CareFirst
Family of health care plans

CareFirst Formulary 1

2022

PLEASE READ: This document contains information about the drugs we cover in this plan. This formulary is for members of an employer group with 51 or more employees. For your specific prescription benefit plan information, log into your account at carefirst.com.

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

Last updated 12/01/2022—For self-insured plans only

Introduction

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

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

Using Your Formulary

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

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

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

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

- **Prior Authorization** from CareFirst is required before you fill prescriptions for certain drugs. Your doctor may need to provide some of your medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CareFirst, your drugs may not be covered.
- **Step Therapy** requires that you try lower-cost, equally effective drugs that treat the same medical condition before trying a higher-cost alternative. Your doctor will need to provide information to CareFirst about your experience with these alternatives prior to dispensing a more expensive drug.
- **Quantity Limits** have been placed on the use of selected drugs for quality or safety reasons. Limits may be placed on the amount of the drug covered per prescription or for a defined period of time. For example, quantity limits apply to specialty drugs. Specialty drugs are medications that may be used to treat complex and/or rare health conditions and require special handling, administration or monitoring. Specialty drugs are typically covered for a one-month supply.

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

Tier 0: $0 Drugs	■ Preventive drugs (e.g. statins, aspirin, folic acid, fluoride, iron supplements, smoking cessation products and FDA-approved contraceptives for women) are available at a zero-dollar cost share if prescribed under certain medical criteria by your doctor. ■ Oral chemotherapy drugs and diabetic supplies (e.g. insulin syringes, pen needles, lancets, test strips, and alcohol swabs) are also available at a zero-dollar cost share.
Tier 1: Generic Drugs $	■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. ■ Generic drugs generally cost less than brand-name drugs.
Tier 2: Preferred Brand Drugs $$	■ Preferred brand drugs are brand-name drugs that may not be available in generic form, but are chosen for their cost effectiveness compared to alternatives. Your cost-share will be more than generics but less than non-preferred brand drugs. If a generic drug becomes available, the preferred brand drug may be moved to the non-preferred brand category.
Tier 3: Non-preferred Brand Drugs $$$	■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.

Drug Name	Drug Tier	Requirements/Limits
ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS		
AMPHETAMINES		
ADDERALL TAB 5MG	3	QL (120 tabs every month)
ADDERALL TAB 7.5MG	3	QL (120 tabs every month)
ADDERALL TAB 10MG	3	QL (120 tabs every month)
ADDERALL TAB 12.5MG	3	QL (120 tabs every month)
ADDERALL TAB 15MG	3	QL (60 tabs every month)
ADDERALL TAB 20MG	3	QL (60 tabs every month)
ADDERALL TAB 30MG	3	QL (30 tabs every month)
ADDERALL XR CAP 5MG	3	QL (120 caps every month)
ADDERALL XR CAP 10MG	3	QL (120 caps every month)
ADDERALL XR CAP 15MG	3	QL (30 caps every month)
ADDERALL XR CAP 20MG	3	QL (30 caps every month)
ADDERALL XR CAP 25MG	3	QL (30 caps every month)
ADDERALL XR CAP 30MG	3	QL (30 caps every month)
ADZENYS ER SUS 1.25MG	3	QL (540 mL every month)
ADZENYS XR TAB 3.1MG	3	QL (60 ea every month)
ADZENYS XR TAB 6.3MG	3	QL (60 ea every month)
ADZENYS XR TAB 9.4MG	3	QL (60 ea every month)
ADZENYS XR TAB 12.5MG	3	QL (30 ea every month)
ADZENYS XR TAB 15.7 MG	3	QL (30 ea every month)
ADZENYS XR TAB 18.8MG	3	QL (30 ea every month)
amphetami er sus 1.25/ml	1	QL (540 mL every month)

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

Drug Name	Drug Tier	Requirements/Limits
amphetamine sulfate tab 5 mg	1	QL (150 tabs every month)
amphetamine sulfate tab 10 mg	1	QL (150 tabs every month)
amphetamine-dextroamphetamine cap er 24hr 5 mg	1	QL (120 caps every month)
amphetamine-dextroamphetamine cap er 24hr 10 mg	1	QL (120 caps every month)
amphetamine-dextroamphetamine cap er 24hr 15 mg	1	QL (30 caps every month)
amphetamine-dextroamphetamine cap er 24hr 20 mg	1	QL (30 caps every month)
amphetamine-dextroamphetamine cap er 24hr 25 mg	1	QL (30 caps every month)
amphetamine-dextroamphetamine cap er 24hr 30 mg	1	QL (30 caps every month)
amphetamine-dextroamphetamine tab 5 mg	1	QL (120 tabs every month)
amphetamine-dextroamphetamine tab 7.5 mg	1	QL (120 tabs every month)
amphetamine-dextroamphetamine tab 10 mg	1	QL (120 tabs every month)
amphetamine-dextroamphetamine tab 12.5 mg	1	QL (120 tabs every month)
amphetamine-dextroamphetamine tab 15 mg	1	QL (60 tabs every month)
amphetamine-dextroamphetamine tab 20 mg	1	QL (60 tabs every month)
amphetamine-dextroamphetamine tab 30 mg	1	QL (30 tabs every month)
DESOXYN TAB 5MG	3	QL (180 tabs every month)
DEXEDRINE CAP 5MG CR	3	QL (150 caps every month)
DEXEDRINE CAP 10MG CR	3	QL (150 caps every month)
DEXEDRINE CAP 15MG CR	3	QL (60 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
dextroamphetamine sulfate cap er 24hr 5 mg	1	QL (150 caps every month)
dextroamphetamine sulfate cap er 24hr 10 mg	1	QL (150 caps every month)
dextroamphetamine sulfate cap er 24hr 15 mg	1	QL (60 caps every month)
dextroamphetamine sulfate oral solution 5 mg/5ml	1	QL (1440 mL every month)
dextroamphetamine sulfate tab 2.5 mg	1	QL (150 tabs every month)
DEXTROAMPHETAMINE SULFATE TAB 2.5 MG	3	QL (150 tabs every month)
dextroamphetamine sulfate tab 5 mg	1	QL (150 tabs every month)
dextroamphetamine sulfate tab 7.5 mg	1	QL (150 tabs every month)
DEXTROAMPHETAMINE SULFATE TAB 7.5 MG	3	QL (150 tabs every month)
dextroamphetamine sulfate tab 10 mg	1	QL (150 tabs every month)
dextroamphetamine sulfate tab 15 mg	1	QL (60 tabs every month)
DEXTROAMPHETAMINE SULFATE TAB 15 MG	3	QL (60 tabs every month)
dextroamphetamine sulfate tab 20 mg	1	QL (60 tabs every month)
DEXTROAMPHETAMINE SULFATE TAB 20 MG	3	QL (60 tabs every month)
dextroamphetamine sulfate tab 30 mg	1	QL (30 tabs every month)
DEXTROAMPHETAMINE SULFATE TAB 30 MG	3	QL (30 tabs every month)
DYANAVEL XR CHW 5MG	3	QL (60 tabs every month)
DYANAVEL XR CHW 10MG	3	QL (60 tabs every month)
DYANAVEL XR CHW 15MG	3	QL (30 tabs every month)

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

Drug Name	Drug Tier	Requirements/Limits
DYANAVEL XR CHW 20MG	3	QL (30 tabs every month)
DYANAVEL XR SUS 2.5MG/ML	3	QL (300 mL every month)
EVEKEO ODT TAB 5MG	3	QL (150 tabs every month)
EVEKEO ODT TAB 10MG	3	QL (150 tabs every month)
EVEKEO ODT TAB 15MG	3	QL (60 tabs every month)
EVEKEO ODT TAB 20MG	3	QL (60 tabs every month)
EVEKEO TAB 5MG	3	QL (150 tabs every month)
EVEKEO TAB 10MG	3	QL (150 tabs every month)
methamphetamine hcl tab 5 mg	1	QL (180 tabs every month)
MYDAYIS CAP 12.5MG	2	QL (60 caps every month)
MYDAYIS CAP 25MG	2	QL (60 caps every month)
MYDAYIS CAP 37.5MG	2	QL (30 caps every month)
MYDAYIS CAP 50MG	2	QL (30 caps every month)
VYVANSE CAP 10MG	2	QL (60 caps every month)
VYVANSE CAP 20MG	2	QL (60 caps every month)
VYVANSE CAP 30MG	2	QL (60 caps every month)
VYVANSE CAP 40MG	2	QL (30 caps every month)
VYVANSE CAP 50MG	2	QL (30 caps every month)
VYVANSE CAP 60MG	2	QL (30 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
VYVANSE CAP 70MG	2	QL (30 caps every month)
VYVANSE CHW 10MG	2	QL (60 tabs every month)
VYVANSE CHW 20MG	2	QL (60 tabs every month)
VYVANSE CHW 30MG	2	QL (60 tabs every month)
VYVANSE CHW 40MG	2	QL (30 tabs every month)
VYVANSE CHW 50MG	2	QL (30 tabs every month)
VYVANSE CHW 60MG	2	QL (30 tabs every month)
ANALEPTICS		
caffeine citrate oral soln 60 mg/3ml (10 mg/ml base equiv)	1	
ANTI-OBESITY AGENTS		
WEGOVY INJ 0.5MG	2	Coverage is subject to your plan/benefits
WEGOVY INJ 0.25MG	2	Coverage is subject to your plan/benefits
WEGOVY INJ 1.7MG	2	Coverage is subject to your plan/benefits
WEGOVY INJ 1MG	2	Coverage is subject to your plan/benefits
WEGOVY INJ 2.4MG	2	Coverage is subject to your plan/benefits
ANTIOBESITY AGENTS, INJECTABLE		
SAXENDA INJ 18MG/3ML	2	Coverage is subject to your plan/benefits
ANTIOBESITY AGENTS, ORAL		
ADIPEX-P CAP 37.5MG	3	Coverage is subject to your plan/benefits
ADIPEX-P TAB 37.5MG	3	Coverage is subject to your plan/benefits
benzphetamine hcl tab 25 mg	1	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
benzphetamine hcl tab 50 mg	1	Coverage is subject to your plan/benefits
CONTRAVE TAB 8-90MG	3	Coverage is subject to your plan/benefits
diethylpropion hcl tab 25 mg	1	Coverage is subject to your plan/benefits
diethylpropion hcl tab er 24hr 75 mg	1	Coverage is subject to your plan/benefits
LOMAIRA TAB 8MG	3	Coverage is subject to your plan/benefits
phendimetraz cap 105mg er	1	Coverage is subject to your plan/benefits
phendimetrazine tartrate tab 35 mg	1	Coverage is subject to your plan/benefits
phentermine hcl cap 15 mg	1	Coverage is subject to your plan/benefits
phentermine hcl cap 30 mg	1	Coverage is subject to your plan/benefits
phentermine hcl cap 37.5 mg	1	Coverage is subject to your plan/benefits
phentermine hcl tab 37.5 mg	1	Coverage is subject to your plan/benefits
QSYMIA CAP 3.75-23	2	Coverage is subject to your plan/benefits
QSYMIA CAP 7.5-46MG	2	Coverage is subject to your plan/benefits
QSYMIA CAP 11.25-69	2	Coverage is subject to your plan/benefits
QSYMIA CAP 15-92MG	2	Coverage is subject to your plan/benefits
REGIMEX TAB 25MG	3	Coverage is subject to your plan/benefits
XENICAL CAP 120MG	3	Coverage is subject to your plan/benefits
ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS		
atomoxetine hcl cap 10 mg (base equiv)	1	QL (150 caps every month)
atomoxetine hcl cap 18 mg (base equiv)	1	QL (150 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
atomoxetine hcl cap 25 mg (base equiv)	1	QL (150 caps every month)
atomoxetine hcl cap 40 mg (base equiv)	1	QL (60 caps every month)
atomoxetine hcl cap 60 mg (base equiv)	1	QL (30 caps every month)
atomoxetine hcl cap 80 mg (base equiv)	1	QL (30 caps every month)
atomoxetine hcl cap 100 mg (base equiv)	1	QL (30 caps every month)
clonidine hcl tab er 12hr 0.1 mg	1	
guanfacine hcl tab er 24hr 1 mg (base equiv)	1	
guanfacine hcl tab er 24hr 2 mg (base equiv)	1	
guanfacine hcl tab er 24hr 3 mg (base equiv)	1	
guanfacine hcl tab er 24hr 4 mg (base equiv)	1	
INTUNIV TAB 1MG	3	
INTUNIV TAB 2MG	3	
INTUNIV TAB 3MG	3	
INTUNIV TAB 4MG	3	
KAPVAY TAB 0.1 MG	3	
QELBREE CAP 100MG ER	2	
QELBREE CAP 150MG ER	2	
QELBREE CAP 200MG ER	2	
STRATTERA CAP 10MG	3	QL (150 caps every month)
STRATTERA CAP 18MG	3	QL (150 caps every month)
STRATTERA CAP 25MG	3	QL (150 caps every month)
STRATTERA CAP 40MG	3	QL (60 caps every month)
STRATTERA CAP 60MG	3	QL (30 caps every month)
STRATTERA CAP 80MG	3	QL (30 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
STRATTERA CAP 100MG	3	QL (30 caps every month)
DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)		
SUNOSI TAB 75MG	2	
SUNOSI TAB 150MG	2	
HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS		
WAKIX TAB 4.45MG	2	PA, QL (60 TABLETS PER 30 DAYS)
WAKIX TAB 17.8MG	2	PA, QL (60 TABLETS PER 30 DAYS)
STIMULANTS - MISC.		
ADHANSIA XR CAP 25MG	3	QL (60 caps every month)
ADHANSIA XR CAP 35MG	3	QL (60 caps every month)
ADHANSIA XR CAP 45MG	3	QL (60 caps every month)
ADHANSIA XR CAP 55MG	3	QL (30 caps every month)
ADHANSIA XR CAP 70MG	3	QL (30 caps every month)
ADHANSIA XR CAP 85MG	3	QL (30 caps every month)
APTENSIO XR CAP 10MG	3	QL (60 caps every month)
APTENSIO XR CAP 15MG	3	QL (60 caps every month)
APTENSIO XR CAP 20MG	3	QL (60 caps every month)
APTENSIO XR CAP 30MG	3	QL (60 caps every month)
APTENSIO XR CAP 40MG	3	QL (30 caps every month)
APTENSIO XR CAP 50MG	3	QL (30 caps every month)
APTENSIO XR CAP 60MG	3	QL (30 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
armodafinil tab 50 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
armodafinil tab 150 mg	1	PA, QL (30 TABLETS PER 30 DAYS)
armodafinil tab 200 mg	1	PA, QL (30 TABLETS PER 30 DAYS)
armodafinil tab 250 mg	1	PA, QL (30 TABLETS PER 30 DAYS)
AZSTARYS CAP 26.1-5.2	3	QL (30 caps every 30 days)
AZSTARYS CAP 39.2-7.8	3	QL (30 caps every 30 days)
AZSTARYS CAP 52.3-10.	3	QL (30 caps every 30 days)
CONCERTA TAB 18MG	3	QL (60 tabs every month)
CONCERTA TAB 27MG	3	QL (60 tabs every month)
CONCERTA TAB 36MG	3	QL (60 tabs every month)
CONCERTA TAB 54MG	3	QL (30 tabs every month)
COTEMPLA TAB 8.6MG	3	QL (60 ea every month)
COTEMPLA TAB 17.3MG	3	QL (60 ea every month)
COTEMPLA TAB 25.9MG	3	QL (60 ea every month)
DAYTRANA DIS 10MG/9HR	3	QL (30 patches every month)
DAYTRANA DIS 15MG/9HR	3	QL (30 patches every month)
DAYTRANA DIS 20MG/9HR	3	QL (30 patches every month)
DAYTRANA DIS 30MG/9HR	3	QL (30 patches every month)
dexmethylphenidate hcl cap er 24 hr 5 mg	1	QL (60 caps every month)
dexmethylphenidate hcl cap er 24 hr 10 mg	1	QL (60 caps every month)
dexmethylphenidate hcl cap er 24 hr 15 mg	1	QL (60 caps every month)

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

Drug Name	Drug Tier	Requirements/Limits
dexmethylphenidate hcl cap er 24 hr 20 mg	1	QL (60 caps every month)
dexmethylphenidate hcl cap er 24 hr 25 mg	1	QL (30 caps every month)
dexmethylphenidate hcl cap er 24 hr 30 mg	1	QL (30 caps every month)
dexmethylphenidate hcl cap er 24 hr 35 mg	1	QL (30 caps every month)
dexmethylphenidate hcl cap er 24 hr 40 mg	1	QL (30 caps every month)
dexmethylphenidate hcl tab 2.5 mg	1	QL (150 tabs every month)
dexmethylphenidate hcl tab 5 mg	1	QL (150 tabs every month)
dexmethylphenidate hcl tab 10 mg	1	QL (60 tabs every month)
FOCALIN TAB 2.5MG	3	QL (150 tabs every month)
FOCALIN TAB 5MG	3	QL (150 tabs every month)
FOCALIN TAB 10MG	3	QL (60 tabs every month)
FOCALIN XR CAP 5MG	3	QL (60 caps every month)
FOCALIN XR CAP 10MG	3	QL (60 caps every month)
FOCALIN XR CAP 15MG	3	QL (60 caps every month)
FOCALIN XR CAP 20MG	3	QL (60 caps every month)
FOCALIN XR CAP 25MG	3	QL (30 caps every month)
FOCALIN XR CAP 30MG	3	QL (30 caps every month)
FOCALIN XR CAP 35MG	3	QL (30 caps every month)
FOCALIN XR CAP 40MG	3	QL (30 caps every month)

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

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

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

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl cap er 24hr 50 mg (xr)	1	QL (30 caps every month)
methylphenidate hcl cap er 24hr 60 mg (la)	1	QL (30 caps every month)
methylphenidate hcl cap er 24hr 60 mg (xr)	1	QL (30 caps every month)
methylphenidate hcl cap er 30 mg (cd)	1	QL (60 caps every month)
methylphenidate hcl cap er 40 mg (cd)	1	QL (30 TABLETS PER month)
methylphenidate hcl cap er 50 mg (cd)	1	QL (30 caps every month)
methylphenidate hcl cap er 60 mg (cd)	1	QL (30 caps every month)
methylphenidate hcl chew tab 2.5 mg	1	QL (210 tabs every month)
methylphenidate hcl chew tab 5 mg	1	QL (210 tabs every month)
methylphenidate hcl chew tab 10 mg	1	QL (210 tabs every month)
methylphenidate hcl soln 5 mg/5ml	1	QL (2160 mL every month)
methylphenidate hcl soln 10 mg/5ml	1	QL (1080 mL every month)
methylphenidate hcl tab 5 mg	1	QL (210 tabs every month)
methylphenidate hcl tab 10 mg	1	QL (210 tabs every month)
methylphenidate hcl tab 20 mg	1	QL (120 tabs every month)
methylphenidate hcl tab er 10 mg	1	QL (120 tabs every month)
methylphenidate hcl tab er 20 mg	1	QL (120 tabs every month)
methylphenidate hcl tab er 24hr 18 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er 24hr 27 mg	1	QL (60 tabs every month)

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

Drug Name	Drug Tier	Requirements/Limits
methylphenidate hcl tab er 24hr 36 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er 24hr 54 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er osmotic release (osm) 18 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er osmotic release (osm) 27 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er osmotic release (osm) 36 mg	1	QL (60 tabs every month)
methylphenidate hcl tab er osmotic release (osm) 54 mg	1	QL (30 tabs every month)
methylphenidate td patch 10 mg/9hr	1	QL (30 patches every month)
methylphenidate td patch 15 mg/9hr	1	QL (30 patches every month)
methylphenidate td patch 20 mg/9hr	1	QL (30 patches every month)
methylphenidate td patch 30 mg/9hr	1	QL (30 patches every month)
modafinil tab 100 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
modafinil tab 200 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
NUVIGIL TAB 50MG	3	PA, QL (60 TABLETS PER 30 DAYS)
NUVIGIL TAB 150MG	3	PA, QL (30 TABLETS PER 30 DAYS)
NUVIGIL TAB 200MG	3	PA, QL (30 TABLETS PER 30 DAYS)
NUVIGIL TAB 250MG	3	PA, QL (30 TABLETS PER 30 DAYS)
PROVIGIL TAB 100MG	3	PA, QL (60 TABLETS PER 30 DAYS)
PROVIGIL TAB 200MG	3	PA, QL (60 TABLETS PER 30 DAYS)
QUILLICHEW CHW 20MG ER	3	QL (60 tabs every month)

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

Drug Name	Drug Tier	Requirements/Limits
QUILLICHEW CHW 30MG ER	3	QL (60 tabs every month)
QUILLICHEW CHW 40MG ER	3	QL (30 tabs every month)
QUILLIVANT SUS 25MG/5ML	3	QL (420 mL every month)
RELEXXII TAB 72MG	3	QL (30 tabs every month)
RITALIN LA CAP 10MG	3	QL (60 caps every month)
RITALIN LA CAP 20MG	3	QL (60 caps every month)
RITALIN LA CAP 30MG	3	QL (60 caps every month)
RITALIN LA CAP 40MG	3	QL (30 caps every month)
RITALIN TAB 5MG	3	QL (210 tabs every month)
RITALIN TAB 10MG	3	QL (210 tabs every month)
RITALIN TAB 20MG	3	QL (120 tabs every month)

ALLERGENIC EXTRACTS/BIOLOGICALS MISC

ALLERGENIC EXTRACTS

GRASTEK SUB 2800BAU	2	
ODACTRA SUB	3	
ORALAIR SUB 300 IR	2	
PALFORZIA CAP ESCALAT	3	
PALFORZIA CAP LEVEL 1	3	
PALFORZIA CAP LEVEL 2	3	
PALFORZIA CAP LEVEL 3	3	
PALFORZIA CAP LEVEL 4	3	
PALFORZIA CAP LEVEL 5	3	
PALFORZIA CAP LEVEL 6	3	
PALFORZIA CAP LEVEL 7	3	
PALFORZIA CAP LEVEL 8	3	
PALFORZIA CAP LEVEL 9	3	
PALFORZIA CAP LEVEL 10	3	

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

Drug Name	Drug Tier	Requirements/Limits
PALFORZIA POW LEVEL 11	3	
RAGWITEK SUB	2	
AMEBICIDES		
AMEBICIDES		
SOLOSEC GRA 2GM	3	
AMINOGLYCOSIDES		
AMINOGLYCOSIDES		
ARIKAYCE SUS	3	PA
BETHKIS NEB 300/4ML	2	PA, QL (56 AMPULES PER 28 DAYS)
KITABIS PAK NEB 300/5ML	2	PA, QL (56 AMPULES PER 28 DAYS)
neomycin sulfate tab 500 mg	1	
paromomycin sulfate cap 250 mg	1	
TOBI NEB 300/5ML	3	PA, QL (56 AMPULES PER 28 DAYS)
TOBI PODHALR CAP 28MG	2	PA, QL (224 CAPS PER 28 DAYS)
tobramycin nebu soln 300 mg/4ml	1	PA, QL (56 AMPULES PER 28 DAYS)
tobramycin nebu soln 300 mg/5ml	1	PA, QL (56 AMPULES PER 28 DAYS)
ANALGESICS - ANTI-INFLAMMATORY		
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES		
HUMIRA INJ 10/0.1ML	2	PA, QL (2 PFS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
HUMIRA INJ 20/0.2ML	2	PA, QL (2 PFS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 40/0.4ML	2	PA, QL (4 PFS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA KIT 40MG/0.8	2	PA, QL (6 PFS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEDIA INJ CROHNS	2	PA, QL (3 PFS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN INJ 40/0.4ML	2	PA, QL (4 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 40MG/0.8	2	PA, QL (4 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 80/0.8ML	2	PA, QL (3 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ CD/UC/HS	2	PA, QL (4 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN INJ PS/UV	2	PA, QL (4 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN KIT CD/UC/HS	2	PA, QL (3 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN KIT PED UC	2	PA, QL (4 PENS PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN KIT PS/UV	2	PA, QL (3 PEN PER 28 DAYS); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
SIMPONI INJ 50/0.5ML	2	PA, QL (1 INJ PER 28 DAYS); MNPA
SIMPONI INJ 50/0.5ML	2	PA, QL (1 SYRINGE PER 28 DAYS); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
SIMPONI INJ 100MG/ML	2	PA, QL (1 PFS PER 28 DAYS); MNPA
SIMPONI INJ 100MG/ML	2	PA, QL (1 SYRINGE PER 28 DAYS); MNPA
ANTIRHEUMATIC - ENZYME INHIBITORS		
OLUMIANT TAB 1MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OLUMIANT TAB 2MG	3	PA, QL (30 TABLETS PER 30 DAYS)
RINVOQ TAB 15MG ER	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
RINVOQ TAB 30MG ER	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
RINVOQ TAB 45MG ER	2	PA
XELJANZ SOL 1MG/ML	2	PA, QL (240ML PER 24 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
XELJANZ TAB 5MG	2	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and 2nd line for Ulcerative colitis after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ TAB 10MG	2	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and 2nd line for Ulcerative colitis after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ XR TAB 11MG	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and 2nd line for Ulcerative colitis after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
XELJANZ XR TAB 22MG	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and 2nd line for Ulcerative colitis after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ANTIRHEUMATIC ANTIMETABOLITES		
OTREXUP INJ 10MG	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 12.5/0.4	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 15MG	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 17.5/0.4	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 20MG	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 22.5/0.4	3	PA, QL (4 inj per 28 days)
OTREXUP INJ 25MG	3	PA, QL (4 inj per 28 days)
RASUVO INJ 7.5MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 10MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 12.5MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 15MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 17.5MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 20MG	2	PA, QL (4 inj per 28 days)

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

Drug Name	Drug Tier	Requirements/Limits
RASUVO INJ 22.5MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 25MG	2	PA, QL (4 inj per 28 days)
RASUVO INJ 30MG	2	PA, QL (4 inj per 28 days)
REDITREX INJ 7.5/.3ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 10/.4ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 12.5/0.5	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 15/.6ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 17.5/0.7	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 20/.8ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 22.5/0.9	3	PA, QL (4 SYRINGES PER 28 DAYS)
REDITREX INJ 25MG/ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
GOLD COMPOUNDS		
RIDAURA CAP 3MG	3	
INTERLEUKIN-1 BLOCKERS		
ARCALYST INJ 220MG	3	PA, QL (8 VIALS PER 28 DAYS)
INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA)		
KINERET INJ	3	PA, QL (30 SYRINGES PER 30 DAYS); MNPA
INTERLEUKIN-6 RECEPTOR INHIBITORS		
ACTEMRA INJ 162/0.9	3	PA, QL (4 SYRINGES PER 28 DAYS); MNPA
ACTEMRA INJ ACTPEN	3	PA, QL (4 AUTOINJECTORS PER 28 DAYS); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
KEVZARA INJ 150/1.14	2	PA, QL (2 SYRINGES PER 4 WEEKS); Must try 2 preferred agents for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	2	PA, QL (2 SYRINGES PER 4 WEEKS); Must try 2 preferred agents for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)		
ARTHROTEC 50 TAB	3	
ARTHROTEC 75 TAB	3	
CELEBREX CAP 50MG	3	
CELEBREX CAP 100MG	3	
CELEBREX CAP 200MG	3	
CELEBREX CAP 400MG	3	
celecoxib cap 50 mg	1	
celecoxib cap 100 mg	1	
celecoxib cap 200 mg	1	
celecoxib cap 400 mg	1	
DAYPRO TAB 600MG	3	
DICLOFENAC CAP 35MG	3	PA
diclofenac potassium tab 50 mg	1	
diclofenac sodium tab delayed release 25 mg	1	
diclofenac sodium tab delayed release 50 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
diclofenac sodium tab delayed release 75 mg	1	
diclofenac sodium tab er 24hr 100 mg	1	
diclofenac w/ misoprostol tab delayed release 50-0.2 mg	1	
diclofenac w/ misoprostol tab delayed release 75-0.2 mg	1	
DUEXIS TAB 800-26.6	3	
EC-NAPROSYN TAB 375MG	3	
EC-NAPROSYN TAB 500MG	3	
etodolac cap 200 mg	1	
etodolac cap 300 mg	1	
etodolac tab 400 mg	1	
etodolac tab 500 mg	1	
etodolac tab er 24hr 400 mg	1	
etodolac tab er 24hr 500 mg	1	
etodolac tab er 24hr 600 mg	1	
FELDENE CAP 10MG	3	
FELDENE CAP 20MG	3	
fenoprofen calcium cap 400 mg	1	PA; MNPA
fenoprofen calcium tab 600 mg	1	PA; MNPA
fenoprofen cap 200mg	1	PA; MNPA
FENOPROFEN CAP 200MG	3	PA; MNPA
FENORTHO CAP 200MG	3	PA
flurbiprofen tab 50 mg	1	
flurbiprofen tab 100 mg	1	
ibuprofen tab 400 mg	1	
ibuprofen tab 600 mg	1	
ibuprofen tab 800 mg	1	
INDOCIN SUP 50MG	3	PA
INDOCIN SUS 25MG/5ML	3	PA
indomethacin cap 20 mg	1	PA; MNPA
indomethacin cap 25 mg	1	
indomethacin cap 50 mg	1	
indomethacin cap er 75 mg	1	
ketoprofen cap 25 mg	1	PA; MNPA
ketoprofen cap 50 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
ketoprofen cap 75 mg	1	
ketoprofen cap er 24hr 200 mg	1	PA; MNPA
KETOR TROMET SPR 15.75MG	3	PA
ketorolac tromethamine tab 10 mg	1	
LODINE TAB 400MG	3	
meclofenamate sodium cap 50 mg	1	
meclofenamate sodium cap 100 mg	1	
mefenamic acid cap 250 mg	1	
mefenamic acid cap 250 mg	1	PA
meloxicam cap 5 mg	1	
meloxicam cap 10 mg	1	
meloxicam tab 7.5 mg	1	
meloxicam tab 15 mg	1	
MOBIC TAB 7.5MG	3	
MOBIC TAB 15MG	3	
nabumetone tab 500 mg	1	
nabumetone tab 750 mg	1	
NALFON CAP 400MG	3	
NALFON TAB 600MG	3	
NAPRELAN TAB 375MG CR	3	PA
NAPRELAN TAB 500MG CR	3	PA
NAPRELAN TAB 750MG CR	3	
NAPROSYN SUS 125/5ML	3	
NAPROSYN TAB 500MG	3	
naproxen sodium tab 275 mg	1	
naproxen sodium tab 550 mg	1	
naproxen sodium tab er 24hr 375 mg (base equiv)	1	PA; MNPA
naproxen sodium tab er 24hr 500 mg (base equiv)	1	PA; MNPA
naproxen sodium tab er 24hr 750 mg (base equiv)	1	
naproxen susp 125 mg/5ml	1	PA
naproxen tab 250 mg	1	
naproxen tab 375 mg	1	
naproxen tab 500 mg	1	
naproxen tab ec 375 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
NAPROXEN TAB EC 375 MG	1	
naproxen tab ec 500 mg	1	
NAPROXEN TAB EC 500 MG	1	
naproxen-esomeprazole magnesium tab dr 375-20 mg	1	PA; MNPA
naproxen-esomeprazole magnesium tab dr 500-20 mg	1	PA; MNPA
oxaprozin tab 600 mg	1	
piroxicam cap 10 mg	1	
piroxicam cap 20 mg	1	
QMIIZ ODT TAB 7.5MG	3	
QMIIZ ODT TAB 15 MG	3	
RELAFEN DS TAB 1000MG	3	
SPRIX SPR 15.75MG	3	PA; MNPA
sulindac tab 150 mg	1	
sulindac tab 200 mg	1	
TIVORBEX CAP 20MG	3	
tolmetin sodium cap 400 mg	1	
tolmetin sodium tab 600 mg	1	
VIMOVO TAB 375-20MG	3	
VIMOVO TAB 500-20MG	3	
VIVLODEX CAP 5MG	3	
VIVLODEX CAP 10MG	3	
ZIPSOR CAP 25MG	3	
ZORVOLEX CAP 18MG	3	PA; MNPA
ZORVOLEX CAP 35MG	3	PA; MNPA
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
OTEZLA TAB 10/20/30	2	PA, QL (55 TABLETS PER 28 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
OTEZLA TAB 30MG	2	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
PYRIMIDINE SYNTHESIS INHIBITORS		
ARAVA TAB 10MG	2	
ARAVA TAB 20MG	2	
leflunomide tab 10 mg	1	
leflunomide tab 20 mg	1	
SELECTIVE COSTIMULATION MODULATORS		
ORENCIA CLCK INJ 125MG/ML	3	PA, QL (4 INJ PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ORENCIA INJ 50/0.4ML	3	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
ORENCIA INJ 87.5/0.7	3	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ORENCIA INJ 125MG/ML	3	PA, QL (4 PFS PER 28 DAYS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS		
ENBREL INJ 25/0.5ML	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred agent for Anklyosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
ENBREL INJ 25MG	2	PA, QL (4 VIALS PER 28 DAYS); Preferred agent for Anklyosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ENBREL INJ 50MG/ML	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred agent for Anklyosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ENBREL MINI INJ 50MG/ML	2	PA, QL (4 INJ PER 28 DAYS); Preferred agent for Anklyosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
ENBREL SRCLK INJ 50MG/ML	2	PA, QL (4 INJ PER 28 DAYS); Preferred agent for Anklyosing Spondylitis, Psoriatic Arthritis, and Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ANALGESICS - NONNARCOTIC		
ANALGESIC COMBINATIONS		
ALLZITAL TAB 25-325MG	3	
BUT/ASA/CAF TAB	3	
butalbital-acetaminophen cap 50-300 mg	1	
butalbital-acetaminophen tab 25-325 mg	1	
butalbital-acetaminophen tab 50-300 mg	1	PA; MNPA
butalbital-acetaminophen tab 50-325 mg	1	
butalbital-acetaminophen-caffeine cap 50-300-40 mg	1	
butalbital-acetaminophen-caffeine cap 50-325-40 mg	1	
butalbital-acetaminophen-caffeine soln 50-325-40 mg/15ml	1	
butalbital-acetaminophen-caffeine tab 50-325-40 mg	1	
butalbital-aspirin-caffeine cap 50-325-40 mg	1	
ESGIC TAB	3	
FIORICET CAP	3	
SALICYLATES		
aspirin chew tab 81 mg	0	
aspirin chew tab 81 mg	0	OTC; $0 copay-age and gender restrictions apply
aspirin tab delayed release 81 mg	0	

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

Drug Name	Drug Tier	Requirements/Limits
aspirin tab delayed release 81 mg	0	OTC; $0 copay-age and gender restrictions apply
diflunisal tab 500 mg	1	
salsalate tab 500 mg	1	
salsalate tab 750 mg	1	
ANALGESICS - OPIOID		
OPIOID AGONISTS		
ACTIQ LOZ 200MCG	3	PA
ACTIQ LOZ 400MCG	3	PA
ACTIQ LOZ 600MCG	3	PA
ACTIQ LOZ 800MCG	3	PA
ACTIQ LOZ 1200MCG	3	PA
ACTIQ LOZ 1600MCG	3	PA
CODEINE SULF TAB 15MG	3	PA, QL (1 tab per day)
CODEINE SULF TAB 60MG	3	PA, QL (1 tab per day)
CODEINE SULFATE TAB 30 MG	1	PA, QL (1 tab per day)
CONZIP CAP 100MG	3	PA, QL (1 cap per day)
CONZIP CAP 200MG	3	PA, QL (1 cap per day)
CONZIP CAP 300MG	3	PA, QL (1 cap per day)
DILAUDID LIQ 1MG/ML	3	PA, QL (24 mL per day)
DILAUDID TAB 2MG	3	PA, QL (7 tabs per day)
DILAUDID TAB 4MG	3	PA, QL (6 tabs per day)
DILAUDID TAB 8MG	3	PA, QL (2 tabs per day)
DURAGESIC DIS 12MCG/HR	3	PA, QL (10 patches per month)
DURAGESIC DIS 25MCG/HR	3	PA, QL (10 patches per month)
DURAGESIC DIS 50MCG/HR	3	PA
DURAGESIC DIS 75MCG/HR	3	PA
DURAGESIC DIS 100MCG/H	3	PA
fentanyl citrate buccal tab 100 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 200 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 400 mcg (base equiv)	1	PA
fentanyl citrate buccal tab 600 mcg (base equiv)	1	PA

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

Drug Name	Drug Tier	Requirements/Limits
fentanyl citrate buccal tab 800 mcg (base equiv)	1	PA
fentanyl citrate lozenge on a handle 200 mcg	1	PA
fentanyl citrate lozenge on a handle 400 mcg	1	PA
fentanyl citrate lozenge on a handle 600 mcg	1	PA
fentanyl citrate lozenge on a handle 800 mcg	1	PA
fentanyl citrate lozenge on a handle 1200 mcg	1	PA
fentanyl citrate lozenge on a handle 1600 mcg	1	PA
fentanyl td patch 72hr 12 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 25 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 37.5 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 50 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 62.5 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 75 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 87.5 mcg/hr	1	PA, QL (10 patches per month)
fentanyl td patch 72hr 100 mcg/hr	1	PA, QL (10 patches per month)
FENTORA TAB 100MCG	3	PA
FENTORA TAB 200MCG	3	PA
FENTORA TAB 400MCG	3	PA
FENTORA TAB 600MCG	3	PA
FENTORA TAB 800MCG	3	PA
hydrocodone bitartrate cap er 12hr 10 mg	1	PA, QL (2 caps per day)
hydrocodone bitartrate cap er 12hr 15 mg	1	PA, QL (2 caps per day)
hydrocodone bitartrate cap er 12hr 20 mg	1	PA, QL (2 caps per day)
hydrocodone bitartrate cap er 12hr 30 mg	1	PA, QL (2 caps per day)

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

Drug Name	Drug Tier	Requirements/Limits
hydrocodone bitartrate cap er 12hr 40 mg	1	PA, QL (2 caps per day)
hydrocodone bitartrate cap er 12hr 50 mg	1	PA, QL (2 caps per day)
hydrocodone bitartrate tab er 24hr deter 20 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 30 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 40 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 60 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 80 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 100 mg	1	PA, QL (1 tab per day)
hydrocodone bitartrate tab er 24hr deter 120 mg	1	PA, QL (1 tab per day)
HYDROMORPHON SUP 3MG	3	PA, QL (4 supps per day)
hydromorphone hcl liqd 1 mg/ml	1	PA, QL (24 mL per day)
hydromorphone hcl tab 2 mg	1	PA, QL (7 tabs per day)
hydromorphone hcl tab 4 mg	1	PA, QL (6 tabs per day)
hydromorphone hcl tab 8 mg	1	PA, QL (2 tabs per day)
hydromorphone hcl tab er 24hr 8 mg	1	PA, QL (1 tab per day)
hydromorphone hcl tab er 24hr 12 mg	1	PA, QL (1 tab per day)
hydromorphone hcl tab er 24hr 16 mg	1	PA, QL (1 tab per day)
hydromorphone hcl tab er 24hr 32 mg	1	PA
HYSINGLA ER TAB 20 MG	3	PA, QL (1 tab per day)
HYSINGLA ER TAB 30 MG	3	PA, QL (1 tab per day)
HYSINGLA ER TAB 40 MG	3	PA, QL (1 tab per day)
HYSINGLA ER TAB 60 MG	3	PA, QL (1 tab per day)
HYSINGLA ER TAB 80 MG	3	PA, QL (1 tab per day)
HYSINGLA ER TAB 100 MG	3	PA
HYSINGLA ER TAB 120 MG	3	PA
LAZANDA SPR 100MCG	3	PA
LAZANDA SPR 400MCG	3	PA
levorphanol tartrate tab 2 mg	1	PA, QL (4 tabs per day)
levorphanol tartrate tab 3 mg	1	PA, QL (2 tabs per day)
meperidine hcl oral soln 50 mg/5ml	1	PA

