



Express Scripts Medicare (PDP) 2021 Formulary (List of Covered Drugs)

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

Formulary ID Number: 21050, v7

This formulary was updated on 08/25/2020. For more recent information or to price a medication, you can visit us on the Web at [express-scripts.com](https://www.express-scripts.com). Or you can 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.

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 25, 2020. 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, 2022. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.800.268.5707** (TTY: **1.800.716.3231**).

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 **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?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the drug list during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow Medicare rules in making these changes.

Changes that can affect you this year: In the cases below, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our formulary if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, if applicable, we must notify affected members of the change at least 30 days before the change becomes effective or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

This drug list was updated in August 2020.

- If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled “How do I request an exception to the formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2021 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2021 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

To get current information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back covers.

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 77. 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

This drug list was updated in August 2020.

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 **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?” below 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.

This drug list was updated in August 2020.

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 a one-month supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum of a one-month supply of medication. After your first refill of a one-month supply, we will not pay for these drugs, even if you have been a plan member less than 90 days.

If you are a resident of a long-term care facility and 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 minimum of a 31-day emergency transition supply of that drug 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

This drug list was updated in August 2020.

- 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 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 77.

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:

This drug list was updated in August 2020.

- **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>.

This drug list was updated in August 2020.

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 **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 Express Scripts Pharmacy[®], our home delivery service, as well as through select retail network pharmacies. It may also be available through other network pharmacies. Consider using our home delivery service 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	3	PA; MO
AMBISOME	4	PA; MO
<i>amphotericin b</i>	1	PA; MO
<i>caspofungin</i>	4	PA
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA ORAL	4	PA; MO
<i>fluconazole</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	PA; MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	1	PA
<i>flucytosine</i>	4	MO
<i>griseofulvin microsize</i>	1	MO
<i>griseofulvin ultramicrosize</i>	1	MO
<i>itraconazole oral capsule</i>	1	MO; QL (120 per 30 days)
<i>itraconazole oral solution</i>	1	MO
<i>ketoconazole oral</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>micafungin</i>	4	
NOXAFIL ORAL SUSPENSION	4	PA; MO
<i>nystatin oral suspension</i>	1	MO
<i>nystatin oral tablet</i>	1	MO
<i>posaconazole oral tablet, delayed release (drlec)</i>	4	PA; MO
<i>terbinafine hcl oral</i>	1	MO
<i>voriconazole intravenous</i>	4	PA; MO
<i>voriconazole oral suspension for reconstitution</i>	4	PA; MO
<i>voriconazole oral tablet 200 mg</i>	4	PA; MO
<i>voriconazole oral tablet 50 mg</i>	1	PA; MO
ANTIVIRALS		
<i>abacavir</i>	1	MO
<i>abacavir-lamivudine</i>	1	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

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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>amantadine hcl</i>	1	MO
APTIVUS	4	MO
APTIVUS (WITH VITAMIN E)	4	
<i>atazanavir</i>	1	MO
ATRIPLA	4	MO
BARACLUDE ORAL SOLUTION	4	MO
BIKTARVY	4	MO
CIMDUO	4	MO
COMPLERA	4	MO
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	2	MO
DELSTRIGO	4	MO
DESCOVY	4	MO
<i>didanosine oral capsule, delayed release(drlec) 250 mg, 400 mg</i>	1	MO
DOVATO	4	MO
EDURANT	4	MO
<i>efavirenz oral capsule 200 mg</i>	4	MO
<i>efavirenz oral capsule 50 mg</i>	1	MO
<i>efavirenz oral tablet</i>	4	MO
EMTRIVA	2	MO
<i>entecavir</i>	1	MO
EPCLUSA	4	PA; MO; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
EPIVIR HBV ORAL SOLUTION	2	MO
EVOTAZ	4	MO
<i>famciclovir</i>	1	MO
<i>fosamprenavir</i>	4	MO
FUZEON SUBCUTANEOUS RECON SOLN	4	MO
GENVOYA	4	MO
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	4	PA; MO; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	4	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG	4	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	4	PA; MO; QL (28 per 28 days)
INTELENCE	4	MO
INVIRASE ORAL TABLET	4	MO
ISENTRESS HD	4	MO
ISENTRESS ORAL POWDER IN PACKET	4	MO
ISENTRESS ORAL TABLET	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	4	MO
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	2	MO
JULUCA	4	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	3	MO
<i>lopinavir-ritonavir</i>	1	MO
<i>nevirapine oral suspension</i>	1	
<i>nevirapine oral tablet</i>	1	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO
NORVIR ORAL POWDER IN PACKET	2	MO
NORVIR ORAL SOLUTION	2	MO
ODEFSEY	4	MO
<i>oseltamivir</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
PIFELTRO	4	MO
PREVYMIS ORAL	4	MO; QL (30 per 30 days)
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
RELENZA DISKHALER	2	MO
REYATAZ ORAL POWDER IN PACKET	4	MO
<i>ribavirin oral capsule</i>	1	MO
<i>ribavirin oral tablet 200 mg</i>	1	MO
<i>rimantadine</i>	1	MO
<i>ritonavir</i>	1	MO
SELZENTRY ORAL SOLUTION	2	MO
SELZENTRY ORAL TABLET 150 MG, 300 MG	4	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	2	MO
<i>stavudine oral capsule</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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
STRIBILD	4	MO
SYMFI	4	MO
SYMFI LO	4	MO
SYMTUZA	4	MO
TEMIXYS	4	MO
<i>tenofovir disoproxil fumarate</i>	1	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 oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>valganciclovir</i>	4	MO
VEMLIDY	4	MO
VIRACEPT ORAL TABLET	4	MO
VIREAD ORAL POWDER	4	MO
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	4	MO
VOSEVI	4	PA; MO; QL (28 per 28 days)
XOFLUZA	2	MO
<i>zidovudine</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
CEPHALOSPORINS		
<i>cefaclor oral capsule</i>	1	MO
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml</i>	1	MO
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml, 375 mg/5 ml</i>	1	
<i>cefaclor 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 injection</i>	1	MO
<i>cefixime</i>	1	MO
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>cefazolin intravenous recon soln 10 gram</i>	1	PA
<i>cefprozil</i>	1	MO
<i>cefprozil</i>	1	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>ceftazidime injection recon soln 6 gram</i>	1	PA
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	1	MO
<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>cefuroxime axetil oral tablet</i>	1	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	PA; MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	PA; MO
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	1	PA
<i>cephalexin</i>	1	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	3	
SUPRAX ORAL TABLET, CHEWABLE	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>tazicef injection recon soln 1 gram</i>	1	PA
<i>tazicef injection recon soln 2 gram, 6 gram</i>	1	PA; MO
TEFLARO	4	PA; MO
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin intravenous</i>	1	PA; MO
<i>azithromycin oral</i>	1	MO
<i>clarithromycin</i>	1	MO
<i>ery-tab oral tablet, delayed release (drlec) 250 mg, 333 mg</i>	1	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	3	PA; MO
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	MO
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO
<i>erythromycin 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS ANTIINFECTIVES		
<i>albendazole</i>	4	MO
ALINIA	4	MO
<i>amikacin injection solution 500 mg/2 ml</i>	1	PA; MO
ARIKAYCE	4	PA; MO; LA
<i>atovaquone</i>	4	MO
<i>atovaquone-proguanil</i>	1	MO
<i>aztreonam injection recon soln 1 gram</i>	1	PA; MO
BENZNIDAZOLE	2	MO
BETHKIS	4	PA; MO; QL (224 per 28 days)
CAYSTON	4	PA; MO; LA; QL (84 per 28 days)
<i>chloroquine phosphate</i>	1	MO
<i>clindamycin hcl</i>	1	MO
<i>clindamycin in 5 % dextrose</i>	1	PA; MO
<i>clindamycin pediatric</i>	1	MO
<i>clindamycin phosphate injection</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	1	PA; MO
COARTEM	3	MO
<i>colistin (colistimethate na)</i>	1	PA; MO
<i>dapsone oral</i>	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	4	MO
<i>daptomycin intravenous recon soln 500 mg</i>	4	MO
EMVERM	4	MO
<i>ertapenem</i>	1	MO
<i>ethambutol</i>	1	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>	1	PA; MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml</i>	1	PA
<i>gentamicin injection solution 40 mg/ml</i>	1	PA; MO
<i>hydroxychloroquine</i>	1	MO
<i>imipenem-cilastatin</i>	1	PA; MO
<i>isoniazid oral</i>	1	MO
<i>ivermectin 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>linezolid in dextrose 5%</i>	4	PA
<i>linezolid oral suspension for reconstitution</i>	4	MO
<i>linezolid oral tablet</i>	1	MO
<i>mefloquine</i>	1	MO
<i>meropenem</i>	1	MO
<i>metronidazole in nacl (iso-os)</i>	1	PA; MO
<i>metronidazole oral tablet</i>	1	MO
<i>neomycin</i>	1	MO
<i>paromomycin</i>	1	MO
PASER	2	MO
<i>pentamidine inhalation</i>	1	PA; MO; QL (1 per 28 days)
<i>pentamidine injection</i>	1	MO
<i>praziquantel</i>	1	MO
PRIFTIN	2	MO
PRIMAQUINE	2	MO
<i>pyrazinamide</i>	1	MO
<i>pyrimethamine</i>	4	PA; MO
<i>quinine sulfate</i>	1	MO
<i>rifabutin</i>	1	MO
<i>rifampin</i>	1	MO
SIRTURO ORAL TABLET 100 MG	4	PA; MO; LA
STREPTOMYCIN	2	PA; MO
<i>tigecycline</i>	4	PA
<i>tinidazole</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
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	PA; MO
TRECTOR	3	MO
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg</i>	1	MO
<i>vancomycin oral capsule 125 mg</i>	1	PA; MO; QL (40 per 10 days)
<i>vancomycin oral capsule 250 mg</i>	4	PA; MO; QL (80 per 10 days)
XIFAXAN ORAL TABLET 200 MG	4	MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	MO; QL (90 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 **express-scripts.com**.

This drug list was updated in August 2020

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 oral capsule 500 mg</i>	1	MO
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	1	PA; MO
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	PA; MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	PA
BICILLIN C-R	2	PA; MO
BICILLIN L-A	3	PA; MO
<i>dicloxacillin</i>	1	MO
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>nafcillin injection recon soln 10 gram</i>	4	PA; MO
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	1	PA
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>oxacillin injection recon soln 1 gram</i>	1	PA
<i>oxacillin injection recon soln 10 gram</i>	4	PA
<i>oxacillin injection recon soln 2 gram</i>	1	PA; MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML	3	PA
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 3 MILLION UNIT/50 ML	3	PA; MO
<i>penicillin g potassium injection recon soln 20 million unit</i>	1	PA; MO
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	1	PA; MO
<i>penicillin g sodium</i>	1	PA; MO
<i>penicillin v potassium</i>	1	MO
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
QUINOLONES		
<i>ciprofloxacin hcl oral</i>	1	MO
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	1	PA; MO
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	PA; MO
<i>levofloxacin intravenous</i>	1	PA; MO
<i>levofloxacin oral</i>	1	MO
<i>moxifloxacin oral</i>	1	MO
<i>moxifloxacin-sod.chloride(iso)</i>	1	PA
<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
<i>sulfamethoxazole-trimethoprim oral</i>	1	MO
TETRACYCLINES		
<i>demeclocycline</i>	1	MO
<i>doxy-100</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline hyclate oral capsule</i>	1	MO
<i>doxycycline hyclate oral tablet 20 mg</i>	1	MO
<i>doxycycline monohydrate oral capsule 100 mg, 50 mg</i>	1	MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO
<i>doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg</i>	1	MO
<i>minocycline oral capsule</i>	1	MO
<i>minocycline oral tablet</i>	1	MO
<i>mondoxyne nl oral capsule 100 mg</i>	1	MO
<i>tetracycline</i>	1	MO
VIBRAMYCIN ORAL SYRUP	2	MO
URINARY TRACT AGENTS		
<i>methenamine hippurate</i>	1	MO
<i>nitrofurantoin</i>	1	MO
<i>nitrofurantoin macrocrystal</i>	1	MO
<i>nitrofurantoin monohydrate-cryst</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>trimethoprim</i>	1	MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>leucovorin calcium oral</i>	1	MO
MESNEX ORAL	4	MO
XGEVA	4	PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
<i>abiraterone</i>	4	PA; MO; QL (120 per 30 days)
AFINITOR DISPERZ	4	PA; MO
AFINITOR ORAL TABLET 10 MG	4	PA; MO; QL (30 per 30 days)
ALECENSA	4	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	4	PA; MO; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ALUNBRIG ORAL TABLETS, DOSE PACK	4	PA; MO; QL (30 per 30 days)
<i>anastrozole</i>	1	MO
AYVAKIT	4	PA; MO; LA; QL (30 per 30 days)
<i>azathioprine</i>	1	PA; MO
BALVERSA	4	PA; MO; LA
<i>bexarotene</i>	4	PA; MO
<i>bicalutamide</i>	1	MO
BOSULIF ORAL TABLET 100 MG	4	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	4	PA; MO; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	4	PA; MO; LA; QL (180 per 30 days)
BRUKINSA	4	PA; MO; LA
CABOMETYX	4	PA; MO; LA
CALQUENCE	4	PA; MO; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	4	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	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 [express-scripts.com](https://www.express-scripts.com).

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
COMETRIQ	4	PA; MO
COPIKTRA	4	PA; MO; LA; QL (60 per 30 days)
COTELLIC	4	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide oral capsule</i>	1	PA; MO
<i>cyclosporine modified</i>	1	PA; MO
<i>cyclosporine oral capsule</i>	1	PA; MO
DAURISMO ORAL TABLET 100 MG	4	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	4	PA; MO; QL (60 per 30 days)
DROXIA	2	MO
EMCYT	4	MO
ENVARUS XR	3	PA; MO
ERIVEDGE	4	PA; MO; QL (30 per 30 days)
ERLEADA	4	PA; MO; QL (120 per 30 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	4	PA; MO; QL (30 per 30 days)
<i>erlotinib oral tablet 25 mg</i>	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>everolimus (antineoplastic)</i>	4	PA; MO; QL (30 per 30 days)
<i>everolimus (immunosuppressive)</i>	4	PA; MO
<i>exemestane</i>	1	MO
FARYDAK ORAL CAPSULE 10 MG, 20 MG	4	PA; MO; QL (6 per 21 days)
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	4	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	3	PA; MO
<i>flutamide</i>	1	MO
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	PA; MO
<i>gengraf oral solution</i>	1	PA; MO
GILOTRIF	4	PA; MO; QL (30 per 30 days)
<i>hydroxyurea</i>	1	MO
IBRANCE	4	PA; MO; QL (21 per 28 days)
ICLUSIG ORAL TABLET 15 MG	4	PA; 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ICLUSIG ORAL TABLET 45 MG	4	PA; QL (30 per 30 days)
IDHIFA	4	PA; MO; LA; QL (30 per 30 days)
<i>imatinib oral tablet 100 mg</i>	4	PA; MO; QL (180 per 30 days)
<i>imatinib oral tablet 400 mg</i>	4	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	4	PA; MO; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	4	PA; MO; QL (30 per 30 days)
IMBRUVICA ORAL TABLET	4	PA; MO; QL (30 per 30 days)
INLYTA ORAL TABLET 1 MG	4	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	4	PA; MO; QL (120 per 30 days)
INREBIC	4	PA; MO; LA; QL (120 per 30 days)
IRESSA	4	PA; MO; QL (30 per 30 days)
JAKAFI	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
KISQALI	4	PA; MO
KISQALI FEMARA CO-PACK	4	PA; MO
LENVIMA	4	PA; MO
<i>letrozole</i>	1	MO
LEUKERAN	2	MO
<i>leuprolide subcutaneous kit</i>	4	PA; MO
LONSURF	4	PA; MO
LORBRENA ORAL TABLET 100 MG	4	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	4	PA; MO; QL (90 per 30 days)
LUPRON DEPOT	4	PA; MO
LUPRON DEPOT (3 MONTH)	4	PA; MO
LUPRON DEPOT (4 MONTH)	4	PA; MO
LUPRON DEPOT (6 MONTH)	4	PA; MO
LYNPARZA ORAL TABLET	4	PA; MO; QL (120 per 30 days)
LYSODREN	2	MO
MATULANE	4	MO
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	1	PA; MO
<i>megestrol oral tablet</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
MEKINIST ORAL TABLET 0.5 MG	4	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	4	PA; MO; QL (30 per 30 days)
MEKTOVI	4	PA; MO; LA; QL (180 per 30 days)
<i>mercaptopurine</i>	1	MO
<i>methotrexate sodium</i>	1	PA; MO
<i>methotrexate sodium (pf) injection solution</i>	1	PA; MO
MVASI	4	PA; MO
<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
NERLYNX	4	PA; MO; LA
NEXAVAR	4	PA; MO; LA; QL (120 per 30 days)
<i>nilutamide</i>	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
NINLARO	4	PA; MO; QL (3 per 28 days)
NUBEQA	4	PA; MO; LA; QL (120 per 30 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	4	PA; MO
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	1	PA; MO
ODOMZO	4	PA; MO; LA; QL (30 per 30 days)
PEMAZYRE	4	PA; MO; LA; QL (14 per 21 days)
PIQRAY	4	PA; MO
POMALYST	4	PA; MO; LA
PROGRAF ORAL GRANULES IN PACKET	2	PA; MO
PURIXAN	4	
QINLOCK	4	PA; MO; LA; QL (90 per 30 days)
RETEVMO ORAL CAPSULE 40 MG	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 [express-scripts.com](https://www.express-scripts.com).

