (180 per 30 days)
<i>duramorph (pf) injection solution 0.5 mg/ml</i>	1	MO; QL (4000 per 30 days)
<i>duramorph (pf) injection solution 1 mg/ml</i>	1	QL (2000 per 30 days)
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>fentanyl citrate</i>	4	PA; MO; QL (120 per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr</i>	1	PA; MO; QL (10 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	PA; MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 10-325 mg, 2.5-325 mg, 5-300 mg, 5-325 mg, 7.5-300 mg, 7.5-325 mg</i>	1	PA; MO; QL (360 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	PA; MO; QL (50 per 30 days)
<i>hydromorphone (pf)</i>	1	MO; QL (240 per 30 days)
<i>hydromorphone injection syringe 2 mg/ml</i>	1	QL (1200 per 30 days)
<i>hydromorphone oral liquid</i>	1	PA; MO; QL (2400 per 30 days)
<i>hydromorphone oral tablet</i>	1	PA; MO; QL (180 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 8 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr 16 mg, 32 mg</i>	4	PA; MO; QL (60 per 30 days)
<i>ibuprofen-oxycodone</i>	1	PA; MO; QL (28 per 30 days)
<i>levorphanol tartrate</i>	1	PA; MO; QL (120 per 30 days)
<i>lorcet (hydrocodone)</i>	1	PA; QL (360 per 30 days)
<i>lorcet hd</i>	1	PA; QL (360 per 30 days)
<i>lorcet plus oral tablet 7.5-325 mg</i>	1	PA; QL (360 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>lorstab 10-325</i>	1	PA; QL (360 per 30 days)
<i>lorstab 5-325</i>	1	PA; QL (360 per 30 days)
<i>lorstab 7.5-325</i>	1	PA; QL (360 per 30 days)
<i>methadone injection solution</i>	1	QL (150 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	1	PA; MO; QL (600 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	1	PA; MO; QL (1200 per 30 days)
<i>methadone oral tablet 10 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>methadone oral tablet 5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>morphine concentrate oral solution</i>	1	PA; MO; QL (900 per 30 days)
<i>morphine intravenous syringe 2 mg/ml</i>	1	QL (1000 per 30 days)
<i>morphine intravenous syringe 4 mg/ml</i>	1	QL (500 per 30 days)
<i>morphine oral capsule, er multiphase 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>morphine oral capsule, extend. release pellets</i>	1	PA; MO; QL (90 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>morphine oral solution</i>	1	PA; MO; QL (900 per 30 days)
<i>morphine oral tablet</i>	1	PA; MO; QL (180 per 30 days)
<i>morphine oral tablet extended release 100 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>morphine oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>oxycodone oral capsule</i>	1	PA; MO; QL (360 per 30 days)
<i>oxycodone oral concentrate</i>	1	PA; MO; QL (180 per 30 days)
<i>oxycodone oral solution</i>	1	PA; MO; QL (1200 per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>oxycodone oral tablet 5 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>oxycodone-acetaminophen oral solution</i>	1	PA; QL (1860 per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	PA; MO; QL (360 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>oxycodone-aspirin</i>	1	PA; MO; QL (360 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	2	PA; MO; QL (90 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	4	PA; MO; QL (60 per 30 days)
<i>oxymorphone oral tablet 10 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>oxymorphone oral tablet 5 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>oxymorphone oral tablet extended release 12 hr</i>	1	PA; MO; QL (90 per 30 days)
<i>vicodin</i>	1	PA; MO; QL (360 per 30 days)
<i>vicodin es</i>	1	PA; MO; QL (360 per 30 days)
<i>vicodin hp</i>	1	PA; MO; QL (360 per 30 days)
<i>zamicet</i>	1	PA; QL (5550 per 30 days)

NON-NARCOTIC ANALGESICS

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	MO; QL (90 per 30 days)
<i>butorphanol tartrate injection solution 1 mg/ml</i>	1	MO; QL (857 per 30 days)
<i>butorphanol tartrate injection solution 2 mg/ml</i>	1	MO; QL (428 per 30 days)
<i>butorphanol tartrate nasal</i>	1	MO; QL (10 per 28 days)
<i>celecoxib</i>	1	MO
<i>diclofenac potassium</i>	1	MO
<i>diclofenac sodium oral</i>	1	MO
<i>diclofenac sodium topical drops</i>	1	MO; QL (300 per 28 days)
<i>diclofenac sodium topical gel 1 %</i>	1	MO; QL (1000 per 28 days)
<i>diclofenac-misoprostol</i>	1	MO
<i>diflunisal</i>	1	MO
<i>etodolac</i>	1	MO
<i>fenoprofen oral tablet</i>	1	MO
FLECTOR	3	PA; MO; QL (60 per 30 days)
<i>flurbiprofen</i>	1	MO
<i>ibuprofen oral suspension</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	MO
<i>ketoprofen oral capsule</i>	1	MO
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	1	MO
<i>meclofenamate</i>	1	MO
<i>mefenamic acid</i>	1	MO
<i>meloxicam oral tablet 15 mg</i>	1	MO
<i>meloxicam oral tablet 7.5 mg</i>	1	MO; QL (30 per 30 days)
<i>nabumetone</i>	1	MO
<i>nalbuphine injection solution 10 mg/ml</i>	1	MO; QL (200 per 30 days)
<i>nalbuphine injection solution 20 mg/ml</i>	1	MO; QL (100 per 30 days)
<i>naloxone injection solution</i>	1	MO
<i>naloxone injection syringe 1 mg/ml</i>	1	MO
<i>naltrexone</i>	1	MO
<i>naproxen</i>	1	MO
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	MO
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	2	MO; QL (2 per 28 days)
<i>oxaprozin</i>	1	MO
<i>piroxicam</i>	1	MO
SUBOXONE SUBLINGUAL FILM 12-3 MG	2	MO; QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	2	MO; QL (360 per 30 days)
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	2	MO; QL (90 per 30 days)
<i>sulindac</i>	1	MO
<i>tolmetin oral capsule</i>	1	MO
<i>tolmetin oral tablet 600 mg</i>	1	MO
<i>tramadol oral tablet</i>	1	MO; QL (240 per 30 days)
<i>tramadol oral tablet extended release 24 hr 100 mg, 200 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>tramadol oral tablet, er multiphase 24 hr 300 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>tramadol-acetaminophen</i>	1	MO; QL (240 per 30 days)
VOLTAREN GEL TOPICAL GEL 1 %	2	MO; QL (1000 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	2	MO; QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	2	MO; QL (60 per 30 days)
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY MAINTENA	4	MO
<i>amitriptyline</i>	1	PA; MO
<i>amoxapine</i>	1	MO
<i>aripiprazole oral tablet 10 mg</i>	1	MO; QL (90 per 30 days)
<i>aripiprazole oral tablet 15 mg</i>	1	MO; QL (60 per 30 days)
<i>aripiprazole oral tablet 2 mg</i>	1	MO; QL (450 per 30 days)
<i>aripiprazole oral tablet 20 mg</i>	4	MO; QL (60 per 30 days)
<i>aripiprazole oral tablet 30 mg</i>	4	MO; QL (30 per 30 days)
<i>aripiprazole oral tablet 5 mg</i>	1	MO; QL (180 per 30 days)
<i>aripiprazole oral tablet, disintegrating 10 mg</i>	4	MO; QL (90 per 30 days)
<i>aripiprazole oral tablet, disintegrating 15 mg</i>	4	MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	4	
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML, 662 MG/2.4 ML, 882 MG/3.2 ML	4	MO
<i>armodafinil</i>	1	PA; MO
<i>atomoxetine</i>	1	MO
<i>bupropion hcl oral tablet</i>	1	MO
<i>bupropion hcl oral tablet extended release 12 hr 100 mg</i>	1	MO; QL (120 per 30 days)
<i>bupropion hcl oral tablet extended release 12 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 12 hr 200 mg</i>	1	MO; QL (60 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (60 per 30 days)
<i>bupropion</i>	1	MO
<i>chlorpromazine</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>citalopram oral solution</i>	1	MO
<i>citalopram oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)
<i>citalopram oral tablet 20 mg</i>	1	MO; QL (60 per 30 days)
<i>citalopram oral tablet 40 mg</i>	1	MO; QL (30 per 30 days)
<i>clomipramine</i>	1	PA; MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO
<i>clorazepate dipotassium</i>	1	PA; MO
<i>clozapine oral tablet</i>	1	MO
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	1	
<i>desipramine</i>	1	MO
<i>desvenlafaxine succinate oral tablet extended release 24 hr 100 mg</i>	1	MO; QL (120 per 30 days)
<i>desvenlafaxine succinate oral tablet extended release 24 hr 25 mg</i>	1	MO; QL (480 per 30 days)
<i>desvenlafaxine succinate oral tablet extended release 24 hr 50 mg</i>	1	MO; QL (240 per 30 days)
<i>dexmethylphenidate</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>dextroamphetamine oral capsule, extended release</i>	1	MO
<i>dextroamphetamine oral tablet</i>	1	MO
<i>dextroamphetamine-amphetamine</i>	1	MO
<i>diazepam intensol</i>	1	PA; MO
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	PA; MO
<i>diazepam oral tablet</i>	1	PA; MO
<i>doxepin oral</i>	1	PA; MO
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg</i>	1	MO; QL (180 per 30 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 30 mg</i>	1	MO; QL (120 per 30 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 40 mg</i>	1	MO; QL (90 per 30 days)
<i>duloxetine oral capsule, delayed release(dr/ec) 60 mg</i>	1	MO; QL (60 per 30 days)
EMSAM	4	MO
<i>ergoloid</i>	1	MO
<i>escitalopram oxalate oral solution</i>	1	MO
<i>escitalopram oxalate oral tablet 10 mg</i>	1	MO; QL (60 per 30 days)
<i>escitalopram oxalate oral tablet 20 mg</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>escitalopram oxalate oral tablet 5 mg</i>	1	MO; QL (120 per 30 days)
<i>eszopiclone</i>	1	ST; MO; QL (30 per 30 days)
FANAPT ORAL TABLET 1 MG	3	MO; QL (720 per 30 days)
FANAPT ORAL TABLET 10 MG, 8 MG	4	MO; QL (90 per 30 days)
FANAPT ORAL TABLET 12 MG	4	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 2 MG	3	MO; QL (360 per 30 days)
FANAPT ORAL TABLET 4 MG	3	MO; QL (180 per 30 days)
FANAPT ORAL TABLET 6 MG	4	MO; QL (120 per 30 days)
FANAPT ORAL TABLETS, DOSE PACK	3	MO; QL (8 per 28 days)
FAZACLO ORAL TABLET, DISINTEGRATING 150 MG, 200 MG	3	
FETZIMA ORAL CAPSULE, EXT REL 24HR DOSE PACK	2	MO; QL (28 per 28 days)
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24 HR 120 MG	2	MO; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	2	MO; QL (180 per 30 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 40 MG	2	MO; QL (90 per 30 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 80 MG	2	MO; QL (45 per 30 days)
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (240 per 30 days)
<i>fluoxetine oral capsule 20 mg</i>	1	MO
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluoxetine oral capsule, delayed release(dr/ec)</i>	1	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	1	MO
<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (240 per 30 days)
<i>fluoxetine oral tablet 20 mg</i>	1	MO
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO
<i>fluvoxamine oral capsule, extended release 24hr 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral capsule, extended release 24hr 150 mg</i>	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
FORFIVO XL	3	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	3	MO
<i>guanidine</i>	1	MO
<i>haloperidol</i>	1	MO
<i>haloperidol decanoate</i>	1	MO
<i>haloperidol lactate</i>	1	MO
HETLIOZ	4	PA; MO; QL (30 per 30 days)
<i>imipramine hcl</i>	1	PA; MO
<i>imipramine pamoate</i>	1	PA; MO
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	4	MO
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	MO
INVEGA TRINZA	4	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
LATUDA ORAL TABLET 120 MG	4	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 20 MG	2	MO; QL (240 per 30 days)
LATUDA ORAL TABLET 40 MG	2	MO; QL (120 per 30 days)
LATUDA ORAL TABLET 60 MG, 80 MG	2	MO; QL (60 per 30 days)
<i>lithium carbonate</i>	1	MO
<i>lithium citrate oral solution 8 meq/5 ml</i>	1	MO
<i>lorazepam intensol</i>	1	PA; MO
<i>lorazepam oral tablet</i>	1	PA; MO
<i>loxapine succinate</i>	1	MO
<i>maprotiline</i>	1	MO
MARPLAN	2	MO
<i>metadate er</i>	1	MO
<i>methamphetamine</i>	1	PA; MO
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	1	MO
<i>methylphenidate hcl oral capsule, er biphasic 50-50 20 mg, 40 mg, 60 mg</i>	1	MO
<i>methylphenidate hcl oral solution</i>	1	MO
<i>methylphenidate hcl oral tablet</i>	1	MO
<i>methylphenidate hcl oral tablet extended release</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>methylphenidate hcl oral tablet extended release 24hr</i>	1	MO
<i>methylphenidate hcl oral tablet, chewable</i>	1	MO
<i>mirtazapine</i>	1	MO
<i>modafinil</i>	1	PA; MO
<i>nefazodone</i>	1	MO
<i>nortriptyline</i>	1	MO
NUPLAZID	4	MO
<i>olanzapine intramuscular</i>	1	MO
<i>olanzapine oral tablet 10 mg</i>	1	MO; QL (60 per 30 days)
<i>olanzapine oral tablet 15 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>olanzapine oral tablet 2.5 mg</i>	1	MO; QL (240 per 30 days)
<i>olanzapine oral tablet 5 mg</i>	1	MO; QL (120 per 30 days)
<i>olanzapine oral tablet 7.5 mg</i>	1	MO; QL (81 per 30 days)
<i>olanzapine oral tablet, disintegrating 10 mg</i>	1	MO; QL (60 per 30 days)
<i>olanzapine oral tablet, disintegrating 15 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>olanzapine oral tablet, disintegrating 5 mg</i>	1	MO; QL (120 per 30 days)
<i>olanzapine-fluoxetine</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>paliperidone oral tablet extended release 24hr 1.5 mg</i>	1	MO; QL (240 per 30 days)
<i>paliperidone oral tablet extended release 24hr 3 mg</i>	1	MO; QL (120 per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	1	MO; QL (60 per 30 days)
<i>paliperidone oral tablet extended release 24hr 9 mg</i>	4	MO; QL (41 per 30 days)
<i>paroxetine hcl oral tablet 10 mg</i>	1	MO; QL (180 per 30 days)
<i>paroxetine hcl oral tablet 20 mg</i>	1	MO; QL (90 per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	1	MO; QL (60 per 30 days)
<i>paroxetine hcl oral tablet 40 mg</i>	1	MO; QL (45 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr 12.5 mg</i>	1	MO; QL (180 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr 25 mg</i>	1	MO; QL (90 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr 37.5 mg</i>	1	MO; QL (60 per 30 days)
PAXIL ORAL SUSPENSION	3	MO
<i>perphenazine</i>	1	MO
<i>phenelzine</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>pimozide</i>	1	MO
<i>procentra</i>	1	MO
<i>protriptyline</i>	1	MO
<i>quetiapine oral tablet 100 mg</i>	1	MO; QL (240 per 30 days)
<i>quetiapine oral tablet 200 mg</i>	1	MO; QL (120 per 30 days)
<i>quetiapine oral tablet 25 mg</i>	1	MO; QL (902 per 30 days)
<i>quetiapine oral tablet 300 mg</i>	1	MO; QL (81 per 30 days)
<i>quetiapine oral tablet 400 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet 50 mg</i>	1	MO; QL (480 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (160 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 200 mg</i>	1	MO; QL (120 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (81 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 400 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 50 mg</i>	1	MO; QL (480 per 30 days)
REXULTI ORAL TABLET 0.25 MG	4	MO; QL (480 per 30 days)
REXULTI ORAL TABLET 0.5 MG	4	MO; QL (240 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
REXULTI ORAL TABLET 1 MG	4	MO; QL (120 per 30 days)
REXULTI ORAL TABLET 2 MG	4	MO; QL (60 per 30 days)
REXULTI ORAL TABLET 3 MG	4	MO; QL (40 per 30 days)
REXULTI ORAL TABLET 4 MG	4	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML	2	MO
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 37.5 MG/2 ML, 50 MG/2 ML	4	MO
<i>risperidone oral solution</i>	1	MO; QL (480 per 30 days)
<i>risperidone oral tablet 0.25 mg</i>	1	MO; QL (1920 per 30 days)
<i>risperidone oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>risperidone oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)
<i>risperidone oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)
<i>risperidone oral tablet 3 mg</i>	1	MO; QL (161 per 30 days)
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>risperidone oral tablet, disintegrating 0.25 mg</i>	1	MO; QL (1920 per 30 days)
<i>risperidone oral tablet, disintegrating 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>risperidone oral tablet, disintegrating 1 mg</i>	1	MO; QL (480 per 30 days)
<i>risperidone oral tablet, disintegrating 2 mg</i>	1	MO; QL (240 per 30 days)
<i>risperidone oral tablet, disintegrating 3 mg</i>	1	MO; QL (161 per 30 days)
<i>risperidone oral tablet, disintegrating 4 mg</i>	1	MO; QL (120 per 30 days)
ROZEREM	2	MO; QL (30 per 30 days)
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 10 MG	2	MO; QL (60 per 30 days)
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 2.5 MG	2	MO; QL (240 per 30 days)
SAPHRIS (BLACK CHERRY) SUBLINGUAL TABLET 5 MG	2	MO; QL (120 per 30 days)
<i>sertraline oral concentrate</i>	1	MO
<i>sertraline oral tablet 100 mg</i>	1	MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (240 per 30 days)
<i>sertraline oral tablet 50 mg</i>	1	MO; QL (120 per 30 days)
<i>thioridazine</i>	1	MO
<i>thiothixene</i>	1	MO
<i>tranlycypromine</i>	1	MO
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	1	MO
<i>trimipramine</i>	1	PA; MO
TRINTELLIX ORAL TABLET 10 MG	2	MO; QL (60 per 30 days)
TRINTELLIX ORAL TABLET 20 MG	2	MO; QL (30 per 30 days)
TRINTELLIX ORAL TABLET 5 MG	2	MO; QL (120 per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 150 mg</i>	1	MO; QL (60 per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 37.5 mg</i>	1	MO; QL (180 per 30 days)
<i>venlafaxine oral capsule,extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet 100 mg, 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet 25 mg</i>	1	MO; QL (270 per 30 days)
<i>venlafaxine oral tablet 37.5 mg</i>	1	MO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>venlafaxine oral tablet 50 mg</i>	1	MO; QL (150 per 30 days)
VERSACLOZ	4	
VIIBRYD ORAL TABLET 10 MG	2	MO; QL (120 per 30 days)
VIIBRYD ORAL TABLET 20 MG	2	MO; QL (60 per 30 days)
VIIBRYD ORAL TABLET 40 MG	2	MO; QL (30 per 30 days)
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 180 days)
VRAYLAR ORAL CAPSULE 1.5 MG	4	MO; QL (120 per 30 days)
VRAYLAR ORAL CAPSULE 3 MG	4	MO; QL (60 per 30 days)
VRAYLAR ORAL CAPSULE 4.5 MG	4	MO; QL (40 per 30 days)
VRAYLAR ORAL CAPSULE 6 MG	4	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	3	MO; QL (7 per 30 days)
XYREM	4	PA; MO; LA
<i>zaleplon oral capsule 10 mg</i>	1	ST; MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 mg</i>	1	ST; MO; QL (30 per 30 days)
<i>zenzedi oral tablet 10 mg, 5 mg</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	3	MO
<i>ziprasidone hcl oral capsule 20 mg</i>	1	MO; QL (240 per 30 days)
<i>ziprasidone hcl oral capsule 40 mg</i>	1	MO; QL (120 per 30 days)
<i>ziprasidone hcl oral capsule 60 mg</i>	1	MO; QL (80 per 30 days)
<i>ziprasidone hcl oral capsule 80 mg</i>	1	MO; QL (60 per 30 days)
<i>zolpidem oral</i>	1	ST; MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	2	

CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

<i>amiodarone intravenous solution</i>	1	PA; MO
<i>amiodarone oral</i>	1	MO
<i>dofetilide</i>	1	MO
<i>flecainide</i>	1	MO
<i>mexiletine</i>	1	MO
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>procainamide injection solution 100 mg/ml</i>	1	MO
<i>procainamide injection solution 500 mg/ml</i>	1	
<i>propafenone</i>	1	MO
<i>quinidine gluconate</i>	1	MO
<i>quinidine sulfate oral tablet</i>	1	MO
<i>sorine oral tablet 120 mg, 160 mg, 80 mg</i>	1	MO
<i>sorine oral tablet 240 mg</i>	1	
<i>sotalol af oral tablet 120 mg</i>	1	MO
<i>sotalol oral tablet 160 mg, 240 mg, 80 mg</i>	1	MO
SOTYLIZE	2	MO

ANTIHYPERTENSIVE THERAPY

<i>acebutolol</i>	1	MO
<i>afeditab cr</i>	1	MO
<i>amiloride</i>	1	MO
<i>amiloride-hydrochlorothiazide</i>	1	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthiazyd</i>	1	MO
<i>atenolol</i>	1	MO
<i>atenolol-chlorthalidone</i>	1	MO
<i>benazepril</i>	1	MO
<i>benazepril-hydrochlorothiazide</i>	1	MO
<i>betaxolol oral</i>	1	MO
BIDIL	2	MO
<i>bisoprolol fumarate</i>	1	MO
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide</i>	1	MO
BYSTOLIC	2	MO
BYVALSON	2	MO
<i>candesartan</i>	1	MO
<i>candesartan-hydrochlorothiazid</i>	1	MO
<i>captopril</i>	1	MO
<i>captopril-hydrochlorothiazide</i>	1	MO
<i>cartia xt</i>	1	MO
<i>carvedilol</i>	1	MO
<i>chlorothiazide</i>	1	MO
<i>chlorothiazide sodium</i>	1	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>clonidine</i>	1	MO; QL (4 per 28 days)
<i>clonidine hcl oral tablet</i>	1	MO
COREG CR	2	MO
DEMSER	4	MO
<i>diltiazem hcl intravenous</i>	1	
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24 hr 120 mg, 180mg, 240 mg, 300 mg, 360 mg, 420mg</i>	1	MO
<i>diltiazem hcl oral tablet</i>	1	MO
<i>dilt-xr</i>	1	MO
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	1	MO; QL (30 per 30 days)
<i>doxazosin oral tablet 8 mg</i>	1	MO; QL (60 per 30 days)
EDARBI	2	MO
EDARBYCLOR	2	MO
<i>enalapril maleate</i>	1	MO
<i>enalapril-hydrochlorothiazide</i>	1	MO
<i>eplerenone</i>	1	MO
<i>eprosartan</i>	1	MO
<i>ethacrynate sodium</i>	4	
<i>ethacrynic acid</i>	4	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>felodipine</i>	1	MO
<i>fosinopril</i>	1	MO
<i>fosinopril-hydrochlorothiazide</i>	1	MO
<i>furosemide injection</i>	1	MO
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	MO
<i>furosemide oral tablet</i>	1	MO
<i>hydralazine</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO
<i>indapamide</i>	1	MO
<i>irbesartan</i>	1	MO
<i>irbesartan-hydrochlorothiazide</i>	1	MO
<i>isradipine</i>	1	MO
<i>labetalol intravenous solution</i>	1	MO
<i>labetalol oral</i>	1	MO
<i>lisinopril</i>	1	MO
<i>lisinopril-hydrochlorothiazide</i>	1	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO
<i>matzim la</i>	1	MO
<i>methyclothiazide</i>	1	MO
<i>methyldopa</i>	1	MO
<i>metolazone</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>metoprolol succinate</i>	1	MO
<i>metoprolol ta-hydrochlorothiaz</i>	1	MO
<i>metoprolol tartrate intravenous solution</i>	1	MO
<i>metoprolol tartrate intravenous syringe</i>	1	
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	MO
<i>minoxidil oral</i>	1	MO
<i>moexipril</i>	1	MO
<i>moexipril-hydrochlorothiazide</i>	1	MO
<i>nadolol</i>	1	MO
<i>nadolol-bendroflumethiazide</i>	1	MO
<i>nicardipine intravenous solution</i>	1	MO
<i>nicardipine oral</i>	1	MO
<i>nifedipine oral tablet extended release</i>	1	MO
<i>nifedipine oral tablet extended release 24hr</i>	1	MO
<i>nimodipine</i>	1	MO
<i>nisoldipine</i>	1	MO
<i>olmesartan</i>	1	MO
<i>olmesartan-amlodipin-hcthiazid</i>	1	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>perindopril erbumine</i>	1	MO
<i>phenoxybenzamine</i>	4	MO
<i>pindolol</i>	1	MO
<i>prazosin</i>	1	MO
<i>propranolol intravenous</i>	1	
<i>propranolol oral</i>	1	MO
<i>propranolol-hydrochlorothiazid</i>	1	MO
<i>quinapril</i>	1	MO
<i>quinapril-hydrochlorothiazide</i>	1	MO
<i>ramipril</i>	1	MO
REMODULIN	4	PA; MO; LA
<i>spironolactone</i>	1	MO
<i>spironolacton-hydrochlorothiaz</i>	1	MO
<i>taztia xt</i>	1	MO
TEKTURNA	2	MO
TEKTURNA HCT	2	MO
<i>telmisartan</i>	1	MO
<i>telmisartan-amlodipine</i>	1	MO
<i>telmisartan-hydrochlorothiazid</i>	1	MO
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
<i>timolol maleate oral</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>torseamide oral</i>	1	MO
<i>trandolapril</i>	1	MO
<i>trandolapril-verapamil</i>	1	MO
<i>triamterene-hydrochlorothiazid</i>	1	MO
UPTRAVI	4	PA; MO; LA
<i>valsartan</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
<i>verapamil intravenous solution</i>	1	MO
<i>verapamil oral</i>	1	MO
CARDIAC GLYCOSIDES		
<i>digitek</i>	1	MO
<i>digoxin oral solution 50 mcg/ml</i>	1	MO
<i>digoxin oral tablet</i>	1	MO
LANOXIN ORAL TABLET 187.5 MCG, 62.5 MCG	2	MO
COAGULATION THERAPY		
<i>aspirin-dipyridamole</i>	1	MO
BRILINTA	2	MO
<i>cilostazol</i>	1	MO
<i>clopidogrel</i>	1	MO
<i>dipyridamole oral</i>	1	MO
EFFIENT	2	MO
ELIQUIS	2	MO
<i>enoxaparin</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	4	MO
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	1	MO
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 20,000 unit/500 ml (40 unit/ml)</i>	1	
<i>heparin (porcine) in 5 % dex intravenous parenteral solution 25,000 unit/250 ml(100 unit/ml), 25,000 unit/500 ml (50 unit/ml)</i>	1	MO
<i>heparin (porcine) injection solution</i>	1	MO
<i>jantoven</i>	1	MO
<i>pentoxifylline</i>	1	MO
PRADAXA	3	MO
PROMACTA	4	PA; MO; LA
<i>tranexamic acid intravenous</i>	1	MO
<i>warfarin</i>	1	MO
XARELTO	2	MO
ZONTIVITY	2	MO

LIPID/CHOLESTEROL LOWERING AGENTS

Drug Name	Drug Tier	Requirements /Limits
<i>amlodipine-atorvastatin</i>	1	MO; QL (30 per 30 days)
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)
<i>cholestyramine (with sugar) oral powder</i>	1	MO
<i>cholestyramine light oral powder</i>	1	MO
<i>colestipol oral granules</i>	1	MO
<i>colestipol oral tablet</i>	1	MO
<i>ezetimibe</i>	1	MO
<i>ezetimibe-simvastatin</i>	1	MO; QL (30 per 30 days)
<i>fenofibrate micronized</i>	1	MO
<i>fenofibrate nanocrystallized</i>	1	MO
<i>fenofibrate oral tablet</i>	1	MO
<i>fenofibric acid</i>	1	MO
<i>fenofibric acid (choline)</i>	1	MO
<i>fluvastatin oral capsule 20 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvastatin oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluvastatin oral tablet extended release 24 hr</i>	1	MO; QL (30 per 30 days)
<i>gemfibrozil</i>	1	MO
JUXTAPID	4	PA; MO; LA

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
LIVALO	2	MO; QL (30 per 30 days)
<i>lovastatin oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
<i>niacin oral tablet extended release 24 hr</i>	1	MO
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 150 MG/ML	4	PA; MO; QL (2 per 28 days)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 75 MG/ML	4	PA; MO; QL (4 per 28 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite oral powder</i>	1	MO
REPATHA PUSHTRONEX	4	PA; MO; QL (3.5 per 28 days)
REPATHA SURECLICK	4	PA; MO; QL (3 per 28 days)
REPATHA SYRINGE	4	PA; MO; QL (3 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin</i>	1	MO; QL (30 per 30 days)
VASCEPA	2	MO
WELCHOL	2	MO

Drug Name	Drug Tier	Requirements /Limits
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR	2	PA; MO
ENTRESTO	2	MO; QL (60 per 30 days)
RANEXA	2	MO
VECAMYL	4	
NITRATES		
<i>isosorbide dinitrate oral</i>	1	MO
<i>isosorbide mononitrate</i>	1	MO
<i>nitro-bid</i>	1	MO
<i>nitroglycerin intravenous</i>	1	PA
<i>nitroglycerin sublingual</i>	1	MO
<i>nitroglycerin transdermal patch 24 hour</i>	1	MO
<i>nitroglycerin translingual spray, non-aerosol</i>	1	MO
DERMATOLOGICALS/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHEIC		
<i>acitretin oral capsule 10 mg</i>	1	MO
<i>acitretin oral capsule 17.5 mg, 25 mg</i>	4	MO
<i>calcipotriene</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>calcipotriene-betamethasone</i>	1	MO
<i>calcitriol topical</i>	1	MO
COSENTYX (2 SYRINGES)	4	PA; MO
COSENTYX PEN (2 PENS)	4	PA; MO
<i>selenium sulfide topical lotion</i>	1	MO
STELARA SUBCUTANEOUS SYRINGE	4	PA; MO
BURN THERAPY		
<i>silver sulfadiazine</i>	1	MO
<i>ssd</i>	1	MO
MISCELLANEOUS DERMATOLOGICALS		
<i>ammonium lactate</i>	1	MO
CARAC	4	MO
CONDYLOX TOPICAL GEL	2	MO
<i>diclofenac sodium topical gel 3 %</i>	4	PA; MO; QL (100 per 28 days)
<i>doxepin topical</i>	1	MO
DUPIXENT	4	PA; MO
FLUOROURACIL TOPICAL CREAM 0.5 %	4	ST; MO
<i>fluorouracil topical cream 5 %</i>	1	MO
<i>fluorouracil topical solution</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>imiquimod</i>	1	MO
<i>methoxsalen</i>	4	MO
PANRETIN	4	MO
PICATO	4	MO
<i>podofilox</i>	1	MO
<i>prudoxin</i>	1	MO
REGRANEX	4	MO
<i>tacrolimus topical</i>	1	PA; MO; QL (100 per 30 days)
TOLAK	3	MO
VALCHLOR	4	MO
ZYCLARA	4	ST; MO
THERAPY FOR ACNE		
<i>adapalene topical cream</i>	1	PA; MO
<i>adapalene topical gel</i>	1	PA; MO
<i>avita topical cream</i>	1	PA; MO
<i>claravis</i>	1	MO
<i>clindacin p</i>	1	MO
<i>clindamycin phosphate topical</i>	1	MO
<i>clindamycin-benzoyl peroxide topical gel</i>	1	MO
<i>clindamycin-tretinoin</i>	1	PA; MO
<i>ery pads</i>	1	MO
<i>erygel</i>	1	MO
<i>erythromycin with ethanol topical gel</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>erythromycin with ethanol topical solution</i>	1	MO
<i>erythromycin-benzoyl peroxide</i>	1	MO
<i>metronidazole topical cream</i>	1	MO
<i>metronidazole topical gel</i>	1	MO
<i>metronidazole topical lotion</i>	1	MO
<i>myorisan oral capsule 10 mg, 20 mg, 40 mg</i>	1	MO
<i>myorisan oral capsule 30 mg</i>	1	
<i>neuac</i>	1	MO
<i>tazarotene</i>	1	PA; MO
TAZORAC TOPICAL CREAM 0.05 %	2	PA; MO
TAZORAC TOPICAL GEL	2	PA; MO
<i>tretinoin microspheres topical gel</i>	1	PA; MO
<i>tretinoin topical</i>	1	PA; MO
<i>zenatane</i>	1	MO
TOPICAL ANESTHETICS		
<i>lidocaine (pf) injection solution 10 mg/ml (1 %), 5 mg/ml (0.5 %)</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>lidocaine hcl injection solution 20 mg/ml (2 %)</i>	1	MO
<i>lidocaine hcl mucous membrane jelly</i>	1	MO; QL (60 per 30 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	1	MO
<i>lidocaine topical adhesive patch, medicated</i>	1	PA; MO
<i>lidocaine topical ointment</i>	1	MO; QL (36 per 30 days)
<i>lidocaine viscous</i>	1	MO
<i>lidocaine-prilocaine topical cream</i>	1	MO; QL (30 per 30 days)
TOPICAL ANTIBACTERIALS		
<i>gentamicin topical</i>	1	MO
<i>mupirocin</i>	1	MO
<i>mupirocin calcium</i>	1	MO
<i>sulfacetamide sodium (acne)</i>	1	MO
SULFAMYLON	2	MO
TOPICAL ANTIFUNGALS		
<i>ciclopirox</i>	1	MO
<i>clotrimazole topical</i>	1	MO
<i>clotrimazole-betamethasone</i>	1	MO
<i>econazole</i>	1	MO
KERYDIN	3	MO
<i>ketconazole topical</i>	1	MO
<i>naftifine</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
NAFTIN TOPICAL GEL	2	MO
<i>nyamyc</i>	1	MO
<i>nyata</i>	1	
<i>nystatin topical</i>	1	MO
<i>nystatin-triamcinolone</i>	1	MO
<i>nystop</i>	1	MO
<i>oxiconazole</i>	1	MO