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

Drug Name	Drug Tier	Requirements/Limits
meperidine hcl tab 50 mg	1	PA
methadone hcl conc 10 mg/ml	1	PA, QL (2 mL per day)
methadone hcl soln 5 mg/5ml	1	PA, QL (18 mL per day)
methadone hcl soln 10 mg/5ml	1	PA, QL (12 mL per day)
methadone hcl tab 5 mg	1	PA, QL (3 tabs per day)
methadone hcl tab 10 mg	1	PA, QL (2 Tabs per day)
methadone hcl tab for oral susp 40 mg	1	
METHADOSE CON 10MG/ML	3	QL (2 mL per day)
METHADOSE SF CON 10MG/ML	3	QL (2 mL per day)
morphine sulfate beads cap er 24hr 30 mg	1	PA, QL (1 cap per day)
morphine sulfate beads cap er 24hr 45 mg	1	PA, QL (1 cap per day)
morphine sulfate beads cap er 24hr 60 mg	1	PA, QL (1 cap per day)
morphine sulfate beads cap er 24hr 75 mg	1	PA, QL (1 cap per day)
morphine sulfate beads cap er 24hr 90 mg	1	PA, QL (1 cap per day)
morphine sulfate beads cap er 24hr 120 mg	1	PA
morphine sulfate cap er 24hr 10 mg	1	PA, QL (2 caps per day)
morphine sulfate cap er 24hr 20 mg	1	PA, QL (2 caps per day)
morphine sulfate cap er 24hr 30 mg	1	PA, QL (2 caps per day)
morphine sulfate cap er 24hr 40 mg	1	PA, QL (2 caps per day)
morphine sulfate cap er 24hr 50 mg	1	PA, QL (1 cap per day)
morphine sulfate cap er 24hr 60 mg	1	PA, QL (1 cap per day)
morphine sulfate cap er 24hr 80 mg	1	PA, QL (1 cap per day)
morphine sulfate cap er 24hr 100 mg	1	PA
morphine sulfate oral soln 10 mg/5ml	1	PA, QL (36 mL per day)
morphine sulfate oral soln 20 mg/5ml	1	PA, QL (27 mL per day)
morphine sulfate oral soln 100 mg/5ml (20 mg/ml)	1	PA, QL (5 mL per day)
morphine sulfate suppos 5 mg	1	PA, QL (7 supps per day)
morphine sulfate suppos 10 mg	1	PA, QL (7 supps per day)
morphine sulfate suppos 20 mg	1	PA, QL (4 supps per day)
morphine sulfate suppos 30 mg	1	PA, QL (3 supps per day)
morphine sulfate tab 15 mg	1	PA, QL (7 tabs per day)
morphine sulfate tab 30 mg	1	PA, QL (3 tabs per day)

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

Drug Name	Drug Tier	Requirements/Limits
morphine sulfate tab er 15 mg	1	PA, QL (3 tabs per day)
morphine sulfate tab er 30 mg	1	PA, QL (3 tabs per day)
morphine sulfate tab er 60 mg	1	PA
morphine sulfate tab er 100 mg	1	PA
morphine sulfate tab er 200 mg	1	PA
MS CONTIN TAB 15MG ER	3	PA, QL (3 tabs per day)
MS CONTIN TAB 30MG ER	3	PA, QL (3 tabs per day)
MS CONTIN TAB 60MG ER	3	PA
MS CONTIN TAB 100MG ER	3	PA
MS CONTIN TAB 200MG ER	3	PA
NUCYNTA ER TAB 50MG	2	PA, QL (2 tabs per day)
NUCYNTA ER TAB 100MG	2	PA, QL (2 tabs per day)
NUCYNTA ER TAB 150MG	2	PA
NUCYNTA ER TAB 200MG	2	PA
NUCYNTA ER TAB 250MG	2	PA
NUCYNTA TAB 50MG	2	PA, QL (4 tabs per day)
NUCYNTA TAB 75MG	2	PA, QL (3 tabs per day)
NUCYNTA TAB 100MG	2	PA, QL (2 tabs per day)
OXAYDO TAB 5MG	3	PA, QL (7 tabs per day)
OXAYDO TAB 7.5MG	3	PA, QL (7 tabs per day)
oxycodone hcl cap 5 mg	1	PA, QL (7 caps per day)
oxycodone hcl conc 100 mg/5ml (20 mg/ml)	1	PA, QL (3 mL per day)
oxycodone hcl soln 5 mg/5ml	1	PA, QL (36 mL per day)
oxycodone hcl tab 5 mg	1	PA, QL (7 tabs per day)
oxycodone hcl tab 10 mg	1	PA, QL (7 tabs per day)
oxycodone hcl tab 15 mg	1	PA, QL (4 tabs per day)
oxycodone hcl tab 20 mg	1	PA, QL (3 tabs per day)
oxycodone hcl tab 30 mg	1	PA, QL (2 tabs per day)
oxycodone hcl tab er 12hr deter 10 mg	1	PA, QL (2 tabs per day)
OXYCODONE HCL TAB ER 12HR DETER 10 MG	3	PA, QL (2 tabs per day)
oxycodone hcl tab er 12hr deter 15 mg	1	PA, QL (2 tabs per day)
oxycodone hcl tab er 12hr deter 20 mg	1	PA, QL (2 tabs per day)
OXYCODONE HCL TAB ER 12HR DETER 20 MG	3	PA, QL (2 tabs per day)
oxycodone hcl tab er 12hr deter 30 mg	1	PA, QL (2 tabs per day)

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

Drug Name	Drug Tier	Requirements/Limits
oxycodone hcl tab er 12hr deter 40 mg	1	PA, QL (4 tabs per day)
OXYCODONE HCL TAB ER 12HR DETER 40 MG	3	PA, QL (4 tabs per day)
oxycodone hcl tab er 12hr deter 60 mg	1	PA, QL (2 tabs per day)
oxycodone hcl tab er 12hr deter 80 mg	1	PA, QL (2 tabs per day)
OXYCONTIN TAB 10MG ER	2	PA, QL (2 tabs per day)
OXYCONTIN TAB 15MG ER	2	PA, QL (2 tabs per day)
OXYCONTIN TAB 20MG ER	2	PA, QL (2 tabs per day)
OXYCONTIN TAB 30MG ER	2	PA, QL (2 tabs per day)
OXYCONTIN TAB 40MG ER	2	PA, QL (4 tabs per day)
OXYCONTIN TAB 60MG ER	2	PA, QL (2 tabs per day)
OXYCONTIN TAB 80MG ER	2	PA, QL (2 tabs per day)
oxymorphone hcl tab 5 mg	1	PA, QL (7 tabs per day)
oxymorphone hcl tab 10 mg	1	PA, QL (3 tabs per day)
oxymorphone hcl tab er 12hr 5 mg	1	PA, QL (2 tabs per day)
oxymorphone hcl tab er 12hr 7.5 mg	1	PA, QL (2 tabs per day)
oxymorphone hcl tab er 12hr 10 mg	1	PA, QL (2 tabs per day)
oxymorphone hcl tab er 12hr 15 mg	1	PA, QL (2 tabs per day)
oxymorphone hcl tab er 12hr 20 mg	1	PA
oxymorphone hcl tab er 12hr 30 mg	1	PA
oxymorphone hcl tab er 12hr 40 mg	1	PA
QDOLO SOL 5MG/ML	3	
ROXICODONE TAB 5MG	3	PA, QL (7 tabs per day)
ROXICODONE TAB 15MG	3	PA, QL (4 tabs per day)
ROXICODONE TAB 30MG	3	PA, QL (2 tabs per day)
ROXYBOND TAB 5MG	3	
SUBSYS SPR 100MCG	2	PA
SUBSYS SPR 200MCG	2	PA
SUBSYS SPR 400MCG	2	PA
SUBSYS SPR 600MCG	2	PA
SUBSYS SPR 800MCG	2	PA
SUBSYS SPR 1200MCG	2	PA
SUBSYS SPR 1600MCG	2	PA
tramadol hcl tab 50 mg	1	PA, QL (7 tabs per day)
tramadol hcl tab 100 mg	1	PA, QL (3 tabs per day); MNPA
tramadol hcl tab er 24hr 100 mg	1	PA, QL (1 tab per day)

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

Drug Name	Drug Tier	Requirements/Limits
tramadol hcl tab er 24hr 200 mg	1	PA, QL (1 tab per day)
tramadol hcl tab er 24hr 300 mg	1	PA, QL (1 tab per day)
tramadol hcl tab er 24hr biphasic release 100 mg	1	PA
tramadol hcl tab er 24hr biphasic release 200 mg	1	PA
tramadol hcl tab er 24hr biphasic release 300 mg	1	PA
ULTRAM TAB 50MG	3	PA, QL (7 tabs per day)
XTAMPZA ER CAP 9MG	2	PA, QL (2 caps per day)
XTAMPZA ER CAP 13.5MG	2	PA, QL (2 caps per day)
XTAMPZA ER CAP 18MG	2	PA, QL (2 caps per day)
XTAMPZA ER CAP 27MG	2	PA, QL (2 caps per day)
XTAMPZA ER CAP 36MG	2	PA, QL (2 caps per day)
ZOHYDRO ER CAP 10MG	3	PA, QL (2 caps per day)
ZOHYDRO ER CAP 15MG	3	PA, QL (2 caps per day)
ZOHYDRO ER CAP 20MG	3	PA, QL (2 caps per day)
ZOHYDRO ER CAP 30MG	3	PA, QL (2 caps per day)
ZOHYDRO ER CAP 40MG	3	PA, QL (2 caps per day)
ZOHYDRO ER CAP 50MG	3	PA, QL (2 caps per day)
OPIOID COMBINATIONS		
acetaminophen w/ codeine soln 120-12 mg/5ml	1	PA, QL (2700 mL every month)
acetaminophen w/ codeine tab 300-15 mg	1	PA, QL (13 tabs per day)
acetaminophen w/ codeine tab 300-30 mg	1	PA, QL (12 tabs per day)
acetaminophen w/ codeine tab 300-60 mg	1	PA, QL (6 tabs per day)
acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg	1	PA, QL (10 caps per day)
acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg	1	PA, QL (10 tabs per day)
APADAZ TAB 4.08-325	3	PA, QL (12 tabs per day)
APADAZ TAB 6.12-325	3	PA, QL (12 tabs per day)
APADAZ TAB 8.16-325	3	PA, QL (12 tabs per day)
BENZHY/ACETA TAB 4.08-325	3	PA, QL (12 tabs per day)
BENZHY/ACETA TAB 6.12-325	3	PA, QL (12 tabs per day)
BENZHY/ACETA TAB 8.16-325	3	PA, QL (12 tabs per day)
butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg	1	
butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg	1	
FIORICET CAP CODEINE	3	
hydrocodone-acetaminophen soln 7.5-325 mg/15ml	1	PA, QL (2700 mL every month)
HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML	1	PA, QL (2700 mL every month)
hydrocodone-acetaminophen tab 5-300 mg	1	PA, QL (8 tabs per day)
hydrocodone-acetaminophen tab 5-325 mg	1	PA, QL (8 tabs per day)
hydrocodone-acetaminophen tab 7.5-300 mg	1	PA, QL (6 tabs per day)
hydrocodone-acetaminophen tab 7.5-325 mg	1	PA, QL (6 tabs per day)
hydrocodone-acetaminophen tab 10-300 mg	1	PA, QL (6 tabs per day)
hydrocodone-acetaminophen tab 10-325 mg	1	PA, QL (Add QL 2 packages every 25 days)
hydrocodone-ibuprofen tab 5-200 mg	1	PA, QL (5 tabs per day)
hydrocodone-ibuprofen tab 7.5-200 mg	1	PA, QL (5 tabs per day)
hydrocodone-ibuprofen tab 10-200 mg	1	PA, QL (5 tabs per day)
LORTAB ELX 10-300MG	3	PA, QL (68 mL per day)
NALOCET TAB 2.5-300	3	PA, QL (12 tabs per day)
OXYCOD-APAP TAB 2.5-300	3	PA, QL (12 tabs per day)
OXYCOD/ACETA SOL 10/300MG	3	QL (30 mL per day)
OXYCOD/APAP TAB 5-300MG	3	PA, QL (12 tabs per day)
OXYCOD/APAP TAB 10-300MG	3	PA, QL (6 tabs per day)
oxycodone w/ acetaminophen soln 5-325 mg/5ml	3	
oxycodone w/ acetaminophen tab 2.5-325 mg	1	PA, QL (12 tabs per day)
oxycodone w/ acetaminophen tab 5-325 mg	1	PA, QL (12 tabs per day)
oxycodone w/ acetaminophen tab 7.5-325 mg	1	PA, QL (8 tabs per day)
oxycodone w/ acetaminophen tab 10-325 mg	1	PA, QL (6 tabs per day)

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

Drug Name	Drug Tier	Requirements/Limits
oxycodone-aspirin tab 4.8355-325 mg	1	PA, QL (12 tabs per day)
PERCOCET TAB 2.5-325	3	PA, QL (12 tabs per day)
PERCOCET TAB 5-325MG	3	PA, QL (12 tabs per day)
PERCOCET TAB 7.5-325	3	PA, QL (8 tabs per day)
PERCOCET TAB 10-325MG	3	PA, QL (6 tabs per day)
PROLATE SOL 10/300MG	3	QL (30 mL per day)
PROLATE TAB 5-300MG	3	PA, QL (12 tabs per day)
PROLATE TAB 7.5-300	3	PA, QL (8 tabs per day)
PROLATE TAB 10-300MG	3	PA, QL (6 tabs per day)
SEGLENTIS TAB 56-44MG	3	PA, QL (4 tablets per day)
tramadol-acetaminophen tab 37.5-325 mg	1	PA, QL (8 tabs per day)
ULTRACET TAB 37.5-325	3	PA, QL (8 tabs per day)
OPIOID PARTIAL AGONISTS		
BELBUCA MIS 75MCG	2	PA, QL (60 films per month)
BELBUCA MIS 150MCG	2	PA, QL (60 films per month)
BELBUCA MIS 300MCG	2	PA, QL (60 films per month)
BELBUCA MIS 450MCG	2	PA, QL (60 films per month)
BELBUCA MIS 600MCG	2	PA
BELBUCA MIS 750MCG	2	PA
BELBUCA MIS 900MCG	2	PA
BUNAVAIL MIS 4.2-0.7	2	
BUNAVAIL MIS 6.3-1MG	2	
buprenorphine hcl sl tab 2 mg (base equiv)	1	
buprenorphine hcl sl tab 8 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)	1	

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

Drug Name	Drug Tier	Requirements/Limits
buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)	1	
buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)	1	
buprenorphine td patch weekly 5 mcg/hr	1	PA, QL (4 patches per month)
buprenorphine td patch weekly 7.5 mcg/hr	1	PA, QL (4 patches per month)
buprenorphine td patch weekly 10 mcg/hr	1	PA, QL (4 patches per month)
buprenorphine td patch weekly 15 mcg/hr	1	PA
buprenorphine td patch weekly 20 mcg/hr	1	PA
butorphanol tartrate nasal soln 10 mg/ml	1	QL (2 BOTTLES PER MONTH)
BUTRANS DIS 5MCG/HR	3	PA, QL (4 patches per month)
BUTRANS DIS 7.5/HR	3	PA, QL (4 patches per month)
BUTRANS DIS 10MCG/HR	3	PA, QL (4 patches per month)
BUTRANS DIS 15MCG/HR	3	PA
BUTRANS DIS 20MCG/HR	3	PA
pentazocine w/ naloxone hcl tab 50-0.5 mg	1	PA
SUBOXONE MIS 2-0.5MG	3	
SUBOXONE MIS 4-1MG	3	
SUBOXONE MIS 8-2MG	3	
SUBOXONE MIS 12-3MG	3	
ZUBSOLV SUB 0.7-0.18	2	
ZUBSOLV SUB 1.4-0.36	2	
ZUBSOLV SUB 2.9-0.71	2	
ZUBSOLV SUB 5.7-1.4	2	
ZUBSOLV SUB 8.6-2.1	2	
ZUBSOLV SUB 11.4-2.9	2	
ANDROGENS-ANABOLIC		
ANABOLIC STEROIDS		
oxandrolone tab 2.5 mg	1	
oxandrolone tab 10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
ANDROGENS		
ANDRODERM DIS 2MG/24HR	2	
ANDRODERM DIS 4MG/24HR	2	
ANDROGEL GEL 1%(25MG)	3	
ANDROGEL GEL 1%(50MG)	3	
ANDROGEL GEL 1.62%	3	
danazol cap 50 mg	1	
danazol cap 100 mg	1	
danazol cap 200 mg	1	
DEPO-TESTOST INJ 100MG/ML	3	PA
DEPO-TESTOST INJ 200MG/ML	3	PA
FORTESTA GEL 10MG/ACT	3	
JATENZO CAP 158MG	3	
JATENZO CAP 198MG	3	
JATENZO CAP 237MG	3	
METHITEST TAB 10MG	3	
methyltestosterone cap 10 mg	1	
NATESTO GEL 5.5MG	2	
TESTIM GEL 1%(50MG)	3	
testost cyp inj 200mg/ml	1	PA
testosterone cypionate im inj in oil 100 mg/ml	1	PA
testosterone cypionate im inj in oil 200 mg/ml	1	PA
testosterone enanthate im inj in oil 200 mg/ml	1	PA
testosterone td gel 10mg/act (2%)	1	
testosterone td gel 12.5 mg/act (1%)	1	
testosterone td gel 20.25 mg/1.25gm (1.62%)	1	
testosterone td gel 20.25 mg/act (1.62%)	1	
testosterone td gel 25 mg/2.5gm (1%)	1	
testosterone td gel 40.5 mg/2.5gm (1.62%)	1	
testosterone td gel 50 mg/5gm (1%)	1	
testosterone td soln 30 mg/act	1	
VOGELXO GEL 1%(50MG)	3	
VOGELXO GEL PUMP 1%	3	

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

Drug Name	Drug Tier	Requirements/Limits
XYOSTED INJ 50/0.5	3	PA
XYOSTED INJ 75/0.5	3	PA
XYOSTED INJ 100/0.5	3	PA
ANORECTAL AND RELATED PRODUCTS		
INTRARECTAL STEROIDS		
CORTENEMA ENE 100MG	3	
CORTIFOAM AER 90MG	2	
hydrocortisone enema 100 mg/60ml	1	
UCERIS AER 2MG/ACT	3	
RECTAL COMBINATIONS		
ANALPRAM-HC CRE 1-1%	3	
ANALPRAM-HC LOT 2.5%	3	
hydrocortisone acetate w/ pramoxine perianal cream 1-1%	1	
PROCORT CRE	3	
PROCTOFOAM AER HC 1%	2	
RECTAL STEROIDS		
ANUSOL-HC CRE 2.5%	2	
hydrocortisone acetate suppos 25 mg	1	
hydrocortisone perianal cream 1%	1	
hydrocortisone perianal cream 2.5%	1	
PROCTOCORT CRE 1%	3	
PROCTOCORT SUP 30MG	3	
VASODILATING AGENTS		
RECTIV OIN 0.4%	3	
ANTHELMINTICS		
ANTHELMINTICS		
albendazole tab 200 mg	1	QL (336 tabs every year)
ALBENZA TAB 200MG	3	QL (336 tabs every year)
BENZNIDAZOLE TAB 12.5MG	3	
BENZNIDAZOLE TAB 100MG	3	
BILTRICIDE TAB 600MG	3	QL (24 tabs every year)
EMVERM CHW 100MG	2	QL (12 ea every year)
ivermectin tab 3 mg	1	PA, QL (9 tabs every 90 days)

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

Drug Name	Drug Tier	Requirements/Limits
praziquantel tab 600 mg	1	QL (24 tabs every year)
STROMECTOL TAB 3MG	3	PA, QL (9 tabs every 90 days)
ANTI-INFECTIVE AGENTS - MISC.		
ANTI-INFECTIVE AGENTS - MISC.		
AEMCOLO TAB 194MG	3	
FLAGYL CAP 375MG	3	
FLAGYL TAB 500MG	3	
IMPAVIDO CAP 50MG	3	
metronidazole cap 375 mg	1	
metronidazole tab 250 mg	1	
metronidazole tab 500 mg	1	
PRIMSOL SOL 50MG/5ML	3	
tinidazole tab 250 mg	1	
tinidazole tab 500 mg	1	
trimethoprim tab 100 mg	1	
XIFAXAN TAB 200MG	3	QL (9 tablets per month)
XIFAXAN TAB 550MG	2	PA
ANTI-INFECTIVE MISC. - COMBINATIONS		
BACTRIM DS TAB 800-160	3	
BACTRIM TAB 400-80MG	3	
methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg**	1	
sulfamethoxazole-trimethoprim susp 200-40 mg/5ml	1	
sulfamethoxazole-trimethoprim tab 400-80 mg	1	
sulfamethoxazole-trimethoprim tab 800-160 mg	1	
ANTIPROTOZOAL AGENTS		
ALINIA SUS 100/5ML	3	
ALINIA TAB 500MG	3	
atovaquone susp 750 mg/5ml	1	
LAMPIT TAB 30MG	3	
LAMPIT TAB 120MG	3	
MEPRON SUS	3	

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

Drug Name	Drug Tier	Requirements/Limits
nitazoxanide tab 500 mg	1	
GLYCOPEPTIDES		
FIRVANQ SOL 25MG/ML	3	QL (450 ML every 10 days)
FIRVANQ SOL 50MG/ML	3	QL (450 ML every 10 days)
VANCOCIN CAP 125MG	2	QL (80 caps every 10 days)
VANCOCIN CAP 250MG	2	QL (80 caps every 10 days)
vancomycin hcl cap 125 mg (base equivalent)	1	QL (80 caps every 10 days)
vancomycin hcl cap 250 mg (base equivalent)	1	QL (80 caps every 10 days)
VANCOMYCIN SOL 250/5ML	3	QL (450 ML every 10 days)
LEPROSTATICS		
dapsone tab 25 mg	1	
dapsone tab 100 mg	1	
LINCOSAMIDES		
CLEOCIN CAP 75MG	2	
CLEOCIN CAP 150MG	2	
CLEOCIN CAP 300MG	2	
CLEOCIN PED SOL 75MG/5ML	2	
clindamycin hcl cap 75 mg	1	
clindamycin hcl cap 150 mg	1	
clindamycin hcl cap 300 mg	1	
clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)	1	
MONOBACTAMS		
CAYSTON INH 75MG	3	PA, QL (84 VIALS PER 28 DAYS)
OXAZOLIDINONES		
linezolid for susp 100 mg/5ml	1	PA
linezolid tab 600 mg	1	PA
SIVEXTRO TAB 200MG	3	
ZYVOX SUS 100MG/5M	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
ZYVOX TAB 600MG	3	PA
PLEUROMUTILINS		
XENLETA TAB 600MG	3	
URINARY ANTI-INFECTIVES		
fosfomycin tromethamine powd pack 3 gm (base equivalent)	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	2	
MACRODANTIN CAP 25MG	3	PA; MNPA
MACRODANTIN CAP 50MG	3	PA; MNPA
MACRODANTIN CAP 100MG	3	PA; MNPA
methenamine hippurate tab 1 gm	1	
methenamine mandelate tab 0.5 gm	1	
methenamine mandelate tab 1 gm	1	
MONUROL PAK GRANULES	3	
nitrofurantoin macrocrystalline cap 25 mg	1	
nitrofurantoin macrocrystalline cap 50 mg	1	
nitrofurantoin macrocrystalline cap 100 mg	1	
nitrofurantoin monohydrate macrocrystalline cap 100 mg	1	
nitrofurantoin susp 25 mg/5ml	1	
ANTIANGINAL AGENTS		
ANTIANGINALS-OTHER		
RANEXA TAB 500MG	3	
RANEXA TAB 1000MG	3	
ranolazine tab er 12hr 500 mg	1	
ranolazine tab er 12hr 1000 mg	1	
NITRATES		
DILATRATE SR CAP 40MG	3	
GONITRO POW 400MCG	3	
ISORDIL TAB 5MG	3	
ISORDIL TAB 40MG	3	
isosorbide dinitrate tab 5 mg	1	
isosorbide dinitrate tab 10 mg	1	
isosorbide dinitrate tab 20 mg	1	
isosorbide dinitrate tab 30 mg	1	
isosorbide dinitrate tab 40 mg	1	PA; MNPA

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

Drug Name	Drug Tier	Requirements/Limits
isosorbide mononitrate tab 10 mg	1	
isosorbide mononitrate tab 20 mg	1	
isosorbide mononitrate tab er 24hr 30 mg	1	
isosorbide mononitrate tab er 24hr 60 mg	1	
isosorbide mononitrate tab er 24hr 120 mg	1	
NITRO-BID OIN 2%	3	
NITRO-DUR DIS 0.1MG/HR	2	
NITRO-DUR DIS 0.2MG/HR	2	
NITRO-DUR DIS 0.3MG/HR	2	
NITRO-DUR DIS 0.4MG/HR	2	
NITRO-DUR DIS 0.6MG/HR	2	
NITRO-DUR DIS 0.8MG/HR	2	
nitroglycerin sl tab 0.3 mg	1	
nitroglycerin sl tab 0.4 mg	1	
nitroglycerin sl tab 0.6 mg	1	
nitroglycerin td patch 24hr 0.1 mg/hr	1	
nitroglycerin td patch 24hr 0.2 mg/hr	1	
nitroglycerin td patch 24hr 0.4 mg/hr	1	
nitroglycerin td patch 24hr 0.6 mg/hr	1	
nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)	1	
NITROLINGUAL SPR PUMPSPRA	3	
NITROMIST AER 400MCG	3	
NITROSTAT SUB 0.3MG	3	
NITROSTAT SUB 0.4MG	3	
NITROSTAT SUB 0.6MG	3	

ANTIANXIETY AGENTS

ANTIANXIETY AGENTS - MISC.

buspirone hcl tab 5 mg	1	
buspirone hcl tab 7.5 mg	1	
buspirone hcl tab 10 mg	1	
buspirone hcl tab 15 mg	1	
buspirone hcl tab 30 mg	1	
hydroxyzine hcl syrup 10 mg/5ml	1	
hydroxyzine hcl tab 10 mg	1	
hydroxyzine hcl tab 25 mg	1	
hydroxyzine hcl tab 50 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
hydroxyzine pamoate cap 25 mg	1	
hydroxyzine pamoate cap 50 mg	1	
hydroxyzine pamoate cap 100 mg	1	
meprobamate tab 200 mg	1	
meprobamate tab 400 mg	1	
VISTARIL CAP 25MG	3	
VISTARIL CAP 50MG	3	
BENZODIAZEPINES		
ALPRAZOLAM CON 1 MG/ML	3	
alprazolam orally disintegrating tab 0.5 mg	1	
alprazolam orally disintegrating tab 0.25 mg	1	
alprazolam orally disintegrating tab 1 mg	1	
alprazolam orally disintegrating tab 2 mg	1	
alprazolam tab 0.5 mg	1	
alprazolam tab 0.25 mg	1	
alprazolam tab 1 mg	1	
alprazolam tab 2 mg	1	
alprazolam tab er 24hr 0.5 mg	1	
alprazolam tab er 24hr 1 mg	1	
alprazolam tab er 24hr 2 mg	1	
alprazolam tab er 24hr 3 mg	1	
ATIVAN TAB 0.5MG	3	
ATIVAN TAB 1MG	3	
ATIVAN TAB 2MG	3	
chlordiazepoxide hcl cap 5 mg	1	
chlordiazepoxide hcl cap 10 mg	1	
chlordiazepoxide hcl cap 25 mg	1	
clorazepate dipotassium tab 3.75 mg	1	
clorazepate dipotassium tab 7.5 mg	1	
clorazepate dipotassium tab 15 mg	1	
diazepam conc 5 mg/ml	1	
diazepam oral soln 1 mg/ml	1	
diazepam tab 2 mg	1	
diazepam tab 5 mg	1	
diazepam tab 10 mg	1	
lorazepam conc 2 mg/ml	1	

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

Drug Name	Drug Tier	Requirements/Limits
lorazepam tab 0.5 mg	1	
lorazepam tab 1 mg	1	
lorazepam tab 2 mg	1	
oxazepam cap 10 mg	1	
oxazepam cap 15 mg	1	
oxazepam cap 30 mg	1	
TRANXENE T TAB 7.5MG	3	
VALIUM TAB 2MG	3	
VALIUM TAB 5MG	3	
VALIUM TAB 10MG	3	
XANAX TAB 0.5MG	3	
XANAX TAB 0.25MG	3	
XANAX TAB 1MG	3	
XANAX TAB 2MG	3	
XANAX XR TAB 0.5MG	3	
XANAX XR TAB 1MG	3	
XANAX XR TAB 2MG	3	
XANAX XR TAB 3MG	3	
ANTIARRHYTHMICS		
ANTIARRHYTHMICS TYPE I-A		
disopyramide phosphate cap 100 mg	1	
disopyramide phosphate cap 150 mg	1	
NORPACE CAP 100MG	3	
NORPACE CAP 100MG CR	2	
NORPACE CAP 150MG	3	
NORPACE CAP 150MG CR	2	
quinidine gluconate tab er 324 mg	1	
quinidine sulfate tab 200 mg	1	
quinidine sulfate tab 300 mg	1	
ANTIARRHYTHMICS TYPE I-B		
mexiletine hcl cap 150 mg	1	
mexiletine hcl cap 200 mg	1	
mexiletine hcl cap 250 mg	1	
ANTIARRHYTHMICS TYPE I-C		
flecainide acetate tab 50 mg	1	
flecainide acetate tab 100 mg	1	
flecainide acetate tab 150 mg	1	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
BRONCHODILATORS - ANTICHOLINERGICS		
ATROVENT HFA AER 17MCG	2	QL (2 packages per month)
INCRUSE ELPT INH 62.5MCG	2	QL (1 package per month)
ipratropium bromide inhal soln 0.02%	1	QL (300 nebules per month)
LONHALA MAGN SOL 25MCG	3	QL (1 package per month)
SEEBRI NEOHA CAP 15.6MCG	3	QL (1 package per month)
SPIRIVA AER 1.25MCG	2	QL (1 package per month)
SPIRIVA CAP HANDIHLR	2	QL (1 package per month)
SPIRIVA SPR 2.5MCG	2	QL (1 package per month)
TUDORZA PRES AER 400/ACT	3	QL (1 package per month)
YUPELRI SOL	2	QL (1 package per month)
LEUKOTRIENE MODULATORS		
ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
montelukast sodium chew tab 4 mg (base equiv)	1	
montelukast sodium chew tab 5 mg (base equiv)	1	
montelukast sodium oral granules packet 4 mg (base equiv)	1	
montelukast sodium tab 10 mg (base equiv)	1	
SINGULAIR CHW 4MG	3	
SINGULAIR CHW 5MG	3	
SINGULAIR GRA 4MG	3	
SINGULAIR TAB 10MG	3	
zafirlukast tab 10 mg	1	
zafirlukast tab 20 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
zileuton tab er 12hr 600 mg	1	PA
ZYFLO TAB 600MG	3	
SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS		
DALIRESP TAB 250MCG	2	
DALIRESP TAB 500MCG	2	
roflumilast tab 250 mcg	1	
roflumilast tab 500 mcg	1	
STEROID INHALANTS		
ALVESCO AER 80MCG	3	QL (3 packages every 25 days)
ALVESCO AER 160MCG	3	QL (2 packages every 25 days)
ARMONAIR DIG AER 55MCG	3	QL (1 package every 25 days)
ARMONAIR DIG AER 113MCG	3	QL (1 package every 25 days)
ARMONAIR DIG AER 232MCG	3	QL (1 package every 25 days)
ARNUITY ELPT INH 50MCG	2	QL (1 package every 25 days)
ARNUITY ELPT INH 100MCG	2	QL (1 package every 25 days)
ARNUITY ELPT INH 200MCG	2	QL (1 package every 25 days)
ASMANEX 7 AER 110MCG	2	QL (2 packages every 25 days)
ASMANEX 14 AER 220MCG	2	
ASMANEX 30 AER 110MCG	2	QL (2 packages every 25 days)
ASMANEX 30 AER 220MCG	2	QL (4 packages every 25 days)
ASMANEX 60 AER 220MCG	2	QL (2 packages every 25 days)
ASMANEX 120 AER 220MCG	2	QL (1 package every 25 days)
ASMANEX HFA AER 50MCG	2	QL (1 package every 25 days)

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

Drug Name	Drug Tier	Requirements/Limits
ASMANEX HFA AER 100 MCG	2	QL (1 package every 25 days)
ASMANEX HFA AER 200 MCG	2	QL (1 package every 25 days)
budesonide inhalation susp 0.5 mg/2ml	1	QL (2 packages every 25 days)
budesonide inhalation susp 0.25 mg/2ml	1	QL (3 packages every 25 days)
budesonide inhalation susp 1 mg/2ml	1	QL (1 package every 25 days)
FLOVENT DISK AER 50MCG	2	QL (3 packages per 25 days)
FLOVENT DISK AER 100MCG	2	QL (4 packages per 25 days)
FLOVENT DISK AER 250MCG	2	QL (4 packages per 25 days)
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days)
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days)
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days)
FLUTICAS HFA AER 44MCG	3	QL (2 packages every 25 days)
FLUTICAS HFA AER 110MCG	3	QL (2 packages every 25 days)
FLUTICAS HFA AER 220MCG	3	QL (2 packages every 25 days)
PULMICORT INH 90MCG	2	QL (3 packages every 25 days)
PULMICORT INH 180MCG	2	QL (2 packages per 25 days)
PULMICORT SUS 0.5MG/2	3	QL (2 packages every 25 days)
PULMICORT SUS 0.25MG/2	3	QL (3 packages every 25 days)
PULMICORT SUS 1MG/2ML	3	QL (1 packages every 25 days)

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

Drug Name	Drug Tier	Requirements/Limits
QVAR REDIHA AER 80MCG	2	QL (2 packages every 25 days)
QVAR REDIHAL AER 40MCG	2	QL (2 packages every 25 days)
SYMPATHOMIMETICS		
ADVAIR DISKU AER 100/50	2	QL (1 package per month)
ADVAIR DISKU AER 250/50	2	QL (1 package per month)
ADVAIR DISKU AER 500/50	2	QL (1 package per month)
ADVAIR HFA AER 45/21	2	QL (1 package per month)
ADVAIR HFA AER 115/21	2	QL (1 package per month)
ADVAIR HFA AER 230/21	2	QL (1 package per month)
AIRDUO DGHLR INH 55-14	3	
AIRDUO DGHLR INH 113-14	3	
AIRDUO DGHLR INH 232-14	3	
AIRDUO RESPI INH 55-14	3	QL (1 package per month)
AIRDUO RESPI INH 113-14	3	QL (1 package per month)
AIRDUO RESPI INH 232-14	3	QL (1 package per month)
ALBUTEROL NEB 0.5%	3	QL (120 ea every month)
albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)	1	QL (2 PKG PER MONTH)
albuterol sulfate soln nebu 0.5% (5 mg/ml)	1	QL (120 ea every month)
albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)	1	QL (360 mL every month)
albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)	1	QL (360 mL every month)
albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)	1	QL (360 mL every month)
albuterol sulfate syrup 2 mg/5ml	1	

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

Drug Name	Drug Tier	Requirements/Limits
albuterol sulfate tab 2 mg	1	
albuterol sulfate tab 4 mg	1	
albuterol sulfate tab er 12hr 4 mg	1	
albuterol sulfate tab er 12hr 8 mg	1	
ANORO ELLIPT AER 62.5-25	2	QL (1 package per month)
arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)	1	QL (60 vials per month)
BEVESPI AER 9-4.8MCG	2	QL (1 package per month)
BREO ELLIPTA INH 100-25	2	QL (1 package per month)
BREO ELLIPTA INH 200-25	2	QL (1 package per month)
BREZTRI AERO AER SPHERE	2	
BROVANA NEB 15MCG	3	QL (60 vials per month)
budesonide-formoterol fumarate dihyd aerosol 80-4.5 mcg/act	1	QL (1 package per month)
budesonide-formoterol fumarate dihyd aerosol 160-4.5 mcg/act	1	QL (1 package per month)
COMBIVENT AER 20-100	3	QL (2 packages per month)
DUAKLIR AER 400/12	3	QL (1 package per month)
DULERA AER 50-5MCG	3	QL (1 package per month)
DULERA AER 100-5MCG	3	QL (1 package per month)
DULERA AER 200-5MCG	3	QL (1 package per month)
FLUTIC/VILAN INH 100-25	3	
FLUTIC/VILAN INH 200-25	3	
fluticasone-salmeterol aer powder ba 55-14 mcg/act	1	QL (1 package per month)
fluticasone-salmeterol aer powder ba 100-50 mcg/act	1	QL (1 package per month)
fluticasone-salmeterol aer powder ba 113-14 mcg/act	1	QL (1 package per month)

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

Drug Name	Drug Tier	Requirements/Limits
fluticasone-salmeterol aer powder ba 232-14 mcg/act	1	QL (1 package per month)
fluticasone-salmeterol aer powder ba 250-50 mcg/act	1	QL (1 package per month)
fluticasone-salmeterol aer powder ba 500-50 mcg/act	1	QL (1 package per month)
formoterol fumarate soln nebu 20 mcg/2ml	1	QL (60 vials per month)
ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml	1	QL (540 nebules per month)
levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)	1	QL (300 mL every month)
levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)	1	QL (300 mL every month)
levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)	1	QL (300 mL every month)
levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)	1	QL (90 ea every month)
levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)	1	QL (2 inhalers every month)
PERFOROMIST NEB 20MCG	2	QL (60 vials per month)
PROAIR DIGIH AER	3	QL (2 pkg Per Month)
PROAIR HFA AER	3	QL (2 PKG PER MONTH)
PROAIR RESPI AER	3	QL (2 pkg Per Month)
PROVENTIL AER HFA	3	QL (2 PKG PER MONTH)
SEREVENT DIS AER 50MCG	2	QL (1 package per month)
STIOLTO AER 2.5-2.5	2	QL (1 package per month)
STRIVERDI AER 2.5MCG	2	QL (1 package per month)
SYMBICORT AER 80-4.5	2	QL (1 package per month); Tier 2 with DAW9
SYMBICORT AER 160-4.5	2	QL (1 package per month); Tier 2 with DAW9
terbutaline sulfate tab 2.5 mg	1	
terbutaline sulfate tab 5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
TRELEGY AER 100MCG	2	QL (1 package per month)
TRELEGY AER 200MCG	2	QL (1 inhaler every month)
UTIBRON CAP NEOHALER	3	QL (1 package per month)
VENTOLIN HFA AER	3	QL (2 PKG PER MONTH)
XOPENEX CONC NEB 1.25/0.5	3	QL (90 ea every month)
XOPENEX HFA AER	3	QL (2 inhalers every month)
XOPENEX NEB 0.31MG	3	QL (300 mL every month)
XOPENEX NEB 0.63MG	3	QL (300 mL every month)
XOPENEX NEB 1.25/3ML	3	QL (300 mL every month)
XANTHINES		
THEO-24 CAP 100MG CR	3	PA; MNPA
THEO-24 CAP 200MG CR	3	PA; MNPA
THEO-24 CAP 300MG CR	3	PA; MNPA
THEO-24 CAP 400MG ER	3	PA; MNPA
theophylline elixir 80 mg/15ml	1	
THEOPHYLLINE ELIXIR 80 MG/15ML	3	
theophylline tab er 12hr 300 mg	1	
theophylline tab er 12hr 450 mg	1	
theophylline tab er 24hr 400 mg	1	
theophylline tab er 24hr 600 mg	1	
ANTICOAGULANTS		
COUMARIN ANTICOAGULANTS		
warfarin sodium tab 1 mg	1	
warfarin sodium tab 2 mg	1	
warfarin sodium tab 2.5 mg	1	
warfarin sodium tab 3 mg	1	
warfarin sodium tab 4 mg	1	
warfarin sodium tab 5 mg	1	
warfarin sodium tab 6 mg	1	
warfarin sodium tab 7.5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
warfarin sodium tab 10 mg	1	
DIRECT FACTOR XA INHIBITORS		
ELIQUIS ST P TAB 5MG	2	
ELIQUIS TAB 2.5MG	2	
ELIQUIS TAB 5MG	2	
SAVAYSA TAB 15MG	3	
SAVAYSA TAB 30MG	3	
SAVAYSA TAB 60MG	3	
XARELTO STAR TAB 15/20MG	2	
XARELTO TAB 2.5MG	2	
XARELTO TAB 10MG	2	
XARELTO TAB 15MG	2	
XARELTO TAB 20MG	2	
HEPARINS AND HEPARINOID-LIKE AGENTS		
ARIXTRA INJ 2.5/0.5	2	
ARIXTRA INJ 5/0.4ML	2	
ARIXTRA INJ 7.5/0.6	2	
ARIXTRA INJ 10/0.8ML	2	
enoxaparin sodium inj 300 mg/3ml	1	
enoxaparin sodium inj soln pref syr 30 mg/0.3ml	1	
enoxaparin sodium inj soln pref syr 40 mg/0.4ml	1	
enoxaparin sodium inj soln pref syr 60 mg/0.6ml	1	
enoxaparin sodium inj soln pref syr 80 mg/0.8ml	1	
enoxaparin sodium inj soln pref syr 100 mg/ml	1	
enoxaparin sodium inj soln pref syr 120 mg/0.8ml	1	
enoxaparin sodium inj soln pref syr 150 mg/ml	1	
fondaparinux sodium subcutaneous inj 2.5 mg/0.5ml	1	
fondaparinux sodium subcutaneous inj 5 mg/0.4ml	1	