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
RETEVMO ORAL CAPSULE 80 MG	4	PA; MO; LA; QL (120 per 30 days)
REVLIMID	4	PA; MO; LA; QL (28 per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	4	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	4	PA; MO; QL (90 per 30 days)
RUBRACA	4	PA; MO; LA; QL (120 per 30 days)
RUXIENCE	4	PA; MO
RYDAPT	4	PA; MO
SANDIMMUNE ORAL SOLUTION	2	PA; MO
SIGNIFOR	4	PA; MO
<i>sirolimus oral solution</i>	4	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	4	MO
SOMATULINE DEPOT	4	PA; MO
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SPRYCEL ORAL TABLET 20 MG, 70 MG	4	PA; MO; QL (60 per 30 days)
STIVARGA	4	PA; MO; QL (84 per 28 days)
SUTENT	4	PA; MO; QL (30 per 30 days)
SYNRIBO	4	PA; MO
TABLOID	3	MO
TABRECTA	4	PA; MO
<i>tacrolimus oral</i>	1	PA; MO
TAFINLAR	4	PA; MO; QL (120 per 30 days)
TAGRISSE	4	PA; MO; LA; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG	4	PA; MO; QL (90 per 30 days)
TALZENNA ORAL CAPSULE 1 MG	4	PA; MO; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO
TARGRETIN TOPICAL	4	PA; MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	4	PA; MO; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
TAZVERIK	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
THALOMID	4	PA; MO
TIBSOVO	4	PA; MO
<i>toremifene</i>	4	MO
TRAZIMERA	4	PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	4	PA; MO
<i>tretinoin</i> (antineoplastic)	4	MO
TUKYSA ORAL TABLET 150 MG	4	PA; MO; LA; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	4	PA; MO; LA; QL (300 per 30 days)
TURALIO	4	PA; MO; LA; QL (120 per 30 days)
TYKERB	4	PA; MO; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 10 MG, 50 MG	2	PA; MO; LA
VENCLEXTA ORAL TABLET 100 MG	4	PA; MO; LA

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA STARTING PACK	4	PA; MO; LA; QL (42 per 30 days)
VERZENIO	4	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 100 MG	4	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	4	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	4	PA; MO; LA; QL (300 per 30 days)
VIZIMPRO	4	PA; MO; QL (30 per 30 days)
VOTRIENT	4	PA; MO; QL (120 per 30 days)
XALKORI	4	PA; MO; QL (60 per 30 days)
XATMEP	3	PA; MO
XERMELO	4	PA; MO; LA; QL (90 per 30 days)
XOSPATA	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
XPOVIO ORAL TABLET 100 MG/WEEK (20 MG X 5), 60 MG/WEEK (20 MG X 3), 80 MG/WEEK (20 MG X 4), 80MG TWICE WEEK (160 MG/WEEK)	4	PA; MO; LA
XTANDI	4	PA; MO; QL (120 per 30 days)
YONSA	4	PA; MO; QL (120 per 30 days)
ZEJULA	4	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	4	PA; MO; QL (240 per 30 days)
ZIRABEV	4	PA; MO
ZOLINZA	4	PA; MO
ZORTRESS ORAL TABLET 1 MG	4	PA; MO
ZYDELIG	4	PA; MO; QL (60 per 30 days)
ZYKADIA ORAL TABLET	4	PA; MO; QL (90 per 30 days)
ZYTIGA ORAL TABLET 500 MG	4	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM	4	MO
BANZEL	4	PA; 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	3	MO
<i>clobazam oral suspension</i>	1	PA; MO; QL (480 per 30 days)
<i>clobazam oral tablet</i>	1	PA; 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
<i>clonazepam oral tablet 2 mg</i>	1	MO; QL (300 per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	1	MO; QL (300 per 30 days)
<i>diazepam rectal</i>	1	MO
DILANTIN 30 MG	2	MO
<i>divalproex</i>	1	MO
EPIDIOLEX	4	PA; MO; LA
<i>epitol</i>	1	MO
<i>ethosuximide</i>	1	MO
<i>felbamate oral suspension</i>	4	MO
<i>felbamate oral tablet</i>	1	MO
FYCOMPA ORAL SUSPENSION	4	MO
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	4	MO
FYCOMPA ORAL TABLET 2 MG	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>gabapentin oral capsule 100 mg, 400 mg</i>	1	MO; QL (270 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	MO; QL (360 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 (120 per 30 days)
GRALISE 30-DAY STARTER PACK	2	PA; QL (78 per 30 days)
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

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>lamotrigine oral tablet, disintegrating</i>	1	MO
<i>lamotrigine oral tablets, dose pack</i>	1	MO
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO
<i>levetiracetam oral tablet</i>	1	MO
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO
NAYZILAM	4	PA; MO; QL (10 per 30 days)
<i>oxcarbazepine</i>	1	MO
PEGANONE	3	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>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	1	MO; QL (90 per 30 days)
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	MO; QL (60 per 30 days)
<i>pregabalin oral solution</i>	1	MO; QL (900 per 30 days)
<i>primidone</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>roweepra</i>	1	MO
<i>roweepra xr</i>	1	
SPRITAM	3	MO
SYMPAZAN ORAL FILM 10 MG, 20 MG	4	PA; MO; QL (60 per 30 days)
SYMPAZAN ORAL FILM 5 MG	3	PA; MO; QL (60 per 30 days)
<i>tiagabine</i>	1	MO
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO
<i>topiramate oral tablet</i>	1	PA; MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
VALTOCO	4	PA; MO; QL (10 per 30 days)
<i>vigabatrin</i>	4	MO; LA
<i>vigadrone</i>	4	MO; LA
VIMPAT ORAL SOLUTION	2	MO
VIMPAT ORAL TABLET	2	MO
XCOPRI MAINTENANCE PACK	4	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG	3	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
XCOPRI ORAL TABLET 150 MG	3	MO; QL (60 per 30 days)
XCOPRI ORAL TABLET 200 MG	4	MO; QL (60 per 30 days)
XCOPRI ORAL TABLET 50 MG	3	MO; QL (240 per 30 days)
XCOPRI TITRATION PACK	3	MO; QL (56 per 28 days)
<i>zonisamide</i>	1	PA; MO
ANTIPARKINSONISM AGENTS		
APOKYN	4	PA; MO; LA
<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	3	MO
<i>pramipexole oral tablet</i>	1	MO
<i>rasagiline</i>	1	MO
<i>ropinirole</i>	1	MO
<i>selegiline hcl</i>	1	MO
<i>tolcapone</i>	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR	2	PA; MO; QL (1 per 30 days)
AJOVY AUTOINJECTOR	2	PA; MO; QL (1.5 per 30 days)
AJOVY SYRINGE	2	PA; MO; QL (1.5 per 30 days)
<i>dihydroergotamine nasal</i>	4	MO; QL (8 per 28 days)
<i>eletriptan</i>	1	MO; QL (18 per 28 days)
EMGALITY PEN	2	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	2	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	4	PA; MO; QL (3 per 30 days)
<i>ergotamine-caffeine</i>	1	MO
<i>migergot</i>	1	MO
<i>naratriptan</i>	1	MO; QL (18 per 28 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 [express-scripts.com](https://www.express-scripts.com).

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
NURTEC ODT	4	PA; MO; QL (16 per 30 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)
UBRELVY	4	PA; MO; QL (20 per 30 days)
<i>zolmitriptan</i>	1	MO; QL (18 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS NEUROLOGICAL THERAPY		
AUBAGIO	4	PA; MO; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	4	PA; MO; QL (12 per 28 days)
<i>dalfampridine</i>	4	PA; MO; QL (60 per 30 days)
<i>donepezil</i>	1	MO
FIRDAPSE	4	PA; MO; LA
<i>galantamine</i>	1	MO
GILENYA ORAL CAPSULE 0.5 MG	4	PA; MO; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	4	PA; MO; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	4	PA; MO; QL (12 per 28 days)
<i>glatopa subcutaneous syringe 20 mg/ml</i>	4	PA; MO; QL (30 per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	4	PA; MO; QL (12 per 28 days)
<i>memantine oral capsule, sprinkle, er 24hr</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>memantine oral solution</i>	1	PA; MO
<i>memantine oral tablet</i>	1	PA; MO
NAMZARIC	2	PA; MO
NUEDEXTA	4	PA; MO
<i>rivastigmine</i>	1	MO
<i>rivastigmine tartrate</i>	1	MO
TECFIDERA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 120 MG	4	PA; MO; LA; QL (14 per 30 days)
TECFIDERA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	4	PA; MO; LA; QL (120 per 180 days)
TECFIDERA ORAL CAPSULE, DELAYED RELEASE(DR/EC) 240 MG	4	PA; MO; LA; QL (60 per 30 days)
<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)
VUMERITY	4	PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
<i>baclofen oral tablet 10 mg, 20 mg</i>	1	MO
<i>cyclobenzaprine oral tablet</i>	1	PA; MO
<i>dantrolene oral</i>	1	MO
<i>pyridostigmine bromide oral syrup</i>	4	MO
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	MO
<i>pyridostigmine bromide oral tablet extended release</i>	1	MO
<i>tizanidine</i>	1	MO
NARCOTIC ANALGESICS		
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	1	MO; QL (4500 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	1	MO; QL (360 per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	MO; QL (180 per 30 days)
BELBUCA	2	PA; MO; QL (60 per 30 days)
<i>buprenorphine hcl sublingual</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine transdermal patch</i>	1	PA; MO; QL (4 per 28 days)
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle</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 bitartrate</i>	1	PA; MO; QL (90 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	MO; QL (50 per 30 days)

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

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 express-scripts.com.

This drug list was updated in August 2020

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

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>oxycodone-aspirin</i>	1	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	MO; QL (360 per 30 days)
<i>oxymorphone oral tablet 5 mg</i>	1	MO; QL (180 per 30 days)
NON-NARCOTIC ANALGESICS		
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	1	MO; QL (60 per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	1	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	1	MO; QL (90 per 30 days)
<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 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
<i>flurbiprofen oral tablet 100 mg</i>	1	MO
<i>ibu oral tablet 600 mg, 800 mg</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 25 mg, 75 mg</i>	1	MO
<i>ketoprofen oral capsule 50 mg</i>	1	
<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>naloxone injection solution</i>	1	MO
<i>naloxone injection syringe</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
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	2	MO
<i>oxaprozin</i>	1	MO
<i>piroxicam</i>	1	MO
<i>sulindac</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>tolmetin oral capsule</i>	1	MO
<i>tolmetin oral tablet 600 mg</i>	1	MO
<i>tramadol oral tablet 50 mg</i>	1	MO; QL (240 per 30 days)
<i>tramadol-acetaminophen</i>	1	MO; QL (240 per 30 days)
VIVITROL	4	MO
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	MO
<i>amoxapine</i>	1	MO
<i>aripiprazole oral solution</i>	4	MO
<i>aripiprazole oral tablet</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>aripiprazole oral tablet, disintegrating</i>	4	MO; QL (60 per 30 days)
ARISTADA	4	MO
ARISTADA INITIO	4	MO
<i>armodafinil</i>	1	PA; MO; QL (30 per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	1	MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet</i>	1	MO
<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 (30 per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	1	MO; QL (60 per 30 days)
<i>bupirone</i>	1	MO
CAPLYTA	4	MO; QL (30 per 30 days)
<i>chlorpromazine oral</i>	1	MO
<i>citalopram oral solution</i>	1	MO
<i>citalopram oral tablet</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>clomipramine</i>	1	MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>clozapine oral tablet</i>	1	MO
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	1	
CLOZAPINE ORAL TABLET, DISINTEGRATING 150 MG, 200 MG	3	
<i>desipramine</i>	1	MO
<i>desvenlafaxine succinate</i>	1	MO; QL (30 per 30 days)
<i>dextroamphetamine oral solution</i>	1	MO
<i>dextroamphetamine -amphetamine</i>	1	MO
<i>diazepam oral concentrate</i>	1	PA; MO; QL (240 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	PA; MO; QL (1200 per 30 days)
<i>diazepam oral tablet</i>	1	PA; MO; QL (120 per 30 days)
<i>doxepin oral capsule</i>	1	MO
<i>doxepin oral concentrate</i>	1	MO
<i>doxepin oral tablet</i>	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	3	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	3	MO; QL (90 per 30 days)
<i>duloxetine oral capsule, delayed release (drlec) 20 mg, 30 mg, 60 mg</i>	1	MO; QL (60 per 30 days)
<i>duloxetine oral capsule, delayed release (drlec) 40 mg</i>	1	MO; QL (90 per 30 days)
EMSAM	4	MO
<i>ergoloid</i>	1	MO
<i>escitalopram oxalate oral solution</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>escitalopram oxalate oral tablet</i>	1	MO; QL (30 per 30 days)
<i>eszopiclone</i>	1	MO; QL (30 per 30 days)
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	3	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	4	MO; QL (60 per 30 days)
FANAPT ORAL TABLETS, DOSE PACK	3	MO; QL (8 per 28 days)
FETZIMA ORAL CAPSULE, EXT REL 24HR DOSE PACK	2	MO; QL (28 per 28 days)
FETZIMA ORAL CAPSULE, EXTENDED RELEASE 24 HR	2	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 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 (drlec)</i>	1	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral tablet 20 mg, 60 mg</i>	1	MO
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO
<i>fluvoxamine oral capsule, extended release 24hr</i>	1	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 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 injection</i>	1	MO
<i>haloperidol lactate 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
HETLIOZ	4	PA; MO; QL (30 per 30 days)
<i>imipramine hcl</i>	1	MO
<i>imipramine pamoate</i>	1	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
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	4	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	4	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; QL (150 per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>lorazepam oral tablet 2 mg</i>	1	PA; MO; QL (150 per 30 days)
<i>loxapine succinate</i>	1	MO
<i>maprotiline</i>	1	MO
MARPLAN	3	MO
<i>methylphenidate hcl oral capsule, er biphasic 50-50</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
<i>methylphenidate hcl oral tablet, chewable</i>	1	MO
<i>mirtazapine</i>	1	MO
<i>modafinil oral tablet 100 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>modafinil oral tablet 200 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>molindone</i>	1	MO
<i>nefazodone</i>	1	MO
<i>nortriptyline</i>	1	MO
NUPLAZID ORAL CAPSULE	4	PA; MO; QL (30 per 30 days)
NUPLAZID ORAL TABLET 10 MG	4	PA; 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>olanzapine intramuscular</i>	1	MO
<i>olanzapine oral</i>	1	MO; QL (30 per 30 days)
<i>olanzapine-fluoxetine</i>	1	MO
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg</i>	1	MO; QL (30 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 (30 per 30 days)
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	MO; QL (30 per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	1	MO; QL (60 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr</i>	1	MO; QL (60 per 30 days)
PAXIL ORAL SUSPENSION	3	MO
<i>perphenazine</i>	1	MO
PERSERIS	4	MO
<i>phenelzine</i>	1	MO
<i>pimozide</i>	1	MO
<i>procentra</i>	1	MO
<i>protriptyline</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	1	MO; QL (30 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>ramelteon</i>	1	MO; QL (30 per 30 days)
REXULTI	4	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	2	MO
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION, EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>risperidone oral solution</i>	1	MO
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)
<i>risperidone oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet, disintegrating 4 mg</i>	1	MO; QL (120 per 30 days)
SAPHRIS	4	MO; QL (60 per 30 days)
SECUADO	4	QL (30 per 30 days)
<i>sertraline oral concentrate</i>	1	MO
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 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	MO

Drug Name	Drug Tier	Requirements/Limits
TRINTELLIX	2	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	1	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet</i>	1	MO; QL (90 per 30 days)
VERSACLOZ	4	
VIIBRYD ORAL TABLET	2	MO; QL (30 per 30 days)
VIIBRYD ORAL TABLETS, DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	4	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE, DOSE PACK	3	MO; QL (7 per 30 days)
XYREM	4	PA; MO; LA; QL (540 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>ziprasidone hcl</i>	1	MO; QL (60 per 30 days)
<i>ziprasidone mesylate</i>	1	
<i>zolpidem oral tablet</i>	1	MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	3	MO
CARDIOVASCULAR, HYPERTENSION / LIPIDS		
ANTIARRHYTHMIC AGENTS		
<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</i> 100 mg, 200 mg, 400 mg	1	MO
<i>propafenone</i>	1	MO
<i>quinidine gluconate oral</i>	1	MO
<i>quinidine sulfate oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>sorine oral tablet</i> 120 mg, 160 mg, 80 mg	1	MO
<i>sorine oral tablet</i> 240 mg	1	
<i>sotalol af</i>	1	MO
<i>sotalol oral</i>	1	MO
ANTIHYPERTENSIVE THERAPY		
<i>acebutolol</i>	1	MO
<i>aliskiren</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
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthiacid</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