TOPICAL ANTIVIRALS

<i>acyclovir topical</i>	1	PA; MO; QL (30 per 30 days)
DENAVIR	2	MO
XERESE	3	MO
ZOVIRAX TOPICAL CREAM	4	PA; MO; QL (5 per 30 days)

TOPICAL CORTICOSTEROIDS

<i>ala-cort topical cream</i>	1	MO
<i>alclometasone</i>	1	MO
<i>amcinonide</i>	1	MO
<i>apexicon e</i>	1	MO
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate</i>	1	MO
<i>betamethasone, augmented</i>	1	MO
CAPEX	2	MO
<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical gel</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical lotion</i>	1	MO; QL (118 per 28 days)
<i>clobetasol topical ointment</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical shampoo</i>	1	MO; QL (236 per 28 days)
<i>clobetasol topical spray, non-aerosol</i>	1	MO; QL (125 per 28 days)
<i>clobetasol-emollient topical cream</i>	1	MO; QL (120 per 28 days)
<i>clodan</i>	1	MO; QL (236 per 28 days)
<i>cormax scalp</i>	1	QL (100 per 28 days)
<i>desonide</i>	1	MO
<i>desoximetasone</i>	1	MO
<i>diflorasone</i>	1	MO
<i>fluocinolone</i>	1	MO
<i>fluocinonide topical cream 0.1 %</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical gel</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical ointment</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical solution</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide-e</i>	1	MO; QL (120 per 30 days)
<i>flurandrenolide</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>fluticasone topical</i>	1	MO
<i>halobetasol propionate</i>	1	MO
<i>hydrocortisone butyrate topical ointment</i>	1	MO
<i>hydrocortisone butyrate topical solution</i>	1	MO
<i>hydrocortisone butyr-emollient</i>	1	MO
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	1	MO
<i>hydrocortisone topical lotion 2.5 %</i>	1	MO
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	1	MO
<i>hydrocortisone valerate</i>	1	MO
LOCOID TOPICAL LOTION	2	MO
<i>mometasone topical</i>	1	MO
<i>nolix</i>	1	
<i>prednicarbate</i>	1	MO
<i>triamcinolone acetonide topical aerosol</i>	1	MO
<i>triamcinolone acetonide topical cream</i>	1	MO
<i>triamcinolone acetonide topical lotion</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	MO
<i>trianex</i>	1	MO
<i>triderm topical cream</i>	1	MO
TOPICAL ENZYMES		
SANTYL	2	MO
TOPICAL SCABICIDES / PEDICULICIDES		
<i>lindane topical shampoo</i>	1	MO
<i>malathion</i>	1	MO
<i>permethrin topical cream</i>	1	MO
SKLICE	2	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
IRRIGATING SOLUTIONS		
<i>lactated ringers irrigation</i>	1	MO
<i>neomycin-polymyxin b gu</i>	1	MO
<i>ringer's irrigation</i>	1	MO
MISCELLANEOUS AGENTS		
<i>acamprosate</i>	1	MO
ADAGEN	4	MO
<i>alendronate oral tablet 40 mg</i>	1	MO; QL (30 per 30 days)
<i>anagrelide</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ARALAST NP INTRAVENOUS RECON SOLN 500 MG	4	MO; LA
BUPHENYL ORAL TABLET	4	MO
CARBAGLU	4	MO; LA
<i>cevimeline</i>	1	MO
CHEMET	2	PA; MO
CLINIMIX 4.25%/D5W SULFIT FREE	2	PA
<i>d10 %-0.45 % sodium chloride</i>	1	
<i>d2.5 %-0.45 % sodium chloride</i>	1	
<i>d5 % and 0.9 % sodium chloride</i>	1	MO
<i>d5 %-0.45 % sodium chloride</i>	1	MO
<i>dextrose 10 % and 0.2 % nacl</i>	1	
<i>dextrose 10 % in water (d10w)</i>	1	MO
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	1	MO
<i>dextrose 5 %- lactated ringers</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>dextrose 5%-0.3 % sod.chloride</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>dextrose with sodium chloride</i>	1	
<i>disulfiram</i>	1	MO
<i>etidronate disodium</i>	1	MO
EXJADE	4	PA; MO; LA
FERRIPROX ORAL SOLUTION	4	PA
FERRIPROX ORAL TABLET	4	PA; MO
INCRELEX	4	MO; LA
JADENU	4	PA; MO
<i>kionex</i>	1	MO
<i>levocarnitine (with sugar)</i>	1	MO
<i>levocarnitine oral tablet</i>	1	MO
<i>midodrine</i>	1	MO
NORTHERA	4	PA; MO
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG	4	LA
ORFADIN ORAL SUSPENSION	4	MO; LA
<i>pilocarpine hcl oral</i>	1	MO
PROLASTIN-C	4	LA
RAVICTI	4	MO
REVELA ORAL TABLET	4	MO
<i>riluzole</i>	1	MO
<i>risedronate oral tablet 30 mg</i>	1	MO; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>sevelamer carbonate oral powder in packet</i>	4	MO
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride irrigation</i>	1	MO
<i>sodium phenylbutyrate</i>	4	MO
<i>sodium polystyrene (sorb free)</i>	1	MO
<i>sps (with sorbitol) oral</i>	1	MO
SYPRINE	4	PA; MO
THIOLA	4	MO
VELTASSA	2	MO
<i>water for irrigation, sterile</i>	1	MO
<i>zoledronic acid-mannitol-water</i>	1	PA; MO
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter)</i>	1	MO
CHANTIX	2	MO
CHANTIX CONTINUING MONTH BOX	2	MO
CHANTIX STARTING MONTH BOX	2	MO
NICOTROL	3	MO
NICOTROL NS	3	MO

Drug Name	Drug Tier	Requirements /Limits
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
<i>azelastine nasal</i>	1	MO; QL (60 per 30 days)
BACTROBAN NASAL	2	MO
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)
<i>olopatadine nasal</i>	1	MO; QL (30.5 per 30 days)
<i>periogard</i>	1	MO
<i>triamcinolone acetate dental</i>	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetazol hc</i>	1	MO
<i>acetic acid otic</i>	1	MO
<i>floxin otic drops</i>	1	
<i>fluocinolone acetate oil</i>	1	MO
<i>hydrocortisone-acetic acid</i>	1	MO
<i>ofloxacin otic</i>	1	MO
OTIC STEROID / ANTIBIOTIC		
CIPRODEX	2	MO
<i>neomycin-polymyxin-hc otic</i>	1	MO
OTOVEL	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
<i>cortisone</i>	1	MO
<i>dexamethasone intensol</i>	1	MO
<i>dexamethasone oral elixir</i>	1	MO
<i>dexamethasone oral tablet</i>	1	MO
<i>dexamethasone sodium phosphate injection solution</i>	1	MO
<i>fludrocortisone</i>	1	MO
<i>hydrocortisone oral</i>	1	MO
<i>methylprednisolone acetate</i>	1	MO
<i>methylprednisolone oral tablet</i>	1	PA; MO
<i>methylprednisolone oral tablets, dose pack</i>	1	MO
<i>methylprednisolone sodium succ injection recon soln 125 mg, 40 mg</i>	1	MO
<i>methylprednisolone sodium succ intravenous</i>	1	MO
<i>millipred oral tablet</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 15 mg/5 ml (3 mg/ml), 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	1	MO
<i>prednisolone sodium phosphate oral tablet, disintegrating</i>	1	PA; MO
<i>prednisone intensol</i>	1	PA; MO
<i>prednisone oral solution</i>	1	MO
<i>prednisone oral tablet</i>	1	PA; MO
<i>prednisone oral tablets, dose pack</i>	1	MO
<i>veripred 20</i>	1	MO
ANTITHYROID AGENTS		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
<i>propylthiouracil</i>	1	MO
DIABETES THERAPY		
<i>acarbose oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>acarbose oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>acarbose oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
ALCOHOL PADS	2	MO
APIDRA	3	ST; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
APIDRA SOLOSTAR	3	ST; MO
BYDUREON	2	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	2	PA; MO; QL (1.2 per 30 days)
CYCLOSET	3	MO; QL (180 per 30 days)
FARXIGA ORAL TABLET 10 MG	2	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	2	MO; QL (60 per 30 days)
GAUZE PADS 2 X 2	2	MO
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)
<i>glimepiride oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)
<i>glimepiride oral tablet 4 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide oral tablet 5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide-metformin oral tablet 2.5-250 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 per 30 days)
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY KIT (HUMAN)	2	MO
HUMALOG	2	MO
HUMALOG KWIKPEN	2	MO
HUMALOG MIX 50-50	2	MO
HUMALOG MIX 50-50 KWIKPEN	2	MO
HUMALOG MIX 75-25	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO
HUMULIN 70/30	2	MO
HUMULIN 70/30 KWIKPEN	2	MO
HUMULIN N	2	MO
HUMULIN N KWIKPEN	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
HUMULIN R U-100	2	MO
HUMULIN R U-500 (CONC) KWIKPEN	2	MO
HUMULIN R U-500 (CONCENTRATED)	2	MO
INSULIN PEN NEEDLE	2	MO
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	2	MO
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	2	MO; QL (120 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	2	MO; QL (120 per 30 days)
INVOKANA ORAL TABLET 100 MG	2	MO; QL (90 per 30 days)
INVOKANA ORAL TABLET 300 MG	2	MO; QL (30 per 30 days)
JANUMET	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	2	MO; QL (60 per 30 days)
JANUVIA	2	MO; QL (30 per 30 days)
JARDIANCE	2	MO; QL (30 per 30 days)
JENTADUETO	3	ST; MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	3	ST; MO; QL (60 per 30 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	3	ST; MO; QL (30 per 30 days)
KAZANO	3	ST; MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 2.5-1,000 MG	2	MO; QL (60 per 30 days)
KOMBIGLYZE XR ORAL TABLET, ER MULTIPHASE 24 HR 5-1,000 MG, 5-500 MG	2	MO; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
LANTUS	2	MO
LANTUS SOLOSTAR	2	MO
LEVEMIR	2	MO
LEVEMIR FLEXTOUCH	2	MO
<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)
<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
<i>metformin oral tablet 850 mg</i>	1	MO; QL (90 per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	MO; QL (120 per 30 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	MO; QL (75 per 30 days)
<i>miglitol oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>miglitol oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>miglitol oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
<i>nateglinide oral tablet 120 mg</i>	1	MO; QL (90 per 30 days)
<i>nateglinide oral tablet 60 mg</i>	1	MO; QL (180 per 30 days)
NEEDLES, INSULIN DISP., SAFETY	2	MO
NESINA	3	ST; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
NOVOFINE 32	2	MO
NOVOLOG	3	ST; MO
NOVOLOG FLEXPEN	3	ST; MO
NOVOLOG MIX 70-30	3	ST; MO
NOVOLOG MIX 70-30 FLEXPEN	3	ST; MO
NOVOLOG PENFILL	3	ST; MO
ONGLYZA	2	MO; QL (30 per 30 days)
<i>pioglitazone</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-glimepiride</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-metformin</i>	1	MO; QL (90 per 30 days)
PROGLYCEM	2	MO
<i>repaglinide oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>repaglinide oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)
<i>repaglinide-metformin</i>	1	MO; QL (150 per 30 days)
RIOMET	2	MO; QL (765 per 30 days)
SYMLINPEN 120	4	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	4	PA; MO; QL (6 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
SYNJARDY ORAL TABLET 5-500 MG	2	MO; QL (120 per 30 days)
TANZEUM	3	PA; MO; QL (4 per 28 days)
<i>tolazamide oral tablet 250 mg</i>	1	MO; QL (120 per 30 days)
<i>tolazamide oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>tolbutamide</i>	1	MO; QL (180 per 30 days)
TOUJEO SOLOSTAR	2	MO
TRADJENTA	3	ST; MO; QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100	2	MO
TRESIBA FLEXTOUCH U-200	2	MO
TRULICITY	3	PA; MO; QL (2 per 28 days)
VGO 20	2	MO
VGO 30	2	MO
VGO 40	2	MO
VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG	2	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-500 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
MISCELLANEOUS HORMONES		
ALDURAZYME	4	MO
ANADROL-50	4	PA; MO
ANDRODERM	2	PA; MO
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	2	PA; MO
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM), 1.62 % (40.5 MG/2.5 GRAM)	2	PA; MO
AXIRON	3	PA; MO
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon)</i>	1	MO
<i>calcitriol intravenous solution 1 mcg/ml</i>	1	MO
<i>calcitriol oral</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
CERDELGA	4	MO
CEREZYME INTRAVENOUS RECON SOLN 400 UNIT	4	MO
<i>danazol</i>	1	MO
<i>desmopressin injection</i>	1	MO
<i>desmopressin nasal solution</i>	1	
<i>desmopressin nasal spray, non-aerosol</i>	1	MO
<i>desmopressin oral</i>	1	MO
<i>doxercalciferol intravenous</i>	1	
<i>doxercalciferol oral</i>	1	MO
ELAPRASE	4	MO
FABRAZYME INTRAVENOUS RECON SOLN 35 MG	4	MO
FORTESTA	3	PA; MO
KANUMA	4	MO
KORLYM	4	MO
KUVAN	4	MO
LUMIZYME	4	MO
<i>methyltestosterone oral capsule</i>	4	MO
MIACALCIN INJECTION	3	MO
MYALEPT	4	PA; MO; LA
NAGLAZYME	4	MO; LA

Drug Name	Drug Tier	Requirements /Limits
NATPARA	4	PA; MO; LA
<i>oxandrolone oral tablet 10 mg</i>	4	PA; MO
<i>oxandrolone oral tablet 2.5 mg</i>	1	PA; MO
<i>pamidronate intravenous solution</i>	1	MO
<i>paricalcitol intravenous</i>	1	
<i>paricalcitol oral</i>	1	MO
SAMSCA	4	PA; MO
SENSIPAR ORAL TABLET 30 MG	2	MO
SENSIPAR ORAL TABLET 60 MG, 90 MG	4	MO
SOMAVERT	4	MO
STIMATE	2	MO
STRENSIQ	4	MO; LA
SYNAREL	4	MO
TESTIM	3	PA; MO
<i>testosterone cypionate</i>	1	MO
<i>testosterone enanthate</i>	1	MO
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	1	PA; MO
<i>testosterone transdermal gel in packet</i>	1	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ZAVESCA	4	MO; LA
<i>zoledronic acid intravenous solution</i>	1	PA; MO
THYROID HORMONES		
<i>levothyroxine oral</i>	1	MO
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO
<i>liothyronine</i>	1	MO
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
<i>atropine injection syringe 0.05 mg/ml</i>	1	
<i>dicyclomine intramuscular</i>	1	
<i>dicyclomine oral capsule</i>	1	MO
<i>dicyclomine oral solution</i>	1	MO
<i>dicyclomine oral tablet</i>	1	MO
<i>diphenoxylate-atropine</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>glycopyrrolate injection</i>	1	MO
<i>glycopyrrolate oral</i>	1	MO
<i>loperamide oral capsule</i>	1	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron</i>	4	MO
ALOXI	4	MO
AMITIZA	2	MO
<i>aprepitant</i>	1	PA; MO
APRISO	3	MO
ASACOL HD	2	MO
<i>balsalazide</i>	1	MO
<i>budesonide oral</i>	4	MO
CHENODAL	4	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	4	PA; MO
CHOLBAM ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
CIMZIA	4	PA; MO
CIMZIA POWDER FOR RECONST	4	PA; MO
<i>colocort</i>	1	MO
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 - 60,000 UNIT, 24,000-76,000 - 120,000 UNIT, 3,000-9,500- 15,000 UNIT, 6,000-19,000 -30,000 UNIT	2	MO
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 36,000-114,000-180,000 UNIT	4	MO
<i>cromolyn oral</i>	1	MO
CYSTADANE	4	MO
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	2	MO
DIPENTUM	4	MO
<i>dronabinol oral capsule 10 mg</i>	4	PA; MO
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	1	PA; MO
EMEND INTRAVENOUS	2	MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	2	PA
<i>emulose</i>	1	MO
GATTEX 30-VIAL	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>gavilyte-h and bisacodyl</i>	1	MO
<i>gavilyte-n</i>	1	MO
<i>generlac</i>	1	MO
<i>granisetron (pf) intravenous solution 100 mcg/ml</i>	1	MO
<i>granisetron hcl intravenous</i>	1	MO
<i>granisetron hcl oral</i>	1	PA; MO
<i>hydrocortisone rectal</i>	1	MO
INFLECTRA	4	PA; MO
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO
LIALDA	2	MO
LINZESS	2	MO
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO
<i>mesalamine with cleansing wipe</i>	1	MO
<i>metoclopramide hcl injection solution</i>	1	MO
<i>metoclopramide hcl oral</i>	1	MO
MOVANTIK	2	MO
MOVIPREP	3	MO
OICALIVA	4	PA; MO; LA; QL (30 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>ondansetron</i>	1	PA; MO
<i>ondansetron hcl (pf)</i>	1	MO
<i>ondansetron hcl oral solution</i>	1	PA; MO
<i>ondansetron hcl oral tablet 24 mg</i>	1	PA
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	PA; MO
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	1	MO
<i>peg-electrolyte soln</i>	1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	2	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	4	MO
<i>polyethylene glycol 3350 oral powder</i>	1	MO
<i>prochlorperazine</i>	1	MO
<i>prochlorperazine edisylate injection solution 10 mg/2 ml (5 mg/ml)</i>	1	MO
<i>prochlorperazine maleate oral</i>	1	MO
<i>procto-med hc</i>	1	MO
<i>procto-pak</i>	1	MO
<i>proctosol hc topical</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>proctozone-hc</i>	1	MO
RECTIV	2	MO
RELISTOR SUBCUTANEOUS SOLUTION	4	MO
RELISTOR SUBCUTANEOUS SYRINGE	4	MO
REMICADE	4	PA; MO
SANCUSO	4	MO
SUCRAID	4	MO
<i>sulfasalazine</i>	1	MO
SUPREP BOWEL PREP KIT	2	MO
TRANSDERM-SCOP	3	MO
<i>trilyte with flavor packets</i>	1	MO
UCERIS ORAL	4	MO
<i>ursodiol</i>	1	MO
VARUBI	2	PA; MO
VIBERZI	4	MO
VIOKACE	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-34,000 - 55,000 UNIT, 15,000-51,000 - 82,000 UNIT, 20,000-68,000 - 109,000 UNIT, 25,000-85,000-136,000 UNIT, 3,000-10,000-16,000 UNIT, 5,000-17,000 -27,000 UNIT	2	MO

ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40,000-136,000-218,000 UNIT	4	MO
--	---	----

ULCER THERAPY

<i>amoxicil-clarithromy-lansopraz</i>	1	MO; QL (112 per 30 days)
---------------------------------------	---	--------------------------

<i>cimetidine</i>	1	MO
-------------------	---	----

<i>cimetidine hcl oral</i>	1	MO
----------------------------	---	----

DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 30 MG	3	MO; QL (30 per 30 days)
---	---	-------------------------

DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 60 MG	3	MO
---	---	----

Drug Name	Drug Tier	Requirements /Limits
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)

<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO
---	---	----

<i>esomeprazole sodium</i>	1	
----------------------------	---	--

<i>famotidine (pf)</i>	1	MO
------------------------	---	----

<i>famotidine (pf)-nacl (iso-os)</i>	1	MO
--------------------------------------	---	----

<i>famotidine oral suspension</i>	1	MO
-----------------------------------	---	----

<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO
--	---	----

<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg</i>	1	MO; QL (30 per 30 days)
---	---	-------------------------

<i>lansoprazole oral capsule,delayed release(dr/ec) 30 mg</i>	1	MO
---	---	----

<i>misoprostol</i>	1	MO
--------------------	---	----

NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	2	MO; QL (30 per 30 days)
--	---	-------------------------

NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	2	MO
---	---	----

<i>nizatidine</i>	1	MO
-------------------	---	----

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>omeprazole oral capsule, delayed release(dr/ec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>omeprazole oral capsule, delayed release(dr/ec) 40 mg</i>	1	MO
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram</i>	1	MO; QL (30 per 30 days)
<i>omeprazole-sodium bicarbonate oral capsule 40-1.1 mg-gram</i>	1	MO
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i>	1	MO; QL (30 per 30 days)
<i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i>	1	MO
<i>pantoprazole intravenous</i>	1	MO
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	1	MO
PYLERA	2	MO
<i>rabeprazole</i>	1	MO
<i>ranitidine hcl injection solution 50 mg/2 ml (25 mg/ml)</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>ranitidine hcl oral capsule</i>	1	MO
<i>ranitidine hcl oral syrup</i>	1	MO
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	1	MO
<i>sucralfate oral tablet</i>	1	MO

IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

BIOTECHNOLOGY DRUGS

ACTIMMUNE	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML, 60 MCG/ML	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 150 MCG/0.75 ML	4	PA
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML	3	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	3	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	4	PA; MO
ARCALYST	4	PA; MO
AVONEX (WITH ALBUMIN)	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	4	PA; MO; QL (4 per 28 days)
BETASERON SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO

Drug Name	Drug Tier	Requirements /Limits
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	4	PA; MO
EXTAVIA SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)
GRANIX	4	PA; MO
ILARIS (PF) SUBCUTANEOUS RECON SOLN	4	PA; MO; LA
INTRON A INJECTION RECON SOLN 10 MILLION UNIT (1 ML)	2	PA; MO
INTRON A INJECTION RECON SOLN 18 MILLION UNIT (1 ML), 50 MILLION UNIT (1 ML)	4	PA; MO
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	2	PA; MO
LEUKINE INJECTION RECON SOLN	4	MO
MOZOBIL	4	MO
NEULASTA SUBCUTANEOUS SYRINGE	4	PA; MO
NEUPOGEN	4	PA; MO
NORDITROPIN FLEXPRO	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
OMNITROPE	4	PA; MO
PEGASYS PROCLICK	4	MO; QL (2 per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION	4	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	4	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	2	PA; MO

Drug Name	Drug Tier	Requirements /Limits
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	4	PA; MO
PROLEUKIN	4	PA; MO
REBIF (WITH ALBUMIN)	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	4	PA; MO; QL (4.2 per 180 days)
REBIF TITRATION PACK	4	PA; MO; QL (4.2 per 180 days)
SYLATRON	4	MO
ZARXIO	4	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT) (PF) INTRAMUSCULA R SUSPENSION	2	MO
BCG VACCINE, LIVE (PF)	2	MO
BEXSERO	2	MO
BOOSTRIX TDAP	2	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
BOTOX	2	PA; MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
ENGERIX-B PEDIATRIC (PF)	2	PA; MO
<i>fomepizole</i>	1	MO
GAMASTAN S/D	2	MO
GARDASIL 9 (PF)	2	MO
GRASTEK	2	PA; MO
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	2	
HIBERIX (PF)	2	MO
IMOGAM RABIES-HT (PF)	2	MO
IMOVAX RABIES VACCINE (PF)	2	MO
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	2	MO
IPOL	2	MO
IXIARO (PF)	2	MO

Drug Name	Drug Tier	Requirements /Limits
KINRIX (PF) INTRAMUSCULAR SUSPENSION	2	
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	2	MO
MENOMUNE - A/C/Y/W-135 (PF)	2	MO
MENVEO A-C-Y-W-135-DIP (PF)	2	MO
M-M-R II (PF)	2	MO
PEDIARIX (PF)	2	MO
PEDVAX HIB (PF)	2	MO
PRIVIGEN	4	PA; MO
PROQUAD (PF)	2	MO
QUADRACEL (PF)	2	
RABAVERT (PF)	2	MO
RAGWITEK	2	MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	2	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	2	PA
ROTARIX	2	
ROTATEQ VACCINE	2	MO
TENIVAC (PF) INTRAMUSCULAR SYRINGE	2	MO
TETANUS, DIPHTHERIA TOX PED (PF)	2	MO
TETANUS-DIPHTHERIA TOXOIDS-TD	2	MO
TRUMENBA	2	MO
TWINRIX (PF) INTRAMUSCULAR SUSPENSION	2	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
TYPHIM VI INTRAMUSCULAR SYRINGE	2	MO
VAQTA (PF) INTRAMUSCULAR SYRINGE	2	MO
VARIVAX (PF)	2	MO
VARIZIG INTRAMUSCULAR SOLUTION	2	MO
YF-VAX (PF)	2	MO

Drug Name	Drug Tier	Requirements /Limits
ZOSTAVAX (PF)	2	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol</i>	1	MO
<i>allopurinol sodium</i>	1	
<i>aloprim</i>	1	
COLCRYS	3	ST; MO
MITIGARE	2	MO
<i>probenecid</i>	1	MO
<i>probenecid-colchicine</i>	1	MO
ULORIC	2	ST; MO
OSTEOPOROSIS THERAPY		
<i>alendronate oral solution</i>	1	MO; QL (1286 per 30 days)
<i>alendronate oral tablet 10 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
FORTEO	4	PA; MO; QL (2.4 per 28 days)
FOSAMAX PLUS D	3	ST; MO; QL (4 per 28 days)
<i>ibandronate intravenous solution</i>	1	PA; MO
<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
PROLIA	2	PA; MO
<i>raloxifene</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>risedronate oral tablet 150 mg</i>	1	MO; QL (1 per 30 days)
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	1	MO; QL (4 per 28 days)
<i>risedronate oral tablet 5 mg</i>	1	MO; QL (30 per 30 days)
<i>risedronate oral tablet, delayed release (dr/ec)</i>	1	MO; QL (4 per 28 days)
TYMLOS	4	PA; MO; QL (1.56 per 30 days)

OTHER RHEUMATOLOGICALS

ACTEMRA	4	PA; MO
BENLYSTA INTRAVENOUS	4	MO
CUPRIMINE	4	MO
DEPEN TITRATABS	4	MO
ENBREL	4	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	4	PA; MO; QL (8 per 28 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	4	PA; MO; QL (3 per 180 days)

Drug Name	Drug Tier	Requirements /Limits
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	4	PA; MO; QL (6 per 180 days)
HUMIRA PEN	4	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHN'S-UC-HS START	4	PA; MO; QL (6 per 180 days)
HUMIRA PEN PSORIASIS-UVEITIS	4	PA; MO; QL (4 per 180 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	4	PA; MO; QL (2 per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	4	PA; MO; QL (4 per 28 days)
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
ORENCIA	4	PA; MO
ORENCIA (WITH MALTOSE)	4	PA; MO
ORENCIA CLICKJECT	4	PA; MO
OTEZLA	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	4	PA; MO
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG(19)	4	PA
RASUVO (PF)	2	MO
RIDAURA	4	MO
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (55 per 30 days)
SIMPONI	4	PA; MO
SIMPONI ARIA	4	PA; MO
XELJANZ	4	PA; MO
XELJANZ XR	4	PA; MO
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
<i>camila</i>	1	MO
CRINONE VAGINAL GEL 4 %	3	MO
CRINONE VAGINAL GEL 8 %	3	PA; MO
<i>deblitane</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
DEPO-PROVERA INTRAMUSCULAR SOLUTION	2	MO
DEPO-SUBQ PROVERA 104	3	MO
DUAVEE	2	MO
<i>errin</i>	1	MO
ESTRACE VAGINAL	2	MO
<i>estradiol oral</i>	1	PA; MO
<i>estradiol transdermal patch semiweekly</i>	1	PA; MO; QL (8 per 28 days)
<i>estradiol transdermal patch weekly</i>	1	PA; MO; QL (4 per 28 days)
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	MO
<i>estradiol-norethindrone acet</i>	1	PA; MO
ESTRING	2	MO
<i>hydroxyprogesterone caproate</i>	4	MO
<i>jolivette</i>	1	MO
<i>lyza</i>	1	MO
MAKENA INTRAMUSCULAR OIL 250 MG/ML (1 ML)	4	MO
<i>medroxyprogesterone intramuscular suspension</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>medroxyprogesterone oral</i>	1	MO
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	2	PA; MO
<i>nora-be</i>	1	MO
<i>norethindrone (contraceptive)</i>	1	MO
<i>norethindrone acetate</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	PA; MO
<i>norlyroc</i>	1	
PREMARIN ORAL	2	MO
<i>progesterone micronized</i>	1	MO
<i>sharobel</i>	1	MO
<i>yuvafem</i>	1	MO
MISCELLANEOUS OB/GYN		
CLEOCIN VAGINAL SUPPOSITORY	2	MO
<i>clindamycin phosphate vaginal</i>	1	MO
<i>metronidazole vaginal</i>	1	MO
<i>miconazole-3 vaginal suppository</i>	1	MO
<i>terconazole</i>	1	MO
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>xulane</i>	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>alyacen 1/35 (28)</i>	1	MO
<i>amethia</i>	1	MO
<i>amethia lo</i>	1	MO
<i>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>ashlyna</i>	1	MO
<i>aubra</i>	1	MO
<i>aviane</i>	1	MO
<i>balziva (28)</i>	1	MO
<i>bekyree (28)</i>	1	MO
<i>blisovi 24 fe</i>	1	MO
<i>blisovi fe 1.5/30 (28)</i>	1	MO
<i>blisovi fe 1/20 (28)</i>	1	MO
<i>briellyn</i>	1	MO
<i>camrese lo</i>	1	MO
<i>caziant (28)</i>	1	MO
<i>cryselle (28)</i>	1	MO
<i>cyclafem 1/35 (28)</i>	1	MO
<i>cyclafem 7/7/7 (28)</i>	1	MO
<i>delyla (28)</i>	1	
<i>desog-e.estradiol/e.estradiol</i>	1	MO
<i>drospirenone-e.estradiol-lm.fa</i>	1	MO
<i>drospirenone-ethinyl estradiol</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>emoquette</i>	1	MO
<i>enpresse</i>	1	MO
<i>ethynodiol diac-eth estradiol</i>	1	
<i>falmina (28)</i>	1	MO
<i>fayosim</i>	1	MO
<i>femynor</i>	1	
<i>gianvi (28)</i>	1	MO
<i>gildagia</i>	1	MO
<i>introvale</i>	1	MO
<i>juleber</i>	1	MO
<i>junel 1.5/30 (21)</i>	1	MO
<i>junel 1/20 (21)</i>	1	MO
<i>junel fe 1.5/30 (28)</i>	1	MO
<i>junel fe 1/20 (28)</i>	1	MO
<i>junel fe 24</i>	1	MO
<i>kaitlib fe</i>	1	MO
<i>kariva (28)</i>	1	MO
<i>kelnor 1/35 (28)</i>	1	MO
<i>kimidess (28)</i>	1	MO
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-30 mcg (84)/10 mcg (7)</i>	1	MO
<i>larin 1.5/30 (21)</i>	1	MO
<i>larin 1/20 (21)</i>	1	MO
<i>larin fe 1.5/30 (28)</i>	1	MO
<i>larin fe 1/20 (28)</i>	1	MO
<i>larissia</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>layolis fe</i>	1	MO
<i>leena 28</i>	1	MO
<i>lessina</i>	1	MO
<i>levonest (28)</i>	1	MO
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 90-20 mcg</i>	1	MO
<i>levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month</i>	1	MO
<i>levonorg-eth estrad triphasic</i>	1	MO
<i>levora-28</i>	1	MO
<i>lomedica 24 fe</i>	1	MO
<i>loryna (28)</i>	1	MO
<i>low-ogestrel (28)</i>	1	MO
<i>lutra (28)</i>	1	MO
<i>marlissa</i>	1	MO
<i>mibelas 24 fe</i>	1	MO
<i>microgestin 1.5/30 (21)</i>	1	MO
<i>microgestin 1/20 (21)</i>	1	MO
<i>microgestin fe 1.5/30 (28)</i>	1	MO
<i>microgestin fe 1/20 (28)</i>	1	MO
<i>mononessa (28)</i>	1	MO
<i>necon 0.5/35 (28)</i>	1	MO
<i>necon 1/50 (28)</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>necon 10/11 (28)</i>	1	
<i>necon 7/7/7 (28)</i>	1	MO
<i>nikki (28)</i>	1	MO
<i>noreth-ethinyl estradiol-iron oral tablet, chewable 0.4mg-35mcg(21) and 75 mg (7)</i>	1	
<i>noreth-ethinyl estradiol-iron oral tablet, chewable 0.8mg-25mcg(24) and 75 mg (4)</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	1	MO
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4)</i>	1	MO
<i>norethindrone-e.estradiol-iron oral tablet, chewable</i>	1	MO
<i>norgestimate-ethinyl estradiol</i>	1	MO
<i>nortrel 0.5/35 (28)</i>	1	MO
<i>nortrel 1/35 (21)</i>	1	MO
<i>nortrel 1/35 (28)</i>	1	MO
<i>nortrel 7/7/7 (28)</i>	1	MO
<i>ocella</i>	1	MO
<i>ogestrel (28)</i>	1	MO
<i>orsythia</i>	1	MO
<i>pimtrea (28)</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>pirmella oral tablet 1-35 mg-mcg</i>	1	MO
<i>portia</i>	1	MO
<i>previfem</i>	1	MO
<i>quasense</i>	1	MO
<i>reclipsen (28)</i>	1	MO
<i>rivelsa</i>	1	MO
<i>setlakin</i>	1	MO
<i>sprintec (28)</i>	1	MO
<i>sronyx</i>	1	MO
<i>tarina fe 1/20 (28)</i>	1	MO
<i>tri-legest fe</i>	1	MO
<i>tri-lo-estarylla</i>	1	MO
<i>tri-lo-sprintec</i>	1	MO
<i>trinessa (28)</i>	1	MO
<i>tri-previfem (28)</i>	1	MO
<i>tri-sprintec (28)</i>	1	MO
<i>trivora (28)</i>	1	MO
<i>velivet triphasic regimen (28)</i>	1	MO
<i>vestura (28)</i>	1	MO
<i>vienva</i>	1	MO
<i>vyfemla (28)</i>	1	MO
<i>wymzya fe</i>	1	MO
<i>zarah</i>	1	MO
<i>zenchent (28)</i>	1	MO
<i>zenchent fe</i>	1	MO
<i>zovia 1/35e (28)</i>	1	MO
<i>zovia 1/50e (28)</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
OPHTHALMOLOGY		
ANTIBIOTICS		
AZASITE	2	MO
<i>bacitracin ophthalmic</i>	1	MO
<i>bacitracin-polymyxin b ophthalmic</i>	1	MO
BESIVANCE	2	MO
<i>ciprofloxacin hcl ophthalmic</i>	1	MO
<i>erythromycin ophthalmic</i>	1	MO
<i>gatifloxacin</i>	1	MO
<i>gentak ophthalmic ointment</i>	1	MO
<i>gentamicin ophthalmic drops</i>	1	MO
<i>levofloxacin ophthalmic</i>	1	MO
NATACYN	2	MO
<i>neomycin-bacitracin-polymyxin</i>	1	MO
<i>neomycin-polymyxin-gramicidin</i>	1	MO
<i>ofloxacin ophthalmic</i>	1	MO
<i>polymyxin b sulf-trimethoprim</i>	1	MO
<i>tobramycin</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
TOBREX OPHTHALMIC OINTMENT	2	MO
ANTIVIRALS		
<i>trifluridine</i>	1	MO
ZIRGAN	3	MO
BETA-BLOCKERS		
<i>betaxolol ophthalmic</i>	1	MO
<i>carteolol</i>	1	MO
<i>levobunolol ophthalmic drops 0.5 %</i>	1	MO
<i>metipranolol</i>	1	
<i>timolol maleate ophthalmic</i>	1	MO
CHOLINESTERASE INHIBITOR MIOTICS		
PHOSPHOLINE IODIDE	2	MO
CYCLOPLEGIC MYDRIATICS		
<i>atropine ophthalmic drops</i>	1	MO
DIRECT ACTING MIOTICS		
<i>pilocarpine hcl ophthalmic drops 1 %, 2 %, 4 %</i>	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
<i>azelastine ophthalmic</i>	1	MO
BEPREVE	3	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>cromolyn ophthalmic</i>	1	MO
CYSTARAN	4	MO
<i>epinastine</i>	1	MO
LASTACAPT	3	MO
<i>olopatadine ophthalmic</i>	1	MO
PAZEO	2	MO
RESTASIS	2	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	2	MO; QL (5.5 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
<i>bromfenac</i>	1	MO
BROMSITE	2	MO
<i>diclofenac sodium ophthalmic</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
ILEVRO	2	MO
<i>ketorolac ophthalmic</i>	1	MO
PROLENSA	2	MO
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide</i>	1	MO
<i>acetazolamide sodium</i>	1	MO
<i>methazolamide</i>	1	MO
OTHER GLAUCOMA DRUGS		
<i>bimatoprost ophthalmic</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
COMBIGAN	2	MO
<i>dorzolamide</i>	1	MO
<i>dorzolamide-timolol</i>	1	MO
<i>latanoprost</i>	1	MO
LUMIGAN OPTHALMIC DROPS 0.01 %	2	MO
SIMBRINZA	3	MO
TRAVATAN Z	2	MO
ZIOPTAN (PF)	3	ST; MO
STEROID-ANTIBIOTIC COMBINATIONS		
<i>neomycin-bacitracin-poly-hc</i>	1	MO
<i>neomycin-polymyxin b-dexameth</i>	1	MO
<i>neomycin-polymyxin-hc ophthalmic</i>	1	MO
<i>tobramycin-dexamethasone</i>	1	MO
ZYLET	2	MO
STERIODS		
ALREX	3	MO
<i>dexamethasone sodium phosphate ophthalmic</i>	1	MO
<i>fluorometholone</i>	1	MO
FML S.O.P.	2	MO
LOTEMAX	2	MO
<i>prednisolone acetate</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>prednisolone sodium phosphate ophthalmic</i>	1	MO