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

Drug Name	Drug Tier	Requirements/Limits
fondaparinux sodium subcutaneous inj 7.5 mg/0.6ml	1	
fondaparinux sodium subcutaneous inj 10 mg/0.8ml	1	
FRAGMIN INJ 2500/0.2	2	
FRAGMIN INJ 5000/0.2	2	
FRAGMIN INJ 7500/0.3	2	
FRAGMIN INJ 10000/ML	2	
FRAGMIN INJ 12500UNT	2	
FRAGMIN INJ 15000UNT	2	
FRAGMIN INJ 18000UNT	2	
FRAGMIN INJ 95000UNT	2	
HEPARIN SOD INJ 5000/0.5	3	PA
HEPARIN SOD INJ 5000/ML	3	PA
heparin sodium (porcine) inj 1000 unit/ml	1	PA
heparin sodium (porcine) inj 5000 unit/ml	1	PA
heparin sodium (porcine) inj 10000 unit/ml	1	PA
heparin sodium (porcine) inj 20000 unit/ml	1	PA
heparin sodium (porcine) pf inj 5000 unit/0.5ml	1	PA
LOVENOX INJ 30/0.3ML	3	
LOVENOX INJ 40/0.4ML	3	
LOVENOX INJ 60/0.6ML	3	
LOVENOX INJ 80/0.8ML	3	
LOVENOX INJ 100MG/ML	3	
LOVENOX INJ 120/0.8	3	
LOVENOX INJ 150MG/ML	3	
LOVENOX INJ 300/3ML	3	
THROMBIN INHIBITORS		
PRADAXA CAP 75MG	3	
PRADAXA CAP 110MG	3	
PRADAXA CAP 150MG	3	
ANTICONVULSANTS		
AMPA GLUTAMATE RECEPTOR ANTAGONISTS		
FYCOMPA SUS 0.5MG/ML	2	
FYCOMPA TAB 2MG	2	
FYCOMPA TAB 4MG	2	

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

Drug Name	Drug Tier	Requirements/Limits
FYCOMPA TAB 6MG	2	
FYCOMPA TAB 8MG	2	
FYCOMPA TAB 10MG	2	
FYCOMPA TAB 12MG	2	
ANTICONVULSANTS - BENZODIAZEPINES		
clobazam suspension 2.5 mg/ml	1	
clobazam tab 10 mg	1	
clobazam tab 20 mg	1	
clonazepam orally disintegrating tab 0.5 mg	1	
clonazepam orally disintegrating tab 0.25 mg	1	
clonazepam orally disintegrating tab 0.125 mg	1	
clonazepam orally disintegrating tab 1 mg	1	
clonazepam orally disintegrating tab 2 mg	1	
clonazepam tab 0.5 mg	1	
clonazepam tab 1 mg	1	
clonazepam tab 2 mg	1	
DIASTAT ACDL GEL 5-10MG	3	
DIASTAT ACDL GEL 12.5-20	3	
DIASTAT PED GEL 2.5M GEL	3	
diazepam rectal gel delivery system 2.5 mg	1	
diazepam rectal gel delivery system 10 mg	1	
diazepam rectal gel delivery system 20 mg	1	
KLONOPIN TAB 0.5MG	3	
KLONOPIN TAB 1MG	3	
KLONOPIN TAB 2MG	3	
NAYZILAM SPR 5MG	3	PA, QL (10 nasal spray units per month)
ONFI SUS 2.5MG/ML	3	
ONFI TAB 10MG	3	
ONFI TAB 20MG	3	
SYMPAZAN MIS 5MG	3	
SYMPAZAN MIS 10MG	3	
SYMPAZAN MIS 20MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
VALTOCO SPR 5MG	3	QL (5 boxes per month)
VALTOCO SPR 10MG	3	QL (5 boxes per month)
VALTOCO SPR 15MG	3	QL (5 boxes per month)
VALTOCO SPR 20MG	3	QL (5 boxes per month)
ANTICONVULSANTS - MISC.		
APTIOM TAB 200MG	3	
APTIOM TAB 400MG	3	
APTIOM TAB 600MG	3	
APTIOM TAB 800MG	3	
BANZEL SUS 40MG/ML	3	
BANZEL TAB 200MG	3	
BANZEL TAB 400MG	3	
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	
BRIVIACT TAB 75MG	3	
BRIVIACT TAB 100MG	3	
carbamazepine cap er 12hr 100 mg	1	
carbamazepine cap er 12hr 200 mg	1	
carbamazepine cap er 12hr 300 mg	1	
carbamazepine chew tab 100 mg	1	
carbamazepine susp 100 mg/5ml	1	
carbamazepine tab 200 mg	1	
carbamazepine tab er 12hr 100 mg	1	
carbamazepine tab er 12hr 200 mg	1	
carbamazepine tab er 12hr 400 mg	1	
CARBATROL CAP 100MG	3	
CARBATROL CAP 200MG	3	
CARBATROL CAP 300MG	3	
DIACOMIT CAP 250MG	3	QL (360 CAPSULES PER 30 DAYS)
DIACOMIT CAP 500MG	3	QL (180 CAPSULES PER 30 DAYS)
DIACOMIT PAK 250MG	3	QL (360 PACKETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
DIACOMIT PAK 500MG	3	QL (180 PACKETS PER 30 DAYS)
ELEPSIA XR TAB 1000MG	3	
ELEPSIA XR TAB 1500MG	3	
EPIDIOLEX SOL 100MG/ML	3	PA, QL (800 ML PER 30 DAYS)
EPRONTIA SOL 25MG/ML	3	
FINTEPLA SOL 2.2MG/ML	3	PA, QL (360ML PER 30 DAYS)
gabapentin cap 100 mg	1	
gabapentin cap 300 mg	1	
gabapentin cap 400 mg	1	
gabapentin oral soln 250 mg/5ml	1	
gabapentin tab 600 mg	1	
gabapentin tab 800 mg	1	
KEPPRA SOL 100MG/ML	3	
KEPPRA TAB 250MG	3	
KEPPRA TAB 500MG	3	
KEPPRA TAB 750MG	3	
KEPPRA TAB 1000MG	3	
KEPPRA XR TAB 500MG	3	
KEPPRA XR TAB 750MG	3	
lacosamide oral solution 10 mg/ml	1	
lacosamide tab 50 mg	1	
lacosamide tab 100 mg	1	
lacosamide tab 150 mg	1	
lacosamide tab 200 mg	1	
LAMICTAL CHW 5MG	3	
LAMICTAL CHW 25MG	3	
LAMICTAL KIT START 35	3	
LAMICTAL KIT START 49	3	
LAMICTAL KIT START 98	3	
LAMICTAL ODT KIT	3	
LAMICTAL ODT TAB 25MG	3	
LAMICTAL ODT TAB 50MG	3	
LAMICTAL ODT TAB 100MG	3	
LAMICTAL ODT TAB 200MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL TAB 25MG	3	
LAMICTAL TAB 100MG	3	
LAMICTAL TAB 150MG	3	
LAMICTAL TAB 200MG	3	
LAMICTAL XR KIT	3	
LAMICTAL XR TAB 25MG	3	
LAMICTAL XR TAB 50MG	3	
LAMICTAL XR TAB 100MG	3	
LAMICTAL XR TAB 200MG	3	
LAMICTAL XR TAB 250MG	3	
LAMICTAL XR TAB 300MG	3	
lamotrigine orally disintegrating tab 25 mg	1	
lamotrigine orally disintegrating tab 50 mg	1	
lamotrigine orally disintegrating tab 100 mg	1	
lamotrigine orally disintegrating tab 200 mg	1	
lamotrigine tab 25 mg	1	
lamotrigine tab 25 mg (42) & 100 mg (7) starter kit	1	
lamotrigine tab 35 x 25 mg starter kit	1	
lamotrigine tab 84 x 25 mg & 14 x 100 mg starter kit	1	
lamotrigine tab 100 mg	1	
lamotrigine tab 150 mg	1	
lamotrigine tab 200 mg	1	
lamotrigine tab chewable dispersible 5 mg	1	
lamotrigine tab chewable dispersible 25 mg	1	
lamotrigine tab disint 25 (14) & 50 mg (14) & 100 mg (7) kit	1	
lamotrigine tab er 24hr 25 mg	1	
lamotrigine tab er 24hr 50 mg	1	
lamotrigine tab er 24hr 100 mg	1	
lamotrigine tab er 24hr 200 mg	1	
lamotrigine tab er 24hr 250 mg	1	
lamotrigine tab er 24hr 300 mg	1	
levetiracetam oral soln 100 mg/ml	1	
levetiracetam tab 250 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
levetiracetam tab 500 mg	1	
levetiracetam tab 750 mg	1	
levetiracetam tab 1000 mg	1	
levetiracetam tab er 24hr 500 mg	1	
levetiracetam tab er 24hr 750 mg	1	
LYRICA CAP 25MG	3	QL (120 caps per month)
LYRICA CAP 50MG	3	QL (120 caps per month)
LYRICA CAP 75MG	3	QL (120 caps per month)
LYRICA CAP 100MG	3	QL (120 caps per month)
LYRICA CAP 150MG	3	QL (120 caps per month)
LYRICA CAP 200MG	3	QL (90 caps per month)
LYRICA CAP 225MG	3	QL (60 caps per month)
LYRICA CAP 300MG	3	QL (60 caps per month)
LYRICA SOL 20MG/ML	3	QL (1080 mL every month)
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	
NEURONTIN CAP 100MG	3	
NEURONTIN CAP 300MG	3	
NEURONTIN CAP 400MG	3	
NEURONTIN SOL 250/5ML	3	
NEURONTIN TAB 600MG	3	
NEURONTIN TAB 800MG	3	
oxcarbazepine susp 300 mg/5ml (60 mg/ml)	1	
oxcarbazepine tab 150 mg	1	
oxcarbazepine tab 300 mg	1	
oxcarbazepine tab 600 mg	1	
OXTELLAR XR TAB 150MG	2	
OXTELLAR XR TAB 300MG	2	
OXTELLAR XR TAB 600MG	2	
pregabalin cap 25 mg	1	QL (120 caps per month)

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

Drug Name	Drug Tier	Requirements/Limits
pregabalin cap 50 mg	1	QL (120 caps per month)
pregabalin cap 75 mg	1	QL (120 caps per month)
pregabalin cap 100 mg	1	QL (120 caps per month)
pregabalin cap 150 mg	1	QL (120 caps per month)
pregabalin cap 200 mg	1	QL (90 caps per month)
pregabalin cap 225 mg	1	QL (60 caps per month)
pregabalin cap 300 mg	1	QL (60 caps per month)
pregabalin soln 20 mg/ml	1	QL (1080 mL every month)
primidone tab 50 mg	1	
primidone tab 250 mg	1	
QUDEXY XR CAP 25/24HR	3	
QUDEXY XR CAP 50/24HR	3	
QUDEXY XR CAP 100/24HR	3	
QUDEXY XR CAP 150/24HR	3	
QUDEXY XR CAP 200/24HR	3	
rufinamide susp 40 mg/ml	1	
SPRITAM TAB 250MG	3	
SPRITAM TAB 500MG	3	
SPRITAM TAB 750MG	3	
SPRITAM TAB 1000MG	3	
TEGRETOL SUS 100/5ML	3	
TEGRETOL TAB 200MG	3	
TEGRETOL-XR TAB 100MG	3	
TEGRETOL-XR TAB 200MG	3	
TEGRETOL-XR TAB 400MG	3	
TOPAMAX SPR CAP 15MG	3	
TOPAMAX SPR CAP 25MG	3	
TOPAMAX TAB 25MG	3	
TOPAMAX TAB 50MG	3	
TOPAMAX TAB 100MG	3	
TOPAMAX TAB 200MG	3	
topiramate cap er 24hr sprinkle 25 mg	1	PA; MNPA
topiramate cap er 24hr sprinkle 50 mg	1	PA; MNPA

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

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

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
REMERON TAB 30MG	3	
ANTIDEPRESSANTS - MISC.		
APLENZIN TAB 174MG	3	
APLENZIN TAB 348MG	3	
APLENZIN TAB 522MG	3	
bupropion hcl tab 75 mg	1	
bupropion hcl tab 100 mg	1	
bupropion hcl tab er 12hr 100 mg	1	
bupropion hcl tab er 12hr 150 mg	1	
bupropion hcl tab er 12hr 200 mg	1	
bupropion hcl tab er 24hr 150 mg	1	
bupropion hcl tab er 24hr 300 mg	1	
bupropion hcl tab er 24hr 450 mg	1	PA; MNPA
FORFIVO XL TAB 450MG	3	
maprotiline hcl tab 25 mg	1	
maprotiline hcl tab 50 mg	1	
maprotiline hcl tab 75 mg	1	
WELLBUTRIN TAB 100MG SR	3	
WELLBUTRIN TAB 150MG SR	3	
WELLBUTRIN TAB 200MG SR	3	
WELLBUTRIN TAB XL 150MG	3	
WELLBUTRIN TAB XL 300MG	3	
MONOAMINE OXIDASE INHIBITORS (MAOIS)		
EMSAM DIS 6MG/24HR	3	
EMSAM DIS 9MG/24HR	3	
EMSAM DIS 12MG/24H	3	
MARPLAN TAB 10MG	3	
NARDIL TAB 15MG	2	
PARNATE TAB 10MG	2	
phenelzine sulfate tab 15 mg	1	
tranylcypromine sulfate tab 10 mg	1	
N-METHYL-D-ASPARTIC ACID (NMDA) RECEPTOR ANTAGONISTS		
SPRAVATO SOL 56MG DOS	3	PA
SPRAVATO SOL 84MG DOS	3	PA
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)		
CELEXA TAB 10MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
CELEXA TAB 20MG	3	
CELEXA TAB 40MG	3	
citalopram hydrobromide oral soln 10 mg/5ml	1	
citalopram hydrobromide tab 10 mg (base equiv)	1	
citalopram hydrobromide tab 20 mg (base equiv)	1	
citalopram hydrobromide tab 40 mg (base equiv)	1	
escitalopram oxalate soln 5 mg/5ml (base equiv)	1	
escitalopram oxalate tab 5 mg (base equiv)	1	
escitalopram oxalate tab 10 mg (base equiv)	1	
escitalopram oxalate tab 20 mg (base equiv)	1	
fluoxetine hcl cap 10 mg	1	
fluoxetine hcl cap 20 mg	1	
fluoxetine hcl cap 40 mg	1	
fluoxetine hcl cap delayed release 90 mg	1	
fluoxetine hcl solution 20 mg/5ml	1	
fluoxetine hcl tab 10 mg	1	
fluoxetine hcl tab 20 mg	1	
fluoxetine hcl tab 60 mg	1	PA; MNPA
fluvoxamine maleate cap er 24hr 100 mg	1	
fluvoxamine maleate cap er 24hr 150 mg	1	
fluvoxamine maleate tab 25 mg	1	
fluvoxamine maleate tab 50 mg	1	
fluvoxamine maleate tab 100 mg	1	
LEXAPRO TAB 5MG	3	
LEXAPRO TAB 10MG	3	
LEXAPRO TAB 20MG	3	
paroxetine hcl oral susp 10 mg/5ml (base equiv)	1	
paroxetine hcl tab 10 mg	1	
paroxetine hcl tab 20 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
paroxetine hcl tab 30 mg	1	
paroxetine hcl tab 40 mg	1	
paroxetine hcl tab er 24hr 12.5 mg	1	
paroxetine hcl tab er 24hr 25 mg	1	
paroxetine hcl tab er 24hr 37.5 mg	1	
PAXIL CR TAB 12.5MG	3	
PAXIL CR TAB 25MG	3	
PAXIL CR TAB 37.5MG	3	
PAXIL SUS 10MG/5ML	3	
PAXIL TAB 10MG	3	
PAXIL TAB 20MG	3	
PAXIL TAB 30MG	3	
PAXIL TAB 40MG	3	
PEXEVA TAB 10MG	3	
PEXEVA TAB 20MG	3	
PEXEVA TAB 30MG	3	
PEXEVA TAB 40MG	3	
PROZAC CAP 10MG	3	
PROZAC CAP 20MG	3	
PROZAC CAP 40MG	3	
sertraline hcl oral concentrate for solution 20 mg/ml	1	
sertraline hcl tab 25 mg	1	
sertraline hcl tab 50 mg	1	
sertraline hcl tab 100 mg	1	
ZOLOFT CON 20MG/ML	3	
ZOLOFT TAB 25MG	3	
ZOLOFT TAB 50MG	3	
ZOLOFT TAB 100MG	3	
SEROTONIN MODULATORS		
nefazodone hcl tab 50 mg	1	
nefazodone hcl tab 100 mg	1	
nefazodone hcl tab 150 mg	1	
nefazodone hcl tab 200 mg	1	
nefazodone hcl tab 250 mg	1	
trazodone hcl tab 50 mg	1	
trazodone hcl tab 100 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
trazodone hcl tab 150 mg	1	
trazodone hcl tab 300 mg	1	
TRINTELLIX TAB 5MG	2	
TRINTELLIX TAB 10MG	2	
TRINTELLIX TAB 20MG	2	
VIIBRYD KIT STARTER	2	
VIIBRYD TAB 10MG	2	
VIIBRYD TAB 20MG	2	
VIIBRYD TAB 40MG	2	
vilazodone hcl tab 10 mg	1	
vilazodone hcl tab 20 mg	1	
vilazodone hcl tab 40 mg	1	
SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)		
CYMBALTA CAP 20MG	3	
CYMBALTA CAP 30MG	3	
CYMBALTA CAP 60MG	3	
DESVENLAFAX TAB 50MG ER	3	
DESVENLAFAX TAB 100MG ER	3	
desvenlafaxine succinate tab er 24hr 25 mg (base equiv)	1	
desvenlafaxine succinate tab er 24hr 50 mg (base equiv)	1	
desvenlafaxine succinate tab er 24hr 100 mg (base equiv)	1	
DRIZALMA CAP 20MG DR	3	
DRIZALMA CAP 30MG DR	3	
DRIZALMA CAP 40MG DR	3	
DRIZALMA CAP 60MG DR	3	
duloxetine hcl enteric coated pellets cap 20 mg (base eq)	1	
duloxetine hcl enteric coated pellets cap 30 mg (base eq)	1	
duloxetine hcl enteric coated pellets cap 40 mg (base eq)	1	
duloxetine hcl enteric coated pellets cap 60 mg (base eq)	1	
EFFEXOR XR CAP 37.5MG	3	
EFFEXOR XR CAP 75MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
EFFEXOR XR CAP 150MG	3	
FETZIMA CAP 20MG	2	
FETZIMA CAP 40MG	2	
FETZIMA CAP 80MG	2	
FETZIMA CAP 120MG	2	
FETZIMA CAP TITRATIO	2	
PRISTIQ TAB 25MG	3	
PRISTIQ TAB 50MG	3	
PRISTIQ TAB 100MG	3	
venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)	1	
venlafaxine hcl cap er 24hr 75 mg (base equivalent)	1	
venlafaxine hcl cap er 24hr 150 mg (base equivalent)	1	
venlafaxine hcl tab 25 mg (base equivalent)	1	
venlafaxine hcl tab 37.5 mg (base equivalent)	1	
venlafaxine hcl tab 50 mg (base equivalent)	1	
venlafaxine hcl tab 75 mg (base equivalent)	1	
venlafaxine hcl tab 100 mg (base equivalent)	1	
venlafaxine hcl tab er 24hr 37.5 mg (base equivalent)	1	
venlafaxine hcl tab er 24hr 75 mg (base equivalent)	1	
venlafaxine hcl tab er 24hr 150 mg (base equivalent)	1	
venlafaxine hcl tab er 24hr 225 mg (base equivalent)	1	
TRICYCLIC AGENTS		
amitriptyline hcl tab 10 mg	1	
amitriptyline hcl tab 25 mg	1	
amitriptyline hcl tab 50 mg	1	
amitriptyline hcl tab 75 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
amitriptyline hcl tab 100 mg	1	
amitriptyline hcl tab 150 mg	1	
amoxapine tab 25 mg	1	
amoxapine tab 50 mg	1	
amoxapine tab 100 mg	1	
amoxapine tab 150 mg	1	
ANAFRANIL CAP 25MG	2	
ANAFRANIL CAP 50MG	2	
ANAFRANIL CAP 75MG	2	
clomipramine hcl cap 25 mg	1	
clomipramine hcl cap 50 mg	1	
clomipramine hcl cap 75 mg	1	
desipramine hcl tab 10 mg	1	
desipramine hcl tab 25 mg	1	
desipramine hcl tab 50 mg	1	
desipramine hcl tab 75 mg	1	
desipramine hcl tab 100 mg	1	
desipramine hcl tab 150 mg	1	
doxepin hcl cap 10 mg	1	
doxepin hcl cap 25 mg	1	
doxepin hcl cap 50 mg	1	
doxepin hcl cap 75 mg	1	
doxepin hcl cap 100 mg	1	
doxepin hcl cap 150 mg	1	
doxepin hcl conc 10 mg/ml	1	
imipramine hcl tab 10 mg	1	
imipramine hcl tab 25 mg	1	
imipramine hcl tab 50 mg	1	
imipramine pamoate cap 75 mg	1	
imipramine pamoate cap 100 mg	1	
imipramine pamoate cap 125 mg	1	
imipramine pamoate cap 150 mg	1	
NORPRAMIN TAB 10MG	2	
NORPRAMIN TAB 25MG	2	
nortriptyline hcl cap 10 mg	1	
nortriptyline hcl cap 25 mg	1	
nortriptyline hcl cap 50 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
nortriptyline hcl cap 75 mg	1	
nortriptyline hcl soln 10 mg/5ml	1	
PAMELOR CAP 10MG	2	
PAMELOR CAP 25MG	2	
PAMELOR CAP 50MG	2	
PAMELOR CAP 75MG	2	
protriptyline hcl tab 5 mg	1	
protriptyline hcl tab 10 mg	1	
trimipramine maleate cap 25 mg	1	
trimipramine maleate cap 50 mg	1	
trimipramine maleate cap 100 mg	1	
ANTIDIABETICS		
ALPHA-GLUCOSIDASE INHIBITORS		
acarbose tab 25 mg	1	
acarbose tab 50 mg	1	
acarbose tab 100 mg	1	
miglitol tab 25 mg	1	
miglitol tab 50 mg	1	
miglitol tab 100 mg	1	
PRECOSE TAB 25MG	2	
PRECOSE TAB 50MG	2	
PRECOSE TAB 100MG	2	
ANTIDIABETIC - AMYLIN ANALOGS		
SYMLINPEN 60 INJ 1000MCG	2	ST
SYMLNPEN 120 INJ 1000MCG	2	ST
ANTIDIABETIC COMBINATIONS		
ACTOPLUS MET TAB 15-500MG	3	
ACTOPLUS MET TAB 15-850MG	3	
alogliptin-metformin hcl tab 12.5-500 mg	1	ST
alogliptin-metformin hcl tab 12.5-1000 mg	1	ST
alogliptin-pioglitazone tab 12.5-15 mg	1	ST
alogliptin-pioglitazone tab 12.5-30 mg	1	ST
alogliptin-pioglitazone tab 12.5-45 mg	1	ST
alogliptin-pioglitazone tab 25-15 mg	1	ST
alogliptin-pioglitazone tab 25-30 mg	1	ST
alogliptin-pioglitazone tab 25-45 mg	1	ST
DUETACT TAB 30-2MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
DUETACT TAB 30-4MG	3	
glipizide-metformin hcl tab 2.5-250 mg	1	
glipizide-metformin hcl tab 2.5-500 mg	1	
glipizide-metformin hcl tab 5-500 mg	1	
glyburide-metformin tab 1.25-250 mg	1	
glyburide-metformin tab 2.5-500 mg	1	
glyburide-metformin tab 5-500 mg	1	
GLYXAMBI TAB 10-5 MG	2	ST
GLYXAMBI TAB 25-5 MG	2	ST
INVOKAMET TAB 50-500MG	2	ST
INVOKAMET TAB 50-1000	2	ST
INVOKAMET TAB 150-500	2	ST
INVOKAMET TAB 150-1000	2	ST
INVOKAMET XR TAB 50-500MG	2	ST
INVOKAMET XR TAB 50-1000	2	ST
INVOKAMET XR TAB 150-500	2	ST
INVOKAMET XR TAB 150-1000	2	ST
JANUMET TAB 50-500MG	2	ST
JANUMET TAB 50-1000	2	ST
JANUMET XR TAB 50-500MG	2	ST
JANUMET XR TAB 50-1000	2	ST
JANUMET XR TAB 100-1000	2	ST
JENTADUETO TAB 2.5-500	2	
JENTADUETO TAB 2.5-850	2	
JENTADUETO TAB 2.5-1000	2	
JENTADUETO TAB XR	2	
KAZANO 12.5- TAB 500MG	3	ST
KAZANO 12.5- TAB 1000MG	3	ST
KOMBIGLYZ XR TAB 2.5-1000	3	ST
KOMBIGLYZ XR TAB 5-500MG	3	ST
KOMBIGLYZ XR TAB 5-1000MG	3	ST
OSENI TAB 12.5-15	3	ST
OSENI TAB 12.5-30	3	ST
OSENI TAB 12.5-45	3	ST
OSENI TAB 25-15MG	3	ST
OSENI TAB 25-30MG	3	ST
OSENI TAB 25-45MG	3	ST

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

Drug Name	Drug Tier	Requirements/Limits
pioglitazone hcl-glimepiride tab 30-2 mg	1	
pioglitazone hcl-glimepiride tab 30-4 mg	1	
pioglitazone hcl-metformin hcl tab 15-500 mg	1	
pioglitazone hcl-metformin hcl tab 15-850 mg	1	
QTERN TAB 5-5MG	2	ST
QTERN TAB 10-5MG	2	ST
SEGLUROMET TAB 2.5-500	3	ST
SEGLUROMET TAB 2.5-1000	3	ST
SEGLUROMET TAB 7.5-500	3	ST
SEGLUROMET TAB 7.5-1000	3	ST
SOLIQUA INJ 100/33	2	ST, QL (10 pens every month)
STEGLUJAN TAB 5-100MG	3	ST
STEGLUJAN TAB 15-100MG	3	ST
SYNJARDY TAB	2	ST
SYNJARDY TAB 5-500MG	2	ST
SYNJARDY TAB 5-1000MG	2	ST
SYNJARDY TAB 12.5-500	2	ST
SYNJARDY XR TAB	2	ST
SYNJARDY XR TAB 5-1000MG	2	ST
SYNJARDY XR TAB 10-1000	2	ST
SYNJARDY XR TAB 25-1000	2	ST
TRIJARDY XR TAB	2	ST
XIGDUO XR TAB 2.5-1000	2	ST
XIGDUO XR TAB 5-500MG	2	ST
XIGDUO XR TAB 5-1000MG	2	ST
XIGDUO XR TAB 10-500MG	2	ST
XIGDUO XR TAB 10-1000	2	ST
XULTOPHY INJ 100/3.6	2	ST, QL (5 PENS PER MONTH)
BIGUANIDES		
FORTAMET TAB 500MG	3	PA
FORTAMET TAB 1000MG	3	PA
GLUMETZA TAB 500MG	3	PA
GLUMETZA TAB 1000MG	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
metformin hcl oral soln 500 mg/5ml	1	
metformin hcl tab 500 mg	1	
metformin hcl tab 850 mg	1	
metformin hcl tab 1000 mg	1	
metformin hcl tab er 24hr 500 mg	1	
metformin hcl tab er 24hr 750 mg	1	
metformin hcl tab er 24hr modified release 500 mg	1	PA; MNPA
metformin hcl tab er 24hr modified release 1000 mg	1	PA; MNPA
metformin hcl tab er 24hr osmotic 500 mg	1	PA; MNPA
metformin hcl tab er 24hr osmotic 1000 mg	1	PA; MNPA
METFORMIN TAB 625MG	3	
RIOMET SOL	3	
RIOMET SOL 500/5ML	3	
DIABETIC OTHER		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
diazoxide susp 50 mg/ml	1	
GLUCAGEN INJ HYPOKIT	2	
glucagon (rdna) for inj kit 1 mg	1	
GLUCAGON EMR SOL 1MG	3	
GLUCAGON KIT 1MG	2	
GVOKE HYPO 1 INJ 1MG/.2ML	2	
GVOKE HYPO 1 INJ .5/.1ML	2	
GVOKE HYPO 2 INJ 1MG/.2ML	2	
GVOKE HYPO 2 INJ .5/.1ML	2	
GVOKE KIT SOL 1MG/0.2M	2	
GVOKE PFS INJ	2	
KORLYM TAB 300MG	3	PA, QL (120 TABLETS PER 30 DAYS)
PROGLYCEM SUS 50MG/ML	3	
ZEGALOGUE INJ 0.6/0.6	2	
DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS		
alogliptin benzoate tab 6.25 mg (base equiv)	1	ST

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

Drug Name	Drug Tier	Requirements/Limits
alogliptin benzoate tab 12.5 mg (base equiv)	1	ST
alogliptin benzoate tab 25 mg (base equiv)	1	ST
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST
JANUVIA TAB 100MG	2	ST
NESINA TAB 6.25MG	3	ST
NESINA TAB 12.5MG	3	ST
NESINA TAB 25MG	3	ST
ONGLYZA TAB 2.5MG	3	ST
ONGLYZA TAB 5MG	3	ST
TRADJENTA TAB 5MG	2	ST
DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC		
CYCLOSET TAB 0.8MG	3	
INCRETIN MIMETIC AGENTS		
BYDUREON PEN INJ 2MG	3	ST, QL (4 PENS PER MONTH)
INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)		
ADLYXIN INJ 10/20MCG	3	ST, QL (2 pens per month)
ADLYXIN INJ 20MCG	3	ST, QL (2 pens per month)
BYDUREON BC INJ 2/0.85ML	3	ST, QL (4 pens per month)
BYETTA INJ 5MCG	3	ST, QL (1 pen per month)
BYETTA INJ 10MCG	3	ST, QL (1 pen per month)
MOUNJARO INJ 2.5/0.5	3	ST, QL (4 PENS PER MONTH)
MOUNJARO INJ 5MG/0.5	3	ST, QL (4 PENS PER MONTH)
MOUNJARO INJ 7.5/0.5	3	ST, QL (4 PENS PER MONTH)
MOUNJARO INJ 10MG/0.5	3	ST, QL (4 PENS PER MONTH)
MOUNJARO INJ 12.5/0.5	3	ST, QL (4 PENS PER MONTH)

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

Drug Name	Drug Tier	Requirements/Limits
MOUNJARO INJ 15MG/0.5	3	ST, QL (4 PENS PER MONTH)
OZEMPIC INJ 2/1.5ML	2	ST, QL (1 PEN PER MONTH); Starter Pen
OZEMPIC INJ 4MG/3ML	2	ST, QL (1 PEN PER MONTH)
OZEMPIC INJ 8MG/3ML	2	ST, QL (1 PEN PER MONTH)
RYBELSUS TAB 3MG	2	ST, QL (30 tabs every month)
RYBELSUS TAB 7MG	2	ST, QL (30 tabs every month)
RYBELSUS TAB 14MG	2	ST, QL (30 tabs every month)
TRULICITY INJ 0.75/0.5	2	ST, QL (4 PENS PER MONTH)
TRULICITY INJ 1.5/0.5	2	ST, QL (4 PENS PER MONTH)
TRULICITY INJ 3/0.5	2	ST, QL (4 PENS PER MONTH)
TRULICITY INJ 4.5/0.5	2	ST, QL (4 PENS PER MONTH)
VICTOZA INJ 18MG/3ML	2	ST, QL (3 PENS PER MONTH)
INSULIN		
ADMELOG INJ 100U/ML	3	
ADMELOG SOLO INJ 100U/ML	3	
AFREZZA POW 4-8 UNIT	3	
AFREZZA POW 4-8-12	3	
AFREZZA POW 4UNIT	3	
AFREZZA POW 8 UNIT	3	
AFREZZA POW 8-12UNIT	3	
AFREZZA POW 12 UNIT	3	
APIDRA INJ SOLOSTAR	3	
APIDRA INJ U-100	3	
BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	
FIASP INJ 100/ML	2	

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

Drug Name	Drug Tier	Requirements/Limits
FIASP PENFIL INJ U-100	2	
HUMALOG INJ 100/ML	2	
HUMALOG JR INJ 100/ML	3	
HUMALOG KWIK INJ 100/ML	2	
HUMALOG KWIK INJ 200/ML	2	
HUMALOG MIX INJ 50/50	2	
HUMALOG MIX INJ 50/50KWP	2	
HUMALOG MIX INJ 75/25KWP	2	
HUMALOG MIX SUS 75/25	2	
HUMULIN INJ 70/30	2	
HUMULIN INJ 70/30KWP	2	
HUMULIN N INJ U-100	2	
HUMULIN N INJ U-100KWP	2	
HUMULIN R INJ U-100	2	
HUMULIN R INJ U-500	2	
INS ASP PROT INJ FLEXPEN	2	
INSULIN ASPA INJ 70/30	2	
INSULIN ASPA INJ 100/ML	2	
INSULIN ASPA INJ FLEXPEN	2	
INSULIN ASPA INJ PENFILL	2	
INSULIN LISP INJ 100/ML	2	
INSULIN LISP INJ JUNIOR	2	
INSULIN LISP INJ PROTAMIN	2	
LANTUS INJ 100/ML	2	
LANTUS SOLOS INJ 100/ML	2	
LEVEMIR INJ	2	
LEVEMIR INJ FLEXTOUC	2	
LYUMJEV INJ 100UT/ML	2	
LYUMJEV KWPN INJ 100UT/ML	2	
LYUMJEV KWPN INJ 200UT/ML	2	
MYXREDLIN SOL 1UNIT/ML	3	
NOVOLIN70/30 INJ RELION	3	
NOVOLIN INJ 70/30	2	
NOVOLIN INJ 70/30 FP	2	
NOVOLIN INJ 70/30 FP	3	
NOVOLIN N INJ 100 UNIT	2	
NOVOLIN N INJ 100 UNIT	3	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
INVOKANA TAB 100MG	2	ST
INVOKANA TAB 300MG	2	ST
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
STEGLATRO TAB 5MG	3	ST
STEGLATRO TAB 15MG	3	ST
SULFONYLUREAS		
AMARYL TAB 1MG	3	
AMARYL TAB 2MG	3	
AMARYL TAB 4MG	3	
glimepiride tab 1 mg	1	
glimepiride tab 2 mg	1	
glimepiride tab 4 mg	1	
glipizide tab 5 mg	1	
glipizide tab 10 mg	1	
glipizide tab er 24hr 2.5 mg	1	
glipizide tab er 24hr 5 mg	1	
glipizide tab er 24hr 10 mg	1	
GLUCOTROL TAB 10MG	3	
GLUCOTROL XL TAB 2.5MG	3	
GLUCOTROL XL TAB 5MG	3	
GLUCOTROL XL TAB 10MG	3	
glyburide micronized tab 1.5 mg	1	
glyburide micronized tab 3 mg	1	
glyburide micronized tab 6 mg	1	
glyburide tab 1.25 mg	1	
glyburide tab 2.5 mg	1	
glyburide tab 5 mg	1	
GLYNASE TAB 1.5MG	3	
GLYNASE TAB 3MG	3	
GLYNASE TAB 6MG	3	
tolbutamide tab 500 mg	1	
ANTIDIARRHEAL/PROBIOTIC AGENTS		
ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS		
MYTESI TAB 125MG	3	PA; MNPA
ANTIDIARRHEAL/PROBIOTIC AGENTS - MISC.		
PRODIGEN CAP	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
PROVAD CAP	3	PA
ZELAC CAP	3	PA
ANTIDIARRHEAL/PROBIOTIC COMBINATIONS		
RESTORA RX CAP 60-1.25	3	
ANTIPERISTALTIC AGENTS		
diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml	1	
diphenoxylate w/ atropine tab 2.5-0.025 mg	1	
LOMOTIL TAB 2.5MG	2	
MOTOFEN TAB 1-0.025	3	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
ANTIDOTES - CHELATING AGENTS		
CHEMET CAP 100MG	3	
deferasirox granules packet 90 mg	1	PA
deferasirox granules packet 180 mg	1	PA
deferasirox granules packet 360 mg	1	PA
deferasirox tab 90 mg	1	PA
deferasirox tab 180 mg	1	PA
deferasirox tab 360 mg	1	PA
deferasirox tab for oral susp 125 mg	1	PA
deferasirox tab for oral susp 250 mg	1	PA
deferasirox tab for oral susp 500 mg	1	PA
deferiprone tab 500 mg	1	PA
EXJADE TAB 125MG	3	PA
EXJADE TAB 250MG	3	PA
EXJADE TAB 500MG	3	PA
FERPRX 2-DAY TAB 1000MG	3	PA
FERRIPROX SOL 100MG/ML	3	PA
FERRIPROX TAB 500MG	3	PA
FERRIPROX TAB 1000MG	3	PA
JADENU SPRKL GRA 90MG	3	PA
JADENU SPRKL GRA 180MG	3	PA
JADENU SPRKL GRA 360MG	3	PA
JADENU TAB 90MG	3	PA
JADENU TAB 180MG	3	PA
JADENU TAB 360MG	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
PENTETATE CA SOL 200MG/ML	3	
PENTETATE ZI SOL 200MG/ML	3	
ANTIDOTES AND SPECIFIC ANTAGONISTS		
deferoxamine mesylate for inj 2 gm	1	PA
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	2	QL (20 PACKETS PER 5 DAYS)
OPIOID ANTAGONISTS		
KLOXXADO SPR 8MG	2	
naloxone hcl inj 0.4 mg/ml	1	
naloxone hcl inj 4 mg/10ml	1	
naloxone hcl nasal spray 4 mg/0.1ml	1	
naloxone hcl soln cartridge 0.4 mg/ml	1	
naloxone hcl soln prefilled syringe 2 mg/2ml	1	
naltrexone hcl tab 50 mg	1	
NARCAN SPR 4MG	2	
ANTIEMETICS		
5-HT3 RECEPTOR ANTAGONISTS		
ANZEMET TAB 50MG	3	
ANZEMET TAB 50MG	3	QL (6 tabs every 21 days)
ANZEMET TAB 100MG	3	QL (6 tabs every 21 days)
granisetron hcl tab 1 mg	1	QL (12 tabs every 21 days)
ondansetron hcl oral soln 4 mg/5ml	1	QL (200 mL every 21 days)
ondansetron hcl tab 4 mg	1	QL (18 tabs every 21 days)
ondansetron hcl tab 8 mg	1	QL (18 tabs every 21 days)
ondansetron hcl tab 24 mg	1	QL (2 ea every 21 days)
ondansetron orally disintegrating tab 4 mg	1	QL (18 tabs every 21 days)
ondansetron orally disintegrating tab 8 mg	1	QL (18 tabs every 21 days)