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide</i>	1	MO
BYSTOLIC	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>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO
<i>clonidine</i>	1	MO; QL (4 per 28 days)
<i>clonidine hcl oral tablet</i>	1	MO
DEMSER	4	PA; MO
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24 hr 360 mg, 420 mg</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	1	MO
<i>diltiazem hcl oral tablet</i>	1	MO
<i>dilt-xr</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<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>ethacrynic acid</i>	1	MO
<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 oral</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 oral</i>	1	MO
<i>lisinopril</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>lisinopril-hydrochlorothiazide</i>	1	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO
<i>matzim la</i>	1	MO
<i>methyldopa</i>	1	MO
<i>metolazone</i>	1	MO
<i>metoprolol succinate</i>	1	MO
<i>metoprolol ta-hydrochlorothiaz</i>	1	MO
<i>metoprolol tartrate oral</i>	1	MO
<i>minoxidil oral</i>	1	MO
<i>moexipril</i>	1	MO
<i>nadolol</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-hcthiiazid</i>	1	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO
<i>perindopril erbumine</i>	1	MO
<i>phenoxybenzamine</i>	4	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>pindolol</i>	1	MO
<i>prazosin</i>	1	MO
<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
<i>spironolactone</i>	1	MO
<i>spironolacton-hydrochlorothiaz</i>	1	MO
<i>taztia xt</i>	1	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>tiadylt er</i>	1	MO
<i>timolol maleate oral</i>	1	MO
<i>torseamide oral</i>	1	MO
<i>trandolapril</i>	1	MO
<i>trandolapril-verapamil</i>	1	MO
<i>triamterene</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	MO
<i>triamterene-hydrochlorothiazid oral tablet</i>	1	MO
UPTRAVI	4	PA; MO; LA
<i>valsartan</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
<i>verapamil oral</i>	1	MO
COAGULATION THERAPY		
<i>aspirin-dipyridamole</i>	1	MO
BRILINTA	2	MO
CABLIVI INJECTION KIT	4	PA; MO; LA
<i>cilostazol</i>	1	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
<i>dipyridamole oral</i>	1	MO
DOPTelet (10 TAB PACK)	4	PA; MO; LA
DOPTelet (15 TAB PACK)	4	PA; MO; LA
DOPTelet (30 TAB PACK)	4	PA; MO; LA
ELIQUIS	2	MO
ELIQUIS DVT-PE TREAT 30D START	2	MO

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	1	MO; QL (28 per 28 days)
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	1	MO; QL (22.4 per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	1	MO; QL (16.8 per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	1	MO; QL (11.2 per 28 days)
<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) injection solution</i>	1	MO
<i>jantoven</i>	1	MO
MULPLETA	4	PA; MO
<i>pentoxifylline</i>	1	MO
<i>prasugrel</i>	1	MO
PROMACTA	4	PA; MO; LA
<i>warfarin</i>	1	MO
XARELTO	2	MO
ZONTIVITY	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
LIPID/CHOLESTEROL LOWERING AGENTS		
<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 in packet</i>	1	MO
<i>cholestyramine light oral powder</i>	1	MO
<i>colesevelam</i>	1	MO
<i>colestipol oral packet</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 oral tablet 145 mg, 48 mg</i>	1	MO
<i>fenofibrate oral tablet 160 mg, 54 mg</i>	1	MO
<i>fenofibric acid (choline)</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<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
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)
NEXLETOL	2	PA; MO
NEXLIZET	2	PA; MO
<i>niacin oral tablet extended release 24 hr</i>	1	MO
PRALUENT PEN	2	PA; MO; QL (2 per 28 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite oral powder in packet</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
REPATHA	2	PA; MO; QL (3 per 28 days)
REPATHA PUSHTRONEX	2	PA; MO; QL (3.5 per 28 days)
REPATHA SURECLICK	2	PA; MO; QL (3 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin oral tablet</i>	1	MO; QL (30 per 30 days)
VASCEPA	2	MO
MISCELLANEOUS CARDIOVASCULAR AGENTS		
CORLANOR ORAL SOLUTION	2	PA
CORLANOR ORAL TABLET	2	PA; MO
<i>digitek</i>	1	MO
<i>digox</i>	1	MO
<i>digoxin oral solution 50 mcg/ml (0.05 mg/ml)</i>	1	MO
<i>digoxin oral tablet</i>	1	MO
ENTRESTO	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
LANOXIN ORAL TABLET 62.5 MCG (0.0625 MG)	2	MO
<i>ranolazine</i>	1	MO
VECAMYL	4	
VYNDAMAX	4	PA; MO
VYNDAQEL	4	PA; MO
NITRATES		
<i>isosorbide dinitrate oral tablet</i>	1	MO
<i>isosorbide mononitrate</i>	1	MO
<i>nitro-bid</i>	1	MO
<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		
ANTIPSORIATICS / ANTISEBORRHOIC		
<i>acitretin oral capsule 10 mg, 25 mg</i>	1	MO
<i>acitretin oral capsule 17.5 mg</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>calcipotriene scalp</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene topical cream</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene topical ointment</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene-betamethasone</i>	1	MO; QL (400 per 30 days)
<i>calcitriol topical</i>	1	MO
<i>selenium sulfide topical lotion</i>	1	MO
SKYRIZI SUBCUTANEOUS SYRINGE KIT	4	PA; MO; QL (1 per 28 days)
STELARA INTRAVENOUS	4	PA; MO; QL (4 per 28 days)
STELARA SUBCUTANEOUS SOLUTION	4	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	4	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	4	PA; MO; QL (1 per 28 days)
TALTZ AUTOINJECTOR	4	PA; MO; QL (1 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
TALTZ SYRINGE	4	PA; MO; QL (1 per 28 days)

MISCELLANEOUS DERMATOLOGICALS		
<i>ammonium lactate</i>	1	MO
CONDYLOX TOPICAL GEL	3	MO
<i>diclofenac sodium topical gel 3 %</i>	1	PA; MO; QL (100 per 28 days)
<i>doxepin topical</i>	1	MO; QL (45 per 30 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	4	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	4	PA; MO; QL (8 per 28 days)
<i>fluorouracil topical cream 5 %</i>	1	MO
<i>fluorouracil topical solution</i>	1	MO
<i>imiquimod topical cream in packet</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

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>lidocaine topical adhesive patch, medicated 5 %</i>	1	PA; MO; QL (90 per 30 days)
<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)
<i>methoxsalen</i>	4	MO
PICATO	4	MO
<i>pimecrolimus</i>	1	PA; MO; QL (100 per 30 days)
<i>podofilox</i>	1	MO
<i>prudoxin</i>	1	MO; QL (45 per 30 days)
REGRANEX	4	MO
SANTYL	2	MO
<i>silver sulfadiazine</i>	1	MO
<i>ssd</i>	1	MO
<i>tacrolimus topical</i>	1	PA; MO; QL (100 per 30 days)
VALCHLOR	4	PA; MO
THERAPY FOR ACNE		
<i>avita topical cream</i>	1	PA; MO
<i>azelaic acid</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>claravis oral capsule 10 mg, 20 mg, 30 mg</i>	1	MO
<i>clindamycin phosphate topical gel</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical lotion</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical solution</i>	1	MO; QL (120 per 30 days)
<i>dapsone topical gel</i>	1	MO
<i>erythromycin with ethanol topical solution</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</i>	1	MO
<i>tazarotene</i>	1	PA; MO
TAZORAC TOPICAL CREAM 0.05 %	3	PA; MO
TAZORAC TOPICAL GEL	3	PA; MO
<i>tretinoin topical</i>	1	PA; MO
TOPICAL ANTIBACTERIALS		
<i>gentamicin topical</i>	1	MO
<i>mafenide 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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>mupirocin</i>	1	MO; QL (30 per 30 days)
<i>sulfacetamide sodium (acne)</i>	1	MO
SULFAMYLON TOPICAL CREAM	2	MO
TOPICAL ANTIFUNGALS		
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (45 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	1	MO
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>econazole</i>	1	MO; QL (85 per 28 days)
KERYDIN	3	MO
<i>ketconazole topical cream</i>	1	MO; QL (60 per 28 days)
<i>ketconazole topical foam</i>	1	MO; QL (100 per 28 days)
<i>ketconazole topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ketodan</i>	1	MO; QL (100 per 28 days)
<i>naftifine topical cream</i>	1	MO; QL (60 per 28 days)
NAFTIN TOPICAL GEL 2 %	3	MO; QL (60 per 28 days)
<i>nyamyc</i>	1	MO
<i>nystatin topical cream</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical ointment</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical powder</i>	1	MO
<i>nystatin-triamcinolone</i>	1	MO; QL (60 per 28 days)
<i>nystop</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>oxiconazole</i>	1	PA; MO; QL (60 per 28 days)

TOPICAL ANTIVIRALS

<i>acyclovir topical cream</i>	1	PA; MO; QL (5 per 30 days)
<i>acyclovir topical ointment</i>	1	PA; MO; QL (30 per 30 days)
DENAVIR	4	MO
XERESE	3	MO

TOPICAL CORTICOSTEROIDS

<i>ala-cort topical cream 1 %</i>	1	MO
<i>alclometasone</i>	1	MO
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate</i>	1	MO
<i>betamethasone, augmented</i>	1	MO
CAPEX	3	MO
<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical cream</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<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>clobetasol-emollient topical foam</i>	1	MO; QL (100 per 28 days)
<i>clodan</i>	1	MO; QL (236 per 28 days)
<i>desonide topical cream</i>	1	MO
<i>desonide topical lotion</i>	1	MO
<i>desonide topical ointment</i>	1	MO
<i>fluocinolone and shower cap</i>	1	MO
<i>fluocinolone topical cream</i>	1	MO
<i>fluocinolone topical ointment</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>fluocinolone topical solution</i>	1	MO
<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>halobetasol propionate topical cream</i>	1	MO
<i>halobetasol propionate topical ointment</i>	1	MO
<i>hydrocortisone butyrate topical lotion</i>	1	MO; QL (118 per 30 days)
<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>mometasone topical</i>	1	MO
<i>prednicarbate</i>	1	MO
<i>tovet emollient</i>	1	MO; QL (100 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>triamcinolone acetonide topical aerosol</i>	1	MO; QL (126 per 28 days)
<i>triamcinolone acetonide topical cream</i>	1	MO
<i>triamcinolone acetonide topical lotion</i>	1	MO
<i>triamcinolone acetonide topical ointment</i>	1	MO
<i>triderm topical cream 0.1 %</i>	1	MO

TOPICAL SCABICIDES / PEDICULICIDES

<i>lindane topical shampoo</i>	1	MO
<i>malathion</i>	1	MO
<i>permethrin topical cream</i>	1	MO
SKLICE	3	MO

DIAGNOSTICS / MISCELLANEOUS AGENTS

MISCELLANEOUS AGENTS

<i>acamprosate</i>	1	MO
<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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	4	MO; LA
CARBAGLU	4	PA; MO; LA
<i>cevimeline</i>	1	MO
CHEMET	2	PA; MO
CLINIMIX 4.25%/D5W SULFIT FREE	3	PA
<i>clovique</i>	4	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>deferasirox oral tablet</i>	4	PA; MO
<i>deferasirox oral tablet, dispersible</i>	4	PA; 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 piggyback</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>dextrose with sodium chloride</i>	1	
<i>disulfiram</i>	1	MO
FERRIPROX	4	PA; MO
INCRELEX	4	MO; LA
<i>kionex (with sorbitol)</i>	1	MO
<i>lanthanum</i>	1	MO
<i>levocarnitine (with sugar)</i>	1	MO
<i>levocarnitine oral tablet</i>	1	MO
LOKELMA	2	MO
<i>midodrine</i>	1	MO
<i>nitisinone</i>	4	PA; MO
NORTHERA	4	PA; MO
ORFADIN ORAL CAPSULE 20 MG	4	PA; MO; LA
ORFADIN ORAL SUSPENSION	4	PA; MO; LA
<i>pilocarpine hcl oral</i>	1	MO
PROLASTIN-C INTRAVENOUS RECON SOLN	4	LA
PROLASTIN-C INTRAVENOUS SOLUTION	4	MO; LA
RAVICTI	4	PA; MO
<i>riluzole</i>	1	PA; 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>sevelamer carbonate oral powder in packet</i>	4	MO
<i>sevelamer carbonate oral tablet</i>	1	MO
<i>sevelamer hcl</i>	1	MO
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride irrigation</i>	1	MO
<i>sodium phenylbutyrate</i>	4	PA; MO
<i>sodium polystyrene (sorb free)</i>	1	MO
<i>sodium polystyrene sulfonate oral powder</i>	1	MO
<i>sps (with sorbitol) oral</i>	1	MO
THIOLA	4	MO
THIOLA EC	4	MO
trientine	4	PA; MO
VELTASSA	2	MO
XURIDEN	4	PA; MO
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter)</i>	1	MO
CHANTIX	3	MO
CHANTIX CONTINUING MONTH BOX	3	MO

Drug Name	Drug Tier	Requirements/Limits
CHANTIX STARTING MONTH BOX	3	MO
NICOTROL	3	MO
NICOTROL NS	3	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
<i>azelastine nasal</i>	1	MO; QL (60 per 30 days)
<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>triamcinolone acetate dental</i>	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear)</i>	1	MO
<i>ciprofloxacin hcl otic (ear)</i>	1	MO
<i>flac otic oil</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>fluocinolone acetonide oil</i>	1	MO
<i>hydrocortisone-acetic acid</i>	1	MO
<i>ofloxacin otic (ear)</i>	1	MO
OTIC STEROID / ANTIBIOTIC		
CIPRODEX	2	MO
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO
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 oral tablets,dose pack</i>	1	MO
<i>fludrocortisone</i>	1	MO
<i>hydrocortisone oral</i>	1	MO
<i>methylprednisolone oral tablet</i>	1	PA; MO
<i>methylprednisolone oral tablets,dose pack</i>	1	MO
<i>millipred oral tablet</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>prednisolone oral solution 15 mg/5 ml</i>	1	MO
<i>prednisolone sodium phosphate oral solution 10 mg/5 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>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
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

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
APIDRA SOLOSTAR U-100 INSULIN	3	ST; MO
APIDRA U-100 INSULIN	3	ST; MO
BD AUTOSHIELD DUO PEN NEEDLE	2	MO
BD INSULIN SYRINGE HALF UNIT 0.3 ML 31 GAUGE X 5/16"	2	MO
BD INSULIN SYRINGE U-500	2	MO
BD INSULIN ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2"	2	MO
BD NANO 2ND GEN PEN NEEDLE	2	MO
BD ULTRA-FINE MICRO PEN NEEDLE	2	MO
BD ULTRA-FINE MINI PEN NEEDLE	2	MO
BD ULTRA-FINE NANO PEN NEEDLE	2	MO

Drug Name	Drug Tier	Requirements/Limits
BD ULTRA-FINE SHORT PEN NEEDLE	2	MO
BD VEO INSULIN SYR HALF UNIT	2	MO
BD VEO INSULIN SYRINGE UF	2	MO
BYDUREON BCISE	2	PA; MO; QL (4 per 28 days)
BYDUREON SUBCUTANEOUS PEN INJECTOR	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)
<i>diazoxide</i>	1	MO
DROPLET INSULIN SYR HALF UNIT	2	
DROPLET INSULIN SYRINGE	2	

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32"	2	MO
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)

Drug Name	Drug Tier	Requirements/Limits
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)
<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)
GVOKE HYPOPEN 2- PACK	2	MO
GVOKE PFS 2- PACK SYRINGE	2	MO
HUMALOG JUNIOR KWIKPEN U-100	2	MO
HUMALOG KWIKPEN INSULIN	2	MO
HUMALOG MIX 50-50 INSULN U- 100	2	MO
HUMALOG MIX 50-50 KWIKPEN	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO
HUMALOG MIX 75-25(U- 100)INSULN	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
HUMALOG U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 KWIKPEN	2	MO
HUMULIN N NPH INSULIN KWIKPEN	2	MO
HUMULIN N NPH U-100 INSULIN	2	MO
HUMULIN R REGULAR U-100 INSULIN	2	MO
HUMULIN R U-500 (CONC) INSULIN	2	MO
HUMULIN R U-500 (CONC) KWIKPEN	2	MO
INSULIN PEN NEEDLE	2	MO
INSULIN SYRINGE (DISP) U-100 0.3 ML, 1 ML, 1/2 ML	2	MO
INVOKAMET	2	MO; QL (60 per 30 days)
INVOKAMET XR	2	MO; QL (60 per 30 days)
INVOKANA	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
JANUMET	2	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	2	MO; QL (60 per 30 days)
JANUVIA	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)