STEROID-SULFONAMIDE COMBINATIONS

BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
<i>sulfacetamide-prednisolone</i>	1	MO

SULFONAMIDES

<i>sulfacetamide sodium ophthalmic</i>	1	MO
--	---	----

SYMPATHOMIMETICS

ALPHAGAN P OPHTHALMIC DROPS 0.1 %	2	MO
<i>apraclonidine</i>	1	MO
<i>brimonidine</i>	1	MO
IOPIDINE OPHTHALMIC DROPPERETTE	3	MO

RESPIRATORY AND ALLERGY

ANTI-HISTAMINE / ANTI-ALLERGENIC AGENTS

<i>adrenalin injection solution 1 mg/ml (1 ml)</i>	1	
<i>cetirizine oral solution 1 mg/ml</i>	1	MO
<i>desloratadine</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>diphenhydramine hcl injection solution 50 mg/ml</i>	1	MO

EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML, 0.3 MG/0.3 ML (manufactured by Mylan Specialty)	2	MO; QL (4 per 30 days)
---	---	------------------------

EPIPEN 2-PAK	2	MO; QL (4 per 30 days)
--------------	---	------------------------

EPIPEN JR 2-PAK	2	MO; QL (4 per 30 days)
-----------------	---	------------------------

<i>hydroxyzine hcl oral tablet</i>	1	PA; MO
------------------------------------	---	--------

<i>levocetirizine oral solution</i>	1	MO
-------------------------------------	---	----

<i>levocetirizine oral tablet</i>	1	MO; QL (30 per 30 days)
-----------------------------------	---	-------------------------

<i>promethazine injection solution</i>	1	MO
--	---	----

<i>promethazine oral</i>	1	PA; MO
--------------------------	---	--------

PULMONARY AGENTS

<i>acetylcysteine</i>	1	PA; MO
-----------------------	---	--------

ADCIRCA	4	PA; MO; QL (60 per 30 days)
---------	---	-----------------------------

ADEMPAS	4	PA; MO; LA
---------	---	------------

ADVAIR DISKUS	2	MO; QL (60 per 30 days)
---------------	---	-------------------------

ADVAIR HFA	2	MO; QL (12 per 30 days)
------------	---	-------------------------

AEROSPAN	2	MO; QL (17.8 per 30 days)
----------	---	---------------------------

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 5 mg/ml</i>	1	PA; MO
<i>albuterol sulfate oral</i>	1	MO
ANORO ELLIPTA	2	MO; QL (60 per 30 days)
ARCAPTA NEOHALER	2	MO; QL (30 per 30 days)
ARNUITY ELLIPTA	2	MO; QL (30 per 30 days)
ASMANEX HFA	2	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	2	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (120 DOSES)	2	MO; QL (2 per 30 days)
ATROVENT HFA	2	MO; QL (25.8 per 30 days)
BEVESPI AEROSPHERE	2	MO; QL (10.7 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
BREO ELLIPTA	2	MO; QL (60 per 30 days)
<i>budesonide inhalation</i>	1	PA; MO
<i>budesonide nasal</i>	1	MO; QL (17.2 per 30 days)
CINRYZE	4	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	PA; MO
DALIRESP	3	PA; MO
DULERA	2	MO; QL (13 per 30 days)
DYMISTA	2	MO; QL (23 per 30 days)
ESBRIET ORAL CAPSULE	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 267 MG	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 801 MG	4	PA; MO; QL (90 per 30 days)
FIRAZYR	4	PA; MO
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION , 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	1	MO; QL (50 per 30 days)
<i>fluticasone nasal</i>	1	MO; QL (16 per 30 days)
<i>ipratropium bromide inhalation</i>	1	PA; MO
<i>ipratropium-albuterol</i>	1	PA; MO
KALYDECO ORAL GRANULES IN PACKET	4	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	4	PA; MO; QL (60 per 30 days)
LETAIRIS	4	PA; MO; LA
<i>levalbuterol hcl</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>metaproterenol</i>	1	MO
<i>mometasone nasal</i>	1	MO; QL (34 per 30 days)
<i>montelukast</i>	1	MO
NUCALA	4	PA; MO; LA; QL (1 per 28 days)
OFEV	4	PA; MO; QL (60 per 30 days)
OPSUMIT	4	PA; MO; LA
ORKAMBI	4	PA; MO; QL (112 per 28 days)
PERFOROMIST	2	PA; MO
PROAIR HFA	2	MO; QL (17 per 30 days)
PROAIR RESPICLICK	2	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	2	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	2	MO; QL (1 per 30 days)
PULMOZYME	4	PA; MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	2	MO; QL (4.9 per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	2	MO; QL (8.7 per 30 days)
QVAR	2	MO; QL (17.4 per 30 days)
SEREVENT DISKUS	2	MO; QL (60 per 30 days)
<i>sildenafil intravenous</i>	4	PA
<i>sildenafil oral</i>	1	PA; MO; QL (90 per 30 days)
SPIRIVA RESPIMAT	2	MO; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	2	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)
SYMBICORT	2	MO; QL (10.2 per 30 days)
<i>terbutaline</i>	1	MO
THEO-24	2	MO
<i>theophylline oral solution</i>	1	MO
<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
TRACLEER	4	PA; MO; LA
<i>triamcinolone acetonide nasal</i>	1	MO; QL (16.5 per 30 days)
TUDORZA PRESSAIR	2	MO; QL (1 per 30 days)
VENTOLIN HFA	2	MO; QL (36 per 30 days)
XOLAIR	4	PA; MO; LA; QL (6 per 28 days)
<i>zafirlukast</i>	1	MO
<i>zileuton</i>	4	MO
ZYFLO	4	MO

UROLOGICALS

ANTICHOLINERGICS / ANTISPASMODICS

<i>darifenacin</i>	1	MO
<i>flavoxate</i>	1	MO
MYRBETRIQ	2	MO
<i>oxybutynin chloride</i>	1	MO
<i>tolterodine</i>	1	MO
TOVIAZ	2	MO
<i>tropium</i>	1	MO
VESICARE	2	MO

BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY

<i>alfuzosin</i>	1	MO
<i>dutasteride</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>dutasteride-tamsulosin</i>	1	MO
<i>finasteride oral tablet 5 mg</i>	1	MO
RAPAFLO	2	ST; MO
<i>tamsulosin</i>	1	MO

CHOLINERGIC STIMULANTS

<i>bethanechol chloride</i>	1	MO
-----------------------------	---	----

MISCELLANEOUS UROLOGICALS

CIALIS ORAL TABLET 2.5 MG, 5 MG	2	PA; MO; QL (30 per 30 days)
---------------------------------	---	-----------------------------

CYSTAGON	2	MO; LA
----------	---	--------

ELMIRON	2	MO
---------	---	----

<i>potassium citrate</i>	1	MO
--------------------------	---	----

VITAMINS, HEMATINICS / ELECTROLYTES

ELECTROLYTES

<i>calcium acetate oral capsule</i>	1	MO
-------------------------------------	---	----

<i>calcium acetate oral tablet 667 mg</i>	1	MO
---	---	----

<i>eliphos</i>	1	MO
----------------	---	----

<i>klor-con 10</i>	1	MO
--------------------	---	----

<i>klor-con 8</i>	1	MO
-------------------	---	----

<i>klor-con m10</i>	1	MO
---------------------	---	----

<i>klor-con m15</i>	1	MO
---------------------	---	----

<i>klor-con m20</i>	1	MO
---------------------	---	----

<i>klor-con sprinkle</i>	1	MO
--------------------------	---	----

Drug Name	Drug Tier	Requirements /Limits
K-TAB ORAL TABLET EXTENDED RELEASE 20 MEQ	3	MO
<i>k-tab oral tablet extended release 8 meq</i>	1	MO
<i>lactated ringers intravenous</i>	1	MO
<i>magnesium sulfate injection solution</i>	1	MO
<i>magnesium sulfate injection syringe</i>	1	
NORMOSOL-R IN 5 % DEXTROSE	2	
<i>potassium chlorid-d5-0.45%nacl intravenous parenteral solution 10 meq/l, 30 meq/l, 40 meq/l</i>	1	
<i>potassium chlorid-d5-0.45%nacl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l</i>	1	
<i>potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l, 40 meq/l</i>	1	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride intravenous piggyback 10 meq/100 ml</i>	1	MO
<i>potassium chloride intravenous piggyback 20 meq/100 ml, 40 meq/100 ml</i>	1	
<i>potassium chloride intravenous solution</i>	1	
<i>potassium chloride oral capsule, extended release</i>	1	MO
<i>potassium chloride oral liquid</i>	1	MO
<i>potassium chloride oral tablet extended release</i>	1	MO
<i>potassium chloride oral tablet,er particles/crystals</i>	1	MO
<i>potassium chloride-0.45 % nacl</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 40 meq/l</i>	1	
<i>ringer's intravenous</i>	1	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride 3 %</i>	1	MO
<i>sodium chloride 5 %</i>	1	
<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	1	MO
<i>sodium lactate intravenous</i>	1	
MISCELLANEOUS NUTRITION PRODUCTS		
<i>amino acids 15 %</i>	1	PA
AMINOSYN 7 % WITH ELECTROLYTES	2	PA
AMINOSYN 8.5 %-ELECTROLYTES	2	PA

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Drug Name	Drug Tier	Requirements /Limits
AMINOSYN II 10 %	2	PA
AMINOSYN II 15 %	2	PA
AMINOSYN II 7 %	2	PA
AMINOSYN II 8.5 %	2	PA
AMINOSYN II 8.5 %- ELECTROLYTES	2	PA
AMINOSYN-HBC 7%	2	PA
AMINOSYN-PF 10 %	2	PA
AMINOSYN-PF 7 % (SULFITE-FREE)	2	PA
AMINOSYN-RF 5.2 %	2	PA
CLINIMIX 5%/D15W SULFITE FREE	2	PA
CLINIMIX 5%/D25W SULFITE-FREE	2	PA
CLINIMIX 2.75%/D5W SULFIT FREE	2	PA
CLINIMIX 4.25%/D10W SULF FREE	2	PA
CLINIMIX 4.25%-D20W SULF-FREE	2	PA
CLINIMIX 4.25%-D25W SULF-FREE	2	PA

Drug Name	Drug Tier	Requirements /Limits
CLINIMIX 5%-D20W(SULFITE-FREE)	2	PA
HEPATAMINE 8%	2	PA
<i>intralipid intravenous emulsion 20 %</i>	1	PA
IONOSOL-MB IN D5W	2	
ISOLYTE-P IN 5 % DEXTROSE	2	
ISOLYTE-S	2	
NEPHRAMINE 5.4 %	2	PA
NORMOSOL-R PH 7.4	2	
PLASMA-LYTE 148	2	
PLASMA-LYTE A	2	
<i>premasol 10 %</i>	1	PA; MO
PREMASOL 6 %	2	PA
<i>travasol 10 %</i>	1	PA; MO
TROPHAMINE 10 %	2	PA; MO
TROPHAMINE 6%	2	PA
VITAMINS / HEMATINICS		
<i>fluoride (sodium) oral tablet</i>	1	MO
<i>prenatal vitamin oral tablet</i>	1	MO