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

Drug Name	Drug Tier	Requirements/Limits
SANCUSO DIS 3.1MG	2	QL (2 patches every 21 days)
SUSTOL INJ 10/0.4ML	3	QL (2 injections every 21 days)
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)
ZUPLENZ MIS 4MG	3	QL (18 films every 21 days)
ZUPLENZ MIS 8MG	3	QL (18 films every 21 days)
ANTIEMETICS - ANTICHOLINERGIC		
MECLIZINE TAB 50MG	3	
scopolamine td patch 72hr 1 mg/3days	1	
TIGAN CAP 300MG	3	
TRANSDERM SC DIS 1MG/3DAY	3	
TRANSDERM-SC DIS 1MG/3DAY	3	
trimethobenzamide hcl cap 300 mg	1	
ANTIEMETICS - MISCELLANEOUS		
AKYNZEO CAP 300-0.5	3	QL (2 caps every 21 days)
BONJESTA TAB 20-20MG	3	
DICLEGIS TAB 10-10MG	3	
doxylamine-pyridoxine tab delayed release 10-10 mg	1	
dronabinol cap 2.5 mg	1	
dronabinol cap 5 mg	1	
dronabinol cap 10 mg	1	
MARINOL CAP 2.5MG	3	
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	
SYNDROS SOL 5MG/ML	3	
SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS		
aprepitant capsule 40 mg	1	QL (3 caps every 180 days)
aprepitant capsule 80 mg	1	QL (4 caps every 21 days)
aprepitant capsule 125 mg	1	QL (2 ea every 21 days)

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

Drug Name	Drug Tier	Requirements/Limits
aprepitant capsule therapy pack 80 & 125 mg	1	QL (6 caps every 21 days)
EMEND CAP 80MG	3	QL (4 caps every 21 days)
EMEND SUS 125MG	3	QL (6 kits every 21 days)
EMEND TRIPAC PAK 80 & 125	3	QL (6 caps every 21 days)
VARUBI TAB 90MG	2	QL (4 tabs every 21 days)

ANTIFUNGALS

ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)

BREXAFEMME TAB 150MG	3	ST, QL (4 tablets per week)

ANTIFUNGALS

ANCOBON CAP 250MG	3	
ANCOBON CAP 500MG	3	MNPA
BIO-STATIN CAP 500000	3	
BIO-STATIN CAP 1000000	3	
flucytosine cap 250 mg	1	
flucytosine cap 500 mg	1	PA; MNPA
griseofulvin microsize susp 125 mg/5ml	1	
griseofulvin microsize tab 500 mg	1	
griseofulvin ultramicrosize tab 125 mg	1	
griseofulvin ultramicrosize tab 250 mg	1	
nystatin oral powder	1	
nystatin tab 500000 unit	1	
terbinafine hcl tab 250 mg	1	

IMIDAZOLE-RELATED ANTIFUNGALS

CRESEMBA CAP 186 MG	3	
DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	
DIFLUCAN TAB 100MG	3	
DIFLUCAN TAB 150MG	3	
DIFLUCAN TAB 200MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
fluconazole for susp 10 mg/ml	1	
fluconazole for susp 40 mg/ml	1	
fluconazole tab 50 mg	1	
fluconazole tab 100 mg	1	
fluconazole tab 150 mg	1	
fluconazole tab 200 mg	1	
itraconazole cap 100 mg	1	
itraconazole oral soln 10 mg/ml	1	
ketoconazole tab 200 mg	1	
NOXAFIL SUS 40MG/ML	3	PA
NOXAFIL TAB 100MG	3	PA
posaconazole tab delayed release 100 mg	1	PA
SPORANOX CAP 100MG	3	
SPORANOX CAP PULSEPAK	3	
SPORANOX SOL 10MG/ML	3	
TOLSURA CAP 65MG	3	
VFEND SUS 40MG/ML	2	PA
VFEND TAB 50MG	2	PA
VFEND TAB 200MG	2	PA
VIVJOA CAP 150MG	3	PA
voriconazole for susp 40 mg/ml	1	PA
voriconazole tab 50 mg	1	PA
voriconazole tab 200 mg	1	PA
ANTIHISTAMINES		
ANTIHISTAMINES - ALKYLAMINES		
dexchlorpheniramine maleate oral soln 2 mg/5ml	1	PA; MNPA
ANTIHISTAMINES - ETHANOLAMINES		
CARBINOXAMIN TAB 6MG	3	PA; MNPA
carbinoxamine maleate soln 4 mg/5ml	1	
carbinoxamine maleate tab 4 mg	1	
clemastine fumarate tab 2.68 mg	1	
diphenhydramine hcl elixir 12.5 mg/5ml	1	PA
KARBINAL ER SUS 4MG/5ML	3	
RYVENT TAB 6MG	3	
ANTIHISTAMINES - NON-SEDATING		
QUZYTTIR INJ 10MG/ML	3	

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

Drug Name	Drug Tier	Requirements/Limits
ANTIHISTAMINES - PHENOTHIAZINES		
promethazine hcl suppos 12.5 mg	1	
promethazine hcl suppos 25 mg	1	
promethazine hcl suppos 50 mg	1	
promethazine hcl syrup 6.25 mg/5ml	1	
promethazine hcl tab 12.5 mg	1	
promethazine hcl tab 25 mg	1	
promethazine hcl tab 50 mg	1	
ANTIHISTAMINES - PIPERIDINES		
cyproheptadine hcl syrup 2 mg/5ml	1	
cyproheptadine hcl tab 4 mg	1	
ANTIHYPERLIPIDEMICS		
ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS		
NEXLETOL TAB 180MG	2	PA
ANTIHYPERLIPIDEMICS - COMBINATIONS		
ezetimibe-simvastatin tab 10-10 mg	1	
ezetimibe-simvastatin tab 10-20 mg	1	
ezetimibe-simvastatin tab 10-40 mg	1	
ezetimibe-simvastatin tab 10-80 mg	1	
NEXLIZET TAB 180/10MG	2	PA
ROSZET TAB 5-10MG	3	
ROSZET TAB 10-10MG	3	
ROSZET TAB 20-10MG	3	
ROSZET TAB 40-10MG	3	
VYTORIN TAB 10-10MG	3	
VYTORIN TAB 10-20MG	3	
VYTORIN TAB 10-40MG	3	
VYTORIN TAB 10-80MG	3	
ANTIHYPERLIPIDEMICS - MISC.		
icosapent ethyl cap 1 gm	1	PA
LOVAZA CAP 1GM	3	PA
omega-3-acid ethyl esters cap 1 gm	1	PA
VASCEPA CAP 0.5GM	2	PA
VASCEPA CAP 1GM	2	PA
BILE ACID SEQUESTRANTS		
cholestyramine light powder 4 gm/dose	1	

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

Drug Name	Drug Tier	Requirements/Limits
cholestyramine light powder packets 4 gm	1	
cholestyramine powder 4 gm/dose	1	
cholestyramine powder packets 4 gm	1	
colesevelam hcl packet for susp 3.75 gm	1	
colesevelam hcl tab 625 mg	1	
COLESTID FLA GRA 5/7.5GM	3	
COLESTID FLA GRA 5GM	3	
COLESTID GRA 5GM	3	
COLESTID POW 5GM	3	
COLESTID TAB 1GM	3	
colestipol hcl granule packets 5 gm	1	
colestipol hcl granules 5 gm	1	
colestipol hcl tab 1 gm	1	
QUESTRAN POW 4GM	3	
QUESTRAN POW 4GM LITE	3	
WELCHOL PAK 3.75GM	3	
WELCHOL TAB 625MG	3	
FIBRIC ACID DERIVATIVES		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	
choline fenofibrate cap dr 45 mg (fenofibric acid equiv)	1	
choline fenofibrate cap dr 135 mg (fenofibric acid equiv)	1	
fenofibrate cap 50 mg	1	PA; MNPA
fenofibrate cap 150 mg	1	
fenofibrate micronized cap 30 mg	1	
fenofibrate micronized cap 43 mg	1	
fenofibrate micronized cap 67 mg	1	
fenofibrate micronized cap 90 mg	1	
fenofibrate micronized cap 130 mg	1	PA; MNPA
fenofibrate micronized cap 134 mg	1	
fenofibrate micronized cap 200 mg	1	
fenofibrate tab 40 mg	1	PA; MNPA
fenofibrate tab 48 mg	1	
fenofibrate tab 54 mg	1	
fenofibrate tab 120 mg	1	PA; MNPA

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

Drug Name	Drug Tier	Requirements/Limits
fenofibrate tab 145 mg	1	
fenofibrate tab 160 mg	1	
fenofibric acid tab 35 mg	1	
fenofibric acid tab 105 mg	1	
FENOGLIDE TAB 40MG	3	
FENOGLIDE TAB 120MG	3	PA; MNPA
FIBRICOR TAB 35MG	3	
FIBRICOR TAB 105MG	3	
gemfibrozil tab 600 mg	1	
LIPOFEN CAP 50MG	3	
LIPOFEN CAP 150MG	3	
LOPID TAB 600MG	3	
TRICOR TAB 48MG	3	
TRICOR TAB 145MG	3	
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	
HMG COA REDUCTASE INHIBITORS		
ALTOPREV TAB 20MG ER	3	
ALTOPREV TAB 40MG ER	3	
ALTOPREV TAB 60MG ER	3	
atorvastatin calcium tab 10 mg (base equivalent)	0	$0 copay for members age 40 through 75
atorvastatin calcium tab 20 mg (base equivalent)	0	$0 copay for members age 40 through 75
atorvastatin calcium tab 40 mg (base equivalent)	1	
atorvastatin calcium tab 80 mg (base equivalent)	1	
CRESTOR TAB 5MG	3	
CRESTOR TAB 10MG	3	
CRESTOR TAB 20MG	3	
CRESTOR TAB 40MG	3	
EZALLOR SPR CAP 5MG	3	
EZALLOR SPR CAP 10MG	3	
EZALLOR SPR CAP 20MG	3	
EZALLOR SPR CAP 40MG	3	
FLOLIPID SUS 20MG/5ML	3	

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

Drug Name	Drug Tier	Requirements/Limits
FLOLIPID SUS 40MG/5ML	3	
fluvastatin sodium cap 20 mg (base equivalent)	0	$0 copay for members age 40 through 75
fluvastatin sodium cap 40 mg (base equivalent)	0	$0 copay for members age 40 through 75
fluvastatin sodium tab er 24 hr 80 mg (base equivalent)	0	$0 copay for members age 40 through 75
LESCOL XL TAB 80MG	3	
LIPITOR TAB 10MG	3	
LIPITOR TAB 20MG	3	
LIPITOR TAB 40MG	3	
LIPITOR TAB 80MG	3	
LIVALO TAB 1MG	3	
LIVALO TAB 2MG	3	
LIVALO TAB 4MG	3	
lovastatin tab 10 mg	0	$0 copay for members age 40 through 75
lovastatin tab 20 mg	0	$0 copay for members age 40 through 75
lovastatin tab 40 mg	0	$0 copay for members age 40 through 75
pravastatin sodium tab 10 mg	0	$0 copay for members age 40 through 75
pravastatin sodium tab 20 mg	0	$0 copay for members age 40 through 75
pravastatin sodium tab 40 mg	0	$0 copay for members age 40 through 75
pravastatin sodium tab 80 mg	0	$0 copay for members age 40 through 75
rosuvastatin calcium tab 5 mg	0	$0 copay for members age 40 through 75
rosuvastatin calcium tab 10 mg	0	$0 copay for members age 40 through 75
rosuvastatin calcium tab 20 mg	1	
rosuvastatin calcium tab 40 mg	1	
simvastatin tab 5 mg	0	$0 copay for members age 40 through 75
simvastatin tab 10 mg	0	$0 copay for members age 40 through 75

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

Drug Name	Drug Tier	Requirements/Limits
simvastatin tab 20 mg	0	$0 copay for members age 40 through 75
simvastatin tab 40 mg	0	$0 copay for members age 40 through 75
simvastatin tab 80 mg	1	
ZOCOR TAB 10MG	3	
ZOCOR TAB 20MG	3	
ZOCOR TAB 40MG	3	
ZOCOR TAB 80MG	3	
ZYPITAMAG TAB 2MG	3	
ZYPITAMAG TAB 4MG	3	
INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS		
ezetimibe tab 10 mg	1	
ZETIA TAB 10MG	3	
MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS		
JUXTAPID CAP 5MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
JUXTAPID CAP 10MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
JUXTAPID CAP 20MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
JUXTAPID CAP 30MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
NICOTINIC ACID DERIVATIVES		
niacin (antihyperlipidemic) tab 500 mg	1	PA; MNPA
niacin tab er 500 mg (antihyperlipidemic)	1	
niacin tab er 750 mg (antihyperlipidemic)	1	
niacin tab er 1000 mg (antihyperlipidemic)	1	
NIASPAN TAB 500MG ER	3	
NIASPAN TAB 750MG ER	3	
NIASPAN TAB 1000 ER	3	
PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS		
PRALUENT INJ 75MG/ML	2	PA, QL (2 PENS PER MONTH)
PRALUENT INJ 150MG/ML	2	PA, QL (2 injections every month)

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

Drug Name	Drug Tier	Requirements/Limits
REPATHA INJ 140MG/ML	2	PA, QL (3 SYRINGE PER 28 DAYS)
REPATHA PUSH INJ 420/3.5	2	PA, QL (1 CARTRIDGE PER 28 DAYS)
REPATHA SURE INJ 140MG/ML	2	PA, QL (3 PENS PER 28 DAYS)
ANTIHYPERTENSIVES		
ACE INHIBITORS		
ACCUPRIL TAB 5MG	3	
ACCUPRIL TAB 10MG	3	
ACCUPRIL TAB 20MG	3	
ACCUPRIL TAB 40MG	3	
ALTACE CAP 1.25MG	3	
ALTACE CAP 2.5MG	3	
ALTACE CAP 5MG	3	
ALTACE CAP 10MG	3	
benazepril hcl tab 5 mg	1	
benazepril hcl tab 10 mg	1	
benazepril hcl tab 20 mg	1	QL (3 packages every 25 days)
benazepril hcl tab 40 mg	1	
captopril tab 12.5 mg	1	
captopril tab 25 mg	1	
captopril tab 50 mg	1	
captopril tab 100 mg	1	
enalapril maleate oral soln 1 mg/ml	1	
enalapril maleate tab 2.5 mg	1	
enalapril maleate tab 5 mg	1	
enalapril maleate tab 10 mg	1	
enalapril maleate tab 20 mg	1	
EPANED SOL 1MG/ML	3	
fosinopril sodium tab 10 mg	1	
fosinopril sodium tab 20 mg	1	
fosinopril sodium tab 40 mg	1	
lisinopril tab 2.5 mg	1	
lisinopril tab 5 mg	1	
lisinopril tab 10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
lisinopril tab 20 mg	1	
lisinopril tab 30 mg	1	
lisinopril tab 40 mg	1	
LOTENSIN TAB 10MG	3	
LOTENSIN TAB 20MG	3	
LOTENSIN TAB 40MG	3	
moexipril hcl tab 7.5 mg	1	
moexipril hcl tab 15 mg	1	
perindopril erbumine tab 2 mg	1	
perindopril erbumine tab 4 mg	1	
perindopril erbumine tab 8 mg	1	
PRINIVIL TAB 20MG	3	
QBRELIS SOL 1MG/ML	3	
quinapril hcl tab 5 mg	1	
quinapril hcl tab 10 mg	1	
quinapril hcl tab 20 mg	1	
quinapril hcl tab 40 mg	1	
ramipril cap 1.25 mg	1	
ramipril cap 2.5 mg	1	
ramipril cap 5 mg	1	
ramipril cap 10 mg	1	
trandolapril tab 1 mg	1	
trandolapril tab 2 mg	1	
trandolapril tab 4 mg	1	
VASOTEC TAB 2.5MG	3	
VASOTEC TAB 5MG	3	
VASOTEC TAB 10MG	3	
VASOTEC TAB 20MG	3	
ZESTRIL TAB 2.5MG	3	
ZESTRIL TAB 5MG	3	
ZESTRIL TAB 10MG	3	
ZESTRIL TAB 20MG	3	
ZESTRIL TAB 30MG	3	
ZESTRIL TAB 40MG	3	
AGENTS FOR PHEOCHROMOCYTOMA		
DEMSER CAP 250MG	3	
DIBENZYLINE CAP 10MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
metyrosine cap 250 mg	1	
phenoxybenzamine hcl cap 10 mg	1	
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
ATACAND TAB 4MG	3	
ATACAND TAB 8MG	3	
ATACAND TAB 16MG	3	
ATACAND TAB 32MG	3	
AVAPRO TAB 75MG	3	
AVAPRO TAB 150MG	3	
AVAPRO TAB 300MG	3	
BENICAR TAB 5MG	3	
BENICAR TAB 20MG	3	
BENICAR TAB 40MG	3	
candesartan cilexetil tab 4 mg	1	
candesartan cilexetil tab 8 mg	1	
candesartan cilexetil tab 16 mg	1	
candesartan cilexetil tab 32 mg	1	
COZAAR TAB 25MG	3	
COZAAR TAB 50MG	3	
COZAAR TAB 100MG	3	
DIOVAN TAB 40MG	3	
DIOVAN TAB 80MG	3	
DIOVAN TAB 160MG	3	
DIOVAN TAB 320MG	3	
EDARBI TAB 40MG	3	
EDARBI TAB 80MG	3	
irbesartan tab 75 mg	1	
irbesartan tab 150 mg	1	
irbesartan tab 300 mg	1	
losartan potassium tab 25 mg	1	
losartan potassium tab 50 mg	1	
losartan potassium tab 100 mg	1	
MICARDIS TAB 20MG	3	
MICARDIS TAB 40MG	3	
MICARDIS TAB 80MG	3	
olmesartan medoxomil tab 5 mg	1	
olmesartan medoxomil tab 20 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
olmesartan medoxomil tab 40 mg	1	
telmisartan tab 20 mg	1	
telmisartan tab 40 mg	1	
telmisartan tab 80 mg	1	
VALSARTAN SOL 20MG/5ML	3	
valsartan tab 40 mg	1	
valsartan tab 80 mg	1	
valsartan tab 160 mg	1	
valsartan tab 320 mg	1	
ANTIADRENERGIC ANTIHYPERTENSIVES		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	2	
CATAPRES-TTS DIS 0.2/24HR	2	
CATAPRES-TTS DIS 0.3/24HR	2	
clonidine hcl tab 0.1 mg	1	
clonidine hcl tab 0.2 mg	1	
clonidine hcl tab 0.3 mg	1	
clonidine td patch weekly 0.1 mg/24hr	1	
clonidine td patch weekly 0.2 mg/24hr	1	
clonidine td patch weekly 0.3 mg/24hr	1	
doxazosin mesylate tab 1 mg	1	
doxazosin mesylate tab 2 mg	1	
doxazosin mesylate tab 4 mg	1	
doxazosin mesylate tab 8 mg	1	
guanfacine hcl tab 1 mg	1	
guanfacine hcl tab 2 mg	1	
methyldopa tab 250 mg	1	
methyldopa tab 500 mg	1	
MINIPRESS CAP 1MG	3	
MINIPRESS CAP 2MG	3	
MINIPRESS CAP 5MG	3	
prazosin hcl cap 1 mg	1	
prazosin hcl cap 2 mg	1	
prazosin hcl cap 5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
terazosin hcl cap 1 mg (base equivalent)	1	
terazosin hcl cap 2 mg (base equivalent)	1	
terazosin hcl cap 5 mg (base equivalent)	1	
terazosin hcl cap 10 mg (base equivalent)	1	
ANTIHYPERTENSIVE COMBINATIONS		
ACCURETIC TAB 10-12.5	3	
ACCURETIC TAB 20-12.5	3	
ACCURETIC TAB 20-25MG	3	
amlodipine besylate-benazepril hcl cap 2.5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-10 mg	1	
amlodipine besylate-benazepril hcl cap 5-20 mg	1	
amlodipine besylate-benazepril hcl cap 5-40 mg	1	
amlodipine besylate-benazepril hcl cap 10-20 mg	1	
amlodipine besylate-benazepril hcl cap 10-40 mg	1	
amlodipine besylate-olmesartan medoxomil tab 5-20 mg	1	
amlodipine besylate-olmesartan medoxomil tab 5-40 mg	1	
amlodipine besylate-olmesartan medoxomil tab 10-20 mg	1	
amlodipine besylate-olmesartan medoxomil tab 10-40 mg	1	
amlodipine besylate-valsartan tab 5-160 mg	1	
amlodipine besylate-valsartan tab 5-320 mg	1	
amlodipine besylate-valsartan tab 10-160 mg	1	
amlodipine besylate-valsartan tab 10-320 mg	1	
amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg	1	
amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg	1	
amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg	1	
amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg	1	
ATACAND HCT TAB 16-12.5	3	
ATACAND HCT TAB 32-12.5	3	
ATACAND HCT TAB 32-25MG	3	
atenolol & chlorthalidone tab 50-25 mg	1	
atenolol & chlorthalidone tab 100-25 mg	1	
AVALIDE TAB 150-12.5	3	
AVALIDE TAB 300-12.5	3	
AZOR TAB 5-20MG	3	
AZOR TAB 5-40MG	3	
AZOR TAB 10-20MG	3	
AZOR TAB 10-40MG	3	
benazepril & hydrochlorothiazide tab 5-6.25 mg	1	
benazepril & hydrochlorothiazide tab 10-12.5 mg	1	
benazepril & hydrochlorothiazide tab 20-12.5 mg	1	
benazepril & hydrochlorothiazide tab 20-25 mg	1	
BENICAR HCT TAB 20-12.5	3	
BENICAR HCT TAB 40-12.5	3	
BENICAR HCT TAB 40-25MG	3	
bisoprolol & hydrochlorothiazide tab 2.5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 5-6.25 mg	1	
bisoprolol & hydrochlorothiazide tab 10-6.25 mg	1	
candesartan cilexetil-hydrochlorothiazide tab 16-12.5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
candesartan cilexetil-hydrochlorothiazide tab 32-12.5 mg	1	
candesartan cilexetil-hydrochlorothiazide tab 32-25 mg	1	
captopril & hydrochlorothiazide tab 25-15 mg	1	
captopril & hydrochlorothiazide tab 25-25 mg	1	
captopril & hydrochlorothiazide tab 50-15 mg	1	
captopril & hydrochlorothiazide tab 50-25 mg	1	
DIOVAN HCT TAB 80/12.5	3	
DIOVAN HCT TAB 160-12.5	3	
DIOVAN HCT TAB 160-25MG	3	
DIOVAN HCT TAB 320-12.5	3	
DIOVAN HCT TAB 320-25MG	3	
DUTOPROL TAB 25-12.5	3	PA; MNPA
DUTOPROL TAB 50-12.5	3	PA; MNPA
DUTOPROL TAB 100-12.5	3	PA; MNPA
EDARBYCLOR TAB 40-12.5	3	
EDARBYCLOR TAB 40-25MG	3	
enalapril maleate & hydrochlorothiazide tab 5-12.5 mg	1	
enalapril maleate & hydrochlorothiazide tab 10-25 mg	1	
EXFORGE HCT TAB 5-160-12.5	3	
EXFORGE HCT TAB 5-160-25	3	
EXFORGE HCT TAB 10-160-12.5	3	
EXFORGE HCT TAB 10-160-25	3	
EXFORGE HCT TAB 10-320-25	3	
EXFORGE TAB 5-160MG	3	
EXFORGE TAB 5-320MG	3	
EXFORGE TAB 10-160MG	3	
EXFORGE TAB 10-320MG	3	
fosinopril sodium & hydrochlorothiazide tab 10-12.5 mg	1	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
MICARDIS HCT TAB 80-25MG	3	
MICARDIS HCT TAB 80/12.5	3	
olmesartan medoxomil-hydrochlorothiazide tab 20-12.5 mg	1	
olmesartan medoxomil-hydrochlorothiazide tab 40-12.5 mg	1	
olmesartan medoxomil-hydrochlorothiazide tab 40-25 mg	1	
olmesartan-amlodipine-hydrochlorothiazide tab 20-5-12.5 mg	1	
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-12.5 mg	1	
olmesartan-amlodipine-hydrochlorothiazide tab 40-5-25 mg	1	
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-12.5 mg	1	
olmesartan-amlodipine-hydrochlorothiazide tab 40-10-25 mg	1	
PRESTALIA TAB 3.5-2.5	3	
PRESTALIA TAB 7-5MG	3	
PRESTALIA TAB 14-10MG	3	
propranolol & hydrochlorothiazide tab 40-25 mg	1	
propranolol & hydrochlorothiazide tab 80-25 mg	1	
quinapril-hydrochlorothiazide tab 10-12.5 mg	1	
quinapril-hydrochlorothiazide tab 20-12.5 mg	1	
quinapril-hydrochlorothiazide tab 20-25 mg	1	
TARKA TAB 2-180 CR	2	
TARKA TAB 2-240 CR	2	
TARKA TAB 4-240 CR	2	
TEKTURNA HCT TAB 150-12.5	2	
TEKTURNA HCT TAB 150-25MG	2	
TEKTURNA HCT TAB 300-12.5	2	
TEKTURNA HCT TAB 300-25MG	2	
telmisartan-amlodipine tab 40-5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
telmisartan-amlodipine tab 40-10 mg	1	
telmisartan-amlodipine tab 80-5 mg	1	
telmisartan-amlodipine tab 80-10 mg	1	
telmisartan-hydrochlorothiazide tab 40-12.5 mg	1	
telmisartan-hydrochlorothiazide tab 80-12.5 mg	1	
telmisartan-hydrochlorothiazide tab 80-25 mg	1	
TENORETIC TAB 50	3	
TENORETIC TAB 100	3	
trandolapril-verapamil hcl tab er 1-240 mg	1	
trandolapril-verapamil hcl tab er 2-180 mg	1	
trandolapril-verapamil hcl tab er 2-240 mg	3	
trandolapril-verapamil hcl tab er 4-240 mg	1	
TRIBENZOR20- TAB 5-12.5MG	3	
TRIBENZOR40- TAB 5-12.5MG	3	
TRIBENZOR40- TAB 5-25MG	3	
TRIBENZOR40- TAB 10-12.5	3	
TRIBENZOR40- TAB 10-25MG	3	
TWYNSTA TAB 40-5MG	3	
TWYNSTA TAB 40-10MG	3	
TWYNSTA TAB 80-5MG	3	
TWYNSTA TAB 80-10MG	3	
valsartan-hydrochlorothiazide tab 80-12.5 mg	1	
valsartan-hydrochlorothiazide tab 160-12.5 mg	1	
valsartan-hydrochlorothiazide tab 160-25 mg	1	
valsartan-hydrochlorothiazide tab 320-12.5 mg	1	
valsartan-hydrochlorothiazide tab 320-25 mg	1	
VASERETIC TAB 10-25MG	3	
ZESTORETIC TAB 10-12.5	3	
ZESTORETIC TAB 20-12.5	3	
ZESTORETIC TAB 20-25MG	3	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
PYRIME/LEUCO CAP 50/25MG	3	
PYRIME/LEUCO CAP 75/25MG	3	
ANTIMALARIALS		
ARAKODA TAB 100MG	3	
chloroquine phosphate tab 250 mg	1	
chloroquine phosphate tab 500 mg	1	
DARAPRIM TAB 25MG	3	PA
hydroxychloroquine sulfate tab 200 mg	1	
KRINTAFEL TAB 150MG	3	
mefloquine hcl tab 250 mg	1	
PLAQUENIL TAB 200MG	2	
primaquine phosphate tab 26.3 mg (15 mg base)	1	
PRIMAQUINE TAB 26.3MG	3	
pyrimethamine tab 25 mg	1	PA
QUALAQUIN CAP 324MG	3	
quinine sulfate cap 324 mg	1	
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
ANTIMYASTHENIC/CHOLINERGIC AGENTS		
FIRDAPSE TAB 10MG	3	PA, QL (240 TABLETS PER 30 DAYS)
GUANIDINE TAB 125MG	3	
MESTINON SOL 60MG/5ML	3	
MESTINON TAB 60MG	3	
MESTINON TAB TIMESPAN	3	
pyridostigmine bromide oral soln 60 mg/5ml	1	
pyridostigmine bromide tab 30 mg	1	
pyridostigmine bromide tab 60 mg	1	
pyridostigmine bromide tab er 180 mg	1	
RUZURGI TAB 10MG	3	PA, QL (300 TABLETS PER 30 DAYS)
ANTIMYCOBACTERIAL AGENTS		
ANTIMYCOBACTERIAL AGENTS		
cycloserine cap 250 mg	1	
ethambutol hcl tab 100 mg	1	
ethambutol hcl tab 400 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
isoniazid syrup 50 mg/5ml	1	
isoniazid tab 100 mg	1	
isoniazid tab 300 mg	1	
MYAMBUTOL TAB 400MG	2	
MYCOBUTIN CAP 150MG	3	
PASER GRA 4GM	3	
PRETOMANID TAB 200MG	3	
PRIFTIN TAB 150MG	3	
pyrazinamide tab 500 mg	1	
rifabutin cap 150 mg	1	
rifampin cap 150 mg	1	
rifampin cap 300 mg	1	
SIRTURO TAB 20MG	3	
SIRTURO TAB 100MG	3	
TRECATOR TAB 250MG	3	

ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES

ALKYLATING AGENTS

ALKERAN TAB 2MG	0	
CYCLOPHOSPH TAB 25MG	0	
CYCLOPHOSPH TAB 50MG	0	
cyclophosphamide cap 25 mg	0	
cyclophosphamide cap 50 mg	0	
GLEOSTINE CAP 10MG	0	
GLEOSTINE CAP 40MG	0	
GLEOSTINE CAP 100MG	0	
LEUKERAN TAB 2MG	0	
melphalan tab 2 mg	0	
MYLERAN TAB 2MG	0	
TEMODAR CAP 100MG	0	PA
TEMODAR CAP 140MG	0	PA
TEMODAR CAP 180MG	0	PA
TEMODAR CAP 250MG	0	PA
temozolomide cap 5 mg	0	PA
temozolomide cap 20 mg	0	PA
temozolomide cap 100 mg	0	PA
temozolomide cap 140 mg	0	PA
temozolomide cap 180 mg	0	PA

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

Drug Name	Drug Tier	Requirements/Limits
temozolomide cap 250 mg	0	PA
ANTIMETABOLITES		
azacitidine for inj 100 mg	1	PA
capecitabine tab 150 mg	0	PA, QL (120 TABLETS PER 30 DAYS)
capecitabine tab 500 mg	0	PA, QL (300 TABLETS PER 30 DAYS)
mercaptopurine tab 50 mg	0	
methotrexate sodium for inj 1 gm	1	
methotrexate sodium inj 50 mg/2ml (25 mg/ml)	1	
methotrexate sodium inj 250 mg/10ml (25 mg/ml)	1	
methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)	1	
methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)	1	
methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)	1	
methotrexate sodium tab 2.5 mg (base equiv)	0	
ONUREG TAB 200MG	0	PA, QL (14 TABLETS PER 28 DAYS)
ONUREG TAB 300MG	0	PA, QL (14 TABLETS PER 28 DAYS)
PURIXAN SUS 20MG/ML	0	PA
TABLOID TAB 40MG	0	
TREXALL TAB 5MG	0	
TREXALL TAB 7.5MG	0	
TREXALL TAB 10MG	0	
TREXALL TAB 15MG	0	
VIDAZA INJ 100MG	3	PA
XATMEP SOL 2.5MG/ML	0	
XELODA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XELODA TAB 500MG	0	PA, QL (300 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS		
INLYTA TAB 1MG	0	PA, QL (240 TABLETS PER 30 DAYS)
INLYTA TAB 5MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LENVIMA CAP 4MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 8 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 10 MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
LENVIMA CAP 12MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 14 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 18 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
LENVIMA CAP 20 MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
LENVIMA CAP 24 MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ANTINEOPLASTIC - ANTI-HER2 AGENTS		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - BCL-2 INHIBITORS		
VENCLEXTA TAB 10MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
VENCLEXTA TAB 100MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VENCLEXTA TAB START PK	0	PA, QL (1 PACK EVERY 28 DAYS)
ANTINEOPLASTIC - EGFR INHIBITORS		
erlotinib hcl tab 25 mg (base equivalent)	0	PA, QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
erlotinib hcl tab 100 mg (base equivalent)	0	PA, QL (30 TABLETS PER 30 DAYS)
erlotinib hcl tab 150 mg (base equivalent)	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IRESSA TAB 250MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TAGRISSO TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TAGRISSO TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TARCEVA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 150MG	0	PA, QL (30 TABLETS PER 30 DAYS)
VIZIMPRO TAB 15MG	0	PA, QL (30 TABLETS PER 30 DAYS)
VIZIMPRO TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
VIZIMPRO TAB 45MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS		
DAURISMO TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
DAURISMO TAB 100MG	0	PA, QL (30 TABS PER 30 DAYS)
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ODOMZO CAP 200MG	0	PA, QL (30 CAPSULES PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS		
abiraterone acetate tab 250 mg	0	PA, QL (120 TABLETS PER 30 DAYS)
abiraterone acetate tab 500 mg	0	PA, QL (60 TABLETS PER 30 DAYS)
anastrozole tab 1 mg	0	
ARIMIDEX TAB 1MG	0	
AROMASIN TAB 25MG	0	
bicalutamide tab 50 mg	0	
CASODEX TAB 50MG	0	
EMCYT CAP 140MG	0	
ERLEADA TAB 60MG	0	PA, QL (120 TABLETS PER 30 DAYS)
exemestane tab 25 mg	0	
FARESTON TAB 60MG	0	
FEMARA TAB 2.5MG	0	
flutamide cap 125 mg	0	
letrozole tab 2.5 mg	0	
leuprolide acetate inj kit 5 mg/ml	1	PA
LUPRON DEPOT INJ 3.75MG	3	PA
LUPRON DEPOT INJ 11.25MG	3	PA
LYSODREN TAB 500MG	0	
megestrol acetate susp 40 mg/ml	0	
megestrol acetate tab 20 mg	0	
megestrol acetate tab 40 mg	0	
NILANDRON TAB 150MG	0	PA; MNPA
nilutamide tab 150 mg	0	
NUBEQA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ORGOVYX TAB 120MG	0	PA, QL (30 tabs every 30 days)
SOLTAMOX SOL 10MG/5ML	0	
tamoxifen citrate tab 10 mg (base equivalent)	0	$0 copay for women > 35 years for the primary prevention of breast cancer