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
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)
LANTUS SOLOSTAR U-100 INSULIN	2	MO
LANTUS U-100 INSULIN	2	MO
LYUMJEV KWIKPEN U-100 INSULIN	2	MO
LYUMJEV KWIKPEN U-200 INSULIN	2	MO
LYUMJEV U-100 INSULIN	2	MO
<i>metformin oral solution</i>	1	MO; QL (765 per 30 days)
<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)

Drug Name	Drug Tier	Requirements/Limits
<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 (60 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)
NOVOFINE 32	2	MO
NOVOFINE PLUS	2	MO
NOVOLOG FLEXPEN U-100 INSULIN	3	ST; MO
NOVOLOG MIX 70-30 U-100 INSULIN	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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
NOVOLOG MIX 70-30FLEXPEN U-100	3	ST; MO
NOVOLOG PENFILL U-100 INSULIN	3	ST; MO
NOVOLOG U-100 INSULIN ASPART	3	ST; MO
NOVOTWIST NEEDLE 32 GAUGE X 1/5"	2	MO
OMNIPOD DASH 5 PACK POD	2	MO
OMNIPOD INSULIN MANAGEMENT	2	MO
OMNIPOD INSULIN REFILL	2	MO
ONGLYZA	2	MO; QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	2	PA; MO; QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/DOSE (2 MG/1.5 ML)	2	PA; MO; QL (3 per 28 days)
<i>pioglitazone</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>pioglitazone-glimepiride</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-metformin</i>	1	MO; QL (90 per 30 days)
QTERN	2	MO; QL (30 per 30 days)
<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)
RYBELSUS	2	PA; MO; QL (30 per 30 days)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	2	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	2	MO; QL (120 per 30 days)
SOLIQUA 100/33	2	MO; QL (15 per 30 days)
STEGLATRO	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
SYMLINPEN 120	4	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	4	PA; MO; QL (6 per 30 days)
TECHLITE INSULIN SYR HALF UNIT	2	
TECHLITE INSULIN SYRINGE	2	
TECHLITE PEN NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 32 GAUGE X 5/32"	2	MO
TECHLITE PEN NEEDLE 29 GAUGE X 3/8"	2	
TOUJEO MAX U-300 SOLOSTAR	2	MO
TOUJEO SOLOSTAR U-300 INSULIN	2	MO
TRADJENTA	3	ST; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	2	
TRUEPLUS INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	2	MO
TRUEPLUS PEN NEEDLE	2	MO
TRULICITY	2	PA; MO; QL (2 per 28 days)
VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
XULTOPHY 100/3.6	2	MO; QL (15 per 30 days)

MISCELLANEOUS HORMONES

ANDRODERM	2	PA; MO; QL (30 per 30 days)
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon)</i>	1	MO
<i>calcitriol oral</i>	1	MO
CERDELGA	4	PA; MO
<i>cinacalcet oral tablet 30 mg</i>	1	MO
<i>cinacalcet oral tablet 60 mg, 90 mg</i>	4	MO
<i>danazol</i>	1	MO
DDAVP NASAL SOLUTION	2	MO
<i>desmopressin nasal spray, non-aerosol</i>	1	MO
<i>desmopressin oral</i>	1	MO
<i>doxercalciferol oral</i>	1	MO
KORLYM	4	PA; MO
KUVAN	4	PA; MO
<i>methyltestosterone oral capsule</i>	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>miglustat</i>	4	PA; MO; LA
MYALEPT	4	PA; MO; LA
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
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	4	PA; MO; LA; QL (15 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	4	PA; MO; LA; QL (4 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	4	PA; MO; LA; QL (60 per 30 days)
<i>paricalcitol oral</i>	1	MO
SAMSCA	4	PA; MO
SOMAVERT	4	PA; MO
STIMATE	4	MO
SYNAREL	4	MO
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)</i>	1	PA; MO
<i>testosterone enanthate</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram lactuation</i>	1	PA; MO; QL (120 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5 gram), 1 % (50 mg/5 gram)</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	1	PA; MO; QL (37.5 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal solution in metered pump w/lapp</i>	1	PA; MO; QL (180 per 30 days)
THYROID HORMONES		
<i>euthyrox</i>	1	MO
<i>levo-t</i>	1	
<i>levothyroxine oral</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<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 oral</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>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
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO
<i>loperamide oral capsule</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron</i>	4	MO
<i>aprepitant</i>	1	PA; MO
<i>balsalazide</i>	1	MO
<i>budesonide oral capsule, delayed, extended release</i>	1	MO
<i>budesonide oral tablet, delayed and ext. release</i>	4	MO
CHENODAL	4	PA; MO; 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; QL (2 per 28 days)
CIMZIA POWDER FOR RECONST	4	PA; MO; QL (2 per 28 days)
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	2	MO
CREON	2	MO
<i>cromolyn oral</i>	1	MO
CYSTADANE	4	MO
DIPENTUM	4	MO

Drug Name	Drug Tier	Requirements/Limits
<i>doxylamine-pyridoxine (vit b6)</i>	1	MO
<i>dronabinol</i>	1	PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	3	PA; MO
<i>enulose</i>	1	MO
GATTEX 30-VIAL	4	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>gavilyte-n</i>	1	MO
<i>generlac</i>	1	MO
<i>granisetron hcl oral</i>	1	PA; MO
<i>hydrocortisone rectal</i>	1	MO
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	MO
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO
LINZESS	2	MO; QL (30 per 30 days)
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO
<i>mesalamine</i>	1	MO
<i>metoclopramide hcl oral</i>	1	MO
MOTEGRITY	3	ST; 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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
MOVANTIK	2	MO; QL (30 per 30 days)
OICALIVA	4	PA; MO; LA; QL (30 per 30 days)
<i>ondansetron</i>	1	PA; MO
<i>ondansetron hcl oral solution</i>	1	PA; MO
<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</i>	1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	2	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	4	MO
<i>prochlorperazine</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
<i>proctozone-hc</i>	1	MO
RECTIV	2	MO

Drug Name	Drug Tier	Requirements/Limits
RELISTOR SUBCUTANEOUS SOLUTION	4	MO
RELISTOR SUBCUTANEOUS SYRINGE	4	MO
REMICADE	4	PA; MO; QL (20 per 28 days)
SANCUSO	4	MO
<i>scopolamine base</i>	1	MO
SUCRAID	4	PA; MO
<i>sulfasalazine</i>	1	MO
SUPREP BOWEL PREP KIT	2	MO
SYMPROIC	2	MO
<i>trilyte with flavor packets</i>	1	MO
TRULANCE	2	MO
<i>ursodiol</i>	1	MO
VARUBI ORAL	2	PA; MO
VIBERZI	4	MO; QL (60 per 30 days)
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 [express-scripts.com](https://www.express-scripts.com).

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ZENPEP ORAL CAPSULE, DELAYED RELEASE (DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000-168,000 UNIT, 5,000-17,000-24,000 UNIT	2	MO
ULCER THERAPY		
<i>cimetidine</i>	1	MO
<i>cimetidine hcl oral</i>	1	MO
DEXILANT ORAL CAPSULE, BIPHASE DELAYED RELEASE 30 MG	3	MO; QL (30 per 30 days)
DEXILANT ORAL CAPSULE, BIPHASE DELAYED RELEASE 60 MG	3	MO
<i>esomeprazole magnesium oral capsule, delayed release (drlec) 20 mg</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>esomeprazole magnesium oral capsule, delayed release (drlec) 40 mg</i>	1	MO
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</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 (drlec) 15 mg</i>	1	MO; QL (30 per 30 days)
<i>lansoprazole oral capsule, delayed release (drlec) 30 mg</i>	1	MO
<i>misoprostol</i>	1	MO
NEXIUM PACKET ORAL GRANULES DR FOR SUSP IN PACKET 2.5 MG, 5 MG	2	MO; QL (30 per 30 days)
<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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>omeprazole oral capsule, delayed release (drlec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>omeprazole oral capsule, delayed release (drlec) 40 mg</i>	1	MO
<i>pantoprazole oral tablet, delayed release (drlec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet, delayed release (drlec) 40 mg</i>	1	MO
<i>sucralfate</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 25 MCG/ML, 40 MCG/ML	3	PA; MO
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 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 (14 per 28 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	4	PA; MO
INTRON A INJECTION	4	PA; MO
LEUKINE INJECTION RECON SOLN	4	PA; MO
NIVESTYM	4	PA; MO
OMNITROPE	4	PA; MO
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	4	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)

Drug Name	Drug Tier	Requirements/Limits
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
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	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)

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
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)
RETACRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	2	PA; MO
RETACRIT INJECTION SOLUTION 40,000 UNIT/ML	4	PA; MO
SYLATRON SUBCUTANEOUS KIT 200 MCG, 300 MCG	4	PA; MO
ZARXIO	4	PA; MO
ZIEXTENZO	4	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT)(PF)	2	MO

Drug Name	Drug Tier	Requirements/Limits
BCG VACCINE, LIVE (PF)	2	MO
BEXSERO	2	MO
BOOSTRIX TDAP	2	MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO
ENGRIX-B (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
ENGRIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
GARDASIL 9 (PF)	2	MO
HAVRIX (PF) INTRAMUSCULAR SUSPENSION 1,440 ELISA UNIT/ML	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
HIBERIX (PF)	2	MO
IMOVAX RABIES VACCINE (PF)	2	MO
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	2	MO
IPOL	2	MO
IXIARO (PF)	2	MO
KINRIX (PF) INTRAMUSCULAR SUSPENSION	2	

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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	2	MO
MENVEO A-C-Y-W-135-DIP (PF)	2	MO
M-M-R II (PF)	2	MO
ODACTRA	2	PA; MO
PEDIARIX (PF)	2	MO
PEDVAX HIB (PF)	2	MO
PRIVIGEN	4	PA; MO
PROQUAD (PF)	2	MO
QUADRACEL (PF)	2	MO
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
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	2	PA
ROTARIX	2	

Drug Name	Drug Tier	Requirements/Limits
ROTATEQ VACCINE	2	MO
SHINGRIX (PF)	2	MO
TDVAX	2	MO
TENIVAC (PF) INTRAMUSCULAR SYRINGE	2	MO
TETANUS,DIPH THERIA TOX PED(PF)	2	MO
TRUMENBA	2	MO
TWINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
TYPHIM VI INTRAMUSCULAR SYRINGE	2	MO
VAQTA (PF)	2	MO
VARIVAX (PF)	2	MO
VARIZIG INTRAMUSCULAR SOLUTION	2	MO
YF-VAX (PF)	2	MO
ZOSTAVAX (PF)	2	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>colchicine oral tablet</i>	1	MO
<i>febuxostat</i>	1	MO
MITIGARE	2	MO
<i>probenecid</i>	1	MO
<i>probenecid-colchicine</i>	1	MO

OSTEOPOROSIS THERAPY

<i>alendronate oral solution</i>	1	MO; QL (1286 per 30 days)
<i>alendronate oral tablet 10 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)
FOSAMAX PLUS D	3	ST; MO; QL (4 per 28 days)
<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
PROLIA	2	PA; MO; QL (1 per 180 days)
<i>raloxifene</i>	1	MO
<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)

Drug Name	Drug Tier	Requirements/Limits
<i>risedronate oral tablet, delayed release (drlec)</i>	1	MO; QL (4 per 28 days)
TERIPARATIDE	4	PA; MO; QL (2.48 per 28 days)

OTHER RHEUMATOLOGICALS

ACTEMRA ACTPEN	4	PA; MO; QL (3.6 per 28 days)
ACTEMRA SUBCUTANEOUS	4	PA; MO; QL (3.6 per 28 days)
BENLYSTA SUBCUTANEOUS	4	PA; MO
ENBREL MINI	4	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	4	PA; MO; QL (16 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	4	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	4	PA; MO; QL (8 per 28 days)
HUMIRA PEN	4	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHNS-UC-HS START	4	PA; MO; QL (6 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN PSOR-UVEITS-ADOL HS	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)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	4	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	4	PA; MO; QL (2 per 180 days)
HUMIRA(CF) PEN CROHNS-UC-HS	4	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	4	PA; MO; QL (3 per 180 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	4	PA; MO; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	4	PA; MO; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	4	PA; MO; QL (4 per 28 days)
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
ORENCIA CLICKJECT	4	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	4	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	4	PA; MO; QL (1.6 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	4	PA; MO; QL (2.8 per 28 days)
OTEZLA	4	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	4	PA; MO; QL (55 per 28 days)
<i>penicillamine</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
RIDAURA	4	MO
RINVOQ	4	PA; MO; QL (30 per 30 days)
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS, DOSE PACK	2	MO; QL (55 per 30 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	4	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	4	PA; MO; QL (0.5 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	4	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	4	PA; MO; QL (0.5 per 28 days)
XELJANZ	4	PA; MO; QL (60 per 30 days)
XELJANZ XR	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
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
DEPO-PROVERA INTRAMUSCULAR SUSPENSION 400 MG/ML	3	MO
DEPO-SUBQ PROVERA 104	3	MO
<i>dotti</i>	1	PA; MO; QL (8 per 28 days)
DUAVEE	2	MO
<i>errin</i>	1	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 vaginal</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 **express-scripts.com**.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<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>fyavolv</i>	1	PA; MO
<i>incassia</i>	1	MO
<i>jinteli</i>	1	PA; MO
<i>lyza</i>	1	MO
<i>medroxyprogesterone</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 acetate estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	PA; MO
PREMARIN ORAL	2	MO
PREMARIN VAGINAL	2	MO
PREMPHASE	2	MO
PREMPRO	2	MO
<i>progesterone micronized</i>	1	MO
<i>sharobel</i>	1	MO
<i>yuvafem</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS OB/GYN		
CLEOCIN VAGINAL SUPPOSITORY	3	MO
<i>clindamycin phosphate vaginal</i>	1	MO
<i>eluryng</i>	1	MO
<i>etonogestrel-ethinyl estradiol</i>	1	MO
<i>metronidazole vaginal</i>	1	MO
<i>terconazole</i>	1	MO
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO
<i>xulane</i>	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>altavera (28)</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO
<i>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>aubra eq</i>	1	MO
<i>aviane</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>cyred eq</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>desog-e.estradiol.e.estradiol</i>	1	MO
<i>drospirenone-ethinyl estradiol</i>	1	MO
<i>emoquette</i>	1	MO
<i>enpresse</i>	1	MO
<i>enskyce</i>	1	MO
<i>estarylla</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	MO
<i>gianvi (28)</i>	1	MO
<i>introvale</i>	1	MO
<i>isibloom</i>	1	MO
<i>jasmiel (28)</i>	1	MO
<i>juleber</i>	1	MO
<i>kariva (28)</i>	1	MO
<i>kelnor 1/35 (28)</i>	1	MO
<i>kelnor 1-50</i>	1	MO
<i>kurvelo (28)</i>	1	MO
<i>l norgestle.estradiol-e.estradiol</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
<i>lessina</i>	1	MO
<i>levonest (28)</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>levonorgestrel-ethinyl estradiol</i>	1	MO
<i>levonorg-eth estradiol triphasic</i>	1	MO
<i>levora-28</i>	1	MO
<i>loryna (28)</i>	1	MO
<i>low-ogestrel (28)</i>	1	MO
<i>luteria (28)</i>	1	MO
<i>marlissa (28)</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>mili</i>	1	MO
<i>nikki (28)</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</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>orsythia</i>	1	MO
<i>pimtrea (28)</i>	1	MO
<i>pirmella oral tablet 1-35 mg-mcg</i>	1	MO
<i>portia 28</i>	1	MO
<i>previfem</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>reclipsen (28)</i>	1	MO
<i>setlakin</i>	1	MO
<i>sprintec (28)</i>	1	MO
<i>sronyx</i>	1	MO
<i>syeda</i>	1	MO
<i>tarina 24 fe</i>	1	MO
<i>tarina fe 1-20 eq (28)</i>	1	MO
<i>tri-estarylla</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>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>vienva</i>	1	MO
<i>zarah</i>	1	MO
<i>zovia 1/35e (28)</i>	1	MO

OPHTHALMOLOGY

ANTIBIOTICS

AZASITE	2	MO
<i>bacitracin ophthalmic (eye)</i>	1	MO
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	1	MO
BESIVANCE	2	MO
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>erythromycin ophthalmic (eye)</i>	1	MO
<i>gatifloxacin</i>	1	MO
<i>gentak ophthalmic (eye) ointment</i>	1	MO
<i>gentamicin ophthalmic (eye) drops</i>	1	MO; QL (15 per 30 days)
<i>levofloxacin ophthalmic (eye)</i>	1	MO
<i>moxifloxacin ophthalmic (eye) drops</i>	1	MO
NATACYN	2	MO
<i>neomycin-bacitracin-polymyxin</i>	1	MO
<i>neomycin-polymyxin-gramicidin</i>	1	MO
<i>ofloxacin ophthalmic (eye)</i>	1	MO
<i>polymyxin b sulf-trimethoprim</i>	1	MO
<i>tobramycin</i>	1	MO