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

Index

A		
abacavir	1	
abacavir-lamivudine	1	
abacavir-lamivudine- zidovudine	1	
ABELCET	1	
ABILIFY MAINTENA	26	
ABRAXANE	10	
acamprosate	43	
acarbose	46	
acebutolol	34	
acetaminophen-codeine	22	
acetazol hc	45	
acetazolamide	67	
acetazolamide sodium	67	
acetic acid	45	
acetylcysteine	68	
acitretin	39	
ACTEMRA	61	
ACTHIB (PF)	58	
ACTIMMUNE	56	
acyclovir	1, 42	
acyclovir sodium	1	
ADACEL(TDAP ADOLESN/ADULT)(PF)	58	
ADAGEN	43	
adapalene	40	
ADCIRCA	68	
adefovir	1	
ADEMPAS	68	
adrenalin	68	
adriamycin	10	
adrucil	10	
ADVAIR DISKUS	68	
ADVAIR HFA	68	
AEROSPAN	68	
afeditab cr	34	
AFINITOR	10	
AFINITOR DISPERZ	10	
ala-cort	42	
ALBENZA	6	
albuterol sulfate	69	
alclometasone	42	
ALCOHOL PADS	46	
ALDURAZYME	50	
ALECENSA	10	
alendronate	43, 60	
alfuzosin	71	
ALIMTA	10	
ALINIA	6	
allopurinol	60	
allopurinol sodium	60	
almotriptan malate	20	
aloprim	60	
alose tron	52	
ALOXI	52	
ALPHAGAN P	68	
ALREX	67	
ALUNBRIG	10	
alyacen 1/35 (28)	63	
amantadine hcl	1	
AMBISOME	1	
amcinonide	42	
amethia	63	
amethia lo	63	
amikacin	6	
amiloride	34	
amiloride-hydrochlorothiazide	34	
amino acids 15 %	73	
AMINOSYN 7 % WITH ELECTROLYTES	73	
AMINOSYN 8.5 %- ELECTROLYTES	73	
AMINOSYN II 10 %	74	
AMINOSYN II 15 %	74	
AMINOSYN II 7 %	74	
AMINOSYN II 8.5 %	74	
AMINOSYN II 8.5 %- ELECTROLYTES	74	
AMINOSYN-HBC 7%	74	
AMINOSYN-PF 10 %	74	
AMINOSYN-PF 7 % (SULFITE-FREE)	74	
AMINOSYN-RF 5.2 %	74	
amiodarone	34	
AMITIZA	52	
amitriptyline	26	
amlodipine	34	
amlodipine-atorvastatin	38	
amlodipine-benazepril	34	
amlodipine-olmesartan	34	
amlodipine-valsartan	35	
amlodipine-valsartan-hcthiamid	35	
ammonium lactate	40	
amoxapine	26	
amoxicil-clarithromy-lansopraz	55	
amoxicillin	7, 8	
amoxicillin-pot clavulanate	8	
amphotericin b	1	
ampicillin	8	
ampicillin sodium	8	
ampicillin-sulbactam	8	
AMPYRA	21	
ANADROL-50	50	
anagrelide	43	
anastrozole	10	
ANDRODERM	50	
ANDROGEL	50	
ANORO ELLIPTA	69	
apexicon e	42	
APIDRA	46	
APIDRA SOLOSTAR	47	
APOKYN	20	
apraclonidine	68	
aprepitant	52	
apri	63	
APRISO	52	
APTIOM	18	
APTIVUS	1	
ARALAST NP	44	
aranelle (28)	63	
ARANESP (IN POLYSORBATE)	56, 57	

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

ARCALYST.....	57	balziva (28).....	63	BRILINTA	37
ARCAPTA NEOHALER.....	69	BANZEL	18	brimonidine.....	68
aripiprazole.....	26	BARACLUDE.....	2	BRIVIACT	18
ARISTADA.....	27	BAVENCIO	10	bromfenac	67
armodafinil	27	BCG VACCINE, LIVE (PF).....	58	bromocriptine	20
ARNUITY ELLIPTA.....	69	bekyree (28).....	63	BROMSITE.....	67
ARRANON	10	BELEODAQ	11	budesonide.....	52, 69
ASACOL HD	52	benazepril	35	bumetanide	35
ashlyna.....	63	benazepril-hydrochlorothiazide	35	BUPHENYL.....	44
ASMANEX HFA	69	BENLYSTA	61	buprenorphine hcl.....	22
ASMANEX TWISTHALER.....	69	benztropine	20	buprenorphine-naloxone.....	25
aspirin-dipyridamole	37	BEPREVE	66	bupropion hcl.....	27
atenolol.....	35	BESIVANCE.....	66	bupropion hcl (smoking deter)	45
atenolol-chlorthalidone.....	35	betamethasone dipropionate.....	42	buspirone	27
atomoxetine	27	betamethasone valerate.....	42	busulfan	11
atorvastatin	38	betamethasone, augmented.....	42	BUSULFEX	11
atovaquone	6	BETASERON	57	butorphanol tartrate	25
atovaquone-proguanil.....	6	betaxolol.....	35, 66	BUTRANS	22
ATRIPLA	1	bethanechol chloride.....	72	BYDUREON.....	47
atropine.....	52, 66	BETHKIS	6	BYETTA	47
ATROVENT HFA	69	BEVESPI AEROSPHERE.....	69	BYSTOLIC.....	35
AUBAGIO	21	bexarotene	11	BYVALSON	35
aubra.....	63	BEXSERO.....	58	C	
AUGMENTIN.....	8	bicalutamide	11	cabergoline	50
AVASTIN	10	BICILLIN C-R	8	CABOMETYX.....	11
aviane	63	BICILLIN L-A	8	calcipotriene	39
avita.....	40	BICNU.....	11	calcipotriene-betamethasone.....	40
AVONEX.....	57	BIDIL	35	calcitonin (salmon)	50
AVONEX (WITH ALBUMIN)	57	BILTRICIDE.....	6	calcitriol.....	40, 50
AXIRON	50	bimatoprost.....	67	calcium acetate	72
azacitidine.....	10	bisoprolol fumarate.....	35	camila	62
AZASITE	66	bisoprolol-hydrochlorothiazide	35	camrese lo.....	63
azathioprine.....	10	bleomycin	11	CANCIDAS.....	1
azathioprine sodium	10	BLEPHAMIDE	68	candesartan	35
azelastine.....	45, 66	BLEPHAMIDE S.O.P.....	68	candesartan-hydrochlorothiazid	35
azithromycin.....	5	blisovi 24 fe.....	63	CAPASTAT	6
aztreonam	6	blisovi fe 1.5/30 (28).....	63	CAPEX.....	42
B		blisovi fe 1/20 (28).....	63	CAPRELSA.....	11
baciim	6	BOOSTRIX TDAP.....	58	captopril.....	35
bacitracin	6, 66	BOSULIF	11	captopril-hydrochlorothiazide	35
bacitracin-polymyxin b	66	BOTOX	59	CARAC	40
baclufen.....	21	BREO ELLIPTA	69	CARBAGLU	44
BACTROBAN NASAL.....	45	briellyn.....	63		
balsalazide.....	52				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

carbamazepine.....	18	chloroquine phosphate.....	6	CLINIMIX 4.25%/D10W	
carbidopa.....	20	chlorothiazide.....	35	SULF FREE.....	74
carbidopa-levodopa.....	20	chlorothiazide sodium.....	35	CLINIMIX 4.25%/D5W	
carbidopa-levodopa-		chlorpromazine.....	27	SULFIT FREE.....	44
entacapone.....	20	chlorthalidone.....	35	CLINIMIX 4.25%-D20W	
carboplatin.....	11	CHOLBAM.....	52	SULF-FREE.....	74
carteolol.....	66	cholestyramine (with sugar).....	38	CLINIMIX 4.25%-D25W	
cartia xt.....	35	cholestyramine light.....	38	SULF-FREE.....	74
carvedilol.....	35	CIALIS.....	72	CLINIMIX 5%-	
CAYSTON.....	6	ciclopirox.....	41	D20W(SULFITE-FREE).....	74
caziant (28).....	63	cidofovir.....	2	clobetasol.....	42
cefaclor.....	4	cilostazol.....	37	clobetasol-emollient.....	42
cefadroxil.....	4	cimetidine.....	55	clodan.....	42
cefazolin.....	4	cimetidine hcl.....	55	clofarabine.....	11
cefdinir.....	4	CIMZIA.....	52	CLOLAR.....	11
cefepime.....	4	CIMZIA POWDER FOR		clomipramine.....	27
cefixime.....	4	RECONST.....	52	clonazepam.....	18
cefotaxime.....	4	CINRYZE.....	69	clonidine.....	35
cefotetan.....	4	CIPRODEX.....	45	clonidine hcl.....	27, 35
cefoxitin.....	5	ciprofloxacin.....	9	clopidogrel.....	37
cefpodoxime.....	5	ciprofloxacin (mixture).....	9	clorazepate dipotassium.....	27
cefprozil.....	5	ciprofloxacin hcl.....	9, 66	clotrimazole.....	1, 41
ceftazidime.....	5	ciprofloxacin in 5 % dextrose.....	9	clotrimazole-betamethasone.....	41
ceftriaxone.....	5	ciprofloxacin lactate.....	9	clozapine.....	27
cefuroxime axetil.....	5	cisplatin.....	11	COARTEM.....	6
cefuroxime sodium.....	5	citalopram.....	27	codeine sulfate.....	22
celecoxib.....	25	cladribine.....	11	COLCRYS.....	60
CELLCEPT INTRAVENOUS		claravis.....	40	colestipol.....	38
.....	11	clarithromycin.....	5	colistin (colistimethate na).....	6
CELONTIN.....	18	CLEOCIN.....	63	colocort.....	52
cephalexin.....	5	clindacin p.....	40	COMBIGAN.....	67
CERDELGA.....	51	clindamycin hcl.....	6	COMBIVENT RESPIMAT.....	69
CEREZYME.....	51	clindamycin in 5 % dextrose.....	6	COMETRIQ.....	11
cetirizine.....	68	clindamycin pediatric.....	6	COMPLERA.....	2
cevimeline.....	44	clindamycin phosphate.....	6, 40,	compro.....	52
CHANTIX.....	45	63		CONDYLOX.....	40
CHANTIX CONTINUING		clindamycin-benzoyl peroxide		constulose.....	52
MONTH BOX.....	45	.....	40	COPAXONE.....	21
CHANTIX STARTING		clindamycin-tretinoin.....	40	COREG CR.....	35
MONTH BOX.....	45	CLINIMIX 5%/D15W		CORLANOR.....	39
CHEMET.....	44	SULFITE FREE.....	74	cormax.....	42
CHENODAL.....	52	CLINIMIX 5%/D25W		CORTIFOAM.....	52
chloramphenicol sod succinate		SULFITE-FREE.....	74	cortisone.....	46
.....	6	CLINIMIX 2.75%/D5W		COSENTYX (2 SYRINGES)	
chlorhexidine gluconate.....	45	SULFIT FREE.....	74	.....	40

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

COSENTYX PEN (2 PENS)	40	diclofenac sodium	25, 40, 67
COSMEGEN	11	diclofenac-misoprostol	25
COTELLIC	11	dicloxacillin	8
CREON	53	dicyclomine	52
CRESEMBA	1	didanosine	2
CRINONE	62	diflorasone	42
CRIXIVAN	2	diflunisal	25
cromolyn	53, 67, 69	digitek	37
cryselle (28)	63	digoxin	37
CUPRIMINE	61	dihydroergotamine	20
cyclafem 1/35 (28)	63	DILANTIN 30 MG	18
cyclafem 7/7/7 (28)	63	diltiazem hcl	35
cyclobenzaprine	22	dilt-xr	35
CYCLOPHOSPHAMIDE	11	DIPENTUM	53
CYCLOSET	47	diphenhydramine hcl	68
cyclosporine	11	diphenoxylate-atropine	52
cyclosporine modified	11	dipyridamole	37
CYRAMZA	11	disulfiram	44
CYSTADANE	53	divalproex	18
CYSTAGON	72	docetaxel	11
CYSTARAN	67	dofetilide	34
cytarabine	11	donepezil	21
cytarabine (pf)	11	dorzolamide	67
D		dorzolamide-timolol	67
d10 %-0.45 % sodium chloride	44	doxazosin	35
d2.5 %-0.45 % sodium chloride	44	doxepin	28, 40
d5 % and 0.9 % sodium chloride	44	doxercalciferol	51
d5 %-0.45 % sodium chloride	44	doxorubicin	11
dacarbazine	11	doxorubicin, peg-liposomal	11
DALIRESP	69	doxy-100	9
danazol	51	doxycycline hyclate	9
dantrolene	22	doxycycline monohydrate	9
dapsone	6	dronabinol	53
DAPTACEL (DTAP PEDIATRIC) (PF)	59	drospirenone-e.estradiol-lm.fa	63
daptomycin	6	drospirenone-ethinyl estradiol	63
DARAPRIM	6	DROXIA	12
darifenacin	71	DUAVEE	62
DARZALEX	11	DULERA	69
daunorubicin	11	duloxetine	28
deblitane	62	DUPIXENT	40
decitabine	11	duramorph (pf)	22
delyla (28)	63	dutasteride	71
DELZICOL	53	dutasteride-tamsulosin	72
demeclocycline	9		
DEMSEER	35		
DENAVIR	42		
DEPEN TITRATABS	61		
DEPO-PROVERA	62		
DEPO-SUBQ PROVERA	104		
DESCOVY	2		
desipramine	27		
desloratadine	68		
desmopressin	51		
desog-e.estradiol/e.estradiol	63		
desonide	42		
desoximetasone	42		
desvenlafaxine succinate	27		
dexamethasone	46		
dexamethasone intensol	46		
dexamethasone sodium phosphate	46, 67		
DEXILANT	55		
dexmethylphenidate	27		
dexrazoxane hcl	10		
dextroamphetamine	28		
dextroamphetamine-amphetamine	28		
dextrose 10 % and 0.2 % nacl	44		
dextrose 10 % in water (d10w)	44		
dextrose 5 % in water (d5w)	44		
dextrose 5 %-lactated ringers	44		
dextrose 5%-0.2 % sod chloride	44		
dextrose 5%-0.3 % sod.chloride	44		
dextrose with sodium chloride	44		
DIASTAT	18		
DIASTAT ACUDIAL	18		
diazepam	28		
diazepam intensol	28		
diclofenac potassium	25		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

DYMISTA.....	69	eprosartan	35	F	
E		ERBITUX.....	12	FABRAZYME	51
e.e.s. 400.....	5	ergoloid.....	28	falmina (28).....	64
econazole.....	41	ergotamine-caffeine.....	20	famciclovir.....	2
EDARBI.....	35	ERIVEDGE	12	famotidine.....	55
EDARBYCLOR.....	35	errin	62	famotidine (pf).....	55
EDURANT.....	2	ERWINAZE	12	famotidine (pf)-nacl (iso-os).....	55
EFFIENT.....	37	ery pads.....	40	FANAPT.....	28
ELAPRASE.....	51	erygel.....	40	FARESTON	12
eliphos.....	72	ery-tab.....	5	FARXIGA	47
ELIQUIS	37	ERY-TAB.....	5	FARYDAK.....	12
ELITEK.....	10	ERYTHROCIN	5	FASLODEX	12
ELMIRON.....	72	erythrocin (as stearate).....	5	fayosim	64
EMCYT.....	12	erythromycin	6, 66	FAZACLO.....	28
EMEND.....	53	erythromycin ethylsuccinate.....	5	felbamate	18
emoquette	64	erythromycin with ethanol...40,		felodipine.....	36
EMPLICITI.....	12	41		femynor.....	64
EMSAM	28	erythromycin-benzoyl peroxide		fenofibrate.....	38
EMTRIVA.....	2	.....	41	fenofibrate micronized.....	38
EMVERM	6	ESBRIET.....	69	fenofibrate nanocrystallized ..	38
enalapril maleate	35	escitalopram oxalate	28	fenofibric acid.....	38
enalapril-hydrochlorothiazide		esomeprazole magnesium.....	55	fenofibric acid (choline)	38
.....	35	esomeprazole sodium	55	fenopropfen.....	25
ENBREL	61	ESTRACE	62	fentanyl.....	22
ENBREL SURECLICK	61	estradiol	62	fentanyl citrate	22
endocet	22	estradiol valerate.....	62	FERRIPROX	44
ENGERIX-B (PF).....	59	estradiol-norethindrone acet.....	62	FETZIMA	28, 29
ENGERIX-B PEDIATRIC		ESTRING	62	finasteride	72
(PF).....	59	eszopiclone.....	28	FIRAZYR.....	69
enoxaparin.....	37	ethacrynate sodium.....	35	FIRMAGON KIT W	
enpresse	64	ethacrynic acid.....	35	DILUENT SYRINGE	12
entacapone.....	20	ethambutol.....	6	flavoxate	71
entecavir	2	ethosuximide	18	flecainide	34
ENTRESTO	39	ethynodiol diac-eth estradiol ..	64	FLECTOR	25
enulose.....	53	etidronate disodium	44	FLOVENT DISKUS	69, 70
EPCLUSA.....	2	etodolac	25	FLOVENT HFA.....	70
epinastine.....	67	ETOPOPHOS.....	12	floxin.....	45
EPINEPHRINE.....	68	etoposide.....	12	fluconazole	1
EPIPEN 2-PAK.....	68	EVOTAZ.....	2	fluconazole in nacl (iso-osm) ..	1
EPIPEN JR 2-PAK.....	68	exemestane	12	flucytosine	1
epirubicin.....	12	EXJADE.....	44	fludarabine.....	12
epitol.....	18	EXTAVIA	57	fludrocortisone.....	46
EPIVIR HBV.....	2	ezetimibe	38	flunisolide.....	70
eplerenone	35	ezetimibe-simvastatin.....	38	fluocinolone.....	42
EPOGEN	57			fluocinolone acetonide oil	45