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

Drug Name	Drug Tier	Requirements/Limits
tamoxifen citrate tab 20 mg (base equivalent)	0	$0 copay for women > 35 years for the primary prevention of breast cancer
toremifene citrate tab 60 mg (base equivalent)	0	
XTANDI CAP 40MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XTANDI TAB 40MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XTANDI TAB 80MG	0	PA, QL (60 TABLETS PER 30 DAYS)
YONSA TAB 125MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ZYTIGA TAB 250MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ZYTIGA TAB 500MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS		
WELIREG TAB 40MG	3	PA, QL (90 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - IMMUNOMODULATORS		
POMALYST CAP 1MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 2MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 3MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
POMALYST CAP 4MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS		
AYVAKIT TAB 25MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AYVAKIT TAB 200MG	0	PA, QL (30 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
AYVAKIT TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ANTINEOPLASTIC - XPO1 INHIBITORS		
XPOVIO PAK 40MG	0	PA, QL (16 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 40MG	0	PA, QL (4 Tablets Per 28 Days); Therapy Pack
XPOVIO PAK 40MG	0	PA, QL (8 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 40MG	0	PA, QL (8 Tablets Per 28 Days); Therapy Pack
XPOVIO PAK 50MG	0	PA, QL (8 Tablets Per 28 Days); Therapy Pack
XPOVIO PAK 60MG	0	PA, QL (12 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 60MG	0	PA, QL (24 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 60MG	0	PA, QL (4 Tablets Per 28 Days); Therapy Pack
XPOVIO PAK 80MG	0	PA, QL (16 TABLETS PER 28 DAYS); Once Weekly
XPOVIO PAK 80MG	0	PA, QL (32 TABLETS PER 28 DAYS); Twice Weekly
XPOVIO PAK 100MG	0	PA, QL (20 TABLETS PER 28 DAYS); Once Weekly
ANTINEOPLASTIC COMBINATIONS		
INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (50 tabs every 28 days)
KISQALI 400 PAK FEMARA	0	PA, QL (70 tabs every 28 days)
KISQALI 600 PAK FEMARA	0	PA, QL (92 tabs every 28 days)
LONSURF TAB 15-6.14	0	PA, QL (100 TABLETS 28 DAYS)
LONSURF TAB 20-8.19	0	PA, QL (80 TABLETS 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC ENZYME INHIBITORS		
AFINITOR DIS TAB 2MG	0	PA, QL (60 TABLETS PER 30 DAYS)
AFINITOR DIS TAB 3MG	0	PA, QL (90 TABLETS PER 30 DAYS)
AFINITOR DIS TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
AFINITOR TAB 2.5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AFINITOR TAB 5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AFINITOR TAB 7.5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
AFINITOR TAB 10MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ALECENSA CAP 150MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
ALUNBRIG PAK	0	PA, QL (30 TABLETS PER 30 DAYS)
ALUNBRIG TAB 30MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ALUNBRIG TAB 90MG	0	PA, QL (30 TABLETS PER 30 DAYS)
ALUNBRIG TAB 180MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BALVERSA TAB 3MG	0	PA, QL (84 TABLETS PER 28 DAYS)
BALVERSA TAB 4MG	0	PA, QL (56 TABLETS PER 28 DAYS)
BALVERSA TAB 5MG	0	PA, QL (28 TABLETS PER 28 DAYS)
BOSULIF TAB 100MG	0	PA, QL (90 TABLETS PER 30 DAYS)
BOSULIF TAB 400MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BOSULIF TAB 500MG	0	PA, QL (30 TABLETS PER 30 DAYS)
BRAFTOVI CAP 75MG	0	PA, QL (180 CAPSULES PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
BRUKINSA CAP 80MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
CABOMETYX TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 60MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CALQUENCE CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
CALQUENCE TAB 100MG	0	PA, QL (60 TABS PER 30 DAYS)
CAPRELSA TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
CAPRELSA TAB 300MG	0	PA, QL (30 TABLETS PER 30 DAYS)
COMETRIQ KIT 60MG	0	PA, QL (84 CAPSULES PER 28 DAYS)
COMETRIQ KIT 100MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
COMETRIQ KIT 140MG	0	PA, QL (112 CAPSULES PER 28 DAYS)
COPIKTRA CAP 15MG	0	PA, QL (56 CAPSULES PER 28 days)
COPIKTRA CAP 25MG	0	PA, QL (56 CAPSULES PER 28 days)
COTELLIC TAB 20MG	0	PA, QL (63 TABLETS 28 DAYS)
everolimus tab 2.5 mg	0	PA, QL (30 TABLETS PER 30 DAYS)
everolimus tab 5 mg	0	PA, QL (30 TABLETS PER 30 DAYS)
everolimus tab 7.5 mg	0	PA, QL (30 TABLETS PER 30 DAYS)
FARYDAK CAP 10MG	0	PA, QL (6 CAPSULES PER 21 DAYS)
FARYDAK CAP 15MG	0	PA, QL (6 CAPSULES PER 21 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
FARYDAK CAP 20MG	0	PA, QL (6 CAPSULES PER 21 DAYS)
FOTIVDA CAP 0.89MG	0	QL (21 tablets per 28 days)
FOTIVDA CAP 1.34MG	0	QL (21 tablets per 28 days)
GAVRETO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
GLEEVEC TAB 100MG	0	PA, QL (90 TABLETS PER 30 DAYS)
GLEEVEC TAB 400MG	0	PA, QL (60 TABLETS PER 30 DAYS)
IBRANCE CAP 75MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 100MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE CAP 125MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
IBRANCE TAB 75MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 100MG	0	PA, QL (21 TABLETS PER 28 DAYS)
IBRANCE TAB 125MG	0	PA, QL (21 TABLETS PER 28 DAYS)
ICLUSIG TAB 10MG	0	PA, QL (30 TABS PER MONTH)
ICLUSIG TAB 15MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ICLUSIG TAB 30MG	0	PA, QL (30 TABS PER MONTH)
ICLUSIG TAB 45MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
imatinib mesylate tab 100 mg (base equivalent)	0	PA, QL (90 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
imatinib mesylate tab 400 mg (base equivalent)	0	PA, QL (60 TABLETS PER 30 DAYS)
IMBRUVICA CAP 70MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
IMBRUVICA CAP 140MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
IMBRUVICA SUS 70MG/ML	0	PA, QL (216 ML PER 36 DAYS)
IMBRUVICA TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 280MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 420MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 560MG	0	PA, QL (30 TABLETS PER 30 DAYS)
INREBIC CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
JAKAFI TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 10MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 15MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 20MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
KISQALI TAB 200DOSE	0	PA, QL (21 TABLETS PER 28 DAYS)
KISQALI TAB 400DOSE	0	PA, QL (42 TABLETS 28 DAYS)
KISQALI TAB 600DOSE	0	PA, QL (63 TABLETS 28 DAYS)
KOSELUGO CAP 10MG	0	PA, QL (240 CAPSULES PER 30 DAYS)
KOSELUGO CAP 25MG	0	PA, QL (120 CAPSULES PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
lapatinib ditosylate tab 250 mg (base equiv)	0	PA, QL (180 TABLETS PER 30 DAYS)
LORBRENA TAB 25MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LORBRENA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
LUMAKRAS TAB 120MG	0	PA, QL (240 tabs Per 30 Days)
LYNPARZA TAB 100MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LYNPARZA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
MEKINIST TAB 0.5MG	0	PA, QL (90 TABLETS PER 30 DAYS)
MEKINIST TAB 2MG	0	PA, QL (30 TABLETS PER 30 DAYS)
MEKTOVI TAB 15MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NERLYNX TAB 40MG	0	PA, QL (180 TABLETS PER 30 DAYS)
NEXAVAR TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
NINLARO CAP 2.3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 3MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
NINLARO CAP 4MG	0	PA, QL (3 CAPSULES PER 28 DAYS)
PEMAZYRE TAB 4.5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
PEMAZYRE TAB 9MG	0	PA, QL (30 TABLETS PER 30 DAYS)
PEMAZYRE TAB 13.5MG	0	PA, QL (30 TABLETS PER 30 DAYS)
PIQRAY 200MG TAB DOSE	0	PA, QL (28 TABLETS PER 28 DAYS)
PIQRAY 250MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
PIQRAY 300MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
QINLOCK TAB 50MG	0	PA, QL (90 TABLETS PER 30 DAYS)
RETEVMO CAP 40MG	0	PA, QL (60 TABLETS PER 30 DAYS)
RETEVMO CAP 80MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ROZLYTREK CAP 100MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ROZLYTREK CAP 200MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
RUBRACA TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
RUBRACA TAB 250MG	0	PA, QL (120 TABLETS PER 30 DAYS)
RUBRACA TAB 300MG	0	PA, QL (120 TABLETS PER 30 DAYS)
RYDAPT CAP 25MG	0	PA, QL (224 CAPSULES PER 28 DAYS)
SCEMBLIX TAB 40MG	3	QL (300 TABLETS PER 30 DAYS)
sorafenib tosylate tab 200 mg (base equivalent)	0	PA, QL (120 TABLETS PER 30 DAYS)
SPRYCEL TAB 20MG	0	PA, QL (90 TABLETS PER 30 DAYS)
SPRYCEL TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 70MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
STIVARGA TAB 40MG	0	PA, QL (84 TABLETS PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
sunitinib malate cap 12.5 mg (base equivalent)	0	PA, QL (30 CAPSULES PER 30 DAYS)
sunitinib malate cap 25 mg (base equivalent)	0	PA, QL (30 CAPSULES PER 30 DAYS)
sunitinib malate cap 37.5 mg (base equivalent)	0	PA, QL (30 CAPSULES PER 30 DAYS)
sunitinib malate cap 50 mg (base equivalent)	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 12.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 25MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 37.5MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
SUTENT CAP 50MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
TABRECTA TAB 150MG	0	PA, QL (112 TABLETS PER 28 DAYS)
TABRECTA TAB 200MG	0	PA, QL (112 TABLETS PER 28 DAYS)
TAFINLAR CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TAFINLAR CAP 75MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TALZENNA CAP 0.25MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
TALZENNA CAP 1MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
TASIGNA CAP 50MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TASIGNA CAP 150MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TASIGNA CAP 200MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TAZVERIK TAB 200MG	0	PA, QL (240 TABLETS PER 30 DAYS)
TEPMETKO TAB 225MG	0	PA, QL (60 TABS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TURALIO CAP 200MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
UKONIQ TAB 200MG	0	PA, QL (120 TABS PER MONTH)
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 150MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 200MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VITRAKVI CAP 25MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
VITRAKVI CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
VITRAKVI SOL 20MG/ML	0	PA, QL (300 ML PER 30 DAYS)
VOTRIENT TAB 200MG	0	PA, QL (120 TABLETS PER 30 DAYS)
XALKORI CAP 200MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XALKORI CAP 250MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XOSPATA TAB 40MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ZEJULA CAP 100MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ZELBORAF TAB 240MG	0	PA, QL (240 TABLETS PER 30 DAYS)
ZOLINZA CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
ZYDELIG TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ZYDELIG TAB 150MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ANTINEOPLASTICS MISC.		
ACTIMMUNE INJ 2MU/0.5	3	PA
BESREMI SOL 500MCG	3	PA, QL (2 PFS PER 28 DAYS)
bexarotene cap 75 mg	0	PA
HYDREA CAP 500MG	0	
hydroxyurea cap 500 mg	0	
INTRON A INJ 10MU	2	PA
INTRON A INJ 18MU	2	PA
INTRON A INJ 25MU	2	PA
INTRON A INJ 50MU	2	PA
MATULANE CAP 50MG	0	
TARGRETIN CAP 75MG	0	PA
tretinoin cap 10 mg	0	
CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS		
leucovorin calcium tab 5 mg	0	
leucovorin calcium tab 10 mg	0	
leucovorin calcium tab 15 mg	0	
leucovorin calcium tab 25 mg	0	
MESNEX TAB 400MG	0	
MITOTIC INHIBITORS		
etoposide cap 50 mg	0	
TOPOISOMERASE I INHIBITORS		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
ANTIPARKINSON AND RELATED THERAPY AGENTS		
ANTIPARKINSON ADJUNCTIVE THERAPY		
carbidopa tab 25 mg	1	
LODOSYN TAB 25MG	3	
NOURIANZ TAB 20MG	3	
NOURIANZ TAB 40MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
ANTIPARKINSON ANTICHOLINERGICS		
benztropine mesylate tab 0.5 mg	1	
benztropine mesylate tab 1 mg	1	
benztropine mesylate tab 2 mg	1	
trihexyphenidyl hcl oral soln 0.4 mg/ml	1	
trihexyphenidyl hcl tab 2 mg	1	
trihexyphenidyl hcl tab 5 mg	1	
ANTIPARKINSON COMT INHIBITORS		
COMTAN TAB 200MG	3	
entacapone tab 200 mg	1	
ONGENTYS CAP 25MG	3	
ONGENTYS CAP 50MG	3	
TASMAR TAB 100MG	3	
tolcapone tab 100 mg	1	
ANTIPARKINSON DOPAMINERGICS		
amantadine hcl cap 100 mg	1	
amantadine hcl soln 50 mg/5ml	1	
amantadine hcl tab 100 mg	1	
APOKYN INJ 10MG/ML	3	PA, QL (20 CARTRIDGES PER 30 DAYS)
bromocriptine mesylate cap 5 mg (base equivalent)	1	
bromocriptine mesylate tab 2.5 mg (base equivalent)	1	
carbidopa & levodopa orally disintegrating tab 10-100 mg	1	
carbidopa & levodopa orally disintegrating tab 25-100 mg	1	
carbidopa & levodopa orally disintegrating tab 25-250 mg	1	
carbidopa & levodopa tab 10-100 mg	1	
carbidopa & levodopa tab 25-100 mg	1	
carbidopa & levodopa tab 25-250 mg	1	
carbidopa & levodopa tab er 25-100 mg	1	
carbidopa & levodopa tab er 50-200 mg	1	
carbidopa-levodopa-entacapone tabs 12.5-50-200 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
carbidopa-levodopa-entacapone tabs 18.75-75-200 mg	1	
carbidopa-levodopa-entacapone tabs 25-100-200 mg	1	
carbidopa-levodopa-entacapone tabs 31.25-125-200 mg	1	
carbidopa-levodopa-entacapone tabs 37.5-150-200 mg	1	
carbidopa-levodopa-entacapone tabs 50-200-200 mg	1	
GOCOVRI CAP 68.5MG	3	
GOCOVRI CAP 137MG	3	
INBRIJA CAP 42MG	2	PA, QL (300 CAPSULES PER 30 DAYS)
KYNMOBI MIS 10MG	3	PA, QL (150 Films per 30 Days)
KYNMOBI MIS 15MG	3	PA, QL (150 Films per 30 Days)
KYNMOBI MIS 20MG	3	PA, QL (150 Films per 30 Days)
KYNMOBI MIS 25MG	3	PA, QL (150 Films per 30 Days)
KYNMOBI MIS 30MG	3	PA, QL (150 Films per 30 Days)
MIRAPEX ER TAB 0.75MG	3	
MIRAPEX ER TAB 0.375MG	3	
MIRAPEX ER TAB 1.5MG	3	
MIRAPEX ER TAB 2.25MG	3	
MIRAPEX ER TAB 3.75MG	3	
MIRAPEX ER TAB 3MG	3	
MIRAPEX ER TAB 4.5MG	3	
MIRAPEX TAB 0.5MG	3	
MIRAPEX TAB 0.75MG	3	
MIRAPEX TAB 0.125MG	3	
MIRAPEX TAB 1MG	3	
NEUPRO DIS 1MG/24HR	2	
NEUPRO DIS 2MG/24HR	2	
NEUPRO DIS 3MG/24HR	2	

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

Drug Name	Drug Tier	Requirements/Limits
NEUPRO DIS 4MG/24HR	2	
NEUPRO DIS 6MG/24HR	2	
NEUPRO DIS 8MG/24HR	2	
OSMOLEX ER TAB	3	
OSMOLEX ER TAB 129MG	3	
OSMOLEX ER TAB 193MG	3	
OSMOLEX ER TAB 258MG	3	
PARLODEL CAP 5MG	3	
PARLODEL TAB 2.5MG	3	
pramipexole dihydrochloride tab 0.5 mg	1	
pramipexole dihydrochloride tab 0.25 mg	1	
pramipexole dihydrochloride tab 0.75 mg	1	
pramipexole dihydrochloride tab 0.125 mg	1	
pramipexole dihydrochloride tab 1 mg	1	
pramipexole dihydrochloride tab 1.5 mg	1	
pramipexole dihydrochloride tab er 24hr 0.75 mg	1	
pramipexole dihydrochloride tab er 24hr 0.375 mg	1	
pramipexole dihydrochloride tab er 24hr 1.5 mg	1	
pramipexole dihydrochloride tab er 24hr 2.25 mg	1	
pramipexole dihydrochloride tab er 24hr 3 mg	1	
pramipexole dihydrochloride tab er 24hr 3.75 mg	1	
pramipexole dihydrochloride tab er 24hr 4.5 mg	1	
ropinirole hydrochloride tab 0.5 mg	1	
ropinirole hydrochloride tab 0.25 mg	1	
ropinirole hydrochloride tab 1 mg	1	
ropinirole hydrochloride tab 2 mg	1	
ropinirole hydrochloride tab 3 mg	1	
ropinirole hydrochloride tab 4 mg	1	
ropinirole hydrochloride tab 5 mg	1	
ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)	1	

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

Drug Name	Drug Tier	Requirements/Limits
ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)	1	
ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)	1	
ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)	1	
ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)	1	
RYTARY CAP 95MG	3	
RYTARY CAP 145MG	3	
RYTARY CAP 195MG	3	
RYTARY CAP 245MG	3	
SINEMET TAB 10-100MG	3	
SINEMET TAB 25-100MG	3	
STALEVO 50 TAB	3	
STALEVO 75 TAB	3	
STALEVO 100 TAB	3	
STALEVO 125 TAB	3	
STALEVO 150 TAB	3	
STALEVO 200 TAB	3	
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS		
AZILECT TAB 0.5MG	3	
AZILECT TAB 1MG	3	
rasagiline mesylate tab 0.5 mg (base equiv)	1	
rasagiline mesylate tab 1 mg (base equiv)	1	
selegiline hcl cap 5 mg	1	
selegiline hcl tab 5 mg	1	
XADAGO TAB 50MG	3	
XADAGO TAB 100MG	3	
ZELAPAR TAB 1.25MG	3	
ANTIPSYCHOTICS/ANTIMANIC AGENTS		
ANTIMANIC AGENTS		
lithium carbonate cap 150 mg	1	
lithium carbonate cap 300 mg	1	
lithium carbonate cap 600 mg	1	
lithium carbonate tab 300 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
lithium carbonate tab er 300 mg	1	
lithium carbonate tab er 450 mg	1	
LITHIUM SOL 8MEQ/5ML	3	
LITHOBID TAB 300MG CR	2	
ANTIPSYCHOTICS - MISC.		
CAPLYTA CAP 10.5MG	2	
CAPLYTA CAP 21MG	2	
CAPLYTA CAP 42MG	3	
EQUETRO CAP 100MG	3	
EQUETRO CAP 200MG	3	
EQUETRO CAP 300MG	3	
GEODON CAP 20MG	3	
GEODON CAP 40MG	3	
GEODON CAP 60MG	3	
GEODON CAP 80MG	3	
GEODON INJ 20MG	3	
LATUDA TAB 20MG	2	
LATUDA TAB 40MG	2	
LATUDA TAB 60MG	2	
LATUDA TAB 80MG	2	
LATUDA TAB 120MG	2	
NUPLAZID CAP 34MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
NUPLAZID TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
VRAYLAR CAP 1.5-3MG	2	
VRAYLAR CAP 1.5MG	2	
VRAYLAR CAP 3MG	2	
VRAYLAR CAP 4.5MG	2	
VRAYLAR CAP 6MG	2	
ziprasidone hcl cap 20 mg	1	
ziprasidone hcl cap 40 mg	1	
ziprasidone hcl cap 60 mg	1	
ziprasidone hcl cap 80 mg	1	
ziprasidone mesylate for inj 20 mg (base equivalent)	1	

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

Drug Name	Drug Tier	Requirements/Limits
BENZISOXAZOLES		
FANAPT PAK	3	PA; MNPA
FANAPT TAB 1MG	3	PA; MNPA
FANAPT TAB 2MG	3	PA; MNPA
FANAPT TAB 4MG	3	PA; MNPA
FANAPT TAB 6MG	3	PA; MNPA
FANAPT TAB 8MG	3	PA; MNPA
FANAPT TAB 10MG	3	PA; MNPA
FANAPT TAB 12MG	3	PA; MNPA
INVEGA SUST INJ 39/0.25	3	
INVEGA SUST INJ 78/0.5ML	3	
INVEGA SUST INJ 117/0.75	3	
INVEGA SUST INJ 156MG/ML	3	
INVEGA SUST INJ 234/1.5	3	
INVEGA TAB 1.5MG	3	
INVEGA TAB 3MG	3	
INVEGA TAB 6MG	3	
INVEGA TAB 9MG	3	
INVEGA TRINZ INJ 273MG	3	
INVEGA TRINZ INJ 410MG	3	
INVEGA TRINZ INJ 546MG	3	
INVEGA TRINZ INJ 819MG	3	
paliperidone tab er 24hr 1.5 mg	1	
paliperidone tab er 24hr 3 mg	1	
paliperidone tab er 24hr 6 mg	1	
paliperidone tab er 24hr 9 mg	1	
PERSERIS INJ 90MG	3	
PERSERIS INJ 120MG	3	
RISPERDAL INJ 12.5MG	3	
RISPERDAL INJ 25MG	3	
RISPERDAL INJ 37.5MG	3	
RISPERDAL INJ 50MG	3	
RISPERDAL SOL 1MG/ML	3	
RISPERDAL TAB 0.5MG	3	
RISPERDAL TAB 1MG	3	
RISPERDAL TAB 2MG	3	
RISPERDAL TAB 3MG	3	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
clozapine orally disintegrating tab 12.5 mg	1	
clozapine orally disintegrating tab 25 mg	1	
clozapine orally disintegrating tab 100 mg	1	
clozapine orally disintegrating tab 150 mg	1	
clozapine orally disintegrating tab 200 mg	1	
clozapine tab 25 mg	1	
clozapine tab 50 mg	1	
clozapine tab 100 mg	1	
clozapine tab 200 mg	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	
CLOZARIL TAB 200MG	3	
loxapine succinate cap 5 mg	1	
loxapine succinate cap 10 mg	1	
loxapine succinate cap 25 mg	1	
loxapine succinate cap 50 mg	1	
olanzapine for im inj 10 mg	1	
olanzapine orally disintegrating tab 5 mg	1	
olanzapine orally disintegrating tab 10 mg	1	
olanzapine orally disintegrating tab 15 mg	1	
olanzapine orally disintegrating tab 20 mg	1	
olanzapine tab 2.5 mg	1	
olanzapine tab 5 mg	1	
olanzapine tab 7.5 mg	1	
olanzapine tab 10 mg	1	
olanzapine tab 15 mg	1	
olanzapine tab 20 mg	1	
quetiapine fumarate tab 25 mg	1	
quetiapine fumarate tab 50 mg	1	
quetiapine fumarate tab 100 mg	1	
quetiapine fumarate tab 200 mg	1	
quetiapine fumarate tab 300 mg	1	
quetiapine fumarate tab 400 mg	1	
quetiapine fumarate tab er 24hr 50 mg	1	
quetiapine fumarate tab er 24hr 150 mg	1	
quetiapine fumarate tab er 24hr 200 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
quetiapine fumarate tab er 24hr 300 mg	1	
quetiapine fumarate tab er 24hr 400 mg	1	
SAPHRIS SUB 2.5MG	3	
SAPHRIS SUB 5MG	3	
SAPHRIS SUB 10MG	3	
SECUADO DIS 3.8MG	3	
SECUADO DIS 5.7MG	3	
SECUADO DIS 7.6MG	3	
SEROQUEL TAB 25MG	3	
SEROQUEL TAB 50MG	3	
SEROQUEL TAB 100MG	3	
SEROQUEL TAB 200MG	3	
SEROQUEL TAB 300MG	3	
SEROQUEL TAB 400MG	3	
SEROQUEL XR TAB 50MG	3	
SEROQUEL XR TAB 150MG	3	
SEROQUEL XR TAB 200MG	3	
SEROQUEL XR TAB 300MG	3	
SEROQUEL XR TAB 400MG	3	
VERSACLOZ SUS 50MG/ML	3	
ZYPREXA INJ 10MG	3	
ZYPREXA RELP INJ 210MG	3	
ZYPREXA RELP INJ 300MG	3	
ZYPREXA RELP INJ 405MG	3	
ZYPREXA TAB 2.5MG	3	
ZYPREXA TAB 5MG	3	
ZYPREXA TAB 7.5MG	3	
ZYPREXA TAB 10MG	3	
ZYPREXA TAB 15MG	3	
ZYPREXA TAB 20MG	3	
ZYPREXA ZYDI TAB 5MG	3	
ZYPREXA ZYDI TAB 10MG	3	
ZYPREXA ZYDI TAB 15MG	3	
ZYPREXA ZYDI TAB 20MG	3	
DIHYDROINDOLONES		
molindone hcl tab 5 mg	1	
molindone hcl tab 10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
molindone hcl tab 25 mg	1	
PHENOTHIAZINES		
CHLORPROMAZINE HCL INJ 25 MG/ML	1	
CHLORPROMAZINE HCL INJ 50 MG/2ML	1	
chlorpromazine hcl tab 10 mg	1	
chlorpromazine hcl tab 25 mg	1	
chlorpromazine hcl tab 50 mg	1	
chlorpromazine hcl tab 100 mg	1	
chlorpromazine hcl tab 200 mg	1	
fluphenazine decanoate inj 25 mg/ml	1	
fluphenazine hcl elixir 2.5 mg/5ml	1	
fluphenazine hcl inj 2.5 mg/ml	1	
fluphenazine hcl oral conc 5 mg/ml	1	
fluphenazine hcl tab 1 mg	1	
fluphenazine hcl tab 2.5 mg	1	
fluphenazine hcl tab 5 mg	1	
fluphenazine hcl tab 10 mg	1	
perphenazine tab 2 mg	1	
perphenazine tab 4 mg	1	
perphenazine tab 8 mg	1	
perphenazine tab 16 mg	1	
prochlorperazine edisylate inj 10 mg/2ml	1	
prochlorperazine edisylate inj 50 mg/10ml	1	
prochlorperazine maleate tab 5 mg (base equivalent)	1	
prochlorperazine maleate tab 10 mg (base equivalent)	1	
prochlorperazine suppos 25 mg	1	
thioridazine hcl tab 10 mg	1	
thioridazine hcl tab 25 mg	1	
thioridazine hcl tab 50 mg	1	
thioridazine hcl tab 100 mg	1	
trifluoperazine hcl tab 1 mg (base equivalent)	1	
trifluoperazine hcl tab 2 mg (base equivalent)	1	

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

Drug Name	Drug Tier	Requirements/Limits
trifluoperazine hcl tab 5 mg (base equivalent)	1	
trifluoperazine hcl tab 10 mg (base equivalent)	1	
QUINOLINONE DERIVATIVES		
ABILIFY MAIN INJ 300MG	2	
ABILIFY MAIN INJ 400MG	2	
ABILIFY MYCI TAB 2MG	3	
ABILIFY MYCI TAB 2MG MANT	3	
ABILIFY MYCI TAB 2MG STRT	3	
ABILIFY MYCI TAB 5MG	3	
ABILIFY MYCI TAB 5MG MANT	3	
ABILIFY MYCI TAB 5MG STRT	3	
ABILIFY MYCI TAB 10MG	3	
ABILIFY MYCI TAB 10MG MNT	3	
ABILIFY MYCI TAB 10MG STR	3	
ABILIFY MYCI TAB 15MG	3	
ABILIFY MYCI TAB 15MG MNT	3	
ABILIFY MYCI TAB 15MG STR	3	
ABILIFY MYCI TAB 20MG	3	
ABILIFY MYCI TAB 20MG MNT	3	
ABILIFY MYCI TAB 20MG STR	3	
ABILIFY MYCI TAB 30MG	3	
ABILIFY MYCI TAB 30MG MNT	3	
ABILIFY MYCI TAB 30MG STR	3	
ABILIFY TAB 2MG	3	
ABILIFY TAB 5MG	3	
ABILIFY TAB 10MG	3	
ABILIFY TAB 15MG	3	
ABILIFY TAB 20MG	3	
ABILIFY TAB 30MG	3	
aripiprazole oral solution 1 mg/ml	1	
aripiprazole orally disintegrating tab 10 mg	1	
aripiprazole orally disintegrating tab 15 mg	1	
aripiprazole tab 2 mg	1	
aripiprazole tab 5 mg	1	
aripiprazole tab 10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
aripiprazole tab 15 mg	1	
aripiprazole tab 20 mg	1	
aripiprazole tab 30 mg	1	
ARISTADA INJ 441MG/1.	2	
ARISTADA INJ 662MG/2	2	
ARISTADA INJ 882MG/3	2	
ARISTADA INJ 1064MG	2	QL (23.077 injections every year)
ARISTADA INJ INITIO	2	
REXULTI TAB 0.5MG	3	
REXULTI TAB 0.25MG	3	
REXULTI TAB 1MG	3	
REXULTI TAB 2MG	3	
REXULTI TAB 3MG	3	
REXULTI TAB 4MG	3	
THIOXANTHENES		
thiothixene cap 1 mg	1	
thiothixene cap 2 mg	1	
thiothixene cap 5 mg	1	
thiothixene cap 10 mg	1	
ANTISEPTICS & DISINFECTANTS		
ANTISEPTICS & DISINFECTANTS		
formaldehyde solution 10%	1	
GLUTARALDEHY SOL 25%	3	
hydrogen peroxide soln 30%	1	
CHLORINE ANTISEPTICS		
BENZALKONIUM SOL NF	3	
CHLORHEX GLU SOL 20%	3	
ANTIVIRALS		
ANTIRETROVIRALS		
abacavir sulfate soln 20 mg/ml (base equiv)	1	QL (900 ML PER 30 DAYS)
abacavir sulfate tab 300 mg (base equiv)	1	QL (60 TABLETS PER 30 DAYS)
abacavir sulfate-lamivudine tab 600-300 mg	1	QL (30 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg	1	QL (60 TABLETS PER 30 DAYS)
APTIVUS CAP 250MG	3	QL (120 CAPSULES PER 30 DAYS)
APTIVUS SOL	3	QL (285 ML PER 28 DAYS)
atazanavir sulfate cap 150 mg (base equiv)	1	QL (30 CAPSULES PER 30 DAYS)
atazanavir sulfate cap 200 mg (base equiv)	1	QL (60 CAPSULES PER 30 DAYS)
atazanavir sulfate cap 300 mg (base equiv)	1	QL (30 CAPSULES PER 30 DAYS)
ATRIPLA TAB	3	QL (30 TABLETS PER 30 DAYS)
BIKTARVY TAB	2	QL (30 TABLETS PER 30 DAYS)
CABENUVA SUS 400-600	3	PA, QL (1 KIT PER MONTH)
CABENUVA SUS 600-900	3	PA, QL (1 KIT PER MONTH)
CIMDUO TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
COMBIVIR TAB 150-300	3	QL (60 TABLETS PER 30 DAYS)
COMPLERA TAB	3	QL (30 TABLETS PER 30 DAYS)
CRIXIVAN CAP 400MG	3	QL (180 CAPSULES PER 30 DAYS)
DELSTRIGO TAB	3	QL (30 TABLETS PER 30 DAYS)
DESCOVY TAB 120-15MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for $0 copay when medically necessary for pre-exposure prophylaxis

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

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

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

Drug Name	Drug Tier	Requirements/Limits
EPIVIR TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
EPIVIR TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
EPZICOM TAB 600-300	3	QL (30 TABLETS PER 30 DAYS)
etravirine tab 100 mg	1	QL (120 TABLETS PER 30 DAYS)
etravirine tab 200 mg	1	QL (60 TABLETS PER 30 DAYS)
EVOTAZ TAB 300-150	2	QL (30 TABLETS PER 30 DAYS)
fosamprenavir calcium tab 700 mg (base equiv)	1	QL (120 TABLETS PER 30 DAYS)
FUZEON INJ 90MG	2	PA, QL (60 VIALS PER 30 DAYS)
GENVOYA TAB	2	QL (30 TABLETS PER 30 DAYS)
INTELENCE TAB 25MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 100MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 200MG	2	QL (60 TABLETS PER 30 DAYS)
INVIRASE TAB 500MG	3	QL (120 TABLETS PER 30 DAYS)
ISENTRESS CHW 25MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS CHW 100MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS HD TAB 600MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS POW 100MG	2	QL (60 PACKETS PER 30 DAYS)
ISENTRESS TAB 400MG	2	QL (120 TABLETS PER 30 DAYS)
JULUCA TAB 50-25MG	3	QL (30 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
KALETRA SOL	3	QL (480 ML PER 30 DAYS)
KALETRA TAB 100-25MG	3	QL (240 TABLETS PER 30 DAYS)
KALETRA TAB 200-50MG	3	QL (120 TABLETS PER 30 DAYS)
lamivudine oral soln 10 mg/ml	1	QL (960 ML PER 30 DAYS)
lamivudine tab 150 mg	1	QL (60 TABLETS PER 30 DAYS)
lamivudine tab 300 mg	1	QL (30 TABLETS PER 30 DAYS)
lamivudine-zidovudine tab 150-300 mg	1	QL (60 TABLETS PER 30 DAYS)
LEXIVA SUS 50MG/ML	3	QL (1575 ML PER 28 DAYS)
LEXIVA TAB 700MG	3	QL (120 TABLETS PER 30 DAYS)
lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)	1	QL (1575 ML PER 28 DAYS)
lopinavir-ritonavir tab 100-25 mg	1	QL (240 TABLETS PER 30 DAYS)
lopinavir-ritonavir tab 200-50 mg	1	QL (120 TABLETS PER 30 DAYS)
nevirapine susp 50 mg/5ml	1	QL (1200 ML PER 30 ML DAYS)
nevirapine tab 200 mg	1	QL (60 TABLETS PER 30 DAYS)
nevirapine tab er 24hr 100 mg	1	QL (90 TABLETS PER 30 DAYS)
nevirapine tab er 24hr 400 mg	1	QL (30 TABLETS PER 30 DAYS)
NORVIR POW 100MG	2	QL (360 PACKETS PER 30 DAYS)
NORVIR SOL 80MG/ML	2	QL (480 ML PER 30 DAYS)
NORVIR TAB 100MG	2	QL (360 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ODEFSEY TAB	2	QL (30 TABLETS PER 30 DAYS)
PIFELTRO TAB 100MG	3	QL (60 TABLETS PER 30 DAYS)
PREZCOBIX TAB 800-150	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA SUS 100MG/ML	2	QL (400 ML PER 30 DAYS)
PREZISTA TAB 75MG	2	QL (300 TABLETS PER 30 DAYS)
PREZISTA TAB 150MG	2	QL (180 TABLETS PER 30 DAYS)
PREZISTA TAB 600MG	2	QL (60 TABLETS PER 30 DAYS)
PREZISTA TAB 800MG	2	QL (30 TABLETS PER 30 DAYS)
RETROVIR CAP 100MG	2	QL (180 CAPSULES PER 30 DAYS)
RETROVIR SYP 50MG/5ML	2	QL (1920 ML PER 30 DAYS)
REYATAZ CAP 150MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ CAP 200MG	3	QL (60 CAPSULES PER 30 DAYS)
REYATAZ CAP 300MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ POW 50MG	3	QL (180 PACKETS PER 30 DAYS)
ritonavir tab 100 mg	1	QL (360 TABLETS PER 30 DAYS)
RUKOBIA TAB 600MG ER	3	QL (60 TABLETS PER 30 DAYS)
SELZENTRY SOL 20MG/ML	3	QL (1840 ML PER 30 days)
SELZENTRY TAB 25MG	3	QL (240 TABLETS PER 30 DAYS)
SELZENTRY TAB 75MG	3	QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
SELZENTRY TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
SELZENTRY TAB 300MG	3	QL (120 TABLETS PER 30 DAYS)
stavudine cap 15 mg	1	QL (60 CAPSULES PER 30 DAYS)
stavudine cap 20 mg	1	QL (60 CAPSULES PER 30 DAYS)
stavudine cap 30 mg	1	QL (60 CAPSULES PER 30 DAYS)
stavudine cap 40 mg	1	QL (60 CAPSULES PER 30 DAYS)
STRIBILD TAB	2	QL (30 TABLETS PER 30 DAYS)
SUSTIVA CAP 50MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA CAP 200MG	3	QL (90 CAPSULES PER 30 DAYS)
SUSTIVA TAB 600MG	3	QL (30 TABLETS PER 30 DAYS)
SYMFI LO TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMFI TAB	3	QL (30 TABLETS PER 30 DAYS)
SYMTUZA TAB	2	QL (30 TABLETS PER 30 DAYS)
TEMIXYS TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
tenofovir disoproxil fumarate tab 300 mg	1	QL (30 TABLETS PER 30 DAYS)
TIVICAY PD TAB 5MG	2	QL (360 TABLETS PER 30 DAYS)
TIVICAY TAB 10MG	2	QL (240 TABLETS PER 30 DAYS)
TIVICAY TAB 25MG	2	QL (60 TABLETS PER 30 DAYS)
TIVICAY TAB 50MG	2	QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
TRIUMEQ PD TAB	2	QL (180 tablets per 30 days)
TRIUMEQ TAB	2	QL (30 TABLETS PER 30 DAYS)
TRIZIVIR TAB	3	QL (60 TABLETS PER 30 DAYS)
TRUVADA TAB 100-150	3	QL (30 TABLETS PER 30 DAYS)
TRUVADA TAB 133-200	3	QL (30 TABLETS PER 30 DAYS)
TRUVADA TAB 167-250	3	QL (30 TABLETS PER 30 DAYS)
TRUVADA TAB 200-300	3	QL (30 TABLETS PER 30 DAYS)
TYBOST TAB 150MG	3	QL (30 TABLETS PER 30 DAYS)
VIRACEPT TAB 250MG	3	QL (300 TABLETS PER 30 DAYS)
VIRACEPT TAB 625MG	3	QL (120 TABLETS PER 30 DAYS)
VIRAMUNE SUS 50MG/5ML	3	QL (1200 ML PER 30 ML DAYS)
VIRAMUNE XR TAB 400MG	3	QL (30 TABLETS PER 30 DAYS)
VIREAD POW 40MG/GM	2	QL (240 GM PER 30 DAYS)
VIREAD TAB 150MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 200MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 250MG	2	QL (30 TABLETS PER 30 DAYS)
VIREAD TAB 300MG	2	QL (30 TABLETS PER 30 DAYS)
ZIAGEN SOL 20MG/ML	3	QL (900 ML PER 30 DAYS)
ZIAGEN TAB 300MG	3	QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
zidovudine cap 100 mg	1	QL (180 CAPSULES PER 30 DAYS)
zidovudine syrup 10 mg/ml	1	QL (1920 ML PER 30 DAYS)
zidovudine tab 300 mg	1	QL (60 TABLETS PER 30 DAYS)
ANTIVIRAL COMBINATIONS		
PAXLOVID TAB 150-100	3	QL (40 tablets per 30 days)
PAXLOVID TAB 300-100	3	QL (60 tablets per 30 days)
CMV AGENTS		
PREVYMIS TAB 240MG	3	
PREVYMIS TAB 480MG	3	
VALCYTE SOL 50MG/ML	3	QL (1000 ML PER 30 DAYS)
VALCYTE TAB 450MG	3	QL (120 tablets for 30 days)
valganciclovir hcl for soln 50 mg/ml (base equiv)	1	QL (1000 ML PER 30 DAYS)
valganciclovir hcl tab 450 mg (base equivalent)	1	QL (120 tablets for 30 days)
HEPATITIS AGENTS		
adefovir dipivoxil tab 10 mg	1	
BARACLUDE SOL	2	QL (630 ml per 30 days)
BARACLUDE TAB 0.5MG	3	QL (30 tabs per 30 days)
BARACLUDE TAB 1MG	3	QL (30 tabs per 30 days)
entecavir tab 0.5 mg	1	QL (30 tabs per 30 days)
entecavir tab 1 mg	1	QL (30 tabs per 30 days)
EPCLUSA PAK 150-37.5	2	PA, QL (28 packs per 28 days); Genotypes 1, 2, 3, 4, 5, 6

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

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA PAK 200-50MG	2	PA, QL (28 packs per 28 days); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 200-50MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPCLUSA TAB 400-100	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 2, 3, 4, 5, 6
EPIVIR HBV SOL 5MG/ML	3	
EPIVIR HBV TAB 100MG	3	
HARVONI PAK	2	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5 ,6
HARVONI PAK 45-200MG	2	PA, QL (28 PELLETS PER 28 DAYS); Genotypes 1, 4, 5 ,6
HARVONI TAB 45-200MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5 ,6
HARVONI TAB 90-400MG	2	PA, QL (28 TABLETS PER 28 DAYS); Genotypes 1, 4, 5 ,6
HEPSERA TAB 10MG	3	
lamivudine tab 100 mg (hbv)	1	
MAVYRET PAK 50-20MG	3	PA, QL (140 pkts per 28 days)
MAVYRET TAB 100-40MG	3	PA, QL (84 TABLETS PER 28 DAYS)
PEGASYS INJ	2	PA, QL (4 Injections per Month)
PEGASYS INJ 180MCG/M	2	PA, QL (4 Injections per Month)
PEGINTRON KIT 50MCG	3	PA
ribavirin cap 200 mg	1	PA
ribavirin tab 200 mg	1	PA
SOVALDI PAK 150MG	3	PA, QL (28 PELLETS PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
SOVALDI PAK 200MG	3	PA, QL (28 PELLETS PER 28 DAYS)
SOVALDI TAB 200MG	3	PA, QL (28 TABLETS PER 28 DAYS)
SOVALDI TAB 400MG	3	PA, QL (28 TABLETS PER 28 DAYS)
VEMLIDY TAB 25MG	2	QL (30 TABLETS PER 30 DAYS)
VIEKIRA PAK TAB	3	PA, QL (112 TABLETS PER 28 DAYS); MNPA
VOSEVI TAB	2	PA, QL (28 TABLETS PER 28 DAYS); For use in patients previously treated with an HCV regimen containing an NS5A inhibitor (for genotypes 1-6) or sofosbuvir without an NS5A inhibitor (for genotypes 1a or 3)
ZEPATIER TAB 50-100MG	3	PA, QL (28 TABLETS PER 28 DAYS)
HERPES AGENTS		
acyclovir cap 200 mg	1	
acyclovir susp 200 mg/5ml	1	
acyclovir tab 400 mg	1	
acyclovir tab 800 mg	1	
famciclovir tab 125 mg	1	
famciclovir tab 250 mg	1	
famciclovir tab 500 mg	1	
SITAVIG TAB 50MG	3	
valacyclovir hcl tab 1 gm	1	
valacyclovir hcl tab 500 mg	1	
VALTREX TAB 1GM	3	
VALTREX TAB 500MG	3	
ZOVIRAX SUS 200/5ML	3	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
COREG CR CAP 10MG	3	
COREG CR CAP 20MG	3	
COREG CR CAP 40MG	3	
COREG CR CAP 80MG	3	
COREG TAB 3.125MG	3	
COREG TAB 6.25MG	3	
COREG TAB 12.5MG	3	
COREG TAB 25MG	3	
labetalol hcl tab 100 mg	1	
labetalol hcl tab 200 mg	1	
labetalol hcl tab 300 mg	1	
BETA BLOCKERS CARDIO-SELECTIVE		
acebutolol hcl cap 200 mg	1	
acebutolol hcl cap 400 mg	1	
atenolol tab 25 mg	1	
atenolol tab 50 mg	1	
atenolol tab 100 mg	1	
betaxolol hcl tab 10 mg	1	
betaxolol hcl tab 20 mg	1	
bisoprolol fumarate tab 5 mg	1	
bisoprolol fumarate tab 10 mg	1	
BYSTOLIC TAB 2.5MG	3	
BYSTOLIC TAB 5MG	3	
BYSTOLIC TAB 10MG	3	
BYSTOLIC TAB 20MG	3	
KAPSPARGO CAP 25MG	3	
KAPSPARGO CAP 50MG	3	
KAPSPARGO CAP 100MG	3	
KAPSPARGO CAP 200MG	3	
LOPRESSOR TAB 50MG	3	
LOPRESSOR TAB 100MG	3	
metoprolol succinate tab er 24hr 25 mg (tartrate equiv)	1	
metoprolol succinate tab er 24hr 50 mg (tartrate equiv)	1	
metoprolol succinate tab er 24hr 100 mg (tartrate equiv)	1	