ANTIVIRALS

<i>trifluridine</i>	1	MO
ZIRGAN	3	MO

BETA-BLOCKERS

<i>betaxolol ophthalmic (eye)</i>	1	MO
<i>carteolol</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>timolol maleate ophthalmic (eye)</i>	1	MO
MISCELLANEOUS OPHTHALMOLOGICS		
<i>atropine ophthalmic (eye) drops</i>	1	MO
<i>azelastine ophthalmic (eye)</i>	1	MO
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
<i>cromolyn ophthalmic (eye)</i>	1	MO
CYSTARAN	4	PA; MO
<i>epinastine</i>	1	MO
<i>olopatadine ophthalmic (eye)</i>	1	MO
OXERVATE	4	PA; MO
PAZEO	2	MO
PHOSPHOLINE IODIDE	3	MO
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO
RESTASIS	2	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	2	MO; QL (5.5 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>sulfacetamide sodium ophthalmic (eye)</i>	1	MO
<i>sulfacetamide-prednisolone</i>	1	MO
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
<i>bromfenac</i>	1	MO
BROMSITE	2	MO
<i>diclofenac sodium ophthalmic (eye)</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
ILEVRO	2	MO
<i>ketorolac ophthalmic (eye)</i>	1	MO
PROLENSA	2	MO
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide</i>	1	MO
<i>methazolamide</i>	1	MO
OTHER GLAUCOMA DRUGS		
<i>bimatoprost ophthalmic (eye)</i>	1	MO
COMBIGAN	2	MO
<i>dorzolamide</i>	1	MO
<i>dorzolamide-timolol</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	1	MO
<i>latanoprost</i>	1	MO
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	2	MO
RHOPRESSA	2	MO
ROCKLATAN	2	MO
SIMBRINZA	3	MO
<i>travoprost</i>	1	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 (eye)</i>	1	MO
TOBRADEX OPHTHALMIC (EYE) OINTMENT	2	MO
<i>tobramycin-dexamethasone</i>	1	MO
STERIODS		
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	1	MO
<i>fluorometholone</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
INVELTYS	3	MO
LOTEMAX OPHTHALMIC (EYE) DROPS, GEL	2	MO
LOTEMAX OPHTHALMIC (EYE) OINTMENT	2	MO
LOTEMAX SM	2	MO
<i>loteprednol etabonate</i>	1	MO
<i>prednisolone acetate</i>	1	MO
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	1	MO
SYMPATHOMIMETICS		
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	2	MO
<i>apraclonidine</i>	1	MO
<i>brimonidine</i>	1	MO
IOPIDINE OPHTHALMIC (EYE) DROPPERETTE	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
RESPIRATORY AND ALLERGY		
ANTIHISTAMINE / ANTIALLERGIC AGENTS		
<i>cetirizine oral solution 1 mg/ml</i>	1	MO
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	1	MO; QL (2 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 oral</i>	1	PA; MO
SYMJEPI	3	MO; QL (2 per 30 days)
PULMONARY AGENTS		
<i>acetylcysteine</i>	1	PA; MO
ADEMPAS	4	PA; MO; LA
ADVAIR DISKUS	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ADVAIR HFA	2	MO; QL (12 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/lactuation</i>	1	MO; QL (17 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/lactuation (nda020503)</i>	1	MO; QL (13.4 per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/3 ml (0.083 %), 2.5 mg/0.5 ml</i>	1	PA; MO
<i>albuterol sulfate oral</i>	1	MO
<i>alyq</i>	4	PA; MO; QL (60 per 30 days)
<i>ambrisentan</i>	4	PA; MO; LA
ANORO ELLIPTA	2	MO; QL (60 per 30 days)
ARNUITY ELLIPTA	2	MO; QL (30 per 30 days)
ASMANEX HFA	2	MO; QL (13 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	2	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	2	MO; QL (2 per 30 days)
ATROVENT HFA	2	MO; QL (25.8 per 30 days)
<i>azelastine-fluticasone</i>	1	MO; QL (23 per 30 days)
<i>bosentan</i>	4	PA; MO; LA
BREO ELLIPTA	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	1	PA; MO; QL (120 per 30 days)
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	1	PA; MO; QL (60 per 30 days)
CINRYZE	4	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	PA; MO
DALIRESP ORAL TABLET 250 MCG	3	PA; MO; QL (30 per 30 days)
DALIRESP ORAL TABLET 500 MCG	3	PA; MO
DULERA	2	MO; QL (13 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)
FASENRA	4	PA; MO; QL (1 per 28 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
FASENRA PEN	4	PA; MO; QL (1 per 28 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)
FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)
FLOVENT 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)

Drug Name	Drug Tier	Requirements/Limits
<i>fluticasone propionate nasal</i>	1	MO; QL (16 per 30 days)
HAEGARDA	4	PA; MO; LA
<i>icatibant</i>	4	PA; MO
INCRUSE ELLIPTA	2	MO; QL (30 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)
<i>levalbuterol hcl</i>	1	PA; MO
<i>metaproterenol oral syrup</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 (3 per 28 days)
OFEV	4	PA; MO; QL (60 per 30 days)
OPSUMIT	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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI ORAL GRANULES IN PACKET	4	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	4	PA; MO; QL (112 per 28 days)
PERFOROMIST	2	PA; MO
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
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)

Drug Name	Drug Tier	Requirements/Limits
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	2	MO; QL (21.2 per 30 days)
SEREVENT DISKUS	2	MO; QL (60 per 30 days)
<i>sildenafil (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml</i>	4	PA; MO; QL (224 per 30 days)
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</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)

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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)
SYMBICORT	2	MO; QL (10.2 per 30 days)
SYMDEKO	4	PA; MO; QL (56 per 28 days)
<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	4	PA; MO; QL (60 per 30 days)
<i>terbutaline oral</i>	1	MO
THEO-24	2	MO
<i>theophylline oral solution</i>	1	MO
<i>theophylline oral tablet extended release 12 hr 300 mg</i>	1	MO
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
TRELEGY ELLIPTA	2	MO; QL (60 per 30 days)
TRIKAFTA	4	PA; MO
XOLAIR SUBCUTANEOUS RECON SOLN	4	PA; MO; LA; QL (6 per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML	4	PA; MO; LA; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	4	PA; MO; LA; QL (1 per 28 days)
<i>zafirlukast</i>	1	MO
ZYFLO	4	MO

UROLOGICALS

ANTICHOLINERGICS / ANTISPASMODICS

<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

BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY

<i>alfuzosin</i>	1	MO
<i>dutasteride</i>	1	MO
<i>dutasteride-tamsulosin</i>	1	MO
<i>finasteride oral tablet 5 mg</i>	1	MO
<i>silodosin</i>	1	MO
<i>tamsulosin</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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS UROLOGICALS		
<i>bethanechol chloride</i>	1	MO
CYSTAGON	3	PA; MO; LA
ELMIRON	2	MO
<i>potassium citrate</i>	1	MO
<i>tadalafil oral tablet 2.5 mg, 5 mg</i>	1	PA; MO; QL (30 per 30 days)
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
<i>calcium acetate (phosphate bind)</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 oral packet 20</i>	1	MO
<i>k-tab oral tablet extended release 8 meq</i>	1	MO
<i>magnesium sulfate injection solution</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>magnesium sulfate injection syringe</i>	1	
NORMOSOL-R	3	MO
<i>potassium chloride 0.45% NaCl intravenous parenteral solution 10 meq/l, 30 meq/l, 40 meq/l</i>	1	
<i>potassium chloride 0.45% NaCl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride 10 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% dextrose intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride in 0.45% NaCl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride in water intravenous piggyback 10 meq/100 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride in water intravenous piggyback 20 meq/100 ml, 40 meq/100 ml</i>	1	
<i>potassium chloride-0.45 % nacl</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	MO
<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>sodium chloride 0.45 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride 3 %</i>	1	MO
<i>sodium chloride 5 %</i>	1	MO
MISCELLANEOUS NUTRITION PRODUCTS		
AMINOSYN II 10 %	3	PA
AMINOSYN II 15 %	3	PA

Drug Name	Drug Tier	Requirements/Limits
AMINOSYN-PF 7 % (SULFITE-FREE)	3	PA
CLINIMIX 5%/D15W SULFITE FREE	3	PA
CLINIMIX 4.25%/D10W SULF FREE	3	PA
CLINIMIX 5%-D20W(SULFITE-FREE)	3	PA
HEPATAMINE 8%	2	PA
<i>intralipid intravenous emulsion 20 %</i>	1	PA
ISOLYTE-P IN 5 % DEXTROSE	3	
ISOLYTE-S	3	
NEPHRAMINE 5.4 %	3	PA
PLASMA-LYTE 148	2	
PLASMA-LYTE A	2	
<i>plenamine</i>	1	PA
<i>premasol 10 %</i>	1	PA; MO
<i>travasol 10 %</i>	1	PA; MO
TROPHAMINE 10 %	3	PA; MO
VITAMINS / HEMATINICS		
<i>fluoride (sodium) 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 express-scripts.com.

This drug list was updated in August 2020

Drug Name	Drug Tier	Requirements/Limits
<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 **[express-scripts.com](https://www.express-scripts.com)**.

This drug list was updated in August 2020

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 **express-scripts.com**.

This drug list was updated in August 2020

Index

<i>abacavir</i>	1	<i>aliskiren</i>	31	APOKYN.....	19
<i>abacavir-lamivudine</i>	1	<i>allopurinol</i>	59	<i>apraclonidine</i>	67
<i>abacavir-lamivudine-</i> <i>zidovudine</i>	1	<i>alosetron</i>	53	<i>aprepitant</i>	53
ABELCET.....	1	ALPHAGAN P.....	67	<i>apri</i>	63
ABILIFY MAINTENA.....	25	<i>altavera (28)</i>	63	APTIOM.....	16
<i>abiraterone</i>	10	ALUNBRIG.....	10	APTIVUS.....	2
<i>acamprosate</i>	41	<i>alyacen 1/35 (28)</i>	63	APTIVUS (WITH	
<i>acarbose</i>	44	<i>alyq</i>	68	VITAMIN E).....	2
<i>acebutolol</i>	31	<i>amantadine hcl</i>	2	ARALAST NP.....	42
<i>acetaminophen-codeine</i>	21	AMBISOME.....	1	<i>aranelle (28)</i>	63
<i>acetazolamide</i>	66	<i>ambrisentan</i>	68	ARANESP (IN	
<i>acetic acid</i>	43	<i>amikacin</i>	6	POLYSORBATE).....	56
<i>acetylcysteine</i>	68	<i>amiloride</i>	31	ARCALYST.....	56
<i>acitretin</i>	36	<i>amiloride-hydrochlorothiazide</i>	31	ARIKAYCE.....	6
ACTEMRA.....	60	AMINOSYN II 10 %.....	74	<i>aripiprazole</i>	25
ACTEMRA ACTPEN.....	60	AMINOSYN II 15 %.....	74	ARISTADA.....	25
ACTHIB (PF).....	58	AMINOSYN-PF 7 %		ARISTADA INITIO.....	25
ACTIMMUNE.....	56	(SULFITE-FREE).....	74	<i>armodafinil</i>	25
<i>acyclovir</i>	1, 40	<i>amiodarone</i>	31	ARNUITY ELLIPTA.....	68
<i>acyclovir sodium</i>	1	<i>amitriptyline</i>	25	ASMANEX HFA.....	68
ADACEL(TDAP		<i>amlodipine</i>	31	ASMANEX	
ADOLESN/ADULT)(PF)....	58	<i>amlodipine-atorvastatin</i>	35	TWISTHALER.....	69
<i>adefovir</i>	1	<i>amlodipine-benazepril</i>	31	<i>aspirin-dipyridamole</i>	34
ADEMPAS.....	68	<i>amlodipine-olmesartan</i>	31	<i>atazanavir</i>	2
ADVAIR DISKUS.....	68	<i>amlodipine-valsartan</i>	31	<i>atenolol</i>	31
ADVAIR HFA.....	68	<i>amlodipine-valsartan-</i>		<i>atenolol-chlorthalidone</i>	31
AFINITOR.....	10	<i>hcthiiazid</i>	31	<i>atomoxetine</i>	25
AFINITOR DISPERZ.....	10	<i>ammonium lactate</i>	37	<i>atorvastatin</i>	35
AIMOVIG		<i>amoxapine</i>	25	<i>atovaquone</i>	6
AUTOINJECTOR.....	19	<i>amoxicillin</i>	7, 8	<i>atovaquone-proguanil</i>	6
AJOVY AUTOINJECTOR..	19	<i>amoxicillin-pot clavulanate</i>	8	ATRIPLA.....	2
AJOVY SYRINGE.....	19	<i>amphotericin b</i>	1	<i>atropine</i>	66
<i>ala-cort</i>	40	<i>ampicillin</i>	8	ATROVENT HFA.....	69
<i>albendazole</i>	6	<i>ampicillin sodium</i>	8	AUBAGIO.....	20
<i>albuterol sulfate</i>	68	<i>ampicillin-sulbactam</i>	8	<i>aubra eq</i>	63
<i>alclometasone</i>	40	<i>anagrelide</i>	41	<i>aviane</i>	63
ALCOHOL PADS.....	44	<i>anastrozole</i>	10	<i>avita</i>	38
ALECENSA.....	10	ANDRODERM.....	51	AVONEX.....	56
<i>alendronate</i>	60	ANORO ELLIPTA.....	68	AYVAKIT.....	10
<i>alfuzosin</i>	72	APIDRA SOLOSTAR U-		AZASITE.....	65
ALINIA.....	6	100 INSULIN.....	45	<i>azathioprine</i>	10
		APIDRA U-100 INSULIN...	45	<i>azelaic acid</i>	38

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 express-scripts.com.

This drug list was updated in August 2020

<i>azelastine</i>	43, 66	<i>betamethasone valerate</i>	40	BYDUREON BCISE.....	45
<i>azelastine-fluticasone</i>	69	<i>betamethasone, augmented</i>	40	BYETTA.....	45
<i>azithromycin</i>	5	BETASERON.....	56	BYSTOLIC.....	32
<i>aztreonam</i>	6	<i>betaxolol</i>	31, 65	<i>cabergoline</i>	51
<i>bacitracin</i>	65	<i>bethanechol chloride</i>	73	CABLIVI.....	34
<i>bacitracin-polymyxin b</i>	65	BETHKIS.....	6	CABOMETYX.....	10
<i>baclofen</i>	21	<i>bexarotene</i>	10	<i>calcipotriene</i>	37
<i>balsalazide</i>	53	BEXSERO.....	58	<i>calcipotriene-betamethasone</i> ...	37
BALVERSA.....	10	<i>bicalutamide</i>	10	<i>calcitonin (salmon)</i>	51
BANZEL.....	16	BICILLIN C-R.....	8	<i>calcitriol</i>	37, 51
BARACLUDE.....	2	BICILLIN L-A.....	8	<i>calcium acetate (phosphat</i>	
BCG VACCINE, LIVE (PF).....	58	BIDIL.....	31	<i>bind)</i>	73
BD AUTOSHIELD DUO		BIKTARVY.....	2	CALQUENCE.....	10
PEN NEEDLE.....	45	<i>bimatoprost</i>	66	<i>camila</i>	62
BD INSULIN SYRINGE		<i>bisoprolol fumarate</i>	31	<i>candesartan</i>	32
HALF UNIT.....	45	<i>bisoprolol-</i>		<i>candesartan-</i>	
BD INSULIN SYRINGE		<i>hydrochlorothiazide</i>	32	<i>hydrochlorothiazid</i>	32
U-500.....	45	BLEPHAMIDE.....	66	CAPEX.....	40
BD INSULIN SYRINGE		BLEPHAMIDE S.O.P.....	66	CAPLYTA.....	25
ULTRA-FINE.....	45	BOOSTRIX TDAP.....	58	CAPRELSA.....	10
BD NANO 2ND GEN PEN		<i>bosentan</i>	69	<i>captopril</i>	32
NEEDLE.....	45	BOSULIF.....	10	<i>captopril-hydrochlorothiazide</i> ...	32
BD ULTRA-FINE MICRO		BRAFTOVI.....	10	CARBAGLU.....	42
PEN NEEDLE.....	45	BREO ELLIPTA.....	69	<i>carbamazepine</i>	16
BD ULTRA-FINE MINI		BRILINTA.....	34	<i>carbidopa</i>	19
PEN NEEDLE.....	45	<i>brimonidine</i>	67	<i>carbidopa-levodopa</i>	19
BD ULTRA-FINE NANO		BRIVIACT.....	16	<i>carbidopa-levodopa-</i>	
PEN NEEDLE.....	45	<i>bromfenac</i>	66	<i>entacapone</i>	19
BD ULTRA-FINE SHORT		<i>bromocriptine</i>	19	<i>carteolol</i>	65
PEN NEEDLE.....	45	BROMSITE.....	66	<i>cartia xt</i>	32
BD VEO INSULIN SYR		BRUKINSA.....	10	<i>carvedilol</i>	32
HALF UNIT.....	45	<i>budesonide</i>	53, 69	<i>caspofungin</i>	1
BD VEO INSULIN		<i>bumetanide</i>	32	CAYSTON.....	6
SYRINGE UF.....	45	<i>buprenorphine hcl</i>	21	<i>caziant (28)</i>	63
BELBUCA.....	21	<i>buprenorphine transdermal</i>		<i>cefaclor</i>	4
<i>benazepril</i>	31	<i>patch</i>	22	<i>cefadroxil</i>	4
<i>benazepril-</i>		<i>buprenorphine-naloxone</i>	23, 24	<i>cefazolin</i>	4
<i>hydrochlorothiazide</i>	31	<i>bupropion hcl</i>	25	<i>cefdinir</i>	4
BENLYSTA.....	60	<i>bupropion hcl (smoking</i>		<i>cefepime</i>	4
BENZNIDAZOLE.....	6	<i>deter)</i>	43	<i>cefixime</i>	4
<i>benztropine</i>	19	<i>buspirone</i>	25	<i>cefoxitin</i>	4, 5
BESIVANCE.....	65	<i>butorphanol</i>	24	<i>cefpodoxime</i>	5
<i>betamethasone dipropionate</i> ...	40	BYDUREON.....	45	<i>cefprozil</i>	5

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 **express-scripts.com**.