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

fluocinonide.....	42	gavilyte-n.....	53	HERCEPTIN.....	13
fluocinonide-e.....	42	gemcitabine.....	12	HETLIOZ.....	29
fluoride (sodium).....	74	gemfibrozil.....	38	HEXALEN.....	13
fluorometholone.....	67	generlac.....	53	HIBERIX (PF).....	59
fluorouracil.....	12, 40	gengraf.....	12	HUMALOG.....	47
FLUOROURACIL.....	40	gentak.....	66	HUMALOG KWIKPEN.....	47
fluoxetine.....	29	gentamicin.....	6, 41, 66	HUMALOG MIX 50-50.....	47
fluphenazine decanoate.....	29	gentamicin in nacl (iso-osm).....	6	HUMALOG MIX 50-50	
fluphenazine hcl.....	29	gentamicin sulfate (pf).....	7	KWIKPEN.....	47
flurandrenolide.....	42	GENVOYA.....	2	HUMALOG MIX 75-25.....	47
flurbiprofen.....	25	GEODON.....	29	HUMALOG MIX 75-25	
flurbiprofen sodium.....	67	gianvi (28).....	64	KWIKPEN.....	47
flutamide.....	12	gildagia.....	64	HUMIRA.....	61
fluticasone.....	43, 70	GILENYA.....	21	HUMIRA PEDIATRIC	
fluvastatin.....	38	GILOTRIF.....	12	CROHN'S START.....	61
fluvoxamine.....	29	glatopa.....	21	HUMIRA PEN.....	61
FML S.O.P.....	67	GLEOSTINE.....	12	HUMIRA PEN CROHN'S-	
FOLOTYN.....	12	glimepiride.....	47	UC-HS START.....	61
fomepizole.....	59	glipizide.....	47	HUMIRA PEN PSORIASIS-	
fondaparinux.....	38	glipizide-metformin.....	47	UVEITIS.....	61
FORFIVO XL.....	29	GLUCAGEN HYPOKIT.....	47	HUMULIN 70/30.....	47
FORTEO.....	60	GLUCAGON EMERGENCY		HUMULIN 70/30 KWIKPEN	
FORTESTA.....	51	KIT (HUMAN).....	47	.....	47
FOSAMAX PLUS D.....	60	glycopyrrolate.....	52	HUMULIN N.....	47
fosinopril.....	36	GRALISE.....	19	HUMULIN N KWIKPEN.....	47
fosinopril-hydrochlorothiazide		GRALISE 30-DAY STARTER		HUMULIN R U-100.....	48
.....	36	PACK.....	18	HUMULIN R U-500 (CONC)	
fosphenytoin.....	18	granisetron (pf).....	53	KWIKPEN.....	48
frovatriptan.....	21	granisetron hcl.....	53	HUMULIN R U-500	
furosemide.....	36	GRANIX.....	57	(CONCENTRATED).....	48
FUZEON.....	2	GRASTEK.....	59	hydralazine.....	36
FYCOMPA.....	18	griseofulvin microsize.....	1	hydrochlorothiazide.....	36
G		griseofulvin ultramicrosize.....	1	hydrocodone-acetaminophen.....	22
gabapentin.....	18	guanidine.....	29	hydrocodone-ibuprofen.....	23
GABITRIL.....	18	H		hydrocortisone.....	43, 46, 53
galantamine.....	21	HALAVEN.....	12	hydrocortisone butyrate.....	43
GAMASTAN S/D.....	59	halobetasol propionate.....	43	hydrocortisone butyr-emollient	
ganciclovir sodium.....	2	haloperidol.....	29	.....	43
GARDASIL 9 (PF).....	59	haloperidol decanoate.....	29	hydrocortisone valerate.....	43
gatifloxacin.....	66	haloperidol lactate.....	29	hydrocortisone-acetic acid.....	45
GATTEX 30-VIAL.....	53	HARVONI.....	2	hydromorphone.....	23
GAUZE PAD.....	47	HAVRIX (PF).....	59	hydromorphone (pf).....	23
gavilyte-c.....	53	heparin (porcine).....	38	hydroxychloroquine.....	7
gavilyte-g.....	53	heparin (porcine) in 5 % dex.....	38	hydroxyprogesterone caproate	
gavilyte-h and bisacodyl.....	53	HEPATAMINE 8%.....	74	.....	62

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

hydroxyurea.....	13	ipratropium bromide.....	45, 70	KAZANO	48
hydroxyzine hcl.....	68	ipratropium-albuterol.....	70	kelnor 1/35 (28).....	64
I		irbesartan	36	KEPIVANCE	10
ibandronate.....	60	irbesartan-hydrochlorothiazide		KERYDIN	41
IBRANCE	13	.....	36	ketoconazole	1, 41
ibuprofen	25	IRESSA	13	ketoprofen.....	25
ibuprofen-oxycodone	23	irinotecan	13	ketorolac	67
ICLUSIG	13	ISENTRESS	2	KEYTRUDA	13
idarubicin.....	13	ISOLYTE-P IN 5 %		kimidess (28).....	64
ifosfamide.....	13	DEXTROSE	74	KINRIX (PF).....	59
ILARIS (PF).....	57	ISOLYTE-S.....	74	kionex	44
ILEVRO	67	isoniazid.....	7	KISQALI	13
imatinib.....	13	isosorbide dinitrate	39	KISQALI FEMARA CO-	
IMBRUVICA	13	isosorbide mononitrate	39	PACK	13
IMFINZI.....	13	isradipine	36	klor-con 10.....	72
imipenem-cilastatin	7	ISTODAX	13	klor-con 8.....	72
imipramine hcl.....	29	itraconazole	1	klor-con m10	72
imipramine pamoate	29	ivermectin.....	7	klor-con m15	72
imiquimod	40	IXIARO (PF).....	59	klor-con m20	72
IMOGAM RABIES-HT (PF)		J		klor-con sprinkle.....	72
.....	59	JADENU	44	KOMBIGLYZE XR	48
IMOVAX RABIES VACCINE		JAKAFI	13	KORLYM.....	51
(PF).....	59	jantoven	38	k-tab.....	72
INCRELEX	44	JANUMET	48	K-TAB.....	72
indapamide	36	JANUMET XR.....	48	KUVAN.....	51
INFANRIX (DTAP) (PF).....	59	JANUVIA.....	48	KYPROLIS.....	13
INFLECTRA.....	53	JARDIANCE.....	48	L	
INLYTA	13	JENTADUETO	48	l norgest/e.estradiol-e.estrad.	64
INSULIN PEN NEEDLE.....	48	JENTADUETO XR.....	48	labetalol	36
INSULIN SYRINGE (DISP)		JEVTANA	13	lactated ringers.....	43, 72
U-100.....	48	jolivette.....	62	lactulose	53
INTELENCE	2	juleber.....	64	lamivudine	2
intralipid	74	junel 1.5/30 (21).....	64	lamivudine-zidovudine	2
INTRON A	57	junel 1/20 (21).....	64	lamotrigine.....	19
introvale.....	64	junel fe 1.5/30 (28).....	64	LANOXIN	37
INVANZ.....	7	junel fe 1/20 (28).....	64	lansoprazole.....	55
INVEGA SUSTENNA.....	29	junel fe 24.....	64	LANTUS	49
INVEGA TRINZA	29	JUXTAPID	38	LANTUS SOLOSTAR.....	49
INVIRASE	2	K		larin 1.5/30 (21).....	64
INVOKAMET.....	48	KADCYLA	13	larin 1/20 (21).....	64
INVOKAMET XR	48	kaitlib fe.....	64	larin fe 1.5/30 (28).....	64
INVOKANA	48	KALETRA	2	larin fe 1/20 (28).....	64
IONOSOL-MB IN D5W.....	74	KALYDECO	70	larissia.....	64
IOPIDINE.....	68	KANUMA	51	LARTRUVO	13
IPOL	59	kariva (28)	64	LASTACFT	67

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

latanoprost.....	67	lisinopril.....	36	maprotiline.....	30
LATUDA.....	30	lisinopril-hydrochlorothiazide		marlissa.....	64
layolis fe.....	64	.....	36	MARPLAN.....	30
leena 28.....	64	lithium carbonate.....	30	MATULANE.....	14
leflunomide.....	61	lithium citrate.....	30	matzim la.....	36
LENVIMA.....	13	LIVALO.....	39	meclizine.....	53
lessina.....	64	LOCOID.....	43	meclofenamate.....	25
LETAIRIS.....	70	lomedica 24 fe.....	64	medroxyprogesterone.....	62, 63
letrozole.....	13	LONSURF.....	13	mefenamic acid.....	25
leucovorin calcium.....	10	loperamide.....	52	mefloquine.....	7
LEUKERAN.....	13	lopinavir-ritonavir.....	2	megestrol.....	14
LEUKINE.....	57	lorazepam.....	30	MEKINIST.....	14
leuprolide.....	13	lorazepam intensol.....	30	meloxicam.....	25
levabuterol hcl.....	70	lorcet (hydrocodone).....	23	melphalan hcl.....	14
LEVEMIR.....	49	lorcet hd.....	23	memantine.....	21
LEVEMIR FLEXTOUCH.....	49	lorcet plus.....	23	MENACTRA (PF).....	59
levetiracetam.....	19	lortab 10-325.....	23	MENEST.....	63
levetiracetam in nacl (iso-os).....	19	lortab 5-325.....	23	MENOMUNE - A/C/Y/W-135	
levobunolol.....	66	lortab 7.5-325.....	23	(PF).....	59
levocarnitine.....	44	loryna (28).....	64	MENVEO A-C-Y-W-135-DIP	
levocarnitine (with sugar).....	44	losartan.....	36	(PF).....	59
levocetirizine.....	68	losartan-hydrochlorothiazide.....	36	mercaptopurine.....	14
levofloxacin.....	9, 66	LOTEMAX.....	67	meropenem.....	7
levofloxacin in d5w.....	9	lovastatin.....	39	mesalamine with cleansing	
levoleucovorin.....	10	low-ogestrel (28).....	64	wipe.....	53
levonest (28).....	64	loxapine succinate.....	30	mesna.....	10
levonorgestrel-ethinyl estrad.....	64	LUMIGAN.....	67	MESNEX.....	10
levonorg-eth estrad triphasic.....	64	LUMIZYME.....	51	MESTINON.....	22
levora-28.....	64	LUPRON DEPOT.....	13	metadate er.....	30
levorphanol tartrate.....	23	LUPRON DEPOT (3		metaproterenol.....	70
levothyroxine.....	52	MONTH).....	13	metformin.....	49
levoxyl.....	52	LUPRON DEPOT (4		methadone.....	23
LEXIVA.....	2	MONTH).....	13	methamphetamine.....	30
LIALDA.....	53	LUPRON DEPOT (6		methazolamide.....	67
lidocaine.....	41	MONTH).....	14	methenamine hippurate.....	9
lidocaine (pf).....	41	LUPRON DEPOT-PED.....	14	methimazole.....	46
lidocaine hcl.....	41	lutura (28).....	64	methotrexate sodium.....	14
lidocaine viscous.....	41	LYNPARZA.....	14	methotrexate sodium (pf).....	14
lidocaine-prilocaine.....	41	LYRICA.....	19	methoxsalen.....	40
lincomycin.....	7	LYSODREN.....	14	methylclothiazide.....	36
lindane.....	43	lyza.....	62	methyldopa.....	36
linezolid.....	7	M		methylphenidate hcl.....	30
LINZESS.....	53	magnesium sulfate.....	72	methylprednisolone.....	46
LIORESAL.....	22	MAKENA.....	62	methylprednisolone acetate.....	46
liothyronine.....	52	malathion.....	43		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

methylprednisolone sodium succ.....	46	MOVIPREP.....	53	neomycin-polymyxin b gu....	43
methyltestosterone.....	51	moxifloxacin.....	9	neomycin-polymyxin b-dexameth.....	67
metipranolol.....	66	MOZOBIL.....	57	neomycin-polymyxin-gramacidin.....	66
metoclopramide hcl.....	53	mupirocin.....	41	neomycin-polymyxin-hc.45, 67	
metolazone.....	36	mupirocin calcium.....	41	NEPHRAMINE 5.4 %.....	74
metoprolol succinate.....	36	MUSTARGEN.....	14	NESINA.....	49
metoprolol ta-hydrochlorothiaz.....	36	MYALEPT.....	51	neuac.....	41
metoprolol tartrate.....	36	MYCAMINE.....	1	NEULASTA.....	57
metronidazole.....	7, 41, 63	mycophenolate mofetil.....	14	NEUPOGEN.....	57
metronidazole in nacl (iso-os) 7		mycophenolate mofetil hcl... 14		NEUPRO.....	20
mexiletine.....	34	mycophenolate sodium.....	14	nevirapine.....	3
MIACALCIN.....	51	myorisan.....	41	NEXAVAR.....	14
mibelas 24 fe.....	64	MYRBETRIQ.....	71	NEXIUM PACKET.....	55
miconazole-3.....	63	N		niacin.....	39
microgestin 1.5/30 (21).....	64	nabumetone.....	25	nicardipine.....	36
microgestin 1/20 (21).....	64	nadolol.....	36	NICOTROL.....	45
microgestin fe 1.5/30 (28)....	64	nadolol-bendroflumethiazide	36	NICOTROL NS.....	45
microgestin fe 1/20 (28).....	64	nafacillin.....	8	nifedipine.....	36
midodrine.....	44	naftifine.....	41	nikki (28).....	65
migergot.....	21	NAFTIN.....	42	nilutamide.....	14
miglitol.....	49	NAGLAZYME.....	51	nimodipine.....	36
millipred.....	46	nalbuphine.....	25	NINLARO.....	14
minocycline.....	9	naloxone.....	25	nisoldipine.....	36
minoxidil.....	36	naltrexone.....	25	nitro-bid.....	39
mirtazapine.....	30	NAMENDA XR.....	21	nitrofurantoin.....	9
misoprostol.....	55	NAMZARIC.....	21	nitrofurantoin macrocrystal..	10
MITIGARE.....	60	naproxen.....	25	nitrofurantoin monohyd/m-cryst.....	10
mitomycin.....	14	naproxen sodium.....	25	nitroglycerin.....	39
mitoxantrone.....	14	naratriptan.....	21	nizatidine.....	55
M-M-R II (PF).....	59	NARCAN.....	26	nolix.....	43
modafinil.....	30	NATACYN.....	66	nora-be.....	63
moderiba.....	2	nateglinide.....	49	NORDITROPIN FLEXPRO 57	
moderiba dose pack.....	3	NATPARA.....	51	noreth-ethinyl estradiol-iron	65
moexipril.....	36	NEBUPENT.....	7	norethindrone (contraceptive).....	63
moexipril-hydrochlorothiazide.....	36	necon 0.5/35 (28).....	64	norethindrone acetate.....	63
mometasone.....	43, 70	necon 1/50 (28).....	64	norethindrone ac-eth estradiol.....	63, 65
mononessa (28).....	64	necon 10/11 (28).....	65	norethindrone-e.estradiol-iron.....	65
montelukast.....	70	necon 7/7/7 (28).....	65	norgestimate-ethinyl estradiol.....	65
morgidox.....	9	NEEDLES, INSULIN			
morphine.....	23, 24	DISP.,SAFETY.....	49		
morphine concentrate.....	23	nefazodone.....	30		
MOVANTIK.....	53	neomycin.....	7		
		neomycin-bacitracin-poly-hc	67		
		neomycin-bacitracin-polymyxin.....	66		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

norlyroc	63	omeprazole	56	paroxetine hcl	31
NORMOSOL-R IN 5 %		omeprazole-sodium		PASER.....	7
DEXTROSE	72	bicarbonate	56	PAXIL	31
NORMOSOL-R PH 7.4	74	OMNITROPE.....	58	PAZEO	67
NORTHERA	44	ondansetron	54	PEDIARIX (PF)	59
nortrel 0.5/35 (28)	65	ondansetron hcl.....	54	PEDVAX HIB (PF).....	59
nortrel 1/35 (21)	65	ondansetron hcl (pf).....	54	peg 3350-electrolytes.....	54
nortrel 1/35 (28)	65	ONFI.....	19	PEGANONE.....	20
nortrel 7/7/7 (28)	65	ONGLYZA.....	49	PEGASYS	58
nortriptyline.....	30	OPDIVO	15	PEGASYS PROCLICK.....	58
NORVIR.....	3	OPSUMIT	70	peg-electrolyte soln	54
NOVOFINE 32	49	ORAVIG	1	PENICILLIN G POT IN	
NOVOLOG	49	ORENCIA	61	DEXTROSE	8
NOVOLOG FLEXPEN.....	49	ORENCIA (WITH		penicillin g potassium.....	8
NOVOLOG MIX 70-30	49	MALTOSE).....	61	penicillin g procaine	8
NOVOLOG MIX 70-30		ORENCIA CLICKJECT	61	penicillin g sodium	8
FLEXPEN	49	ORFADIN	44	penicillin v potassium.....	8
NOVOLOG PENFILL	49	ORKAMBI	70	PENTAM.....	7
NOXAFIL	1	orsythia	65	PENTASA	54
NUCALA	70	oseltamivir	3	pentoxifylline.....	38
NUEDEXTA	21	OTEZLA	61	PERFOROMIST.....	70
NULOJIX	14	OTEZLA STARTER.....	62	perindopril erbumine	37
NUPLAZID.....	30	OTOVEL	45	perio gard.....	45
nyamyc	42	oxacillin.....	8	PERJETA	15
nyata	42	oxacillin in dextrose(iso-osm)	8	permethrin.....	43
nystatin	1, 42	oxaliplatin.....	15	perphenazine.....	31
nystatin-triamcinolone.....	42	oxandrolone.....	51	phenelzine.....	31
nystop	42	oxaprozin	26	phenobarbital	20
O		oxcarbazepine.....	19	phenoxybenzamine	37
OCALIVA.....	53	oxiconazole.....	42	phenytoin	20
ocella	65	oxybutynin chloride.....	71	phenytoin sodium	20
octreotide acetate.....	14, 15	oxycodone	24	phenytoin sodium extended ..	20
ODEFSEY	3	oxycodone-acetaminophen...	24	PHOSPHOLINE IODIDE ...	66
ODOMZO	15	oxycodone-aspirin	24	PICATO.....	40
OFEV	70	OXYCONTIN	24	pilocarpine hcl	44, 66
ofloxacin.....	9, 45, 66	oxymorphone.....	24	pimozide	31
ogestrel (28).....	65	P		pimtrex (28)	65
olanzapine.....	30	pacerone.....	34	pindolol.....	37
olanzapine-fluoxetine.....	30	paclitaxel	15	pioglitazone	49
olmesartan	36	paliperidone	31	pioglitazone-glimepiride.....	49
olmesartan-amlodipin-		pamidronate	51	pioglitazone-metformin	49
hcthiamid	36	PANRETIN	40	piperacillin-tazobactam	9
olmesartan-		pantoprazole	56	pirmella.....	65
hydrochlorothiazide.....	36	paricalcitol.....	51	piroxicam.....	26
olopatadine	45, 67	paromomycin.....	7	PLASMA-LYTE 148	74