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

Drug Name	Drug Tier	Requirements/Limits
metoprolol succinate tab er 24hr 200 mg (tartrate equiv)	1	
metoprolol tartrate tab 25 mg	1	
metoprolol tartrate tab 37.5 mg	1	
metoprolol tartrate tab 50 mg	1	
metoprolol tartrate tab 75 mg	1	
metoprolol tartrate tab 100 mg	1	
nebivolol hcl tab 2.5 mg (base equivalent)	1	
nebivolol hcl tab 5 mg (base equivalent)	1	
nebivolol hcl tab 10 mg (base equivalent)	1	
nebivolol hcl tab 20 mg (base equivalent)	1	
TENORMIN TAB 25MG	3	
TENORMIN TAB 50MG	3	
TENORMIN TAB 100MG	3	
TOPROL XL TAB 25MG	3	
TOPROL XL TAB 50MG	3	
TOPROL XL TAB 100MG	3	
TOPROL XL TAB 200MG	3	
BETA BLOCKERS NON-SELECTIVE		
BETAPACE AF TAB 80MG	3	PA; MNPA
BETAPACE AF TAB 120MG	3	PA; MNPA
BETAPACE AF TAB 160MG	3	PA; MNPA
BETAPACE TAB 80MG	3	PA; MNPA
BETAPACE TAB 120MG	3	PA; MNPA
BETAPACE TAB 160MG	3	PA; MNPA
CORGARD TAB 20MG	3	
CORGARD TAB 40MG	3	
CORGARD TAB 80MG	3	
HEMANGEOL SOL 4.28/ML	3	
INDERAL LA CAP 60MG	3	
INDERAL LA CAP 80MG	3	
INDERAL LA CAP 120MG	3	
INDERAL LA CAP 160MG	3	
INDERAL XL CAP 80MG	3	
INDERAL XL CAP 120MG	3	
INNOPRAN XL CAP 80MG	3	
INNOPRAN XL CAP 120MG	3	

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

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

CALCIUM CHANNEL BLOCKERS

CALCIUM CHANNEL BLOCKER COMBINATIONS

CONSENSI TAB 2.5-200	3	PA; MNPA
CONSENSI TAB 5-200MG	3	PA; MNPA
CONSENSI TAB 10-200MG	3	PA; MNPA

CALCIUM CHANNEL BLOCKERS

amlodipine besylate tab 2.5 mg (base equivalent)	1	
amlodipine besylate tab 5 mg (base equivalent)	1	

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

Drug Name	Drug Tier	Requirements/Limits
amlodipine besylate tab 10 mg (base equivalent)	1	
CALAN SR TAB 120MG	3	
CALAN SR TAB 180MG	3	
CALAN SR TAB 240MG	3	
CARDIZEM CD CAP 120MG/24	3	
CARDIZEM CD CAP 180MG/24	3	
CARDIZEM CD CAP 240MG/24	3	
CARDIZEM CD CAP 300MG/24	3	
CARDIZEM CD CAP 360MG/24	3	
CARDIZEM LA TAB 120MG	3	
CARDIZEM LA TAB 180MG	3	
CARDIZEM LA TAB 240MG	3	
CARDIZEM LA TAB 300MG/24	3	
CARDIZEM LA TAB 360MG	3	
CARDIZEM LA TAB 420MG/24	3	
CARDIZEM TAB 30MG	3	
CARDIZEM TAB 60MG	3	
CARDIZEM TAB 120MG	3	
CONJUPRI TAB 2.5MG	3	
CONJUPRI TAB 5MG	3	
diltiazem hcl cap er 12hr 60 mg	1	
diltiazem hcl cap er 12hr 90 mg	1	
diltiazem hcl cap er 12hr 120 mg	1	
diltiazem hcl cap er 24hr 120 mg	1	
diltiazem hcl cap er 24hr 180 mg	1	
diltiazem hcl cap er 24hr 240 mg	1	
diltiazem hcl coated beads cap er 24hr 120 mg	1	
diltiazem hcl coated beads cap er 24hr 180 mg	1	
diltiazem hcl coated beads cap er 24hr 240 mg	1	
diltiazem hcl coated beads cap er 24hr 300 mg	1	
diltiazem hcl coated beads cap er 24hr 360 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
diltiazem hcl coated beads tab er 24hr 180 mg	1	
diltiazem hcl coated beads tab er 24hr 240 mg	1	
diltiazem hcl coated beads tab er 24hr 300 mg	1	
diltiazem hcl coated beads tab er 24hr 360 mg	1	
diltiazem hcl coated beads tab er 24hr 420 mg	1	
diltiazem hcl extended release beads cap er 24hr 120 mg	1	
diltiazem hcl extended release beads cap er 24hr 180 mg	1	
diltiazem hcl extended release beads cap er 24hr 240 mg	1	
diltiazem hcl extended release beads cap er 24hr 300 mg	1	
diltiazem hcl extended release beads cap er 24hr 360 mg	1	
diltiazem hcl extended release beads cap er 24hr 420 mg	1	
diltiazem hcl tab 30 mg	1	
diltiazem hcl tab 60 mg	1	
diltiazem hcl tab 90 mg	1	
diltiazem hcl tab 120 mg	1	
felodipine tab er 24hr 2.5 mg	1	
felodipine tab er 24hr 5 mg	1	
felodipine tab er 24hr 10 mg	1	
isradipine cap 2.5 mg	1	
isradipine cap 5 mg	1	
KATERZIA SUS 1MG/ML	3	
nicardipine hcl cap 20 mg	1	
nicardipine hcl cap 30 mg	1	
nifedipine cap 10 mg	1	
nifedipine cap 20 mg	1	
nifedipine tab er 24hr 30 mg	1	
nifedipine tab er 24hr 60 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
nifedipine tab er 24hr 90 mg	1	
nifedipine tab er 24hr osmotic release 30 mg	1	
nifedipine tab er 24hr osmotic release 60 mg	1	
nifedipine tab er 24hr osmotic release 90 mg	1	
nimodipine cap 30 mg	1	
nisoldipine tab er 24hr 8.5 mg	1	
nisoldipine tab er 24hr 17 mg	1	
nisoldipine tab er 24hr 20 mg	1	
nisoldipine tab er 24hr 25.5 mg	1	
nisoldipine tab er 24hr 30 mg	1	
nisoldipine tab er 24hr 34 mg	1	
nisoldipine tab er 24hr 40 mg	1	
NORLIQVA SOL 1MG/ML	3	
NORVASC TAB 2.5MG	3	
NORVASC TAB 5MG	3	
NORVASC TAB 10MG	3	
NYMALIZE SOL	3	
PROCARDIA CAP 10MG	3	
PROCARDIA XL TAB 30MG CR	3	
PROCARDIA XL TAB 60MG CR	3	
PROCARDIA XL TAB 90MG CR	3	
SULAR TAB 8.5MG	3	
SULAR TAB 17MG	3	
SULAR TAB 34MG	3	
TIAZAC CAP 120MG/24	3	
TIAZAC CAP 180MG/24	3	
TIAZAC CAP 240MG/24	3	
TIAZAC CAP 300MG/24	3	
TIAZAC CAP 360MG/24	3	
TIAZAC CAP 420MG/24	3	
verapamil hcl cap er 24hr 100 mg	1	
verapamil hcl cap er 24hr 120 mg	1	
verapamil hcl cap er 24hr 180 mg	1	
verapamil hcl cap er 24hr 200 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
verapamil hcl cap er 24hr 240 mg	1	
verapamil hcl cap er 24hr 300 mg	1	
verapamil hcl cap er 24hr 360 mg	1	
verapamil hcl tab 40 mg	1	
verapamil hcl tab 80 mg	1	
verapamil hcl tab 120 mg	1	
verapamil hcl tab er 120 mg	1	
verapamil hcl tab er 180 mg	1	
verapamil hcl tab er 240 mg	1	
VERELAN CAP 120MG SR	3	
VERELAN CAP 180MG SR	3	
VERELAN CAP 240MG SR	3	
VERELAN CAP 360MG SR	3	
VERELAN PM CAP 100MG ER	3	
VERELAN PM CAP 200MG ER	3	
VERELAN PM CAP 300MG ER	3	
CARDIOTONICS		
CARDIAC GLYCOSIDES		
digoxin oral soln 0.05 mg/ml	1	
digoxin tab 125 mcg (0.125 mg)	1	
digoxin tab 250 mcg (0.25 mg)	1	
LANOXIN TAB 0.25MG	3	PA; MNPA
LANOXIN TAB 0.125MG	3	PA; MNPA
LANOXIN TAB 0.0625MG	3	
CARDIOVASCULAR AGENTS - MISC.		
CARDIAC MYOSIN INHIBITORS		
CAMZYOS CAP 2.5MG	3	PA, QL (30 capsules per 30 days)
CAMZYOS CAP 5MG	3	PA, QL (30 capsules per 30 days)
CAMZYOS CAP 10MG	3	PA, QL (30 capsules per 30 days)
CAMZYOS CAP 15MG	3	PA, QL (30 capsules per 30 days)
CARDIOVASCULAR AGENTS MISC. - COMBINATIONS		
amlodipine besylate-atorvastatin calcium tab 2.5-10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
amlodipine besylate-atorvastatin calcium tab 2.5-20 mg	1	
amlodipine besylate-atorvastatin calcium tab 2.5-40 mg	1	
amlodipine besylate-atorvastatin calcium tab 5-10 mg	1	
amlodipine besylate-atorvastatin calcium tab 5-20 mg	1	
amlodipine besylate-atorvastatin calcium tab 5-40 mg	1	
amlodipine besylate-atorvastatin calcium tab 5-80 mg	1	
amlodipine besylate-atorvastatin calcium tab 10-10 mg	1	
amlodipine besylate-atorvastatin calcium tab 10-20 mg	1	
amlodipine besylate-atorvastatin calcium tab 10-40 mg	1	
amlodipine besylate-atorvastatin calcium tab 10-80 mg	1	
BIDIL TAB	2	
CADUET TAB 5-10MG	3	
CADUET TAB 5-20MG	3	
CADUET TAB 5-40MG	3	
CADUET TAB 5-80MG	3	
CADUET TAB 10-10MG	3	
CADUET TAB 10-20MG	3	
CADUET TAB 10-40MG	3	
CADUET TAB 10-80MG	3	
ENTRESTO TAB 24-26MG	2	
ENTRESTO TAB 49-51MG	2	
ENTRESTO TAB 97-103MG	2	
IMPOTENCE AGENTS		
CAVERJECT IM KIT 10MCG	3	QL (6 UNITS PER MONTH); Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
CAVERJECT INJ 40MCG	3	QL (6 per month); Coverage is subject to your plan/benefits
CAVERJECT KIT 20MCG	3	QL (6 UNITS PER MONTH); Coverage is subject to your plan/benefits
CIALIS TAB 2.5MG	3	ST, QL (30 tabs per month); Coverage is subject to your plan/benefits
CIALIS TAB 5MG	3	ST, QL (30 tabs per month); Coverage is subject to your plan/benefits
CIALIS TAB 10MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
CIALIS TAB 20MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
EDEX KIT 10MCG	3	QL (6 UNITS PER MONTH); Coverage is subject to your plan/benefits
EDEX KIT 20MCG	3	QL (6 UNITS PER MONTH); Coverage is subject to your plan/benefits
EDEX KIT 40MCG	3	QL (6 UNITS PER MONTH); Coverage is subject to your plan/benefits
LEVITRA TAB 10MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
LEVITRA TAB 20MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
MUSE SUP 125MCG	2	QL (6 PELLETS PER MONTH); Coverage is subject to your plan/benefits
MUSE SUP 250MCG	2	QL (6 PELLETS PER MONTH); Coverage is subject to your plan/benefits
MUSE SUP 500MCG	2	QL (6 PELLETS PER MONTH); Coverage is subject to your plan/benefits
MUSE SUP 1000MCG	2	QL (6 PELLETS PER MONTH); Coverage is subject to your plan/benefits
sildenafil citrate tab 25 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
sildenafil citrate tab 50 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
sildenafil citrate tab 100 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
STAXYN TAB 10MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
STENDRA TAB 50MG	3	PA, QL (6 tabs per month); MNPA; Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
STENDRA TAB 100MG	3	PA, QL (6 tabs per month); MNPA; Coverage is subject to your plan/benefits
STENDRA TAB 200MG	3	PA, QL (6 tabs per month); MNPA; Coverage is subject to your plan/benefits
tadalafil tab 2.5 mg	1	ST, QL (30 tabs per month); Coverage is subject to your plan/benefits
tadalafil tab 5 mg	1	ST, QL (30 tabs per month); Coverage is subject to your plan/benefits
tadalafil tab 10 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
tadalafil tab 20 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
vardenafil hcl orally disintegrating tab 10 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
vardenafil hcl tab 2.5 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
vardenafil hcl tab 5 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
vardenafil hcl tab 10 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
vardenafil hcl tab 20 mg	1	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
VIAGRA TAB 25MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
VIAGRA TAB 50MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
VIAGRA TAB 100MG	3	QL (6 TABS PER MONTH); Coverage is subject to your plan/benefits
PROSTAGLANDIN VASODILATORS		
ORENITRAM TAB 0.25MG	2	PA
ORENITRAM TAB 0.125MG	2	PA
ORENITRAM TAB 1MG	2	PA
ORENITRAM TAB 2.5MG	2	PA
ORENITRAM TAB 5MG	2	PA
TYVASO DPI POW 16-32-48	3	PA, QL (252 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 16-32MCG	3	PA, QL (196 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 16MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 32-48MCG	3	PA, QL (224 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 32MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
TYVASO DPI POW 48MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS)
TYVASO DPI POW 64MCG	3	PA, QL (112 CARTRIDGES PER 28 DAYS)
TYVASO REFIL SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
TYVASO START SOL 0.6MG/ML	3	PA, QL (28 AMPULES PER 28 DAYS)
VENTAVIS SOL 10MCG/ML	3	PA, QL (270 AMPULES PER 30 DAYS)
VENTAVIS SOL 20MCG/ML	3	PA, QL (270 AMPULES PER 30 DAYS)
PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS		
ambrisentan tab 5 mg	1	PA, QL (30 TABLETS PER 30 DAYS)
ambrisentan tab 10 mg	1	PA, QL (30 TABLETS PER 30 DAYS)
bosentan tab 62.5 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
bosentan tab 125 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
LETAIRIS TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
LETAIRIS TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OPSUMIT TAB 10MG	2	PA, QL (30 TABLETS PER 30 DAYS)
TRACLEER TAB 32MG	3	PA, QL (112 TABLETS PER 28 DAYS)
TRACLEER TAB 62.5MG	3	PA, QL (60 TABLETS PER 30 DAYS)
TRACLEER TAB 125MG	3	PA, QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS		
ADCIRCA TAB 20MG	3	PA, QL (60 TABLETS PER 30 DAYS)
REVATIO SUS 10MG/ML	3	PA, QL (224 ML PER 30 DAYS)
REVATIO TAB 20MG	3	PA, QL (90 TABLETS PER 30 DAYS)
sildenafil citrate for suspension 10 mg/ml	1	PA, QL (224 ML PER 30 DAYS)
sildenafil citrate tab 20 mg	1	PA, QL (90 TABLETS PER 30 DAYS)
tadalafil tab 20 mg (pah)	1	PA, QL (60 TABLETS PER 30 DAYS)
TADLIQ SUS 20MG/5ML	3	PA, QL (300 ML PER 30 DAYS)
PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST		
UPTRAVI	2	PA, QL (1 PACK EVERY 28 DAYS)
UPTRAVI TAB 200MCG	2	PA, QL (140 TABLETS PER 28 DAYS)
UPTRAVI TAB 400MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 600MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 800MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1000MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1200MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1400MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
UPTRAVI TAB 1600MCG	2	PA, QL (60 TABLETS PER 30 DAYS)
PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR		
ADEMPAS TAB 0.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ADEMPAS TAB 1.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 2MG	2	PA, QL (90 TABLETS PER 30 DAYS)
SINUS NODE INHIBITORS		
CORLANOR SOL 5MG/5ML	3	
CORLANOR TAB 5MG	2	
CORLANOR TAB 7.5MG	2	
TRANSTHYRETIN STABILIZERS		
VYNDAMAX CAP 61MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
VYNDAQEL CAP 20MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC)		
VERQUVO TAB 2.5MG	2	
VERQUVO TAB 5MG	2	
VERQUVO TAB 10MG	2	
CEPHALOSPORINS		
CEPHALOSPORINS - 1ST GENERATION		
cefadroxil cap 500 mg	1	
cefadroxil for susp 250 mg/5ml	1	
cefadroxil for susp 500 mg/5ml	1	
cefadroxil tab 1 gm	1	
cephalexin cap 250 mg	1	
cephalexin cap 500 mg	1	
cephalexin cap 750 mg	1	
cephalexin for susp 125 mg/5ml	1	
cephalexin for susp 250 mg/5ml	1	
cephalexin tab 250 mg	1	
cephalexin tab 500 mg	1	
KEFLEX CAP 750MG	3	
CEPHALOSPORINS - 2ND GENERATION		
cefaclor cap 250 mg	1	

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

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

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

Drug Name	Drug Tier	Requirements/Limits
desogestrel & ethinyl estradiol tab 0.15 mg-30 mcg	0	
drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg	0	
drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg	0	
drospirenone-ethinyl estradiol tab 3-0.02 mg	0	
drospirenone-ethinyl estradiol tab 3-0.03 mg	0	
ESTROSTEP FE TAB	0	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-35 mcg	0	
ethynodiol diacetate & ethinyl estradiol tab 1 mg-50 mcg	0	
GENERESS FE CHW	0	
levonor-eth est tab 0.15-0.02/0.025/0.03 mg &eth est 0.01 mg	0	
levonorg-eth est tab 0.1-0.02mg(84) & eth est tab 0.01mg(7)	0	
levonorg-eth est tab 0.15-0.03mg(84) & eth est tab 0.01mg(7)	0	
levonorgestrel & ethinyl estradiol (91-day) tab 0.15-0.03 mg	0	
levonorgestrel & ethinyl estradiol tab 0.1 mg-20 mcg	0	
levonorgestrel & ethinyl estradiol tab 0.15 mg-30 mcg	0	
levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg	0	
levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg	0	
LO LOESTRIN TAB 1-10-10	0	
LOSEASONIQUE TAB	0	
MINASTRIN 24 CHW FE	0	
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	
norethindrone & ethinyl estradiol tab 0.4 mg-35 mcg	0	

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

Drug Name	Drug Tier	Requirements/Limits
norethindrone & ethinyl estradiol tab 0.5 mg-35 mcg	0	
norethindrone & ethinyl estradiol tab 1 mg-35 mcg	0	
norethindrone & ethinyl estradiol-fe chew tab 0.4 mg-35 mcg	0	
norethindrone & ethinyl estradiol-fe chew tab 0.8 mg-25 mcg	0	
norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg	0	
norethindrone ace & ethinyl estradiol tab 1 mg-20 mcg	0	
NORETHINDRONE ACE & ETHINYL ESTRADIOL TAB 1 MG-20 MCG	0	
norethindrone ace & ethinyl estradiol tab 1.5 mg-30 mcg	0	
NORETHINDRONE ACE & ETHINYL ESTRADIOL TAB 1.5 MG-30 MCG	0	
norethindrone ace & ethinyl estradiol-fe tab 1 mg-20 mcg	0	
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TAB 1 MG-20 MCG	0	
norethindrone ace & ethinyl estradiol-fe tab 1.5 mg-30 mcg	0	
NORETHINDRONE ACE & ETHINYL ESTRADIOL-FE TAB 1.5 MG-30 MCG	0	
norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)	0	
norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)	0	
norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)	0	
norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg	0	
norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg	0	
norgestimate & ethinyl estradiol tab 0.25 mg-35 mcg	0	

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

Drug Name	Drug Tier	Requirements/Limits
norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg	0	
norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg	0	
norgestrel & ethinyl estradiol tab 0.3 mg-30 mcg	0	
QUARTETTE TAB	0	
SAFYRAL TAB	0	
SEASONIQUE TAB	0	PA; MNPA
TAYTULLA CAP 1MG/20MC	3	
TYBLUME CHW 0.1-0.02	0	
YASMIN 28 TAB 3-0.03MG	0	
YAZ TAB 3-0.02MG	0	
COMBINATION CONTRACEPTIVES - TRANSDERMAL		
norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr	0	
TWIRLA DIS 120-30	0	
COMBINATION CONTRACEPTIVES - VAGINAL		
ANNOVERA MIS	0	QL (1 ring every 300 days)
etonogestrel-ethinyl estradiol va ring 0.120-0.015 mg/24hr	0	QL (13 rings every 300 days)
NUVARING MIS	0	QL (13 rings every 300 days)
EMERGENCY CONTRACEPTIVES		
ELLA TAB 30MG	0	
levonorgestrel tab 1.5 mg	0	
PROGESTIN CONTRACEPTIVES - INJECTABLE		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
DEPO-PROVERA INJ 150MG/ML	0	QL (4 injections every 300 days)
DEPO-SQ PROV INJ 104	0	QL (6 injections every 300 days)
medroxyprogesterone acetate im susp 150 mg/ml	0	QL (1 injection every 59 days)
medroxyprogesterone acetate im susp prefilled syr 150 mg/ml	0	QL (4 injections every 300 days)

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

Drug Name	Drug Tier	Requirements/Limits
PROGESTIN CONTRACEPTIVES - ORAL		
norethindrone tab 0.35 mg	0	
ORTHO MICRON TAB 0.35MG	0	
SLYND TAB 4MG	0	
CORTICOSTEROIDS		
GLUCOCORTICOSTEROIDS		
ALKINDI SPRI CAP 0.5MG	3	
ALKINDI SPRI CAP 1MG	3	
ALKINDI SPRI CAP 2MG	3	
ALKINDI SPRI CAP 5MG	3	
budesonide delayed release particles cap 3 mg	1	
budesonide tab er 24hr 9 mg	1	
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	3	
DEXABLISS TAB 1.5MG	3	
DEXAMETHASON CON 1MG/ML	3	
dexamethasone elixir 0.5 mg/5ml	1	
dexamethasone soln 0.5 mg/5ml	1	
dexamethasone tab 0.5 mg	1	
dexamethasone tab 0.75 mg	1	
dexamethasone tab 1 mg	1	
dexamethasone tab 1.5 mg	1	
dexamethasone tab 2 mg	1	
dexamethasone tab 4 mg	1	
dexamethasone tab 6 mg	1	
dexamethasone tab therapy pack 1.5 mg (21)	1	
dexamethasone tab therapy pack 1.5 mg (27)	1	
dexamethasone tab therapy pack 1.5 mg (35)	1	
dexamethasone tab therapy pack 1.5 mg (49)	1	
dexamethasone tab therapy pack 1.5 mg (51)	1	

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

Drug Name	Drug Tier	Requirements/Limits
DXEVO 11-DAY PAK 1.5MG	3	
EMFLAZA SUS 22.75/ML	3	PA, QL (52 ML PER 30 DAYS)
EMFLAZA TAB 6MG	3	PA, QL (60 TABLETS PER 30 DAYS)
EMFLAZA TAB 18MG	3	PA, QL (30 TABLETS PER 30 DAYS)
EMFLAZA TAB 30MG	3	PA, QL (30 TABLETS PER 30 DAYS)
EMFLAZA TAB 36MG	3	PA, QL (30 TABLETS PER 30 DAYS)
ENTOCORT EC CAP 3MG DR	3	
HEMADY TAB 20MG	3	
hydrocortisone tab 5 mg	1	
hydrocortisone tab 10 mg	1	
hydrocortisone tab 20 mg	1	
MEDROL TAB 2MG	3	
MEDROL TAB 4MG	3	
MEDROL TAB 8MG	3	
MEDROL TAB 16MG	3	
MEDROL TAB 32MG	3	
methylprednisolone tab 4 mg	1	
methylprednisolone tab 8 mg	1	
methylprednisolone tab 16 mg	1	
methylprednisolone tab 32 mg	1	
methylprednisolone tab therapy pack 4 mg (21)	1	
MILLIPRED TAB 5MG	3	PA; MNPA
ORAPRED ODT TAB 10MG	3	
ORAPRED ODT TAB 15MG	3	
ORAPRED ODT TAB 30MG	3	
ORTIKOS CAP 6MG ER	3	
ORTIKOS CAP 9MG ER	3	
PEDIAPRED SOL 5MG/5ML	3	
prednisolone sod phos orally disintegr tab 10 mg (base eq)	1	
prednisolone sod phos orally disintegr tab 15 mg (base eq)	1	

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

Drug Name	Drug Tier	Requirements/Limits
prednisolone sod phos orally disintegr tab 30 mg (base eq)	1	
prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)	1	
prednisolone sod phosphate oral soln 10 mg/5ml (base equiv)	1	
prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)	1	
prednisolone sod phosphate oral soln 20 mg/5ml (base equiv)	1	
prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)	1	
prednisolone soln 15 mg/5ml	1	
PREDNISONE CON 5MG/ML	3	
prednisone oral soln 5 mg/5ml	1	
prednisone tab 1 mg	1	
prednisone tab 2.5 mg	1	
prednisone tab 5 mg	1	
prednisone tab 10 mg	1	
prednisone tab 20 mg	1	
prednisone tab 50 mg	1	
prednisone tab therapy pack 5 mg (21)	1	
prednisone tab therapy pack 5 mg (48)	1	
prednisone tab therapy pack 10 mg (21)	1	
prednisone tab therapy pack 10 mg (48)	1	
RAYOS TAB 1MG	3	
RAYOS TAB 2MG	3	
RAYOS TAB 5MG	3	
SOLU-CORTEF INJ 100MG	3	PA
SOLU-CORTEF INJ 250MG	3	PA
SOLU-CORTEF INJ 500MG	3	PA
SOLU-CORTEF INJ 1000MG	3	PA
UCERIS TAB 9MG	3	
ZCORT 7-DAY TAB 1.5MG	3	
MINERALOCORTICOIDS		
fludrocortisone acetate tab 0.1 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
COUGH/COLD/ALLERGY		
ANTITUSSIVES		
benzonatate cap 100 mg	1	
benzonatate cap 150 mg	1	
benzonatate cap 200 mg	1	
HYCODAN SYP 5-1.5/5	3	QL (30 mL/day for 7 days per month)
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml	1	QL (30 mL/day for 7 days per month)
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg	1	QL (6 tablets/day for 7 days per month)
TESSALON PER CAP 100MG	2	
COUGH/COLD/ALLERGY COMBINATIONS		
CLARINEX-D TAB 2.5-120	3	
guaifenesin-codeine liquid 225-7.5 mg/5ml	1	QL (45 mL/day for 7 days per month)
guaifenesin-codeine soln 100-10 mg/5ml	1	QL (60 mL/day for 7 days per month)
hydrocod polst-chlorphen polst er susp 10-8 mg/5ml	1	QL (10 mL/day for 7 days per month)
MAR-COF CG LIQ 225-7.5	3	QL (45 mL/day for 7 days per month)
NEOTUSS PLUS LIQ	3	
promethazine & phenylephrine syrup 6.25-5 mg/5ml	1	
promethazine w/ codeine syrup 6.25-10 mg/5ml	1	QL (30 mL/day for 7 days per month)
promethazine-dm syrup 6.25-15 mg/5ml	1	
promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml	1	QL (30 mL/day for 7 days per month)
pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml	1	
TUSSICAPS CAP 10-8MG	3	QL (2 capsules/day for 7 days per month)
TUXARIN ER TAB 54.3-8MG	3	QL (2 tablets/day for 7 days per month)
TUZISTRA XR SUS	3	QL (20 mL/day for 7 days per month)

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

Drug Name	Drug Tier	Requirements/Limits
MISC. RESPIRATORY INHALANTS		
HYPERSAL NEB 3.5%	3	
HYPERSAL NEB 7%	3	
sodium chloride soln nebu 0.9%	1	
sodium chloride soln nebu 3%	1	
sodium chloride soln nebu 7%	1	
sodium chloride soln nebu 10%	1	
MUCOLYTICS		
acetylcysteine inhal soln 10%	1	
acetylcysteine inhal soln 20%	1	
DERMATOLOGICALS		
ACNE PRODUCTS		
ABSORICA CAP 10MG	2	
ABSORICA CAP 20MG	2	
ABSORICA CAP 25MG	2	
ABSORICA CAP 30MG	2	
ABSORICA CAP 35MG	2	
ABSORICA CAP 40MG	2	
ABSORICA LD CAP 8MG	3	
ABSORICA LD CAP 16MG	3	
ABSORICA LD CAP 24MG	3	
ABSORICA LD CAP 32MG	3	
ACANYA GEL 1.2-2.5%	3	QL (50 grams per month)
ACZONE GEL 5%	3	
ACZONE GEL 7.5%	3	
adapalene cream 0.1%	1	PA
adapalene gel 0.1%	1	PA
adapalene gel 0.1%	1	PA
adapalene gel 0.3%	1	PA
adapalene pads 0.1%	1	PA
ADAPALENE SOL 0.1%	3	PA
adapalene-benzoyl peroxide gel 0.1-2.5%	1	PA
adapalene-benzoyl peroxide gel 0.3-2.5%	1	PA
AKLIEF CRE 0.005%	3	PA
ALTRENO LOT 0.05%	3	PA
AMZEEQ AER 4%	3	

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

Drug Name	Drug Tier	Requirements/Limits
ARAZLO LOT 0.045%	3	PA
ATRALIN GEL 0.05%	3	PA
AZELEX CRE 20%	3	
BENZ PER FOR LOT HC 7.5-1	3	
BENZ PEROXID GEL 6.5%	3	
BENZACLIN GEL 1-5%	3	QL (50 grams per month)
BENZACLIN GEL 1-5%PUMP	3	QL (50 grams per month)
BENZAMYCIN GEL 5-3%	3	QL (47 grams per month)
BENZEPRO AER 5.2%	3	
BENZEPRO AER 9.7%	3	
BENZEPRO LIQ 6.8%	3	
BENZEPRO MIS 5.8%	3	
benzoyl peroxide foam 9.8%	1	
benzoyl peroxide liq 7%	1	
benzoyl peroxide liq 7%	1	
benzoyl peroxide-erythromycin gel 5-3%	1	QL (47 grams per month)
benzoyl peroxide-hydrocortisone lotion 5-0.5%	1	
BENZOYL PERX LIQ 6.9%	3	
CLEOCIN-T LOT 1%	3	QL (60 mL every month)
CLINDAGEL GEL 1%	3	QL (75 gm every month)
clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%	1	QL (50 grams per month)
clindamycin phosphate foam 1%	1	
clindamycin phosphate gel 1%	1	QL (75 gm every month)
clindamycin phosphate gel 1%	1	PA, QL (75 gm every month)
clindamycin phosphate lotion 1%	1	QL (60 mL every month)
clindamycin phosphate soln 1%	1	QL (60 mL every month)
clindamycin phosphate swab 1%	1	
clindamycin phosphate-benzoyl peroxide gel 1-5%	1	QL (50 grams per month)
clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%	1	QL (50 grams per month)

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

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate-tretinoin gel 1.2-0.025%	1	PA
dapsone gel 5%	1	
dapsone gel 7.5%	1	
DIFFERIN CRE 0.1%	3	PA
DIFFERIN GEL 0.1%	3	PA
DIFFERIN GEL 0.3%	3	PA
DIFFERIN LOT 0.1%	3	PA
EPIDUO FORTE GEL 0.3-2.5%	2	PA
EPIDUO GEL 0.1-2.5%	2	PA
EPSOLAY CRE 5%	3	
ERYGEL GEL 2%	3	QL (60 gm every month)
erythromycin gel 2%	1	QL (60 gm every month)
erythromycin pads 2%	1	
erythromycin soln 2%	1	QL (60 mL every month)
EVOCLIN AER 1%	3	
FABIOR AER 0.1%	3	PA
isotretinoin cap 10 mg	1	
isotretinoin cap 20 mg	1	
isotretinoin cap 30 mg	1	
isotretinoin cap 40 mg	1	
KLARON LOT 10%	3	
ONEXTON GEL 1.2-3.75	2	QL (50 grams per month)
OXIAZAR CRE 4-0.1%	3	
RETIN-A CRE 0.1%	3	PA
RETIN-A CRE 0.05%	3	PA
RETIN-A CRE 0.025%	3	PA
RETIN-A GEL 0.01%	3	PA
RETIN-A GEL 0.025%	3	PA
RETIN-A MICR GEL 0.1%	3	PA
RETIN-A MICR GEL 0.1%PUMP	3	PA
RETIN-A MICR GEL 0.04%	3	PA
RETIN-A MICR GEL 0.04%PMP	3	PA
RETIN-A MICR GEL 0.06%	3	PA
RETIN-A MICR GEL 0.08%	3	PA
RIAX AER 5.5%	3	

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

Drug Name	Drug Tier	Requirements/Limits
RIAX AER 9.5%	3	
sulfacetamide sodium lotion 10% (acne)	1	
sulfacetamide sodium w/ sulfur cleansing pad 10-4%	1	
sulfacetamide sodium w/ sulfur emulsion 10-1%	1	
TAZAROTENE AER 0.1%	3	PA
tretinoin cream 0.1%	1	PA
tretinoin cream 0.05%	1	PA
tretinoin cream 0.025%	1	PA
tretinoin gel 0.01%	1	PA
tretinoin gel 0.05%	1	PA
tretinoin gel 0.025%	1	PA
tretinoin microsphere gel 0.1%	1	PA
tretinoin microsphere gel 0.04%	1	PA
TWYNEO CRE 0.1-3%	3	PA
VELTIN GEL	3	PA
WINLEVI CRE 1%	3	
ZACLIR LOT 8%	3	
ZIANA GEL	3	PA
AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS		
VEREGEN OIN 15%	3	PA; MNPA
ANTI-INFLAMMATORY AGENTS - TOPICAL		
diclofenac epolamine patch 1.3%	1	
diclofenac sodium soln 1.5%	1	PA, QL (150 ml per 21 days)
diclofenac sodium soln 2%	1	
DICLONA GEL 1-4.5%	3	
FENOVAR KIT	3	
FLECTOR DIS 1.3%	3	
LICART DIS 1.3%	3	
PENNSAID SOL 2%	3	PA, QL (112 grams per 21 days)
ANTIBIOTICS - TOPICAL		
ALTABAX OIN 1%	3	
CENTANY OIN 2%	3	QL (30 gm every month)
gentamicin sulfate cream 0.1%	1	QL (120 g per 25 days)

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

Drug Name	Drug Tier	Requirements/Limits
gentamicin sulfate oint 0.1%	1	QL (120 g per 25 days)
mupirocin calcium cream 2%	1	PA, QL (30 gm every month)
mupirocin oint 2%	1	QL (30 gm every month)
NEO-SYNALAR CRE	3	PA; MNPA
XEPI CRE 1%	3	
ANTIFUNGALS - TOPICAL		
ciclopirox gel 0.77%	1	QL (120 GM Per month)
ciclopirox olamine cream 0.77% (base equiv)	1	QL (120 GM Per month)
ciclopirox olamine susp 0.77% (base equiv)	1	QL (120 ML Per month)
ciclopirox shampoo 1%	1	QL (120 ML Per month)
ciclopirox solution 8%	1	
clotrimazole w/ betamethasone cream 1-0.05%	1	
clotrimazole w/ betamethasone lotion 1-0.05%	1	
econazole nitrate cream 1%	1	QL (60 GM Per month)
ECOZA AER 1%	3	QL (70 GM Per month)
ERTACZO CRE 2%	3	QL (60 GM per month)
EXELDERM CRE 1%	3	QL (60 GM Per month)
EXELDERM SOL 1%	3	QL (60 ML Per month)
EXODERM LOT 25-1%	3	
EXTINA AER 2%	3	QL (100 GM Per month)
HIXDEFRIMA SOL 8-1-1%	3	
iodoquinol-hc cream 1-1%	1	
iodoquinol-hydrocortisone in aloe vehicle cream 1-1.9%	1	
JUBLIA SOL 10%	3	PA, QL (4 ML PER 21 Days)
KERYDIN SOL 5%	3	PA, QL (4 ML PER 21 Days)
ketoconazole cream 2%	1	QL (120 GM Per month)
ketoconazole foam 2%	1	PA, QL (100 GM Per month); MNPA
ketoconazole shampoo 2%	1	QL (120 ML Per month)
LOPROX CRE 0.77%	3	QL (120 GM Per month)

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

Drug Name	Drug Tier	Requirements/Limits
LOPROX SHA 1%	3	QL (120 ML Per month)
LOPROX SUS 0.77%	3	QL (120 ML Per month)
luliconazole cream 1%	1	PA, QL (60 GM per month); MNPA
LUZU CRE 1%	3	QL (60 GM per month)
miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%	1	QL (120 GM per month)
naftifine hcl cream 1%	1	QL (60 GM Per month)
naftifine hcl cream 2%	1	QL (60 GM Per month)
naftifine hcl gel 1%	1	QL (120 GM Per month)
NAFTIN GEL 1%	2	QL (120 GM Per month)
NAFTIN GEL 2%	2	QL (60 GM Per month)
nystatin cream 100000 unit/gm	1	QL (120 GM per month)
nystatin oint 100000 unit/gm	1	QL (120 GM per month)
nystatin topical powder 100000 unit/gm	1	QL (120 GM per month)
nystatin-triamcinolone cream 100000-0.1 unit/gm-%	1	
nystatin-triamcinolone oint 100000-0.1 unit/gm-%	1	
oxiconazole nitrate cream 1%	1	QL (90 GM Per month)
oxiconazole nitrate cream 1%	1	PA, QL (90 GM Per month)
OXISTAT CRE 1%	3	QL (90 GM Per month)
OXISTAT LOT 1%	3	QL (90 ML Per month)
RECURA CRE	3	
sulconazole nitrate cream 1%	1	QL (60 GM Per month)
sulconazole nitrate solution 1%	1	QL (60 ML Per month)
tavaborole soln 5%	1	PA, QL (4 ML PER 21 Days)
VUSION OIN	3	QL (120 GM per month)
XOLEGEL GEL 2%	3	PA, QL (45 GM Per month); MNPA
ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL		
AMELUZ GEL 10%	3	
CARAC CRE 0.5%	3	
diclofenac sodium (actinic keratoses) gel 3%	1	PA
EFUDEX CRE 5%	3	