This drug list was updated in August 2020

<i>ceftazidime</i>	5	<i>clindamycin pediatric</i>	6	CREON.....	53
<i>ceftriaxone</i>	5	<i>clindamycin phosphate</i> ..	6, 38, 63	CRESEMBA.....	1
<i>cefuroxime axetil</i>	5	CLINIMIX 5%/D15W		CRINONE.....	62
<i>cefuroxime sodium</i>	5	SULFITE FREE.....	74	CRIVIVAN.....	2
<i>celecoxib</i>	24	CLINIMIX 4.25%/D10W		<i>cromolyn</i>	53, 66, 69
CELONTIN.....	16	SULF FREE.....	74	<i>cryselle (28)</i>	63
<i>cephalexin</i>	5	CLINIMIX 4.25%/D5W		<i>cyclafem 1/35 (28)</i>	63
CERDELGA.....	51	SULFIT FREE.....	42	<i>cyclafem 7/7/7 (28)</i>	63
<i>cetirizine</i>	68	CLINIMIX 5%-		<i>cyclobenzaprine</i>	21
<i>cevimeline</i>	42	D20W(SULFITE-FREE).....	74	<i>cyclophosphamide</i>	11
CHANTIX.....	43	<i>clobazam</i>	16	CYCLOSET.....	45
CHANTIX CONTINUING		<i>clobetasol</i>	40	<i>cyclosporine</i>	11
MONTH BOX.....	43	<i>clobetasol-emollient</i>	40	<i>cyclosporine modified</i>	11
CHANTIX STARTING		<i>clodan</i>	40	<i>cyred eq</i>	63
MONTH BOX.....	43	<i>clomipramine</i>	26	CYSTADANE.....	53
CHEMET.....	42	<i>clonazepam</i>	17	CYSTAGON.....	73
CHENODAL.....	53	<i>clonidine</i>	32	CYSTARAN.....	66
<i>chlorhexidine gluconate</i>	43	<i>clonidine hcl</i>	26, 32	<i>d10 %-0.45 % sodium chloride</i>	42
<i>chloroquine phosphate</i>	6	<i>clopidogrel</i>	34	<i>d2.5 %-0.45 % sodium</i>	
<i>chlorpromazine</i>	25	<i>clorazepate dipotassium</i>	26	<i>chloride</i>	42
<i>chlorthalidone</i>	32	<i>clotrimazole</i>	1, 39	<i>d5 % and 0.9 % sodium</i>	
CHOLBAM.....	53	<i>clotrimazole-betamethasone</i>	39	<i>chloride</i>	42
<i>cholestyramine (with sugar)</i> ...	35	<i>clovique</i>	42	<i>d5 %-0.45 % sodium chloride</i> ..	42
<i>cholestyramine light</i>	35	<i>clozapine</i>	26	<i>dalfampridine</i>	20
<i>ciclopixox</i>	39	CLOZAPINE.....	26	DALIRESP.....	69
<i>cilostazol</i>	34	COARTEM.....	6	<i>danazol</i>	51
CIMDUO.....	2	<i>colchicine</i>	60	<i>dantrolene</i>	21
<i>cimetidine</i>	55	<i>colesevelam</i>	35	<i>dapsone</i>	6, 38
<i>cimetidine hcl</i>	55	<i>colestipol</i>	35	DAPTACEL (DTAP	
CIMZIA.....	53	<i>colistin (colistimethate na)</i>	6	PEDIATRIC) (PF).....	58
CIMZIA POWDER FOR		COMBIGAN.....	66	DAPTOMYCIN.....	6
RECONST.....	53	COMBIVENT RESPIMAT ..	69	<i>daptomycin</i>	6
<i>cinacalcet</i>	51	COMETRIQ.....	11	DAURISMO.....	11
CINRYZE.....	69	COMPLERA.....	2	DDAVP.....	51
CIPRODEX.....	44	<i>compro</i>	53	<i>deblitane</i>	62
<i>ciprofloxacin hcl</i>	9, 43, 65	CONDYLOX.....	37	<i>deferasirox</i>	42
<i>ciprofloxacin in 5 % dextrose</i>	9	<i>constulose</i>	53	DELSTRIGO.....	2
<i>italopram</i>	25	COPAXONE.....	20	<i>demeclocycline</i>	9
<i>claravis</i>	38	COPIKTRA.....	11	DEMSEER.....	32
<i>clarithromycin</i>	5	CORLANOR.....	36	DENAVIR.....	40
CLEOCIN.....	63	CORTIFOAM.....	53	DEPO-PROVERA.....	62
<i>clindamycin hcl</i>	6	<i>cortisone</i>	44	DEPO-SUBQ PROVERA	
<i>clindamycin in 5 % dextrose</i>	6	COTELLIC.....	11	104.....	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 express-scripts.com.

This drug list was updated in August 2020

DESCOVY.....	2	<i>donepezil</i>	20	ELIQUIS DVT-PE TREAT	
<i>desipramine</i>	26	DOPTELET (10 TAB		30D START.....	34
<i>desmopressin</i>	51	PACK).....	34	ELMIRON.....	73
<i>desog-e.estradiolle.estradiol</i>	64	DOPTELET (15 TAB		<i>eluryng</i>	63
<i>desonide</i>	40	PACK).....	34	EMCYT.....	11
<i>desvenlafaxine succinate</i>	26	DOPTELET (30 TAB		EMEND.....	53
<i>dexamethasone</i>	44	PACK).....	34	EMGALITY PEN.....	19
<i>dexamethasone intensol</i>	44	<i>dorzolamide</i>	66	EMGALITY SYRINGE.....	19
<i>dexamethasone sodium</i>		<i>dorzolamide-timolol</i>	66	<i>emoquette</i>	64
<i>phosphate</i>	67	<i>dorzolamide-timolol (pf)</i>	67	EMSAM.....	26
DEXILANT.....	55	<i>dotti</i>	62	EMTRIVA.....	2
<i>dextroamphetamine</i>	26	DOVATO.....	2	EMVERM.....	6
<i>dextroamphetamine-</i>		<i>doxazosin</i>	32	<i>enalapril maleate</i>	32
<i>amphetamine</i>	26	<i>doxepin</i>	26, 37	<i>enalapril-hydrochlorothiazide</i> ..	32
<i>dextrose 10 % and 0.2 % nacl</i> ..	42	<i>doxercalciferol</i>	51	ENBREL.....	60
<i>dextrose 10 % in water</i>		<i>doxy-100</i>	9	ENBREL MINI.....	60
<i>(d10w)</i>	42	<i>doxycycline hyclate</i>	9	ENBREL SURECLICK.....	60
<i>dextrose 5 % in water (d5w)</i> ...42		<i>doxycycline monohydrate</i>	9	<i>endocet</i>	22
<i>dextrose 5%-0.2 % sod</i>		<i>doxylamine-pyridoxine (vit</i>		ENGERIX-B (PF).....	58
<i>chloride</i>	42	<i>b6)</i>	53	ENGERIX-B PEDIATRIC	
<i>dextrose with sodium chloride</i> ..	42	DRIZALMA SPRINKLE....	26	(PF).....	58
<i>diazepam</i>	17, 26	<i>dronabinol</i>	53	<i>enoxaparin</i>	34
<i>diazoxide</i>	45	DROPLET INSULIN SYR		<i>enpresse</i>	64
<i>diclofenac potassium</i>	24	HALF UNIT.....	45	<i>enskyce</i>	64
<i>diclofenac sodium</i>	24, 37, 66	DROPLET INSULIN		<i>entacapone</i>	19
<i>diclofenac-misoprostol</i>	24	SYRINGE.....	45	<i>entecavir</i>	2
<i>dicloxacillin</i>	8	DROPLET PEN NEEDLE...46		ENTRESTO.....	36
<i>dicyclomine</i>	52	<i>drospirenone-ethinyl estradiol</i> ..	64	<i>enulose</i>	53
<i>didanosine</i>	2	DROXIA.....	11	ENVARUSUS XR.....	11
<i>diflunisal</i>	24	DUAVEE.....	62	EPCLUSA.....	2
<i>digitek</i>	36	DULERA.....	69	EPIDIOLEX.....	17
<i>digox</i>	36	<i>duloxetine</i>	26	<i>epinastine</i>	66
<i>digoxin</i>	36	DUPIXENT SYRINGE.....	37	<i>epinephrine</i>	68
<i>dihydroergotamine</i>	19	<i>dutasteride</i>	72	<i>epitol</i>	17
DILANTIN 30 MG.....	17	<i>dutasteride-tamsulosin</i>	72	EPIVIR HBV.....	2
<i>diltiazem hcl</i>	32	<i>econazole</i>	39	<i>eplerenone</i>	32
<i>dilt-xr</i>	32	EDARBI.....	32	EPOGEN.....	57
DIPENTUM.....	53	EDARBYCLOR.....	32	<i>ergoloid</i>	26
<i>diphenoxylate-atropine</i>	52	EDURANT.....	2	<i>ergotamine-caffeine</i>	19
<i>dipyridamole</i>	34	<i>efavirenz</i>	2	ERIVEDGE.....	11
<i>disulfiram</i>	42	<i>eletriptan</i>	19	ERLEADA.....	11
<i>divalproex</i>	17	ELIQUIS.....	34	<i>erlotinib</i>	11
<i>dofetilide</i>	31			<i>errin</i>	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 **express-scripts.com**.

This drug list was updated in August 2020

<i>ertapenem</i>	6	<i>fenofibrate</i>	35	<i>fosamprenavir</i>	2
<i>ery-tab</i>	5	<i>fenofibrate micronized</i>	35	<i>fosinopril</i>	32
ERYTHROCIN	5	<i>fenofibrate nanocrystallized</i>	35	<i>fosinopril-hydrochlorothiazide</i>	32
<i>erythrocin (as stearate)</i>	5	<i>fenofibric acid (choline)</i>	35	<i>furosemide</i>	32
<i>erythromycin</i>	5, 65	<i>fenoprofen</i>	24	FUZEON	2
<i>erythromycin ethylsuccinate</i>	5	<i>fentanyl</i>	22	<i>fyavolv</i>	63
<i>erythromycin with ethanol</i>	38	<i>fentanyl citrate</i>	22	FYCOMPA	17
ESBRIET	69	FERRIPROX	42	<i>gabapentin</i>	17
<i>escitalopram oxalate</i>	26, 27	FETZIMA	27	<i>galantamine</i>	20
<i>esomeprazole magnesium</i>	55	<i>finasteride</i>	72	GARDASIL 9 (PF)	58
<i>estarylla</i>	64	FIRDAPSE	20	<i>gatifloxacin</i>	65
<i>estradiol</i>	62	FIRMAGON KIT W		GATTEX 30-VIAL	53
<i>estradiol valerate</i>	63	DILUENT SYRINGE	11	GAUZE PAD	46
<i>estradiol-norethindrone acet...</i>	63	<i>flac otic oil</i>	43	<i>gavilyte-c</i>	53
ESTRING	63	<i>flavoxate</i>	72	<i>gavilyte-g</i>	53
<i>eszopiclone</i>	27	<i>flecainide</i>	31	<i>gavilyte-n</i>	53
<i>ethacrynic acid</i>	32	FLOVENT DISKUS	70	<i>gemfibrozil</i>	35
<i>ethambutol</i>	6	FLOVENT HFA	70	<i>generlac</i>	53
<i>ethosuximide</i>	17	<i>fluconazole</i>	1	<i>gengraf</i>	11
<i>ethynodiol diac-eth estradiol...</i>	64	<i>fluconazole in nacl (iso-osm)</i>	1	<i>gentak</i>	65
<i>etodolac</i>	24	<i>flucytosine</i>	1	<i>gentamicin</i>	6, 38, 65
<i>etonogestrel-ethinyl estradiol..</i>	63	<i>fludrocortisone</i>	44	<i>gentamicin in nacl (iso-osm)</i>	6
<i>euthyrox</i>	52	<i>flunisolide</i>	70	GENVOYA	2
<i>everolimus (antineoplastic)</i>	11	<i>fluocinolone</i>	40, 41	GEODON	27
<i>everolimus</i>		<i>fluocinolone acetonide oil</i>	44	<i>gianvi (28)</i>	64
<i>(immunosuppressive)</i>	11	<i>fluocinolone and shower cap</i>	40	GILENYA	20
EVOTAZ	2	<i>fluocinonide</i>	41	GILOTRIF	11
<i>exemestane</i>	11	<i>fluocinonide-e</i>	41	<i>glatiramer</i>	20
<i>ezetimibe</i>	35	<i>fluoride (sodium)</i>	74	<i>glatopa</i>	20
<i>ezetimibe-simvastatin</i>	35	<i>fluorometholone</i>	67	<i>glimepiride</i>	46
<i>falmina (28)</i>	64	<i>fluorouracil</i>	37	<i>glipizide</i>	46
<i>famciclovir</i>	2	<i>fluoxetine</i>	27	<i>glipizide-metformin</i>	46
<i>famotidine</i>	55	<i>fluphenazine decanoate</i>	27	<i>glycopyrrolate</i>	52
FANAPT	27	<i>fluphenazine hcl</i>	27	GRALISE	17
FARXIGA	46	<i>flurbiprofen</i>	24	GRALISE 30-DAY	
FARYDAK	11	<i>flurbiprofen sodium</i>	66	STARTER PACK	17
FASENRA	69	<i>flutamide</i>	11	<i>granisetron hcl</i>	53
FASENRA PEN	70	<i>fluticasone propionate</i>	70	<i>griseofulvin microsize</i>	1
<i>fayosim</i>	64	<i>fluvastatin</i>	35	<i>griseofulvin ultramicrosize</i>	1
<i>febuxostat</i>	60	<i>fluvoxamine</i>	27	<i>guanidine</i>	27
<i>felbamate</i>	17	<i>fondaparinux</i>	34	GVOKE HYPOPEN 2-	
<i>felodipine</i>	32	FORFIVO XL	27	PACK	46
<i>femynor</i>	64	FOSAMAX PLUS D	60		

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 **express-scripts.com**.