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

PLASMA-LYTE A	74	PRIFTIN	7	Q	
PLEGRIDY	58	PRIMAQUINE	7	QNASL	71
podofilox	40	primidone	20	QUADRACEL (PF)	59
polyethylene glycol 3350	54	PRIMSOL	10	quasense	65
polymyxin b sulfate	7	PRIVIGEN	59	quetiapine	31
polymyxin b sulf-trimethoprim	66	PROAIR HFA	70	quinapril	37
POMALYST	15	PROAIR RESPICLICK	70	quinapril-hydrochlorothiazide	37
portia	65	probenecid	60	quinidine gluconate	34
potassium chlorid-d5-0.45%nacl	72	probenecid-colchicine	60	quinidine sulfate	34
potassium chloride	73	procainamide	34	quinine sulfate	7
potassium chloride in 0.9%nacl	72	procentra	31	QVAR	71
potassium chloride in 5 % dex	72	prochlorperazine	54	R	
potassium chloride in lr-d5... ..	73	prochlorperazine edisylate... ..	54	RABAVERT (PF)	59
potassium chloride-0.45 % nacl	73	prochlorperazine maleate oral	54	rabeprazole	56
potassium chloride-d5-0.2%nacl	73	PROCRIT	58	RAGWITEK	59
potassium chloride-d5-0.3%nacl	73	procto-med hc	54	raloxifene	60
potassium chloride-d5-0.9%nacl	73	procto-pak	54	ramipril	37
potassium citrate	72	proctosol hc	54	RANEXA	39
PRADAXA	38	proctozone-hc	54	ranitidine hcl	56
PRALUENT PEN	39	progesterone micronized	63	RAPAFLO	72
pramipexole	20	PROGLYCEM	49	RAPAMUNE	15
pravastatin	39	PROGRAF	15	rasagiline	20
prazosin	37	PROLASTIN-C	44	RASUVO (PF)	62
prednicarbate	43	PROLENSA	67	RAVICTI	44
prednisolone acetate	67	PROLEUKIN	58	REBETOL	3
prednisolone sodium phosphate	46, 68	PROLIA	60	REBIF (WITH ALBUMIN)	58
prednisone	46	PROMACTA	38	REBIF REBIDOSE	58
prednisone intensol	46	promethazine	68	REBIF TITRATION PACK	58
PREMARIN	63	propafenone	34	reclipsen (28)	65
premasol 10 %	74	propranolol	37	RECOMBIVAX HB (PF)	59,
PREMASOL 6 %	74	propranolol-hydrochlorothiazid	37	60	
prenatal vitamin oral tablet... ..	74	propylthiouracil	46	RECTIV	54
prevalite	39	PROQUAD (PF)	59	REGRANEX	40
previfem	65	protriptyline	31	RELENZA DISKHALER	3
PREZCOBIX	3	prudoxin	40	RELISTOR	54
PREZISTA	3	PULMICORT FLEXHALER	70	REMICADE	54
				REMODULIN	37
		PULMOZYME	70	REVELA	44
		PURIXAN	15	repaglinide	49
		PYLERA	56	repaglinide-metformin	49
		pyrazinamide	7	REPATHA PUSHTRONEX	39
		pyridostigmine bromide	22	REPATHA SURECLICK	39
				REPATHA SYRINGE	39
				RESCRIPTOR	3

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

RESTASIS	67	SELZENTRY	3	sps (with sorbitol)	45
RESTASIS MULTIDOSE ..	67	SENSIPAR	51	sronyx	65
RETROVIR	3	SEREVENT DISKUS	71	ssd	40
REVLIMID	15	sertraline	32, 33	stavudine	3
REXULTI	31, 32	setlakin	65	STELARA	40
REYATAZ	3	sevelamer carbonate	45	STIMATE	51
ribasphere	3	sharobel	63	STIOLTO RESPIMAT	71
ribasphere ribapak	3	SIGNIFOR	15	STIVARGA	15
ribavirin	3	sildenafil	71	STRENSIQ	51
RIDAURA	62	silver sulfadiazine	40	STREPTOMYCIN	7
rifabutin	7	SIMBRINZA	67	STRIBILD	3
rifampin	7	SIMPONI	62	STRIVERDI RESPIMAT ..	71
riluzole	44	SIMPONI ARIA	62	SUBOXONE	26
rimantadine	3	SIMULECT	15	SUCRAID	54
ringer's	43, 73	simvastatin	39	sucralfate	56
RIOMET	49	sirolimus	15	sulfacetamide sodium	68
risedronate	44, 61	SIRTURO	7	sulfacetamide sodium (acne)	41
RISPERDAL CONSTA	32	SIVEXTRO	7	sulfacetamide-prednisolone ..	68
risperidone	32	SKLICE	43	sulfadiazine	9
RITUXAN	15	sodium chloride	45, 73	sulfamethoxazole-trimethoprim	9
rivastigmine	21	sodium chloride 0.45 %	73	SULFAMYLON	41
rivastigmine tartrate	21	sodium chloride 0.9 %	45	sulfasalazine	54
rivelsa	65	sodium chloride 3 %	73	sulindac	26
rizatriptan	21	sodium chloride 5 %	73	sumatriptan	21
ropinirole	20	sodium lactate intravenous ..	73	sumatriptan succinate	21
rosuvastatin	39	sodium phenylbutyrate	45	SUPRAX	5
ROTARIX	60	sodium polystyrene (sorb free)	45	SUPREP BOWEL PREP KIT	54
ROTATEQ VACCINE	60	SOLTAMOX	15	SUSTIVA	3, 4
roweepra	20	SOMATULINE DEPOT	15	SUTENT	15, 16
ROZEREM	32	SOMAVERT	51	SYLATRON	58
RUBRACA	15	sorine	34	SYLVANT	16
RYDAPT	15	sotalol	34	SYMBICORT	71
S		sotalol af	34	SYMLINPEN 120	49
SABRIL	20	SOTYLIZE	34	SYMLINPEN 60	49
SAMSCA	51	SPIRIVA RESPIMAT	71	SYNAGIS	4
SANCUSO	54	SPIRIVA WITH		SYNAREL	51
SANDIMMUNE	15	HANDIHALER	71	SYNERCID	7
SANDOSTATIN LAR		spironolactone	37	SYNJARDY	50
DEPOT	15	spironolacton-hydrochlorothiaz		SYNRIBO	16
SANTYL	43	.....	37	SYPRINE	45
SAPHRIS (BLACK		SPORANOX	1	T	
CHERRY)	32	sprintec (28)	65	TABLOID	16
SAVELLA	62	SPRITAM	20	tacrolimus	16, 40
selegiline hcl	20	SPRYCEL	15		
selenium sulfide	40				

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

TAFINLAR.....	16	timolol maleate.....	37, 66	triamcinolone acetonide.....	43, 45, 71
TAGRISSO.....	16	tinidazole.....	7	triamterene-hydrochlorothiazid	.....37
TAMIFLU.....	4	TIVICAY.....	4	trianex.....	43
tamoxifen.....	16	tizanidine.....	22	triderm.....	43
tamsulosin.....	72	TOBI PODHALER.....	7	trifluoperazine.....	33
TANZEUM.....	50	tobramycin.....	66	trifluridine.....	66
TARCEVA.....	16	tobramycin in 0.225 % nacl....	7	tri-legest fe.....	65
TARGRETIN.....	16	tobramycin sulfate.....	7	tri-lo-estarylla.....	65
tarina fe 1/20 (28).....	65	tobramycin-dexamethasone..	67	tri-lo-sprintec.....	65
TASIGNA.....	16	TOBREX.....	66	trilyte with flavor packets....	54
tazarotene.....	41	TOLAK.....	40	trimethoprim.....	10
TAZORAC.....	41	tolazamide.....	50	trimipramine.....	33
taztia xt.....	37	tolbutamide.....	50	trinessa (28).....	65
TECENTRIQ.....	16	tolcapone.....	20	TRINTELLIX.....	33
TECFIDERA.....	21	tolmetin.....	26	tri-previfem (28).....	65
TEFLARO.....	5	tolterodine.....	71	TRISENOX.....	16
TEKTRNA.....	37	topiramate.....	20	tri-sprintec (28).....	65
TEKTRNA HCT.....	37	toposar.....	16	TRIUMEQ.....	4
telmisartan.....	37	topotecan.....	16	trivora (28).....	65
telmisartan-amlodipine.....	37	TORISEL.....	16	TROPHAMINE 10 %.....	74
telmisartan-hydrochlorothiazid	.....37	torsemide.....	37	TROPHAMINE 6%.....	74
TENIVAC (PF).....	60	TOUJEO SOLOSTAR.....	50	tropium.....	71
terazosin.....	37	TOVIAZ.....	71	TRULICITY.....	50
terbinafine hcl.....	1	TRACLEER.....	71	TRUMENBA.....	60
terbutaline.....	71	TRADJENTA.....	50	TRUVADA.....	4
terconazole.....	63	tramadol.....	26	TUDORZA PRESSAIR.....	71
TESTIM.....	51	tramadol-acetaminophen.....	26	TWINRIX (PF).....	60
testosterone.....	51	trandolapril.....	37	TYGACIL.....	7
testosterone cypionate.....	51	trandolapril-verapamil.....	37	TYKERB.....	16
testosterone enanthate.....	51	tranexamic acid.....	38, 63	TYMLOS.....	61
TETANUS,DIPHThERIA		TRANSDERM-SCOP.....	54	TYPHIM VI.....	60
TOX PED(PF).....	60	tranylcypromine.....	33	TYSABRI.....	21
TETANUS-DIPHThERIA		travasol 10 %.....	74	U	
TOXOIDS-TD.....	60	TRAVATAN Z.....	67	UCERIS.....	54
tetrabenazine.....	21	trazodone.....	33	ULORIC.....	60
tetracycline.....	9	TREANDA.....	16	unithroid.....	52
THALOMID.....	16	TRECTOR.....	7	UPTRAVI.....	37
THEO-24.....	71	TRELSTAR.....	16	ursodiol.....	54
theophylline.....	71	TRESIBA FLEXTOUCH U-		V	
THIOLA.....	45	100.....	50	valacyclovir.....	4
thioridazine.....	33	TRESIBA FLEXTOUCH U-		VALCHLOR.....	40
thiotepa.....	16	200.....	50	valganciclovir.....	4
thiothixene.....	33	tretinoin (chemotherapy).....	16	valproate sodium.....	20
tiagabine.....	20	tretinoin microspheres.....	41		
		tretinoin topical.....	41		

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

valproic acid	20	VIIBRYD	33	zamicet	24
valproic acid (as sodium salt)		VIMPAT	20	ZANOSAR	17
.....	20	vinblastine	17	zarah	65
valsartan	37	vincasar pfs.....	17	ZARXIO	58
valsartan-hydrochlorothiazide		vincristine	17	ZAVESCA.....	52
.....	37	vinorelbine.....	17	ZEJULA	17
vancomycin	10	VIOKACE	54	ZELBORAF	17
vandazole.....	63	VIRACEPT	4	zenatane	41
VAQTA (PF).....	60	VIREAD.....	4	zenchent (28).....	65
VARIVAX (PF)	60	VOLTAREN GEL.....	26	zenchent fe.....	65
VARIZIG	60	voriconazole	1	ZENPEP	55
VARUBI.....	54	VOTRIENT	17	zenzedi	33
VASCEPA.....	39	VRAYLAR.....	33	ZENZEDI	34
VECAMYL.....	39	vyfemla (28).....	65	ZEPATIER	4
VECTIBIX	17	W		ZERIT	4
VELCADE	17	warfarin	38	ZIAGEN	4
velivet triphasic regimen (28)		water for irrigation, sterile....	45	zidovudine	4
.....	65	WELCHOL	39	zileuton	71
VELTASSA	45	wymzya fe	65	ZIOPTAN (PF).....	67
VEMLIDY	4	X		ziprasidone hcl.....	34
VENCLEXTA.....	17	XALKORI.....	17	ZIRGAN	66
VENCLEXTA STARTING		XARELTO	38	zoledronic acid.....	52
PACK	17	XELJANZ	62	zoledronic acid-mannitol-water	
venlafaxine	33	XELJANZ XR.....	62	.....	45
VENTOLIN HFA.....	71	XERESE.....	42	ZOLINZA	17
verapamil.....	37	XERMELO.....	17	zolmitriptan.....	21
veripred 20.....	46	XGEVA	10	zolpidem	34
VERSACLOZ	33	XIFAXAN	7	zonisamide.....	20
VESICARE	71	XIGDUO XR.....	50	ZONTIVITY.....	38
vestura (28).....	65	XOLAIR.....	71	ZORTRESS	17
VGO 20	50	XTANDI.....	17	ZOSTAVAX (PF)	60
VGO 30	50	xulane	63	zovia 1/35e (28).....	65
VGO 40	50	XYREM.....	33	zovia 1/50e (28).....	65
VIBERZI.....	54	Y		ZOVIRAX	42
VIBRAMYCIN	9	YERVOY	17	ZUBSOLV.....	26
vicodin.....	24	YF-VAX (PF).....	60	ZYCLARA	40
vicodin es.....	24	YONDELIS.....	17	ZYDELIG.....	17
vicodin hp.....	24	yuvafem	63	ZYFLO	71
VICTOZA 3-PAK.....	50	Z		ZYKADIA	17
VIDEX 2 GRAM PEDIATRIC		zafirlukast	71	ZYLET	67
.....	4	zaleplon	33	ZYPREXA RELPREVV	34
vienva	65	ZALTRAP	17	ZYTIGA	17

Note: The drug list includes all possible restrictions and limitations. Depending on your plan's specific benefit, you may not experience every restriction or limit indicated in the list. You can find information on what the symbols and abbreviations on this table mean by going to page vii. To confirm your plan's specific coverage, contact Customer Service using the information provided on the front and back covers of this formulary or visit us on the Web at www.Express-Scripts.com.

With Express Scripts Medicare, you will have access to over 68,000 network pharmacies nationally. You may fill your prescriptions at a retail, home infusion, long-term care or Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) pharmacy, or through our convenient home delivery service.

You must use network pharmacies to fill your prescriptions to get the most out of your benefit. However, there are emergency circumstances under which you may be reimbursed for a covered prescription that is not filled at a network pharmacy. Limitations, copayments and restrictions may apply.

This formulary was updated on 08/14/2017. For more recent information or other questions, please contact Express Scripts Medicare Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week. You can also visit us on the Web at **www.express-scripts.com**.

Express Scripts Medicare (PDP) is a prescription drug plan with a Medicare contract.
Enrollment in Express Scripts Medicare depends on contract renewal.

© 2017 Express Scripts Holding Company. All Rights Reserved. Express Scripts and “E” Logo are trademarks of Express Scripts Holding Company and/or its subsidiaries. Other trademarks are the property of their respective owners.

F0PP4Z8A