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

Drug Name	Drug Tier	Requirements/Limits
FLUOROPLEX CRE 1%	3	
fluorouracil cream 0.5%	1	
fluorouracil cream 5%	1	
fluorouracil soln 2%	1	
fluorouracil soln 5%	1	
KLISYRI OIN 1%	3	PA, QL (5 packs per month)
LEVULAN KERA SOL 20%	3	
PANRETIN GEL 0.1%	3	
PICATO GEL 0.05%	2	
PICATO GEL 0.015%	2	
ROAOXIA GEL 3-4%	3	
TARGRETIN GEL 1%	3	PA
VALCHLOR GEL 0.016%	3	PA, QL (2 TUBES PER 30 DAYS)
ANTIPRURITICS - TOPICAL		
doxepin hcl cream 5%	1	ST, PA, QL (45 grams every month); MNPA
PRUDOXIN CRE 5%	3	ST, PA, QL (45 grams every month)
ZONALON CRE 5%	3	ST, PA, QL (45 grams every month)
ANTIPSORIATICS		
acitretin cap 10 mg	1	
acitretin cap 17.5 mg	1	
acitretin cap 25 mg	1	
calcipotriene cream 0.005%	1	PA; MNPA
calcipotriene foam 0.005%	1	PA
calcipotriene oint 0.005%	1	PA
calcipotriene soln 0.005% (50 mcg/ml)	1	PA
calcitriol oint 3 mcg/gm	1	PA; MNPA
COSENTYX INJ 75MG/0.5	2	PA, QL (1 SYRINGE PER 28 DAYS); Preferred agent for Ankylosing Spondylitis and Psoriatic Arthritis

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

Drug Name	Drug Tier	Requirements/Limits
COSENTYX INJ 150MG/ML	2	PA, QL (1 SYRINGE PER 28 DAYS); Preferred agent for Anklyosing Spondylitis and Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
COSENTYX INJ 300DOSE	2	PA, QL (2 SYRINGES PER 28 DAYS); Preferred agent for Anklyosing Spondylitis and Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
COSENTYX PEN INJ 150MG/ML	2	PA, QL (1 PEN PER 28 DAYS); Preferred agent for Anklyosing Spondylitis and Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
COSENTYX PEN INJ 300DOSE	2	PA, QL (2 SYRINGES PER 28 DAYS); Preferred agent for Anklyosing Spondylitis and Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
DOVONEX CRE 0.005%	3	PA
methoxsalen rapid cap 10 mg	1	
OXSORALEN-UL CAP 10MG	3	
SILIQ INJ 210/1.5	3	PA, QL (2 SYRINGES PER 28 DAYS)
SKYRIZI INJ 150DOSE	2	PA, QL (2 SYRINGES PER 12 WEEKS); Preferred for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
SKYRIZI INJ 150MG/ML	2	PA, QL (1 Syringes Per 84 Days); Preferred for Psoriasis
SKYRIZI PEN INJ 150MG/ML	2	PA, QL (1 Syringes Per 84 Days); Preferred for Psoriasis
SORIATANE CAP 10MG	3	
SORIATANE CAP 25MG	3	
SORILUX AER 0.005%	3	PA
SOTYKTU TAB 6MG	3	PA, QL (30 TABLETS PER 30 DAYS)
STELARA INJ 45MG/0.5	2	PA, QL (1 SYRINGE PER 12 WEEKS); Preferred agent for Psoriasis and 2nd line for Ulcerative colitis, Crohn's after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
STELARA INJ 45MG/0.5	2	PA, QL (1 VIAL PER 12 WEEKS); Preferred agent for Psoriasis and 2nd line for Ulcerative colitis, Crohn's after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
STELARA INJ 90MG/ML	2	PA, QL (1 PFS PER 8 WEEKS); Preferred agent for Psoriasis and 2nd line for Ulcerative colitis, Crohn's after failure of Humira; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
TALTZ INJ 80MG/ML	2	PA, QL (1 INJ PER 28 DAYS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

Drug Name	Drug Tier	Requirements/Limits
TALTZ INJ 80MG/ML	2	PA, QL (1 PFS PER 28 DAYS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
tazarotene cream 0.1%	1	
tazarotene gel 0.1%	1	
tazarotene gel 0.05%	1	
TAZORAC CRE 0.1%	2	
TAZORAC CRE 0.05%	2	
TAZORAC GEL 0.1%	2	
TAZORAC GEL 0.05%	2	
TREMFYA INJ 100MG/ML	2	PA, QL (1 PEN PER 8 WEEKS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
TREMFYA INJ 100MG/ML	2	PA, QL (1 PFS PER 8 WEEKS); Preferred agent for Psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
VECTICAL OIN 3MCG/GM	3	PA; MNPA
VTAMA CRE 1%	3	
ANTISEBORRHEIC PRODUCTS		
ESKATA SOL 40%	3	
selenium sulfide lotion 2.5%	1	

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

Drug Name	Drug Tier	Requirements/Limits
SODIUM SULFA LIQ 10% WASH	3	
ANTIVIRALS - TOPICAL		
acyclovir cream 5%	1	PA; MNPA
acyclovir oint 5%	1	
DENAVIR CRE 1%	3	
XERESE CRE 5-1%	3	
ZOVIRAX CRE 5%	3	
ZOVIRAX OIN 5%	3	
BURN PRODUCTS		
mafenide acetate packet for topical soln 5% (50 gm)	1	
SILVADENE CRE 1%	2	
silver sulfadiazine cream 1%	1	
SULFAMYLON CRE 85MG/GM	3	
SULFAMYLON PAK 5%	3	
CORTICOSTEROIDS - TOPICAL		
ala-scalp lot 2%	1	QL (120 mL every month)
ALA-SCALP LOT 2%	3	QL (120 mL every month)
alclometasone dipropionate cream 0.05%	1	QL (120 gm every month)
alclometasone dipropionate oint 0.05%	1	QL (120 gm every month)
amcinonide cream 0.1%	1	QL (120 gm every month)
amcinonide lotion 0.1%	1	QL (120 mL every month)
AMCINONIDE OIN 0.1%	3	QL (120 gm every month)
APEXICON E CRE 0.05%	3	QL (120 gm every month)
betamethasone dipropionate augmented cream 0.05%	1	QL (120 gm every month)
betamethasone dipropionate augmented gel 0.05%	1	QL (120 gm every month)
betamethasone dipropionate augmented lotion 0.05%	1	QL (120 mL every month)

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

Drug Name	Drug Tier	Requirements/Limits
betamethasone dipropionate augmented oint 0.05%	1	QL (120 gm every month)
betamethasone dipropionate cream 0.05%	1	QL (120 gm every month)
betamethasone dipropionate lotion 0.05%	1	QL (120 mL every month)
betamethasone dipropionate oint 0.05%	1	QL (120 gm every month)
betamethasone valerate aerosol foam 0.12%	1	QL (120 gm every month)
betamethasone valerate cream 0.1% (base equivalent)	1	QL (120 gm every month)
betamethasone valerate lotion 0.1% (base equivalent)	1	QL (120 mL every month)
betamethasone valerate oint 0.1% (base equivalent)	1	QL (120 gm every month)
BRYHALI LOT 0.01%	2	QL (120 gm every month)
calcipotriene-betamethasone dipropionate oint 0.005-0.064%	1	PA; MNPA
calcipotriene-betamethasone dipropionate susp 0.005-0.064%	1	PA
CAPEX SHA 0.01%	2	QL (120 mL every month)
clobetasol propionate cream 0.05%	1	QL (120 gm every month)
clobetasol propionate emollient base cream 0.05%	1	QL (120 gm every month)
clobetasol propionate emulsion foam 0.05%	1	QL (120 gm every month)
clobetasol propionate foam 0.05%	1	QL (120 gm every month)
clobetasol propionate gel 0.05%	1	QL (120 gm every month)
clobetasol propionate lotion 0.05%	1	QL (120 mL every month)
clobetasol propionate oint 0.05%	1	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
clobetasol propionate shampoo 0.05%	1	QL (120 mL every month)
clobetasol propionate soln 0.05%	1	QL (120 mL every month)
clobetasol propionate spray 0.05%	1	QL (120 mL every month)
CLOBEX LOT 0.05%	2	QL (120 mL every month)
CLOBEX SHA 0.05%	2	QL (120 mL every month)
CLOBEX SPR 0.05%	3	QL (120 mL every month)
clocortolone pivalate cream 0.1%	1	PA, QL (120 gm every month); MNPA
CLODERM CRE 0.1%	3	QL (120 gm every month)
CORDRAN 80X3 TAP 4MCG/CM	3	QL (120 Units Per Month)
CORDRAN CRE 0.05%	3	QL (120 gm every month)
CORDRAN CRE 0.025%	3	QL (120 gm every month)
CORDRAN LOT 0.05%	3	QL (120 mL every month)
CORDRAN OIN 0.05%	3	PA, QL (120 gm every month); MNPA
CUTIVATE LOT 0.05%	3	QL (120 mL every month)
DERMA-SMOOTH OIL /FS BODY	2	QL (120 mL every month)
DERMA-SMOOTH OIL /FS SCLP	2	QL (120 mL every month)
DESONATE GEL 0.05%	3	QL (120 gm every month)
desonide cream 0.05%	1	QL (120 gm every month)
desonide gel 0.05%	1	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
desonide lotion 0.05%	1	QL (120 mL every month)
desonide oint 0.05%	1	QL (120 gm every month)
DESOWEN CRE 0.05%	3	QL (120 gm every month)
desoximetasone cream 0.05%	1	QL (120 gm every month)
desoximetasone cream 0.25%	1	QL (120 gm every month)
desoximetasone gel 0.05%	1	QL (120 gm every month)
desoximetasone oint 0.05%	1	PA, QL (120 gm every month); MNPA
desoximetasone oint 0.25%	1	QL (120 gm every month)
desoximetasone spray 0.25%	1	QL (120 mL every month)
diflorasone diacetate cream 0.05%	1	PA, QL (120 gm every month); MNPA
diflorasone diacetate oint 0.05%	1	PA, QL (120 gm every month); MNPA
DIPROLENE AF CRE 0.05%	3	QL (120 gm every month)
DIPROLENE OIN 0.05%	3	QL (120 gm every month)
DUOBRII LOT	2	
ENSTILAR AER	2	PA
EPIFOAM AER 1%	3	
fluocinolone acetonide cream 0.01%	1	QL (120 gm every month)
fluocinolone acetonide cream 0.025%	1	QL (120 gm every month)
fluocinolone acetonide oil 0.01% (body oil)	1	QL (120 mL every month)
fluocinolone acetonide oil 0.01% (scalp oil)	1	QL (120 mL every month)
fluocinolone acetonide oint 0.025%	1	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
fluocinolone acetonide soln 0.01%	1	QL (120 mL every month)
fluocinonide cream 0.1%	1	PA, QL (120 gm every month); MNPA
fluocinonide cream 0.05%	1	QL (120 gm every month)
fluocinonide emulsified base cream 0.05%	1	QL (120 gm every month)
fluocinonide gel 0.05%	1	QL (120 gm every month)
fluocinonide oint 0.05%	1	QL (120 gm every month)
fluocinonide soln 0.05%	1	QL (120 mL every month)
flurandrenolide cream 0.05%	1	PA, QL (120 gm every month); MNPA
flurandrenolide lotion 0.05%	1	PA, QL (120 mL every month)
flurandrenolide lotion 0.05%	1	PA, QL (120 mL every month); MNPA
flurandrenolide oint 0.05%	1	PA, QL (120 gm every month); MNPA
fluticasone propionate cream 0.05%	1	QL (120 gm every month)
fluticasone propionate lotion 0.05%	1	QL (120 mL every month)
fluticasone propionate oint 0.005%	1	QL (120 gm every month)
halcinonide cream 0.1%	1	PA, QL (120 gm every month); MNPA
HALOBETASOL AER 0.05%	3	QL (120 gm every month)
halobetasol propionate cream 0.05%	1	QL (120 gm every month)
halobetasol propionate oint 0.05%	1	QL (120 gm every month)
HALOG CRE 0.1%	3	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
HALOG OIN 0.1%	3	QL (120 gm every month)
HALOG SOL 0.1%	3	QL (120 mL every month)
hydrocortisone butyrate cream 0.1%	1	QL (120 gm every month)
hydrocortisone butyrate hydrophilic lipo base cream 0.1%	1	PA, QL (120 gm every month); MNPA
hydrocortisone butyrate lotion 0.1%	1	PA, QL (120 mL every month); MNPA
hydrocortisone butyrate oint 0.1%	1	QL (120 gm every month)
hydrocortisone butyrate soln 0.1%	1	QL (120 mL every month)
hydrocortisone cream 2.5%	1	QL (120 gm every month)
hydrocortisone lotion 2.5%	1	QL (120 mL every month)
hydrocortisone oint 2.5%	1	QL (120 gm every month)
hydrocortisone valerate cream 0.2%	1	QL (120 gm every month)
hydrocortisone valerate oint 0.2%	1	QL (120 gm every month)
IMPEKLO LOT 0.05%	3	QL (120 grams every month)
IMPOYZ CRE 0.025%	3	QL (120 gm every month)
KENALOG AER SPRAY	3	QL (120 gm every month)
LEXETTE AER 0.05%	3	QL (120 gm every month)
LOCOID LIPO CRE 0.1%	3	QL (120 gm every month)
LOCOID LOT 0.1%	3	QL (120 mL every month)
LUXIQ AER 0.12%	3	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
mometasone furoate cream 0.1%	1	QL (120 gm every month)
mometasone furoate oint 0.1%	1	QL (120 gm every month)
mometasone furoate solution 0.1% (lotion)	1	QL (120 mL every month)
OLUX AER 0.05%	3	QL (120 gm every month)
OLUX-E AER 0.05%	3	QL (120 gm every month)
PANDEL CRE 0.1%	3	QL (120 gm every month)
PRAMOSONE CRE 1-1%	3	
PRAMOSONE LOT 1%	3	
PRAMOSONE LOT 2.5%	3	
prednicarbate cream 0.1%	1	QL (120 gm every month)
prednicarbate oint 0.1%	1	QL (120 gm every month)
PSORCON CRE 0.05%	3	PA, QL (120 gm every month); MNPA
SERNIVO SPR	3	QL (120 mL every month)
SERNIVO SPR 0.05%	3	QL (120 mL every month)
SYNALAR CRE 0.025%	3	QL (120 gm every month)
SYNALAR OIN 0.025%	3	QL (120 gm every month)
SYNALAR SOL 0.01%	3	QL (120 mL every month)
TACLONEX OIN	3	PA
TACLONEX SUS	3	PA
TEMOVATE CRE 0.05%	2	QL (120 gm every month)
TEMOVATE OIN 0.05%	2	QL (120 gm every month)
TEXACORT SOL 2.5%	2	QL (120 mL every month)

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

Drug Name	Drug Tier	Requirements/Limits
TOPICORT CRE 0.05%	3	QL (120 gm every month)
TOPICORT CRE 0.25%	3	QL (120 gm every month)
TOPICORT GEL 0.05%	3	QL (120 gm every month)
TOPICORT OIN 0.05%	3	QL (120 gm every month)
TOPICORT OIN 0.25%	3	QL (120 gm every month)
TOPICORT SPR 0.25%	3	QL (120 mL every month)
triamcinolone acetonide aerosol soln 0.147 mg/gm	1	PA, QL (120 gm every month); MNPA
triamcinolone acetonide cream 0.1%	1	QL (120 gm every month)
triamcinolone acetonide cream 0.5%	1	QL (120 gm every month)
triamcinolone acetonide cream 0.025%	1	QL (120 gm every month)
triamcinolone acetonide lotion 0.1%	1	QL (120 mL every month)
triamcinolone acetonide lotion 0.025%	1	QL (120 mL every month)
triamcinolone acetonide oint 0.1%	1	QL (120 gm every month)
triamcinolone acetonide oint 0.5%	1	QL (120 gm every month)
triamcinolone acetonide oint 0.05%	1	PA, QL (120 gm every month); MNPA
triamcinolone acetonide oint 0.025%	1	QL (120 gm every month)
TRIDESILON CRE 0.05%	3	QL (120 gm every month)
ULTRAVATE LOT 0.05%	3	QL (120 mL every month)
VANOS CRE 0.1%	3	QL (120 gm every month)

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

Drug Name	Drug Tier	Requirements/Limits
VERDESO AER 0.05%	3	QL (120 gm every month)
WYNZORA CRE	3	PA
ECZEMA AGENTS		
ADBRY INJ 150MG/ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
CIBINQO TAB 50MG	3	PA, QL (30 Tablets per 30 days)
CIBINQO TAB 100MG	3	PA, QL (30 Tablets per 30 days)
CIBINQO TAB 200MG	3	PA, QL (30 Tablets per 30 days)
DUPIXENT INJ 200MG	2	PA, QL (2 PFS PER 28 DAYS)
DUPIXENT INJ 300/2ML	2	PA, QL (4 PENS PER 28 DAYS)
DUPIXENT INJ 300/2ML	2	PA, QL (4 PFS PER 28 DAYS)
OPZELURA CRE 1.5%	3	PA
EMOLLIENT/KERATOLYTIC AGENTS		
urea cream 39%	1	
urea lotion 40%	1	
EMOLLIENTS		
LACTIC ACID LOT 10%	3	
ENZYMES - TOPICAL		
SANTYL OIN 250/GM	3	
IMMUNOMODULATING AGENTS - TOPICAL		
ALDARA CRE 5%	3	QL (21 packs per month)
imiquimod cream 3.75%	1	
imiquimod cream 5%	1	QL (21 packs per month)
ZYCLARA CRE 3.75%	2	
ZYCLARA PUMP CRE 2.5%	2	
ZYCLARA PUMP CRE 3.75%	2	
IMMUNOSUPPRESSIVE AGENTS - TOPICAL		
ELIDEL CRE 1%	3	ST

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

Drug Name	Drug Tier	Requirements/Limits
OXIANUJO CRE 4-0.1%	3	
pimecrolimus cream 1%	1	ST
PROTOPIC OIN 0.1%	3	ST
PROTOPIC OIN 0.03%	3	ST
tacrolimus oint 0.1%	1	ST
tacrolimus oint 0.03%	1	ST
KERATOLYTIC/ANTIMITOTIC AGENTS		
CANTHARIDIN SOL 0.7%	3	
CONDYLOX GEL 0.5%	2	
GEAMETDRAY GEL 5-2-17%	3	
GORDOFILM SOL	3	
podofilox soln 0.5%	1	
PYROGALL ACD OIN	3	
salimez cre 6%	3	
SALIMEZ FORT CRE 10%	3	
LINIMENTS		
TURPENTINE SOL SPIRITS	3	
LOCAL ANESTHETICS - TOPICAL		
ANACAINE OIN	3	
ELEMAR PATCH KIT 5%-6%	3	
ethyl chlor aer fine pin	3	
ETHYL CHLOR AER FN STRM	3	
ethyl chlor aer med jet	3	
ETHYL CHLOR AER MED STRM	3	
ethyl chlor aer mist	3	
ethyl chloride aerosol spray	1	
LIDOCA/TETRA CRE 7/7%	3	QL (30 gm every month)
LIDOCAINE CRE TETRACAI	3	PA, QL (30 gm every month); MNPA
lidocaine hcl soln 4%	1	QL (50 mL every month)
lidocaine hcl urethral/mucosal gel 2%	1	QL (60 mL every month)
lidocaine hcl urethral/mucosal gel prefilled syringe 2%	1	QL (10 injections every month)
lidocaine oint 5%	1	QL (50 gm every month)
lidocaine patch 5%	1	QL (90 ea every month)
lidocaine-prilocaine cream 2.5-2.5%	1	QL (30 gm every month)
LIDODERM DIS 5%	2	QL (90 ea every month)

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

Drug Name	Drug Tier	Requirements/Limits
PLIAGLIS CRE 7-7%	3	QL (30 gm every month)
PRAMOX GEL 1%	3	
SYNERA DIS 70-70MG	3	QL (2 patches every month)
ZTLIDO PAD 1.8%	3	QL (90 ea every month)
MISC. TOPICAL		
ARNICA TIN FLOWER	3	
DRYSOL SOL 20%	3	
EPICYN SPR	3	
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	
PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL		
EUCRISA OIN 2%	2	
ROSACEA AGENTS		
azelaic acid gel 15%	1	PA
doxycycline (rosacea) cap delayed release 40 mg	1	
FINACEA AER 15%	2	PA
FINACEA GEL 15%	3	PA
METROCREAM CRE 0.75%	3	
METROGEL GEL 1%	3	
METROLOTION LOT 0.75%	3	
metronidazole cream 0.75%	1	
metronidazole gel 0.75%	1	
metronidazole gel 1%	1	
metronidazole lotion 0.75%	1	
MIRVASO GEL 0.33%	3	PA
NORITATE CRE 1%	3	PA
ORACEA CAP 40MG	3	
RHOFADE CRE 1%	3	PA
SOOLANTRA CRE 1%	2	
ZILXI AER 1.5%	3	
SCABICIDES & PEDICULICIDES		
crotamiton lotion 10%	1	
ELIMITE CRE 5%	2	
ivermectin lotion 0.5%	1	
lindane shampoo 1%	1	

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

Drug Name	Drug Tier	Requirements/Limits
malathion lotion 0.5%	1	
NATROBA SUS 0.9%	3	
OVIDE LOT 0.5%	2	
permethrin cream 5%	1	
spinosad susp 0.9%	1	
SULF LIME SOL	3	
TAR PRODUCTS		
coal tar soln 20%	1	
WOUND CARE PRODUCTS		
REGRANEX GEL 0.01%	3	
DIAGNOSTIC PRODUCTS		
DIAGNOSTIC TESTS		
ACCU-CHEK TES AVIVA PL	0	QL (240 strips every month)
ACCU-CHEK TES COMPACT	0	QL (240 strips every month)
ACCU-CHEK TES GUIDE	0	QL (240 strips every month)
ACCU-CHEK TES SMART	0	QL (240 strips every month)
ACCUTREND TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
ADVANCE TES INTUITIO	0	PA, QL (240 strips every month); MNPA
ADVANCE TES MICRO-DW	0	PA, QL (240 strips every month); MNPA
ADVOCATE TES	0	PA, QL (240 strips every month); MNPA
ADVOCATE TES REDI-COD	0	PA, QL (240 strips every month); MNPA
ADVOCATE TES REDICODE	0	PA, QL (240 strips every month); MNPA
AGAMATRIX TES AMP	0	PA, QL (240 strips every month); MNPA
AGAMATRIX TES JAZZ	0	PA, QL (240 strips every month); MNPA
AGAMATRIX TES KEYNOTE	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
AGAMATRIX TES PRESTO	0	PA, QL (240 strips every month); MNPA
ASSURE 3 TES	0	PA, QL (240 strips every month); MNPA
ASSURE 4 TES	0	PA, QL (240 strips every month); MNPA
ASSURE II TES	0	PA, QL (240 strips every month); MNPA
ASSURE II TES CHECK	0	PA, QL (240 strips every month); MNPA
ASSURE PRISM TES MULTI	0	PA, QL (240 strips every month); MNPA
ASSURE PRO TES	0	PA, QL (240 strips every month); MNPA
ASSURE TES PLATINUM	0	PA, QL (240 strips every month); MNPA
AUTOCODE TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
BIOSCANNER TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
BLOOD GLUCOS TES	0	PA, QL (240 strips every month); MNPA
BLOOD GLUCOS TES LE1	0	PA, QL (240 strips every month); MNPA
BLOOD GLUCOS TES PREMIUM	0	PA, QL (240 strips every month); MNPA
BLOOD GLUCOS TES STRIPS	0	PA, QL (240 strips every month); MNPA
CARESENS N TES	0	PA, QL (240 strips every month); MNPA
CARETOUCH MIS TST STRP	0	PA, QL (240 strips every month); MNPA
CHEMSTRIP K TES	0	
CHEMSTRIP TES UGK	0	
CLEVER CHEK TES	0	PA, QL (240 strips every month); MNPA
CLEVER CHEK TES AUTO CD	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
CLEVER CHEK TES TALK	0	PA, QL (240 strips every month); MNPA
CLEVER CHEK TES VOICE	0	PA, QL (240 strips every month); MNPA
CLEVER CHOIC TES MICRO	0	PA, QL (240 strips every month); MNPA
CLEVR CHOICE TES AUTO-CD	0	PA, QL (240 strips every month); MNPA
CLEVR CHOICE TES NOCODE	0	PA, QL (240 strips every month); MNPA
CONFIRM/MICR TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
CONTOUR TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
CONTOUR TES NEXT	0	PA, QL (240 strips every month); MNPA
COOL BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
CVS ADVANCED TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
CVS GLUCOSE TES TEST STR	0	PA, QL (240 strips every month); MNPA
CVS KETONE TES CARE	0	
D-CARE BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
DIASTIX TES STRIPS	0	
DIATHRIVE MIS TEST STR	0	PA, QL (240 strips every month); MNPA
DIATHRIVE+ MIS TEST STR	0	PA, QL (240 strips every month); MNPA
DIATRUE PLUS TES STRIPS	0	PA, QL (240 strips every month); MNPA
DUO-CARE TES	0	PA, QL (240 strips every month); MNPA
EASY PLUS II TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EASY STEP TES	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
EASY TALK TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EASY TOUCH TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
EASY TOUCH TES STRIPS	0	PA, QL (240 strips every month); MNPA
EASY TRAK II TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EASY TRAK TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EASYGLUCO TES	0	PA, QL (240 strips every month); MNPA
EASYGLUCO TES PLUS	0	PA, QL (240 strips every month); MNPA
EASYMAX 15 TES	0	PA, QL (240 strips every month); MNPA
EASYMAX TES	0	PA, QL (240 strips every month); MNPA
EASYPRO PLUS TES	0	PA, QL (240 strips every month); MNPA
EASYPRO TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
ELEMENT TES	0	PA, QL (240 strips every month); MNPA
ELEMNT COMPA TES STRIPS	0	PA, QL (240 strips every month); MNPA
EMBRACE EVO TES	0	PA, QL (240 strips every month); MNPA
EMBRACE PRO TES	0	PA, QL (240 strips every month); MNPA
EMBRACE TALK TES STRIPS	0	PA, QL (240 strips every month); MNPA
EMBRACE TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EVENCARE + TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EVENCARE G2 TES	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
EVENCARE G3 TES	0	PA, QL (240 strips every month); MNPA
EVENCARE TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
EVENCARE TES MINI	0	PA, QL (240 strips every month); MNPA
EVENCARE TES PROVIEW	0	PA, QL (240 strips every month); MNPA
EVOLUTION TES AUTOCODE	0	PA, QL (240 strips every month); MNPA
EXACTECH TES	0	PA, QL (240 strips every month); MNPA
EXACTECH TES R-S-G	0	PA, QL (240 strips every month); MNPA
FIFTY50 GLUC TES 2.0	0	PA, QL (240 strips every month); MNPA
FORA 6 MIS CONNECT	0	QL (240 strips every month)
FORA BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
FORA D15G TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA D20 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA D40/G31 TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
FORA G20 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA G30/V10 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA GD20 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA GD50 TES	0	PA, QL (240 strips every month); MNPA
FORA GTEL TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA GTEL TES KETONE	0	
FORA TN'G TES TN'G VOI	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
FORA V10 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA V12 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA V20 TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORA V30A TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FORACARE TES GD40	0	PA, QL (240 strips every month); MNPA
FORACARE TES PREM V10	0	PA, QL (240 strips every month); MNPA
FORACARE TES TST N GO	0	PA, QL (240 strips every month); MNPA
FORTISCARE TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
FREESTYLE TES	0	PA, QL (240 strips every month); MNPA
FREESTYLE TES INSULINX	0	PA, QL (240 strips every month); MNPA
FREESTYLE TES LITE	0	PA, QL (240 strips every month); MNPA
FREESTYLE TES PREC NEO	0	PA, QL (240 strips every month); MNPA
GE100 BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
GENULTIMATE TES	0	PA, QL (240 strips every month); MNPA
GHT TEST TES STRIPS	0	PA, QL (240 strips every month); MNPA
GLUCO PERFEC TES 3	0	PA, QL (240 strips every month); MNPA
GLUCOCARD 01 TES PLUS	0	PA, QL (240 strips every month); MNPA
GLUCOCARD 01 TES SENSOR	0	PA, QL (240 strips every month); MNPA
GLUCOCARD TES EXPRESSI	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
GLUCOCARD TES SHINE	0	PA, QL (240 strips every month); MNPA
GLUCOCARD TES VITAL	0	PA, QL (240 strips every month); MNPA
GLUCOCARD TES X-SENSOR	0	PA, QL (240 strips every month); MNPA
GLUCOCOM TES	0	PA, QL (240 strips every month); MNPA
GLUCONAVII TES STRIPS	0	PA, QL (240 strips every month); MNPA
GLUCOSE TES STRIPS	0	PA, QL (240 strips every month); MNPA
GOJJI BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
GOJJI BLOOD TES KETONE	0	
GOJJI STRIPS MIS W/LANCET	0	PA, QL (240 strips every month); MNPA
HARMONY TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
HW EMBRACE TES PRO	0	PA, QL (240 strips every month); MNPA
HW EMBRACE TES STRIPS	0	PA, QL (240 strips every month); MNPA
IGLUCOSE TES	0	PA, QL (240 strips every month); MNPA
IN TOUCH TES BLOOD	0	PA, QL (240 strips every month); MNPA
INFINITY TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
INFINITY TES VOICE	0	PA, QL (240 strips every month); MNPA
KETO-DIASTIX TES	0	
KETONE TES	0	
KETONE TEST TES	0	
KETOSTIX TES STRIP	0	
KROGER BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
KROGER TES	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
LIBERTY NEXT TES GEN	0	PA, QL (240 strips every month); MNPA
LIBERTY TES	0	PA, QL (240 strips every month); MNPA
MEIJER BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
MEIJER TES TRUETEST	0	PA, QL (240 strips every month); MNPA
MEIJER TES TRUETRAC	0	PA, QL (240 strips every month); MNPA
MICRODOT TES	0	PA, QL (240 strips every month); MNPA
MICRODOT TES XTRA	0	PA, QL (240 strips every month); MNPA
MYGLUCOHEALT TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
NEUTEK 2TEK TES STRIPS	0	PA, QL (240 strips every month); MNPA
NO CODING TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
NOVA MAX PLS TES KETONE	0	
NOVA MAX TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
ONE DROP TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
ONETOUCH TES ULTRA	0	QL (240 strips every month)
ONETOUCH TES VERIO	0	QL (240 strips every month)
OPTIUM TES	0	PA, QL (240 strips every month); MNPA
OPTIUMEZ TES	0	PA, QL (240 strips every month); MNPA
POCKETCHEM TES EZ	0	PA, QL (240 strips every month); MNPA
PRECISION PT TES OF CARE	0	PA, QL (240 strips every month); MNPA
PRECISION TES PCX	0	PA, QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
PRECISION TES PCX PLUS	0	PA, QL (240 strips every month); MNPA
PRECISION TES QID	0	PA, QL (240 strips every month); MNPA
PRECISION TES SOF-TACT	0	PA, QL (240 strips every month); MNPA
PRECISION TES XTRA	0	PA, QL (240 strips every month); MNPA
PRECISN XTRA TES KETONE	0	
PREMIUM BLOO MIS GLUCOSE	0	PA, QL (240 strips every month); MNPA
PRO VOICE TES V8/V9	0	PA, QL (240 strips every month); MNPA
PRODIGY NO TES CODING	0	PA, QL (240 strips every month); MNPA
PTS PANELS TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
PTS PANELS TES KETONE	0	
QUICKTEK TES	0	PA, QL (240 strips every month); MNPA
QUINTET AC TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
QUINTET TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
REFUAH PLUS TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
RELION BLOOD TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
RELION PREMI TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
RELION PRIME TES	0	PA, QL (240 strips every month); MNPA
RELION PRIME TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
RELION TES KETONE	0	
RELION TES ULTIMA	0	PA, QL (240 strips every month); MNPA
RELION TRUE TES METRIX	0	QL (240 strips every month); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
RIGHTEST TES GS100	0	PA, QL (240 strips every month); MNPA
RIGHTEST TES GS300	0	PA, QL (240 strips every month); MNPA
RIGHTEST TES GS550	0	PA, QL (240 strips every month); MNPA
SMART SENSE TES TEST	0	PA, QL (240 strips every month); MNPA
SMARTEST TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
SOLUS V2 TES AUDIBLE	0	PA, QL (240 strips every month); MNPA
SUPREME TES	0	PA, QL (240 strips every month); MNPA
SURE-TEST TES EASYPLUS	0	PA, QL (240 strips every month); MNPA
TRUE FOCUS MIS BLOOD	0	PA, QL (240 strips every month); MNPA
TRUE METRIX TES GLUCOSE	0	PA, QL (240 strips every month); MNPA
TRUETEST TES	0	PA, QL (240 strips every month); MNPA
TRUETRACK TES	0	PA, QL (240 strips every month); MNPA
TRUETRACK TES BLD GLUC	0	PA, QL (240 strips every month); MNPA
UNISTRIP1 TES GENERIC	0	PA, QL (240 strips every month); MNPA
VERASENS TES	0	PA, QL (240 strips every month); MNPA
VIVAGUARD TES INO	0	PA, QL (240 strips every month); MNPA

DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS

DIETARY MANAGEMENT PRODUCTS

ACERFLEX POW	3	Coverage is subject to your plan/benefits
BCAD 2 POW	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
CAMINO PRO LIQ 15PE	3	Coverage is subject to your plan/benefits
COMPLEAT LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
COMPLEAT PED LIQ ORG BLND	3	PA; Coverage is subject to your plan/benefits
CRUCIAL LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
CYCLINEX-1 POW	3	Coverage is subject to your plan/benefits
CYCLINEX-2 POW	3	Coverage is subject to your plan/benefits
DIABETIC TF LIQ	3	PA; Coverage is subject to your plan/benefits
DIABETISOURC LIQ	3	PA; Coverage is subject to your plan/benefits
EAA SUPPLEME POW TROPICAL	3	Coverage is subject to your plan/benefits
ELECARE DHA/ POW ARA INFA	3	PA; Coverage is subject to your plan/benefits
ELECARE POW DHA/ARA	3	PA; Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
ENTERAGAM POW 5GM	3	PA; MNPA
EO28 SPLASH LIQ ORANGE	3	PA; Coverage is subject to your plan/benefits
F.A.A. LIQ	3	PA; Coverage is subject to your plan/benefits
FIBERSOUR HN LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FIBERSOURCE LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FOSTEUM CAP	3	PA; MNPA
FOSTEUM PLUS CAP	3	PA; MNPA
GA POW	3	Coverage is subject to your plan/benefits
GA-1 ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
GLUCERNA 1.0 LIQ CARB VAN	3	PA; Coverage is subject to your plan/benefits
GLUCERNA LIQ 1.2 CAL	3	PA; Coverage is subject to your plan/benefits
GLUCERNA SEL LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
GLUTAREX-1 POW	3	Coverage is subject to your plan/benefits
GLUTAREX-2 POW	3	Coverage is subject to your plan/benefits
GLYROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
GLYTACTIN PAK BTMK/DLT	3	Coverage is subject to your plan/benefits
GLYTACTIN POW BETMLK15	3	Coverage is subject to your plan/benefits
GLYTACTIN POW RST LT10	3	Coverage is subject to your plan/benefits
GLYTROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
HCU ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
HCU EXP20 PAK UNFLAVOR	3	Coverage is subject to your plan/benefits
HCU EXPRESS PAK	3	Coverage is subject to your plan/benefits
HCY 2 POW	3	Coverage is subject to your plan/benefits
HOM 2 POW	3	Coverage is subject to your plan/benefits
HOMACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
HOMINEX-1 POW	3	Coverage is subject to your plan/benefits
HOMINEX-2 POW	3	Coverage is subject to your plan/benefits
I-VALEX-1 POW	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
I-VALEX-2 POW	3	Coverage is subject to your plan/benefits
ISOSOURCE HN LIQ	3	PA; Coverage is subject to your plan/benefits
ISOSOURCE LIQ	3	PA; Coverage is subject to your plan/benefits
ISOVACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
IVA ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
IVA MAXAMUM POW	3	Coverage is subject to your plan/benefits
JEVITY 1 CAL LIQ	3	PA; Coverage is subject to your plan/benefits
JEVITY 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
JEVITY 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
KETONEX-1 POW	3	Coverage is subject to your plan/benefits
KETONEX-2 POW	3	Coverage is subject to your plan/benefits
LANAFLEX PAK	3	Coverage is subject to your plan/benefits
LIPISTART POW	3	PA; Coverage is subject to your plan/benefits
LIQUID HOPE LIQ	3	PA; Coverage is subject to your plan/benefits
LMD POW	3	Coverage is subject to your plan/benefits
LOPHLEX POW	3	Coverage is subject to your plan/benefits
MCT PRO-CAL PAK	3	PA; Coverage is subject to your plan/benefits
METHIONAID POW	3	Coverage is subject to your plan/benefits
MMA/PA ANAMI POW ERLY YRS	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
MMA/PA MAXAM POW	3	Coverage is subject to your plan/benefits
MODULEN IBD POW	3	PA; Coverage is subject to your plan/benefits
MSUD AID POW	3	Coverage is subject to your plan/benefits
NEOCATE LIQ SPLASH	3	PA; Coverage is subject to your plan/benefits
NEOKE MCT70 POW	3	PA; Coverage is subject to your plan/benefits
NEPRO LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NICAPRIN TAB	3	PA
NOVASOURCE LIQ RENAL	3	PA; Coverage is subject to your plan/benefits
NUTRAMINE PAK	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.0 LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
NUTREN 1.5 LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
NUTREN 2.0 LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
NUTREN JR LIQ	3	PA; Coverage is subject to your plan/benefits
NUTREN LIQ JUNIOR	3	PA; Coverage is subject to your plan/benefits
NUTREN RENAL LIQ	3	PA; Coverage is subject to your plan/benefits
NUTRIRENAL LIQ	3	PA; Coverage is subject to your plan/benefits
OA 2 POW	3	Coverage is subject to your plan/benefits
OMNIVEX TAB	3	PA
OPTIMENTAL LIQ	3	PA; Coverage is subject to your plan/benefits
OS 2 POW	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
OSMOLITE 1 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.2 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE 1.5 LIQ CAL	3	PA; Coverage is subject to your plan/benefits
OSMOLITE HN LIQ	3	PA; Coverage is subject to your plan/benefits
OSMOLITE LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA 1.5 LIQ	3	PA; Coverage is subject to your plan/benefits
OXEPA LIQ	3	PA; Coverage is subject to your plan/benefits
PEDIASURE EN LIQ /FIBER	3	PA; Coverage is subject to your plan/benefits
PEDIASURE LIQ PEPTIDE	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
PEPTAMEN LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ	3	PA; Coverage is subject to your plan/benefits
PEPTINEX DT LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PERATIVE LIQ	3	PA; Coverage is subject to your plan/benefits
PERIFLEX POW ADVANCE	3	Coverage is subject to your plan/benefits
PFD 2 POW	3	Coverage is subject to your plan/benefits
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHENEX-1 POW	3	Coverage is subject to your plan/benefits
PHENEX-2 POW	3	Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
PHENYL-FREE POW 2	3	Coverage is subject to your plan/benefits
PHENYLADE60 POW	3	Coverage is subject to your plan/benefits
PIVOT LIQ 1.5 CAL	3	PA; Coverage is subject to your plan/benefits
PKU EXPLORE5 POW UNFLAVOR	3	Coverage is subject to your plan/benefits
PORTAGEN POW	3	Coverage is subject to your plan/benefits
PPA/MMA POW EXPRESS	3	Coverage is subject to your plan/benefits
PRO-PHREE POW	3	Coverage is subject to your plan/benefits
PROMACTIN AA SUS PLUS	3	Coverage is subject to your plan/benefits
PROMOTE 1.0 LIQ W/ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/FB LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROPIMEX-1 POW	3	Coverage is subject to your plan/benefits
PROPIMEX-2 POW	3	Coverage is subject to your plan/benefits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
PROVIMIN POW	3	Coverage is subject to your plan/benefits
RENASTART POW	3	Coverage is subject to your plan/benefits
REPLETE FIBE LIQ 1 CAL	3	PA; Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
REPLETE LIQ ULTRAPAK	3	PA; Coverage is subject to your plan/benefits
RESOURCE DIA LIQ TF	3	PA; Coverage is subject to your plan/benefits
RHEUMATE CAP	3	PA; MNPA
RIBOZEL CAP	3	PA; MNPA
S.O.S. 20 POW	3	Coverage is subject to your plan/benefits
S.O.S. 25 POW	3	Coverage is subject to your plan/benefits
SOL CARB POW	3	PA; Coverage is subject to your plan/benefits
SUPLENA LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
TOLEREX POW	3	PA; Coverage is subject to your plan/benefits
TWOCAL HN LIQ	3	PA; Coverage is subject to your plan/benefits
TYLACTIN POW BLD 20PE	3	Coverage is subject to your plan/benefits
TYR ANAMIX POW ERLY YRS	3	Coverage is subject to your plan/benefits
TYREX-1 POW	3	Coverage is subject to your plan/benefits
TYREX-2 POW	3	Coverage is subject to your plan/benefits
TYROS 2 POW	3	Coverage is subject to your plan/benefits
UCD ANAMIX POW JUNIOR	3	Coverage is subject to your plan/benefits
ULTRACAL HN LIQ PLUS	3	PA; Coverage is subject to your plan/benefits
ULTRACAL LIQ	3	PA; Coverage is subject to your plan/benefits
ULTRAMINO POW SOY PROT	3	PA; Coverage is subject to your plan/benefits
ULTRIENT 1.5 LIQ SAFE-T	3	PA; Coverage is subject to your plan/benefits
VASCULERA TAB	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
VILACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
VITAL HN POW	3	PA; Coverage is subject to your plan/benefits
VIVONEX RTF LIQ	3	PA; Coverage is subject to your plan/benefits
WND 2 POW	3	Coverage is subject to your plan/benefits
XLYS-XTRP POW MAXAMAID	3	Coverage is subject to your plan/benefits
XMET XCYS POW MAXAMAID	3	Coverage is subject to your plan/benefits
XPHE-XTYR POW MAXAMAID	3	Coverage is subject to your plan/benefits
XYZBAC TAB	3	PA
ZYVIT TAB	3	PA
DIGESTIVE AIDS		
DIGESTIVE ENZYMES		
CREON CAP 3000UNIT	2	
CREON CAP 6000UNIT	2	
CREON CAP 12000UNT	2	
CREON CAP 24000UNT	2	
CREON CAP 36000UNT	2	
PANCREAZE CAP 2600UNIT	3	
PANCREAZE CAP 4200UNIT	3	
PANCREAZE CAP 10500UNT	3	
PANCREAZE CAP 16800UNT	3	
PANCREAZE CAP 21000UNT	3	
PANCREAZE CAP 37000	3	
PERTZYE CAP 4000UNIT	3	
PERTZYE CAP 8000UNIT	3	
PERTZYE CAP 16000U	3	
PERTZYE CAP 24000U	3	
SUCRAID SOL 8500/ML	3	PA
VIOKACE TAB 10440	2	
VIOKACE TAB 20880	2	
ZENPEP CAP 3000UNIT	2	
ZENPEP CAP 5000UNIT	2	