This drug list was updated in August 2020

GVOKE PFS 2-PACK		HUMULIN 70/30 U-100		INCRELEX.....	42
SYRINGE.....	46	KWIKPEN.....	47	INCRUSE ELLIPTA.....	70
HAEGARDA.....	70	HUMULIN N NPH		<i>indapamide</i>	32
<i>halobetasol propionate</i>	41	INSULIN KWIKPEN.....	47	INFANRIX (DTAP) (PF)....	58
<i>haloperidol</i>	27	HUMULIN N NPH U-100		INLYTA.....	12
<i>haloperidol decanoate</i>	27	INSULIN.....	47	INREBIC.....	12
<i>haloperidol lactate</i>	27	HUMULIN R REGULAR		INSULIN PEN NEEDLE....	47
HARVONI.....	2	U-100 INSULN.....	47	INSULIN SYRINGE-	
HAVRIX (PF).....	58	HUMULIN R U-500		NEEDLE U-100.....	47
<i>heparin (porcine)</i>	34	(CONC) INSULIN.....	47	INTELENCE.....	2
HEPATAMINE 8%.....	74	HUMULIN R U-500		<i>intralipid</i>	74
HETLIOZ.....	28	(CONC) KWIKPEN.....	47	INTRON A.....	57
HIBERIX (PF).....	58	<i>hydralazine</i>	32	<i>introvale</i>	64
HUMALOG JUNIOR		<i>hydrochlorothiazide</i>	32	INVEGA SUSTENNA.....	28
KWIKPEN U-100.....	46	<i>hydrocodone bitartrate</i>	22	INVEGA TRINZA.....	28
HUMALOG KWIKPEN		<i>hydrocodone-acetaminophen</i> ...	22	INVELTYS.....	67
INSULIN.....	46	<i>hydrocodone-ibuprofen</i>	22	INVIRASE.....	2
HUMALOG MIX 50-50		<i>hydrocortisone</i>	41, 44, 53	INVOKAMET.....	47
INSULN U-100.....	46	<i>hydrocortisone butyrate</i>	41	INVOKAMET XR.....	47
HUMALOG MIX 50-50		<i>hydrocortisone-acetic acid</i>	44	INVOKANA.....	47
KWIKPEN.....	46	<i>hydrocortisone-pramoxine</i>	53	IOPIDINE.....	67
HUMALOG MIX 75-25		<i>hydromorphone</i>	22	IPOL.....	58
KWIKPEN.....	46	<i>hydromorphone (pf)</i>	22	<i>ipratropium bromide</i>	43, 70
HUMALOG MIX 75-25(U-		<i>hydroxychloroquine</i>	6	<i>ipratropium-albuterol</i>	70
100)INSULN.....	46	<i>hydroxyurea</i>	11	<i>irbesartan</i>	32
HUMALOG U-100		<i>hydroxyzine hcl</i>	68	<i>irbesartan-</i>	
INSULIN.....	47	<i>ibandronate</i>	60	<i>hydrochlorothiazide</i>	32
HUMIRA.....	61	IBRANCE.....	11	IRESSA.....	12
HUMIRA PEN.....	60	<i>ibu</i>	24	ISENTRESS.....	2, 3
HUMIRA PEN CROHNS-		<i>ibuprofen</i>	24	ISENTRESS HD.....	2
UC-HS START.....	60	<i>icatibant</i>	70	<i>isibloom</i>	64
HUMIRA PEN PSOR-		ICLUSIG.....	11, 12	ISOLYTE-P IN 5 %	
UVEITS-ADOL HS.....	61	IDHIFA.....	12	DEXTROSE.....	74
HUMIRA(CF).....	61	ILEVRO.....	66	ISOLYTE-S.....	74
HUMIRA(CF) PEDI		<i>imatinib</i>	12	<i>isoniazid</i>	6
CROHNS STARTER.....	61	IMBRUVICA.....	12	<i>isosorbide dinitrate</i>	36
HUMIRA(CF) PEN.....	61	<i>imipenem-cilastatin</i>	6	<i>isosorbide mononitrate</i>	36
HUMIRA(CF) PEN		<i>imipramine hcl</i>	28	<i>isradipine</i>	32
CROHNS-UC-HS.....	61	<i>imipramine pamoate</i>	28	<i>itraconazole</i>	1
HUMIRA(CF) PEN PSOR-		<i>imiquimod</i>	37	<i>ivermectin</i>	6
UV-ADOL HS.....	61	IMOVAX RABIES		IXIARO (PF).....	58
HUMULIN 70/30 U-100		VACCINE (PF).....	58	JAKAFI.....	12
INSULIN.....	47	<i>incassia</i>	63	<i>jantoven</i>	34

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 **express-scripts.com**.

This drug list was updated in August 2020

JANUMET.....	47	LANOXIN.....	36	linezolid.....	7
JANUMET XR.....	47	lansoprazole.....	55	linezolid in dextrose 5%.....	7
JANUVIA.....	47	lanthanum.....	42	LINZESS.....	53
jasmiel (28).....	64	LANTUS SOLOSTAR U-		liothyronine.....	52
JENTADUETO.....	47	100 INSULIN.....	48	lisinopril.....	32
JENTADUETO XR.....	47	LANTUS U-100 INSULIN..	48	lisinopril-hydrochlorothiazide..	33
jinteli.....	63	larin 1.5/30 (21).....	64	lithium carbonate.....	28
juleber.....	64	larin 1/20 (21).....	64	lithium citrate.....	28
JULUCA.....	3	larin fe 1.5/30 (28).....	64	LIVALO.....	35
JUXTAPID.....	35	larin fe 1/20 (28).....	64	LOKELMA.....	42
KALETRA.....	3	larissia.....	64	LONSURF.....	12
KALYDECO.....	70	latanoprost.....	67	loperamide.....	52
kariva (28).....	64	LATUDA.....	28	lopinavir-ritonavir.....	3
KAZANO.....	47	leflunomide.....	61	lorazepam.....	28
kelnor 1/35 (28).....	64	LENVIMA.....	12	lorazepam intensol.....	28
kelnor 1-50.....	64	lessina.....	64	LORBRENA.....	12
KERYDIN.....	39	letrozole.....	12	lorcet (hydrocodone).....	22
ketoconazole.....	1, 39	leucovorin calcium.....	10	lorcet hd.....	22
ketodan.....	39	LEUKERAN.....	12	lorcet plus.....	22
ketoprofen.....	24	LEUKINE.....	57	loryna (28).....	64
ketorolac.....	66	leuprolide.....	12	losartan.....	33
KINRIX (PF).....	58, 59	levallbuterol hcl.....	70	losartan-hydrochlorothiazide..	33
kionex (with sorbitol).....	42	levetiracetam.....	18	LOTEMAX.....	67
KISQALI.....	12	levobunolol.....	66	LOTEMAX SM.....	67
KISQALI FEMARA CO-		levocarnitine.....	42	loteprednol etabonate.....	67
PACK.....	12	levocarnitine (with sugar).....	42	lovastatin.....	35
klor-con 10.....	73	levocetirizine.....	68	low-ogestrel (28).....	64
klor-con 8.....	73	levofloxacin.....	9, 65	loxapine succinate.....	28
klor-con m10.....	73	levofloxacin in d5w.....	9	LUMIGAN.....	67
klor-con m15.....	73	levonest (28).....	64	LUPRON DEPOT.....	12
klor-con m20.....	73	levonorgestrel-ethinyl estrad...	64	LUPRON DEPOT (3	
klor-con oral packet 20.....	73	levonorg-eth estrad triphasic...	64	MONTH).....	12
KOMBIGLYZE XR.....	48	levora-28.....	64	LUPRON DEPOT (4	
KORLYM.....	51	levorphanol tartrate.....	22	MONTH).....	12
k-tab.....	73	levo-t.....	52	LUPRON DEPOT (6	
kurvelo (28).....	64	levothyroxine.....	52	MONTH).....	12
KUVAN.....	51	levoxyl.....	52	lutura (28).....	64
l norgestle.estradiol-e.estrad...	64	LEXIVA.....	3	LYNPARZA.....	12
labetalol.....	32	lidocaine.....	38	LYSODREN.....	12
lactulose.....	53	lidocaine hcl.....	37	LYUMJEV KWIKPEN U-	
lamivudine.....	3	lidocaine viscous.....	38	100 INSULIN.....	48
lamivudine-zidovudine.....	3	lidocaine-prilocaine.....	38	LYUMJEV KWIKPEN U-	
lamotrigine.....	17, 18	lindane.....	41	200 INSULIN.....	48

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 express-scripts.com.

This drug list was updated in August 2020

LYUMJEV U-100		<i>metolazone</i> 33	<i>mycophenolate sodium</i> 13
INSULIN..... 48		<i>metoprolol succinate</i> 33	<i>myorisan</i> 38
<i>lyza</i> 63		<i>metoprolol ta-</i>	MYRBETRIQ..... 72
<i>mafenide acetate</i> 38		<i>hydrochlorothiaz</i> 33	<i>nabumetone</i> 24
<i>magnesium sulfate</i> 73		<i>metoprolol tartrate</i> 33	<i>nadolol</i> 33
<i>malathion</i> 41		<i>metronidazole</i> 7, 38, 63	<i>nafeillin</i> 8
<i>maprotiline</i> 28		<i>metronidazole in nacl (iso-os)</i> .. 7	<i>naftifine</i> 39
<i>marlissa (28)</i> 64		<i>mexiletine</i> 31	NAFTIN..... 39
MARPLAN..... 28		<i>micafungin</i> 1	<i>naloxone</i> 24
MATULANE..... 12		<i>microgestin 1.5/30 (21)</i> 64	<i>naltrexone</i> 24
<i>matzim la</i> 33		<i>microgestin 1/20 (21)</i> 64	NAMZARIC..... 21
<i>meclizine</i> 53		<i>microgestin fe 1.5/30 (28)</i> 64	<i>naproxen</i> 24
<i>meclofenamate</i> 24		<i>microgestin fe 1/20 (28)</i> 64	<i>naproxen sodium</i> 24
<i>medroxyprogesterone</i> 63		<i>midodrine</i> 42	<i>naratriptan</i> 19
<i>mefenamic acid</i> 24		<i>migergot</i> 19	NARCAN..... 24
<i>mefloquine</i> 7		<i>miglitol</i> 48	NATACYN..... 65
<i>megestrol</i> 12		<i>miglustat</i> 51	<i>nateglinide</i> 48
MEKINIST..... 13		<i>mili</i> 64	NATPARA..... 51
MEKTOVI..... 13		<i>millipred</i> 44	NAYZILAM..... 18
<i>meloxicam</i> 24		<i>minocycline</i> 9	NEEDLES, INSULIN
<i>memantine</i> 20, 21		<i>minoxidil</i> 33	DISP.,SAFETY..... 48
MENACTRA (PF)..... 59		<i>mirtazapine</i> 28	<i>nefazodone</i> 28
MENEST..... 63		<i>misoprostol</i> 55	<i>neomycin</i> 7
MENVEO A-C-Y-W-135-		MITIGARE..... 60	<i>neomycin-bacitracin-poly-hc</i> ... 67
DIP (PF)..... 59		M-M-R II (PF)..... 59	<i>neomycin-bacitracin-</i>
<i>mercaptapurine</i> 13		<i>modafinil</i> 28	<i>polymyxin</i> 65
<i>meropenem</i> 7		<i>moexipril</i> 33	<i>neomycin-polymyxin b-</i>
<i>mesalamine</i> 53		<i>molindone</i> 28	<i>dexameth</i> 67
MESNEX..... 10		<i>mometasone</i> 41, 70	<i>neomycin-polymyxin-</i>
<i>metaproterenol</i> 70		<i>mondoxyne nl</i> 9	<i>gramicidin</i> 65
<i>metformin</i> 48		<i>montelukast</i> 70	<i>neomycin-polymyxin-hc</i> 44, 67
<i>methadone</i> 22		<i>morphine</i> 23	NEPHRAMINE 5.4 %..... 74
<i>methazolamide</i> 66		<i>morphine concentrate</i> 23	NERLYNX..... 13
<i>methenamine hippurate</i> 9		MOTEGRITY..... 53	NESINA..... 48
<i>methimazole</i> 44		MOVANTIK..... 54	NEUPRO..... 19
<i>methotrexate sodium</i> 13		<i>moxifloxacin</i> 9, 65	<i>nevirapine</i> 3
<i>methotrexate sodium (pf)</i> 13		<i>moxifloxacin-</i>	NEXAVAR..... 13
<i>methoxsalen</i> 38		<i>sod.chloride (iso)</i> 9	NEXIUM PACKET..... 55
<i>methyl dopa</i> 33		MULPLETA..... 34	NEXLETOL..... 35
<i>methylphenidate hcl</i> 28		<i>mupirocin</i> 39	NEXLIZET..... 35
<i>methylprednisolone</i> 44		MVASI..... 13	<i>niacin</i> 35
<i>methyltestosterone</i> 51		MYALEPT..... 51	<i>nicardipine</i> 33
<i>metoclopramide hcl</i> 53		<i>mycophenolate mofetil</i> 13	NICOTROL..... 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 express-scripts.com.

This drug list was updated in August 2020

NICOTROL NS.....	43	NOXAFIL.....	1	OTEZLA.....	61
<i>nifedipine</i>	33	NUBEQA.....	13	OTEZLA STARTER.....	61
<i>nikki (28)</i>	64	NUCALA.....	70	<i>oxacillin</i>	8
<i>nilutamide</i>	13	NUEDEXTA.....	21	<i>oxacillin in dextrose(iso-osm) ..</i>	8
<i>nimodipine</i>	33	NUPLAZID.....	28	<i>oxandrolone</i>	51
NINLARO.....	13	NURTEC ODT.....	20	<i>oxaprozin</i>	24
<i>nisoldipine</i>	33	<i>nyamyc</i>	39	<i>oxcarbazepine</i>	18
<i>nitisinone</i>	42	<i>nystatin</i>	1, 39	OXERVATE.....	66
<i>nitro-bid</i>	36	<i>nystatin-triamcinolone</i>	39	<i>oxiconazole</i>	40
<i>nitrofurantoin</i>	9	<i>nystop</i>	39	<i>oxybutynin chloride</i>	72
<i>nitrofurantoin macrocrystal</i>	9	OALIVA.....	54	<i>oxycodone</i>	23
<i>nitrofurantoin monohydlm-</i>		<i>octreotide acetate</i>	13	<i>oxycodone-acetaminophen</i>	23
<i>crist</i>	9	ODACTRA.....	59	<i>oxycodone-aspirin</i>	23
<i>nitroglycerin</i>	36	ODEFSEY.....	3	OXYCONTIN.....	23
NIVESTYM.....	57	ODOMZO.....	13	<i>oxymorphone</i>	23
<i>nizatidine</i>	55	OFEV.....	70	OZEMPIC.....	49
<i>nora-be</i>	63	<i>ofloxacin</i>	9, 44, 65	<i>pacerone</i>	31
<i>norethindrone (contraceptive)</i>	63	<i>olanzapine</i>	29	<i>paliperidone</i>	29
<i>norethindrone acetate</i>	63	<i>olanzapine-fluoxetine</i>	29	PALYNZIQ.....	51
<i>norethindrone ac-eth estradiol</i>		<i>olmesartan</i>	33	<i>pantoprazole</i>	56
.....	63, 64	<i>olmesartan-amlodipin-</i>		<i>paricalcitol</i>	51
<i>norgestimate-ethinyl estradiol</i>	64	<i>hcthiacid</i>	33	<i>paromomycin</i>	7
NORMOSOL-R.....	73	<i>olmesartan-</i>		<i>paroxetine hcl</i>	29
NORTHERA.....	42	<i>hydrochlorothiazide</i>	33	PASER.....	7
<i>nortrel 0.5/35 (28)</i>	64	<i>olopatadine</i>	43, 66	PAXIL.....	29
<i>nortrel 1/35 (21)</i>	64	<i>omeprazole</i>	56	PAZEO.....	66
<i>nortrel 1/35 (28)</i>	64	OMNIPOD DASH 5 PACK		PEDIARIX (PF).....	59
<i>nortrel 7/7/7 (28)</i>	64	POD.....	49	PEDVAX HIB (PF).....	59
<i>nortriptyline</i>	28	OMNIPOD INSULIN		<i>peg 3350-electrolytes</i>	54
NORVIR.....	3	MANAGEMENT.....	49	PEGANONE.....	18
NOVOFINE 32.....	48	OMNIPOD INSULIN		PEGASYS.....	57
NOVOFINE PLUS.....	48	REFILL.....	49	PEGASYS PROCLICK.....	57
NOVOLOG FLEXPEN U-		OMNITROPE.....	57	<i>peg-electrolyte</i>	54
100 INSULIN.....	48	<i>ondansetron</i>	54	PEMAZYRE.....	13
NOVOLOG MIX 70-30 U-		<i>ondansetron hcl</i>	54	<i>penicillamine</i>	61
100 INSULN.....	48	ONGLYZA.....	49	PENICILLIN G POT IN	
NOVOLOG MIX 70-		OPSUMIT.....	70	DEXTROSE.....	8
30FLEXPEN U-100.....	49	ORENCIA.....	61	<i>penicillin g potassium</i>	8
NOVOLOG PENFILL U-		ORENCIA CLICKJECT.....	61	<i>penicillin g procaine</i>	8
100 INSULIN.....	49	ORFADIN.....	42	<i>penicillin g sodium</i>	8
NOVOLOG U-100		ORKAMBI.....	71	<i>penicillin v potassium</i>	8
INSULIN ASPART.....	49	<i>orsythia</i>	64	<i>pentamidine</i>	7
NOVOTWIST.....	49	<i>oseltamivir</i>	3	PENTASA.....	54

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 express-scripts.com.

This drug list was updated in August 2020

<i>pentoxifylline</i>	34	<i>potassium chloride in water</i>	<i>procto-med hc</i>	54
PERFOROMIST	71	<i>procto-pak</i>	54
<i>perindopril erbumine</i>	33	<i>potassium chloride-0.45 %</i>	<i>proctosol hc</i>	54
<i>permethrin</i>	41	<i>nacl</i>	<i>proctozone-hc</i>	54
<i>perphenazine</i>	29	<i>potassium chloride-d5-</i>	<i>progesterone micronized</i>	63
PERSERIS	29	<i>0.2%nacl</i>	PROGRAF	13
<i>phenelzine</i>	29	<i>potassium chloride-d5-</i>	PROLASTIN-C	42
<i>phenobarbital</i>	18	<i>0.9%nacl</i>	PROLENSA	66
<i>phenoxybenzamine</i>	33	<i>potassium citrate</i>	PROLIA	60
<i>phenytoin</i>	18	PRALUENT PEN	PROMACTA	34
<i>phenytoin sodium extended</i>	18	<i>pramipexole</i>	<i>promethazine</i>	68
PHOSPHOLINE IODIDE	66	<i>prasugrel</i>	<i>propafenone</i>	31
PICATO	38	<i>pravastatin</i>	<i>propranolol</i>	33
PIFELTRO	3	<i>praziquantel</i>	<i>propranolol-</i>	
<i>pilocarpine hcl</i>	42, 66	<i>prazosin</i>	<i>hydrochlorothiazid</i>	33
<i>pimecrolimus</i>	38	<i>prednicarbate</i>	<i>propylthiouracil</i>	44
<i>pimozide</i>	29	<i>prednisolone</i>	PROQUAD (PF)	59
<i>pimtrea (28)</i>	64	<i>prednisolone acetate</i>	<i>protriptyline</i>	29
<i>pindolol</i>	33	<i>prednisolone sodium</i>	<i>prudoxin</i>	38
<i>pioglitazone</i>	49	<i>phosphate</i>	PULMICORT	
<i>pioglitazone-glimepiride</i>	49	<i>prednisone</i>	FLEXHALER	71
<i>pioglitazone-metformin</i>	49	<i>prednisone intensol</i>	PULMOZYME	71
<i>piperacillin-tazobactam</i>	8	<i>pregabalin</i>	PURIXAN	13
PIQRAY	13	PREMARIN	<i>pyrazinamide</i>	7
<i>pirmella</i>	64	<i>premasol 10 %</i>	<i>pyridostigmine bromide</i>	21
<i>piroxicam</i>	24	PREMPHASE	<i>pyrimethamine</i>	7
PLASMA-LYTE 148	74	PREMPRO	QINLOCK	13
PLASMA-LYTE A	74	<i>prenatal vitamin oral tablet</i>	QNASL	71
PLEGRIDY	57	<i>prevalite</i>	QTERN	49
<i>plenamine</i>	74	<i>previfem</i>	QUADRACEL (PF)	59
<i>podofilox</i>	38	PREVYMIS	<i>quetiapine</i>	29
<i>polymyxin b sulf-</i>		PREZCOBIX	<i>quinapril</i>	33
<i>trimethoprim</i>	65	PREZISTA	<i>quinapril-hydrochlorothiazide</i>	33
POMALYST	13	PRIFTIN	<i>quinidine gluconate</i>	31
<i>portia 28</i>	64	PRIMAQUINE	<i>quinidine sulfate</i>	31
<i>posaconazole</i>	1	<i>primidone</i>	<i>quinine sulfate</i>	7
<i>potassium chlorid-d5-</i>		PRIVIGEN	QVAR REDIHALER	71
<i>0.45%nacl</i>	73	<i>probenecid</i>	RABAVERT (PF)	59
<i>potassium chloride</i>	73	<i>probenecid-colchicine</i>	RAGWITEK	59
<i>potassium chloride in</i>		<i>procentra</i>	<i>raloxifene</i>	60
<i>0.9%nacl</i>	73	<i>prochlorperazine</i>	<i>ramelteon</i>	29
<i>potassium chloride in 5 % dex</i>	73	<i>prochlorperazine maleate oral</i>	<i>ramipril</i>	33
<i>potassium chloride in lr-d5</i>	73	PROCRT	<i>ranolazine</i>	36

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 **express-scripts.com**.

This drug list was updated in August 2020

<i>rasagiline</i>	19	ROTATEQ VACCINE.....	59	<i>sodium chloride 5 %</i>	74
RAVICTI.....	42	<i>roweepra</i>	18	<i>sodium phenylbutyrate</i>	43
REBIF (WITH ALBUMIN).....	57	<i>roweepra xr</i>	18	<i>sodium polystyrene (sorb</i>	
REBIF REBIDOSE.....	57, 58	ROZLYTREK.....	14	<i>free)</i>	43
REBIF TITRATION PACK.....	58	RUBRACA.....	14	<i>sodium polystyrene sulfonate</i> ..	43
<i>reclipsen (28)</i>	65	RUXIENCE.....	14	SOLQUA 100/33.....	49
RECOMBIVAX HB (PF).....	59	RYBELSUS.....	49	SOLTAMOX.....	14
RECTIV.....	54	RYDAPT.....	14	SOMATULINE DEPOT.....	14
REGRANEX.....	38	SAMSCA.....	51	SOMAVERT.....	51
RELENZA DISKHALER.....	3	SANCUSO.....	54	<i>sorine</i>	31
RELISTOR.....	54	SANDIMMUNE.....	14	<i>sotalol</i>	31
REMICADE.....	54	SANTYL.....	38	<i>sotalol af</i>	31
<i>repaglinide</i>	49	SAPHRIS.....	30	SPIRIVA RESPIMAT.....	71
REPATHA.....	36	SAVELLA.....	62	SPIRIVA WITH	
REPATHA.....		<i>scopolamine base</i>	54	HANDIHALER.....	71
PUSHTRONEX.....	36	SECUADO.....	30	<i>spironolactone</i>	33
REPATHA SURECLICK....	36	SEGLUROMET.....	49	<i>spironolacton-</i>	
RESTASIS.....	66	<i>selegiline hcl</i>	19	<i>hydrochlorothiaz</i>	33
RESTASIS MULTIDOSE....	66	<i>selenium sulfide</i>	37	<i>sprintec (28)</i>	65
RETACRIT.....	58	SELZENTRY.....	3	SPRITAM.....	18
RETEVMO.....	13, 14	SEREVENT DISKUS.....	71	SPRYCEL.....	14
REVLIMID.....	14	<i>sertraline</i>	30	<i>sps (with sorbitol)</i>	43
REXULTI.....	29	<i>setlakin</i>	65	<i>sronyx</i>	65
REYATAZ.....	3	<i>sevelamer carbonate</i>	43	<i>ssd</i>	38
RHOPRESSA.....	67	<i>sevelamer hcl</i>	43	<i>stavudine</i>	3
<i>ribavirin</i>	3	<i>sharobel</i>	63	STEGLATRO.....	49
RIDAURA.....	62	SHINGRIX (PF).....	59	STELARA.....	37
<i>rifabutin</i>	7	SIGNIFOR.....	14	STIMATE.....	51
<i>rifampin</i>	7	<i>sildenafil (pulmonary arterial</i>		STIOLTO RESPIMAT.....	71
<i>riluzole</i>	42	<i>hypertension)</i>	71	STIVARGA.....	14
<i>rimantadine</i>	3	<i>silodosin</i>	72	STREPTOMYCIN.....	7
RINVOQ.....	62	<i>silver sulfadiazine</i>	38	STRIBILD.....	4
<i>risedronate</i>	42, 60	SIMBRINZA.....	67	STRIVERDI RESPIMAT....	72
RISPERDAL CONSTA.....	29	SIMPONI.....	62	SUCRAID.....	54
<i>risperidone</i>	30	<i>simvastatin</i>	36	<i>sucrafate</i>	56
<i>ritonavir</i>	3	<i>sirolimus</i>	14	<i>sulfacetamide sodium</i>	66
<i>rivastigmine</i>	21	SIRTURO.....	7	<i>sulfacetamide sodium (acne)</i> ..	39
<i>rivastigmine tartrate</i>	21	SKLICE.....	41	<i>sulfacetamide-prednisolone</i>	66
<i>rizatriptan</i>	20	SKYRIZI.....	37	<i>sulfadiazine</i>	9
ROCKLATAN.....	67	<i>sodium chloride</i>	43	<i>sulfamethoxazole-</i>	
<i>ropinirole</i>	19	<i>sodium chloride 0.45 %</i>	74	<i>trimethoprim</i>	9
<i>rosuvastatin</i>	36	<i>sodium chloride 0.9 %</i>	43	SULFAMYLON.....	39
ROTARIX.....	59	<i>sodium chloride 3 %</i>	74	<i>sulfasalazine</i>	54

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 express-scripts.com.

This drug list was updated in August 2020

<i>sulindac</i>	24	TAZVERIK.....	14	<i>tizanidine</i>	21
<i>sumatriptan</i>	20	TDVAX.....	59	TOBI PODHALER.....	7
<i>sumatriptan succinate</i>	20	TECFIDERA.....	21	TOBRADEX.....	67
SUPRAX.....	5	TECHLITE INSULIN SYR		<i>tobramycin</i>	65
SUPREP BOWEL PREP		HALF UNIT.....	50	<i>tobramycin in 0.225 % nacl</i>	7
KIT.....	54	TECHLITE INSULIN		<i>tobramycin sulfate</i>	7
SUTENT.....	14	SYRINGE.....	50	<i>tobramycin-dexamethasone</i>	67
<i>syeda</i>	65	TECHLITE PEN NEEDLE..	50	<i>tolcapone</i>	19
SYLATRON.....	58	TEFLARO.....	5	<i>tolmetin</i>	25
SYMBICORT.....	72	TEKTURN HCT.....	33	<i>tolterodine</i>	72
SYMDEKO.....	72	<i>telmisartan</i>	33	<i>topiramate</i>	18
SYMFI.....	4	<i>telmisartan-amlodipine</i>	33	<i>toremifene</i>	15
SYMFI LO.....	4	<i>telmisartan-</i>		<i>torseamide</i>	33
SYMJEPI.....	68	<i>hydrochlorothiazid</i>	33	TOUJEO MAX U-300	
SYMLINPEN 120.....	50	TEMIXYS.....	4	SOLOSTAR.....	50
SYMLINPEN 60.....	50	TENIVAC (PF).....	59	TOUJEO SOLOSTAR U-	
SYMPAZAN.....	18	<i>tenofovir disoproxil fumarate</i>	4	300 INSULIN.....	50
SYMPROIC.....	54	<i>terazosin</i>	33	<i>tovet emollient</i>	41
SYMTUZA.....	4	<i>terbinafine hcl</i>	1	TOVIAZ.....	72
SYNAREL.....	51	<i>terbutaline</i>	72	TRADJENTA.....	50
SYNRIBO.....	14	<i>terconazole</i>	63	<i>tramadol</i>	25
TABLOID.....	14	TERIPARATIDE.....	60	<i>tramadol-acetaminophen</i>	25
TABRECTA.....	14	<i>testosterone</i>	52	<i>trandolapril</i>	33
<i>tacrolimus</i>	14, 38	<i>testosterone cypionate</i>	51	<i>trandolapril-verapamil</i>	33
<i>tadalafil</i>	73	<i>testosterone enanthate</i>	51	<i>tranexamic acid</i>	63
<i>tadalafil (pulmonary arterial</i>		TETANUS,DIPHThERIA		<i>tranylcypromine</i>	30
<i>hypertension) oral tablet 20</i>		TOX PED(PF).....	59	<i>travasol 10 %</i>	74
<i>mg</i>	72	<i>tetrabenazine</i>	21	<i>travoprost</i>	67
TAFINLAR.....	14	<i>tetracycline</i>	9	TRAZIMERA.....	15
TAGRISSO.....	14	THALOMID.....	15	<i>trazodone</i>	30
TALTZ AUTOINJECTOR..	37	THEO-24.....	72	TRECATOR.....	7
TALTZ SYRINGE.....	37	<i>theophylline</i>	72	TRELEGY ELLIPTA.....	72
TALZENNA.....	14	THIOLA.....	43	TRELSTAR.....	15
<i>tamoxifen</i>	14	THIOLA EC.....	43	<i>tretinoin (antineoplastic)</i>	15
<i>tamsulosin</i>	72	<i>thioridazine</i>	30	<i>tretinoin topical</i>	38
TARGRETIN.....	14	<i>thiothixene</i>	30	<i>triamcinolone acetonide</i>	41, 43
<i>tarina 24 fe</i>	65	<i>tiadylt er</i>	33	<i>triamterene</i>	33
<i>tarina fe 1-20 eq (28)</i>	65	<i>tiagabine</i>	18	<i>triamterene-</i>	
TASIGNA.....	14	TIBSOVO.....	15	<i>hydrochlorothiazid</i>	34
<i>tazarotene</i>	38	<i>tigecycline</i>	7	<i>triderm</i>	41
<i>tazicef</i>	5	<i>timolol maleate</i>	33, 66	<i>trientine</i>	43
TAZORAC.....	38	<i>tinidazole</i>	7	<i>tri-estarylla</i>	65
<i>taztia xt</i>	33	TIVICAY.....	4	<i>trifluoperazine</i>	30

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 **express-scripts.com**.

This drug list was updated in August 2020

<i>trifluridine</i>	65	VARUBI.....	54	XELJANZ.....	62
TRIKAFTA.....	72	VASCEPA.....	36	XELJANZ XR.....	62
<i>tri-legest fe</i>	65	VECAMYL.....	36	XERESE.....	40
<i>tri-lo-estarylla</i>	65	<i>velivet triphasic regimen (28)</i>	65	XERMELO.....	15
<i>tri-lo-sprintec</i>	65	VELTASSA.....	43	XGEVA.....	10
<i>trilyte with flavor packets</i>	54	VEMLIDY.....	4	XIFAXAN.....	7
<i>trimethoprim</i>	10	VENCLEXTA.....	15	XIGDUO XR.....	50, 51
<i>trimipramine</i>	30	VENCLEXTA STARTING		XOFLUZA.....	4
TRINTELLIX.....	30	PACK.....	15	XOLAIR.....	72
<i>tri-previfem (28)</i>	65	<i>venlafaxine</i>	30	XOSPATA.....	15
<i>tri-sprintec (28)</i>	65	<i>verapamil</i>	34	XPOVIO.....	16
TRIUMEQ.....	4	VERSACLOZ.....	30	XTANDI.....	16
<i>trivora (28)</i>	65	VERZENIO.....	15	<i>xulane</i>	63
TROPHAMINE 10 %.....	74	VIBERZI.....	54	XULTOPHY 100/3.6.....	51
<i>trospium</i>	72	VIBRAMYCIN.....	9	XURIDEN.....	43
TRUEPLUS INSULIN.....	50	VICTOZA 3-PAK.....	50	XYREM.....	30
TRUEPLUS PEN NEEDLE	50	<i>vienna</i>	65	YF-VAX (PF).....	59
TRULANCE.....	54	<i>vigabatrin</i>	18	YONSA.....	16
TRULICITY.....	50	<i>vigadrone</i>	18	<i>yuvafem</i>	63
TRUMENBA.....	59	VIIBRYD.....	30	<i>zafirlukast</i>	72
TRUVADA.....	4	VIMPAT.....	18	<i>zaleplon</i>	30
TUKYSA.....	15	VIOKACE.....	54	<i>zarah</i>	65
TURALIO.....	15	VIRACEPT.....	4	ZARXIO.....	58
TWINRIX (PF).....	59	VIREAD.....	4	ZEJULA.....	16
TYKERB.....	15	VITRAKVI.....	15	ZELBORAF.....	16
TYPHIM VI.....	59	VIVITROL.....	25	ZENPEP.....	55
UBRELVY.....	20	VIZIMPRO.....	15	<i>zidovudine</i>	4
<i>unithroid</i>	52	<i>voriconazole</i>	1	ZIEXTENZO.....	58
UPTRAVI.....	34	VOSEVI.....	4	<i>ziprasidone hcl</i>	31
<i>ursodiol</i>	54	VOTRIENT.....	15	<i>ziprasidone mesylate</i>	31
<i>valacyclovir</i>	4	VRAYLAR.....	30	ZIRABEV.....	16
VALCHLOR.....	38	VUMERITY.....	21	ZIRGAN.....	65
<i>valganciclovir</i>	4	VYNDAMAX.....	36	ZOLINZA.....	16
<i>valproic acid</i>	18	VYNDAQEL.....	36	<i>zolmitriptan</i>	20
<i>valproic acid (as sodium salt)</i>	18	<i>warfarin</i>	34	<i>zolpidem</i>	31
<i>valsartan</i>	34	XALKORI.....	15	<i>zonisamide</i>	19
<i>valsartan-hydrochlorothiazide</i>	34	XARELTO.....	34	ZONTIVITY.....	34
VALTOCO.....	18	XATMEP.....	15	ZORTRESS.....	16
<i>vancomycin</i>	7	XCOPRI.....	18, 19	ZOSTAVAX (PF).....	59
<i>vandazole</i>	63	XCOPRI MAINTENANCE		<i>zovia 1/35e (28)</i>	65
VAQTA (PF).....	59	PACK.....	18	ZUBSOLV.....	25
VARIVAX (PF).....	59	XCOPRI TITRATION		ZYDELIG.....	16
VARIZIG.....	59	PACK.....	19	ZYFLO.....	72

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 express-scripts.com.

This drug list was updated in August 2020

ZYKADIA.....	16
ZYPREXA RELPREVV	31
ZYTIGA.....	16

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 **express-scripts.com**.

This drug list was updated in August 2020

This page intentionally left blank

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 08/25/2020. For more recent information or to price a medication, you can visit us on the Web at **express-scripts.com**. Or you can 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.

© 2020 Express Scripts. All Rights Reserved.

F0PP4Z1A

This drug list was updated in August 2020.