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

Drug Name	Drug Tier	Requirements/Limits
ZENPEP CAP 10000UNT	2	
ZENPEP CAP 15000UNT	2	
ZENPEP CAP 20000UNT	2	
ZENPEP CAP 25000UNT	2	
ZENPEP CAP 40000UNT	2	
DIURETICS		
CARBONIC ANHYDRASE INHIBITORS		
acetazolamide cap er 12hr 500 mg	1	
acetazolamide tab 125 mg	1	
acetazolamide tab 250 mg	1	
KEVEYIS TAB 50MG	3	PA, QL (120 TABLETS PER 30 DAYS)
methazolamide tab 25 mg	1	
methazolamide tab 50 mg	1	
DIURETIC COMBINATIONS		
ALDACTAZIDE TAB 25/25	3	
ALDACTAZIDE TAB 50/50	3	
amiloride & hydrochlorothiazide tab 5-50 mg	1	
MAXZIDE TAB 75-50	3	
MAXZIDE-25 TAB	3	
spironolactone & hydrochlorothiazide tab 25-25 mg	1	
triamterene & hydrochlorothiazide cap 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 37.5-25 mg	1	
triamterene & hydrochlorothiazide tab 75-50 mg	1	
LOOP DIURETICS		
bumetanide tab 0.5 mg	1	
bumetanide tab 1 mg	1	
bumetanide tab 2 mg	1	
BUMEX TAB 0.5MG	3	
EDECRIN TAB 25MG	3	
ethacrynic acid tab 25 mg	1	
furosemide oral soln 8 mg/ml	1	

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

Drug Name	Drug Tier	Requirements/Limits
furosemide oral soln 10 mg/ml	1	
furosemide tab 20 mg	1	
furosemide tab 40 mg	1	
furosemide tab 80 mg	1	
LASIX TAB 20MG	3	
LASIX TAB 40MG	3	
LASIX TAB 80MG	3	
torsemide tab 5 mg	1	
torsemide tab 10 mg	1	
torsemide tab 20 mg	1	
torsemide tab 100 mg	1	
POTASSIUM SPARING DIURETICS		
ALDACTONE TAB 25MG	2	
ALDACTONE TAB 50MG	2	
ALDACTONE TAB 100MG	2	
amiloride hcl tab 5 mg	1	
CAROSPIR SUS 25MG/5ML	3	
DYRENIUM CAP 50MG	3	PA; MNPA
DYRENIUM CAP 100MG	3	PA; MNPA
spironolactone tab 25 mg	1	
spironolactone tab 50 mg	1	
spironolactone tab 100 mg	1	
triamterene cap 50 mg	1	
triamterene cap 100 mg	1	
THIAZIDES AND THIAZIDE-LIKE DIURETICS		
chlorthalidone tab 25 mg	1	
chlorthalidone tab 50 mg	1	
DIURIL SUS 250/5ML	3	
hydrochlorothiazide cap 12.5 mg	1	
hydrochlorothiazide tab 12.5 mg	1	
hydrochlorothiazide tab 25 mg	1	
hydrochlorothiazide tab 50 mg	1	
indapamide tab 1.25 mg	1	
indapamide tab 2.5 mg	1	
metolazone tab 2.5 mg	1	
metolazone tab 5 mg	1	
metolazone tab 10 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
ENDOCRINE AND METABOLIC AGENTS - MISC.		
ADRENAL STEROID INHIBITORS		
ISTURISA TAB 1MG	3	PA, QL (240 TABLETS PER 30 DAYS)
ISTURISA TAB 5MG	3	PA, QL (360 TABLETS PER 30 DAYS)
ISTURISA TAB 10MG	3	PA, QL (180 TABLETS PER 30 DAYS)
BONE DENSITY REGULATORS		
ACTONEL TAB 35MG	3	
ACTONEL TAB 150MG	3	
alendronate sodium oral soln 70 mg/75ml	1	
alendronate sodium tab 5 mg	1	
alendronate sodium tab 10 mg	1	
alendronate sodium tab 35 mg	1	
alendronate sodium tab 70 mg	1	
ATELVIA TAB	3	
BINOSTO TAB 70MG	3	
BONIVA TAB 150MG	3	
calcitonin (salmon) nasal soln 200 unit/act	1	
FORTEO INJ 600/2.4	2	PA, QL (1 PEN PER MONTH)
FOSAMAX + D TAB 70-2800	3	
FOSAMAX + D TAB 70-5600	3	
FOSAMAX TAB 70MG	3	
ibandronate sodium tab 150 mg (base equivalent)	1	
MIACALCIN INJ 200/ML	3	PA; MNPA
NATPARA INJ 25MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 75MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 100MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
risedronate sodium tab 5 mg	1	
risedronate sodium tab 30 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
risedronate sodium tab 35 mg	1	
risedronate sodium tab 150 mg	1	
risedronate sodium tab delayed release 35 mg	1	
TERIPARATIDE INJ	3	PA, QL (1 PEN PER 28 DAYS)
TYMLOS INJ	2	PA, QL (1PEN PER 30 DAYS)
CORTICOTROPIN		
ACTHAR INJ 80UNIT	3	PA, QL (35ML PER 21 DAYS)
FERTILITY REGULATORS		
CHOR GONADOT INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
clomiphene citrate tab 50 mg	1	Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 300UNIT	3	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 600UNIT	3	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
FOLLISTIM AQ INJ 900UNIT	3	PA, QL (7 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F INJ 450UNIT	2	PA, QL (10 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F INJ 1050UNIT	2	PA, QL (6 VIALS PER 28 DAYS); Coverage is subject to your plan/benefits

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

Drug Name	Drug Tier	Requirements/Limits
GONAL-F RFF INJ 75UNIT	2	PA, QL (60 VIALS PER 28 days); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 300/0.5	2	PA, QL (15 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 450/0.75	2	PA, QL (10 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
GONAL-F RFF INJ 900/1.5	2	PA, QL (7 CARTRIDGE PER 28 DAYS); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	3	PA; Coverage is subject to your plan/benefits
NOVAREL INJ 5000UNIT	3	PA; Coverage is subject to your plan/benefits
NOVAREL INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	2	PA; Coverage is subject to your plan/benefits
PREGNYL INJ 10000UNT	3	PA; Coverage is subject to your plan/benefits
GNRH/LHRH ANTAGONISTS		
CETROTIDE KIT 0.25MG	2	PA
GANIRELIX AC INJ 250/0.5	3	PA
ganirelix acetate soln prefilled syringe 250 mcg/0.5ml	1	PA
ORILISSA TAB 150MG	2	PA
ORILISSA TAB 200MG	2	PA
GROWTH HORMONE RECEPTOR ANTAGONISTS		
SOMAVERT INJ 10MG	2	PA, QL (30 VIALS PER 30 DAYS)
SOMAVERT INJ 15MG	2	PA, QL (30 VIALS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
SOMAVERT INJ 20MG	2	PA, QL (30 VIALS PER 30 DAYS)
SOMAVERT INJ 25MG	2	PA, QL (30 PER 30 DAYS)
SOMAVERT INJ 30MG	2	PA, QL (30 PER 30 DAYS)
GROWTH HORMONE RELEASING HORMONES (GHRH)		
EGRIFTA SV INJ 2MG	3	PA, QL (30 VIALS PER 30 DAYS)
GROWTH HORMONES		
GENOTROPIN INJ 0.2MG	3	PA
GENOTROPIN INJ 0.4MG	3	PA
GENOTROPIN INJ 0.6MG	3	PA
GENOTROPIN INJ 0.8MG	3	PA
GENOTROPIN INJ 1.2MG	3	PA
GENOTROPIN INJ 1.4MG	3	PA
GENOTROPIN INJ 1.6MG	3	PA
GENOTROPIN INJ 1.8MG	3	PA
GENOTROPIN INJ 1MG	3	PA
GENOTROPIN INJ 2MG	3	PA
GENOTROPIN INJ 5MG	3	PA
GENOTROPIN INJ 12MG	3	PA
HUMATROPE INJ 5MG	2	PA
HUMATROPE INJ 6MG	2	PA
HUMATROPE INJ 12MG	2	PA
HUMATROPE INJ 24MG	2	PA
NORDITROPIN INJ 5/1.5ML	2	PA
NORDITROPIN INJ 10/1.5ML	2	PA
NORDITROPIN INJ 15/1.5ML	2	PA
NORDITROPIN INJ 30/3ML	2	PA
NUTROPIN AQ INJ 10MG/2ML	3	PA
NUTROPIN AQ INJ 20MG/2ML	3	PA
NUTROPIN AQ INJ NUSPIN 5	3	PA
OMNITROPE INJ 5.8MG	3	PA
OMNITROPE INJ 5/1.5ML	3	PA
OMNITROPE INJ 10/1.5ML	3	PA
SAIZEN INJ 5MG	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
SAIZEN INJ 8.8MG	3	PA
SAIZENPREP INJ 8.8MG	3	PA
SEROSTIM INJ 4MG	3	PA
SEROSTIM INJ 5MG	3	PA
SEROSTIM INJ 6MG	3	PA
ZOMACTON INJ 5MG	3	PA
ZOMACTON INJ 10MG	3	PA
ZORBTIVE INJ 8.8MG	3	PA
HORMONE RECEPTOR MODULATORS		
EVISTA TAB 60MG	0	
OSPHENA TAB 60MG	2	
raloxifene hcl tab 60 mg	0	
INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)		
INCRELEX INJ 40MG/4ML	3	PA
LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS		
SYNAREL SOL 2MG/ML	3	
METABOLIC MODIFIERS		
BUPHENYL POW	3	PA, QL (600 GRAMS PER 30 DATS)
BUPHENYL TAB 500MG	3	PA, QL (1200 TABLETS PER 30 DAYS)
calcitriol cap 0.5 mcg	1	
calcitriol cap 0.25 mcg	1	
calcitriol oral soln 1 mcg/ml	1	
CARBAGLU TAB 200MG	3	PA
carglumic acid soluble tab 200 mg	1	PA
CARNITOR SF SOL 1GM/10ML	3	PA; MNPA
CARNITOR SOL 1GM/10ML	3	PA; MNPA
CARNITOR TAB 330MG	3	PA; MNPA
cinacalcet hcl tab 30 mg (base equiv)	1	PA, QL (60 TABLETS PER 30 DAYS)
cinacalcet hcl tab 60 mg (base equiv)	1	PA, QL (60 TABLETS PER 30 DAYS)
cinacalcet hcl tab 90 mg (base equiv)	1	PA, QL (120 TABLETS PER 30 DAYS)
CITRULLINE TAB EASY 1GM	3	
CYSTADANE POW	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
doxercalciferol cap 0.5 mcg	1	
doxercalciferol cap 1 mcg	1	
doxercalciferol cap 2.5 mcg	1	
GALAFOLD CAP 123MG	3	PA, QL (14 CAPSULES PER 28 DAYS)
KUVAN POW 100MG	3	PA
KUVAN POW 500MG	3	PA
KUVAN TAB 100MG	3	PA
levocarnitine oral soln 1 gm/10ml (10%)	1	
levocarnitine tab 330 mg	1	
MYALEPT INJ 11.3MG	3	PA, QL (30 VIALS PER 30 DATA)
nitisinone cap 2 mg	1	PA
nitisinone cap 5 mg	1	PA
nitisinone cap 10 mg	1	PA
NITYR TAB 2MG	3	PA
NITYR TAB 5MG	3	PA
NITYR TAB 10MG	3	PA
ORFADIN CAP 2MG	3	PA
ORFADIN CAP 5MG	3	PA
ORFADIN CAP 10MG	3	PA
ORFADIN CAP 20MG	3	PA
ORFADIN SUS 4MG/ML	3	PA
PALYNZIQ INJ 2.5/0.5	3	PA, QL (90 PFS PER 30 DAYS)
PALYNZIQ INJ 10/0.5ML	3	PA, QL (30 PFS PER 30 DAYS)
PALYNZIQ INJ 20MG/ML	3	PA, QL (90 PFS PER 30 DAYS)
paricalcitol cap 1 mcg	1	
paricalcitol cap 2 mcg	1	
paricalcitol cap 4 mcg	1	
PHEBURANE MIS 483/GM	3	PA, QL (672 GRAMS (8 BOTTLES) PER 30 DAYS)
RAVICTI LIQ 1.1GM/ML	3	PA
REVCOVI INJ 1.6MG/ML	3	
ROCALTROL CAP 0.5MCG	2	
ROCALTROL CAP 0.25MCG	2	

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

Drug Name	Drug Tier	Requirements/Limits
ROCALTROL SOL 1MCG/ML	2	
sapropterin dihydrochloride powder packet 100 mg	1	PA
sapropterin dihydrochloride powder packet 500 mg	1	PA
sapropterin dihydrochloride tab 100 mg	1	PA
SENSIPAR TAB 30MG	3	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 60MG	3	PA, QL (60 TABLETS PER 30 DAYS)
SENSIPAR TAB 90MG	3	PA, QL (120 TABLETS PER 30 DAYS)
sodium phenylbutyrate oral powder 3 gm/teaspoonful	1	PA, QL (600 GRAMS PER 30 DATS)
sodium phenylbutyrate tab 500 mg	1	PA, QL (1200 TABLETS PER 30 DAYS)
STRENSIQ INJ 18/0.45	3	PA
STRENSIQ INJ 28/0.7ML	3	PA
STRENSIQ INJ 40MG/ML	3	PA
STRENSIQ INJ 80/0.8ML	3	PA
XURIDEN POW 2GM	3	QL (4 PACKETS PER DAY)
ZEMPLAR CAP 1MCG	2	
ZEMPLAR CAP 2MCG	2	
MINERALOCORTICOID RECEPTOR ANTAGONISTS		
KERENDIA TAB 10MG	3	PA
KERENDIA TAB 20MG	3	PA
NATRIURETIC PEPTIDES		
VOXZOGO INJ 0.4MG	3	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 0.56MG	3	PA, QL (30 VIALS PER 30 DAYS)
VOXZOGO INJ 1.2MG	3	PA, QL (30 VIALS PER 30 DAYS)
POSTERIOR PITUITARY HORMONES		
DDAVP SOL 0.01%	3	
DDAVP TAB 0.1MG	3	
DDAVP TAB 0.2MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
desmopressin acetate nasal spray soln 0.01%	1	
desmopressin acetate nasal spray soln 0.01% (refrigerated)	1	
desmopressin acetate tab 0.1 mg	1	
desmopressin acetate tab 0.2 mg	1	
NOCDURNA SUB 27.7MCG	3	
NOCDURNA SUB 55.3MCG	3	
STIMATE SOL 1.5MG/ML	3	PA
PROGESTERONE RECEPTOR ANTAGONISTS		
MIFEPREX TAB 200MG	3	
mifepristone tab 200 mg	1	
PROLACTIN INHIBITORS		
cabergoline tab 0.5 mg	1	
SOMATOSTATIC AGENTS		
BYNFEZIA PEN INJ 2500MCG	3	PA, QL (7 PENS PER 30 DAYS)
MYCAPSSA CAP 20MG	3	PA, QL (112 CAPSULES PER 28 DAYS)
octreotide acetate inj 50 mcg/ml (0.05 mg/ml)	1	PA, QL (90 AMPULES PER 30 DAYS)
octreotide acetate inj 100 mcg/ml (0.1 mg/ml)	1	PA, QL (90 AMPULES PER 30 DAYS)
octreotide acetate inj 200 mcg/ml (0.2 mg/ml)	1	PA, QL (45 VIALS PER 30 DAYS)
octreotide acetate inj 500 mcg/ml (0.5 mg/ml)	1	PA, QL (90 AMPULES PER 30 DAYS)
octreotide acetate inj 1000 mcg/ml (1 mg/ml)	1	PA, QL (9 VIALS PER 30 DAYS)
SANDOSTATIN INJ 50MCG/ML	3	PA, QL (90 AMPULES PER 30 DAYS)
SANDOSTATIN INJ 100MCG	3	PA, QL (90 AMPULES PER 30 DAYS)
SANDOSTATIN INJ 500MCG	3	PA, QL (90 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.3MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
SIGNIFOR INJ 0.6MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)
SIGNIFOR INJ 0.9MG/ML	3	PA, QL (60 AMPULES PER 30 DAYS)
VASOPRESSIN RECEPTOR ANTAGONISTS		
JYNARQUE PAK 15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 30-15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 45-15MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 60-30MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE PAK 90-30MG	3	PA, QL (56 TABLETS PER 28 DAYS)
JYNARQUE TAB 15MG	3	PA, QL (60 tabs every month)
JYNARQUE TAB 30MG	3	PA, QL (30 tabs every month)
SAMSCA TAB 15MG	3	PA, QL (60 tabs every month)
SAMSCA TAB 30MG	3	PA, QL (30 tabs every month)
tolvaptan tab 30 mg	1	PA, QL (30 tabs every month)
ESTROGENS		
ESTROGEN COMBINATIONS		
ACTIVELLA TAB 1-0.5MG	3	
ANGELIQ TAB 0.5-1MG	3	
ANGELIQ TAB 0.25-0.5	3	
BIJUVA CAP 1-100MG	3	
CLIMARA PRO DIS WEEKLY	2	
COMBIPATCH DIS	2	
DUAVEE TAB 0.45-20	2	
estradiol & norethindrone acetate tab 0.5-0.1 mg	1	
estradiol & norethindrone acetate tab 1-0.5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
FEMHRT TAB 0.5-2.5	3	
MYFEMBREE TAB	2	PA
norethindrone acetate-ethinyl estradiol tab 0.5 mg-2.5 mcg	1	
norethindrone acetate-ethinyl estradiol tab 1 mg-5 mcg	1	
ORIAHNN CAP	2	PA
PREFEST TAB	3	
PREMPHASE TAB	2	
PREMPRO TAB	2	
PREMPRO TAB 0.3-1.5	2	
PREMPRO TAB 0.45-1.5	2	
PREMPRO TAB 0.625-5	2	
ESTROGENS		
ALORA DIS 0.1MG	3	
ALORA DIS 0.05MG	3	
ALORA DIS 0.025MG	3	
ALORA DIS 0.075MG	3	
CLIMARA DIS 0.1MG	3	
CLIMARA DIS 0.05MG	3	
CLIMARA DIS 0.06MG	3	QL (2 packages every 25 days)
CLIMARA DIS 0.025MG	3	
CLIMARA DIS 0.075MG	3	
CLIMARA DIS 0.0375MG	3	
DELESTROGEN INJ 10MG/ML	3	PA
DELESTROGEN INJ 20MG/ML	3	PA
DELESTROGEN INJ 40MG/ML	3	PA
DEPO-ESTRADI INJ 5MG/ML	3	PA
DIVIGEL GEL 0.5MG	2	
DIVIGEL GEL 0.25MG	2	
DIVIGEL GEL 0.75MG	2	
DIVIGEL GEL 1.25MG	2	
DIVIGEL GEL 1MG/GM	2	
ELESTRIN GEL 0.06%	3	
ESTRACE TAB 0.5MG	3	
ESTRACE TAB 1MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
ESTRACE TAB 2MG	3	
estradiol tab 0.5 mg	1	
estradiol tab 1 mg	1	
estradiol tab 2 mg	1	
estradiol td gel 0.5 mg/0.5gm (0.1%)	1	
estradiol td gel 0.25 mg/0.25gm (0.1%)	1	
estradiol td gel 0.75 mg/0.75gm (0.1%)	1	
estradiol td gel 1 mg/gm (0.1%)	1	
estradiol td gel 1.25 mg/1.25gm (0.1%)	1	
estradiol td patch twice weekly 0.1 mg/24hr	1	
estradiol td patch twice weekly 0.05 mg/24hr	1	
estradiol td patch twice weekly 0.025 mg/24hr	1	
estradiol td patch twice weekly 0.075 mg/24hr	1	
estradiol td patch twice weekly 0.0375 mg/24hr	1	
estradiol td patch weekly 0.1 mg/24hr	1	
estradiol td patch weekly 0.05 mg/24hr	1	
estradiol td patch weekly 0.06 mg/24hr	1	
estradiol td patch weekly 0.025 mg/24hr	1	
estradiol td patch weekly 0.075 mg/24hr	1	
estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)	1	
estradiol valerate im in oil 20 mg/ml	1	PA
estradiol valerate im in oil 40 mg/ml	1	PA
ESTROGEL GEL	3	
EVAMIST SPR 1.53MG	2	
MENEST TAB 0.3MG	3	
MENEST TAB 0.625MG	3	
MENEST TAB 1.25MG	3	
MENOSTAR DIS 14MCG	3	
MINIVELLE DIS 0.1MG	3	
MINIVELLE DIS 0.05MG	3	
MINIVELLE DIS 0.025MG	3	
MINIVELLE DIS 0.075MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
MINIVELLE DIS 0.0375MG	3	
PREMARIN INJ 25MG	3	PA
PREMARIN TAB 0.3MG	2	
PREMARIN TAB 0.9MG	2	
PREMARIN TAB 0.45MG	2	
PREMARIN TAB 0.625MG	2	
PREMARIN TAB 1.25MG	2	
VIVELLE-DOT DIS 0.1MG	3	
VIVELLE-DOT DIS 0.05MG	3	
VIVELLE-DOT DIS 0.025MG	3	
VIVELLE-DOT DIS 0.075MG	3	
VIVELLE-DOT DIS 0.0375MG	3	
FLUOROQUINOLONES		
FLUOROQUINOLONES		
BAXDELA TAB 450MG	3	
CIPRO (5%) SUS 250MG/5	3	
CIPRO (10%) SUS 500MG/5	3	
CIPRO TAB 250MG	3	
CIPRO TAB 500MG	3	
ciprofloxacin hcl tab 100 mg (base equiv)	1	
ciprofloxacin hcl tab 250 mg (base equiv)	1	
ciprofloxacin hcl tab 500 mg (base equiv)	1	
ciprofloxacin hcl tab 750 mg (base equiv)	1	
levofloxacin oral soln 25 mg/ml	1	
levofloxacin tab 250 mg	1	
levofloxacin tab 500 mg	1	
levofloxacin tab 750 mg	1	
moxifloxacin hcl tab 400 mg (base equiv)	1	
ofloxacin tab 300 mg	1	
ofloxacin tab 400 mg	1	
GASTROINTESTINAL AGENTS - MISC.		
5-HT4 RECEPTOR AGONISTS		
MOTEGRITY TAB 1MG	3	
MOTEGRITY TAB 2MG	3	
AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)		
TRULANCE TAB 3MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
BILE ACID SYNTHESIS DISORDER AGENTS		
CHOLBAM CAP 50MG	3	PA
CHOLBAM CAP 250MG	3	PA
FARNESOID X RECEPTOR (FXR) AGONISTS		
OCALIVA TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OCALIVA TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
GALLSTONE SOLUBILIZING AGENTS		
CHENODAL TAB 250MG	3	
RELTONE CAP 200MG	3	PA
RELTONE CAP 400MG	3	PA
URSO 250 TAB 250MG	2	
URSO FORTE TAB 500MG	2	
ursodiol cap 300 mg	1	
ursodiol tab 250 mg	1	
ursodiol tab 500 mg	1	
GASTROINTESTINAL ANTIALLERGY AGENTS		
cromolyn sodium oral conc 100 mg/5ml	1	
GASTROCROM CON 100/5ML	3	
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS		
AMITIZA CAP 8MCG	3	
AMITIZA CAP 24MCG	3	
lubiprostone cap 8 mcg	1	
lubiprostone cap 24 mcg	1	
GASTROINTESTINAL STIMULANTS		
GIMOTI SPR 15MG	3	
METOCLOPRAMI TAB 10MG ODT	3	
metoclopramide hcl orally disintegrating tab 5 mg (base eq)	1	
metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)	1	
metoclopramide hcl tab 5 mg (base equivalent)	1	
metoclopramide hcl tab 10 mg (base equivalent)	1	
REGLAN TAB 5MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
REGLAN TAB 10MG	3	
ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS		
BYLVAY CAP 200MCG	3	PA
BYLVAY CAP 400MCG	3	PA
BYLVAY CAP 600MCG	3	PA
BYLVAY CAP 1200MCG	3	PA
LIVMARLI SOL 9.5MG/ML	3	PA, QL (90 ml per 30 days)
INFLAMMATORY BOWEL AGENTS		
APRISO CAP 0.375GM	3	
ASACOL HD TAB 800MG	3	
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
balsalazide disodium cap 750 mg	1	
CANASA SUP 1000MG	3	
CIMZIA KIT 200MG	3	PA, QL (2 KITS PER 28 DAYS); MNPA
CIMZIA PREFL KIT 200MG/ML	3	PA, QL (2 KITS PER 28 DAYS); MNPA
CIMZIA START KIT 200MG/ML	3	PA, QL (1 KIT PER 28 DAYS); MNPA
COLAZAL CAP 750MG	3	PA; MNPA
DELZICOL CAP 400MG	3	
DIPENTUM CAP 250MG	3	
LIALDA TAB 1.2GM	3	
mesalamine cap dr 400 mg	1	
mesalamine cap er 24hr 0.375 gm	1	
mesalamine cap er 500 mg	1	
mesalamine enema 4 gm	1	
mesalamine rectal enema 4 gm & cleanser wipe kit*	1	
mesalamine suppos 1000 mg	1	
mesalamine tab delayed release 1.2 gm	1	
mesalamine tab delayed release 800 mg	1	
PENTASA CAP 250MG CR	2	
PENTASA CAP 500MG CR	2	
ROWASA KIT 4GM	3	

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

Drug Name	Drug Tier	Requirements/Limits
SFROWASA ENE 4GM	3	
SKYRIZI INJ 360/2.4	2	PA, QL (1 cartridge per 56 days)
sulfasalazine tab 500 mg	1	
sulfasalazine tab delayed release 500 mg	1	
INTESTINAL ACIDIFIERS		
lactulose (encephalopathy) solution 10 gm/15ml	1	
IRRITABLE BOWEL SYNDROME (IBS) AGENTS		
alosetron hcl tab 0.5 mg (base equiv)	1	
alosetron hcl tab 1 mg (base equiv)	1	
LINZESS CAP 72MCG	2	
LINZESS CAP 145MCG	2	
LINZESS CAP 290MCG	2	
LOTRONEX TAB 0.5MG	3	
LOTRONEX TAB 1MG	3	
VIBERZI TAB 75MG	2	
VIBERZI TAB 100MG	2	
ZELNORM TAB 6MG	3	
PERIPHERAL OPIOID RECEPTOR ANTAGONISTS		
alvimopan cap 12 mg	1	
ENTEREG CAP 12MG	3	
MOVANTIK TAB 12.5MG	2	PA
MOVANTIK TAB 25MG	2	PA
RELISTOR INJ 8/0.4ML	3	PA
RELISTOR INJ 12/0.6ML	3	PA
RELISTOR TAB 150MG	3	PA
SYMPROIC TAB 0.2MG	2	PA
PHOSPHATE BINDER AGENTS		
AURYXIA TAB 210MG	2	
calcium acetate (phosphate binder) cap 667 mg (169 mg ca)	1	
FOSRENOL CHW 500MG	3	PA
FOSRENOL CHW 750MG	3	PA
FOSRENOL CHW 1000MG	3	PA
FOSRENOL POW 750MG	3	
FOSRENOL POW 1000MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
lanthanum carbonate chew tab 500 mg (elemental)	1	PA
lanthanum carbonate chew tab 750 mg (elemental)	1	PA
lanthanum carbonate chew tab 1000 mg (elemental)	1	PA
PHOSLYRA SOL	2	
RENAGEL TAB 800MG	3	
RENVELA POW 0.8GM	3	
RENVELA POW 2.4GM	3	
RENVELA TAB 800MG	3	
sevelamer carbonate packet 0.8 gm	1	
sevelamer carbonate packet 2.4 gm	1	
sevelamer carbonate tab 800 mg	1	
sevelamer hcl tab 400 mg	1	
sevelamer hcl tab 800 mg	1	
VELPHORO CHW 500MG	2	
SHORT BOWEL SYNDROME (SBS) AGENTS		
GATTEX KIT 5MG	3	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
TRYPTOPHAN HYDROXYLASE INHIBITORS		
XERMELO TAB 250MG	3	PA, QL (90 TABLETS PER 30 DAYS)
GENITOURINARY AGENTS - MISCELLANEOUS		
ACIDIFIERS		
K-PHOS TAB NO 2	3	
ALKALINIZERS		
ORACIT SOL	3	
pot & sod citrates w/ cit ac soln 550-500-334 mg/5ml	1	
potassium citrate & citric acid powder pack 3300-1002 mg	1	
potassium citrate & citric acid soln 1100-334 mg/5ml	1	
potassium citrate tab er 5 meq (540 mg)	1	
potassium citrate tab er 10 meq (1080 mg)	1	
potassium citrate tab er 15 meq (1620 mg)	1	

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

Drug Name	Drug Tier	Requirements/Limits
sodium citrate & citric acid soln 500-334 mg/5ml	1	
UROCIT-K 5 TAB	2	
UROCIT-K 10 TAB	2	
UROCIT-K 15 TAB	2	
CYSTINOSIS AGENTS		
CYSTAGON CAP 50MG	3	PA
CYSTAGON CAP 150MG	3	PA
PROCYSBI CAP 25MG	3	PA, QL (240 CAPSULES PER 30 DAYS)
PROCYSBI CAP 75MG	3	PA, QL (750 CAPSULES PER 30 DAYS)
PROCYSBI GRA 75MG	3	PA, QL (180 PACKETS PER 30 DAYS)
PROCYSBI GRA 300MG	3	PA, QL (180 PACKETS PER 30 DAYS)
INTERSTITIAL CYSTITIS AGENTS		
ELMIRON CAP 100MG	3	
PENTOSAN CAP 150MG	3	
PENTOSAN CAP 200MG	3	
RIMSO-50 SOL 50%	3	PA; MNPA
PROSTATIC HYPERTROPHY AGENTS		
alfuzosin hcl tab er 24hr 10 mg	1	
AVODART CAP 0.5MG	3	
CARDURA XL TAB 4MG	3	
CARDURA XL TAB 8MG	3	
dutasteride cap 0.5 mg	1	
dutasteride-tamsulosin hcl cap 0.5-0.4 mg	1	
finasteride tab 5 mg	1	
FLOMAX CAP 0.4MG	3	
JALYN CAP	3	
PROSCAR TAB 5MG	3	
RAPAFLO CAP 4MG	3	
RAPAFLO CAP 8MG	3	
silodosin cap 4 mg	1	
silodosin cap 8 mg	1	
tamsulosin hcl cap 0.4 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
UROXATRAL TAB 10MG	3	PA; MNPA
URINARY ANALGESICS		
phenazopyridine hcl tab 200 mg	1	
URINARY STONE AGENTS		
LITHOSTAT TAB 250MG	3	
THIOLA EC TAB 100MG	3	
THIOLA EC TAB 300MG	3	
tiopronin tab 100 mg	1	PA
GOUT AGENTS		
GOUT AGENT COMBINATIONS		
colchicine w/ probenecid tab 0.5-500 mg	1	
GOUT AGENTS		
allopurinol tab 100 mg	1	
allopurinol tab 300 mg	1	
colchicine cap 0.6 mg	1	
colchicine tab 0.6 mg	1	
COLCRYS TAB 0.6MG	3	
febuxostat tab 40 mg	1	
febuxostat tab 80 mg	1	
GLOPERBA SOL 0.6/5ML	3	
MITIGARE CAP 0.6MG	3	
ULORIC TAB 40MG	3	
ULORIC TAB 80MG	3	
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
URICOSURICS		
probenecid tab 500 mg	1	
HEMATOLOGICAL AGENTS - MISC.		
ANTIHEMOPHILIC PRODUCTS		
HEMLIBRA INJ 30MG/ML	3	PA
HEMLIBRA INJ 60/0.4	3	PA
HEMLIBRA INJ 105/0.7	3	PA
HEMLIBRA INJ 150/ML	3	PA
BRADYKININ B2 RECEPTOR ANTAGONISTS		
FIRAZYR INJ 30MG/3ML	3	PA, QL (45 SYRINGES PER 90 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
icatibant acetate inj 30 mg/3ml (base equivalent)	1	PA, QL (45 SYRINGES PER 90 DAYS)
COMPLEMENT INHIBITORS		
BERINERT INJ 500UNIT	3	PA, QL (60 VIALS PER 90 DAYS)
CINRYZE SOL 500 UNIT	3	PA, QL (20 VIALS PER 30 DAYS)
HAEGARDA INJ 2000UNIT	3	PA, QL (20 VIALS PER 30 DAYS)
HAEGARDA INJ 3000UNIT	3	PA, QL (20 VIALS PER 30 DAYS)
RUCONEST INJ 2100UNIT	2	PA, QL (60 VIALS PER 90 DAYS)
HEMATAOLOGIC - TYROSINE KINASE INHIBITORS		
TAVALISSE TAB 100MG	2	PA, QL (60 TABLETS PER 30 DAYS)
TAVALISSE TAB 150MG	2	PA, QL (60 TABLETS PER 30 DAYS)
HEMATORHEOLOGIC AGENTS		
pentoxifylline tab er 400 mg	1	
PLASMA KALLIKREIN INHIBITORS		
KALBITOR INJ 10MG/ML	3	PA, QL (30 CARTONS (900 MG) PER 90 DAYS)
ORLADEYO CAP 110MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
ORLADEYO CAP 150MG	3	PA, QL (28 CAPSULES PER 28 DAYS)
TAKHZYRO INJ 300/2ML	2	PA, QL (2 VIALS PER 28 DAYS)
PLATELET AGGREGATION INHIBITORS		
AGRYLIN CAP 0.5MG	2	
anagrelide hcl cap 0.5 mg	1	
anagrelide hcl cap 1 mg	1	
ASA/OMEPRAZO TAB 81-40MG	3	
ASP/OMEPRAZO TAB 325-40MG	3	
aspirin-dipyridamole cap er 12hr 25-200 mg	1	
BRILINTA TAB 60MG	2	

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

Drug Name	Drug Tier	Requirements/Limits
BRILINTA TAB 90MG	2	
cilostazol tab 50 mg	1	
cilostazol tab 100 mg	1	
clopidogrel bisulfate tab 75 mg (base equiv)	1	
clopidogrel bisulfate tab 300 mg (base equiv)	1	
dipyridamole tab 25 mg	1	
dipyridamole tab 50 mg	1	
dipyridamole tab 75 mg	1	
DURLAZA CAP 162.5MG	3	
EFFIENT TAB 5MG	3	
EFFIENT TAB 10MG	3	
PLAVIX TAB 75MG	3	
prasugrel hcl tab 5 mg (base equiv)	1	
prasugrel hcl tab 10 mg (base equiv)	1	
YOSPRALA TAB 81-40MG	3	
YOSPRALA TAB 325-40MG	3	
ZONTIVITY TAB 2.08MG	3	
HEMATOPOIETIC AGENTS		
AGENTS FOR GAUCHER DISEASE		
CERDELGA CAP 84MG	2	PA, QL (56 capsules per 28 days)
miglustat cap 100 mg	1	PA, QL (90 CAPSULES PER 30 DAYS)
ZAVESCA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS)
AGENTS FOR SICKLE CELL DISEASE		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	
ENDARI POW 5GM	3	PA, QL (180 PACKETS PER 30 DAYS)
OXBRYTA TAB 500MG	3	PA, QL (90 TABLETS PER 30 DAYS)
SIKLOS TAB 100MG	3	
SIKLOS TAB 1000MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
COBALAMINS		
CYANOCOBALAM SOL 2000MCG	3	PA
cyanocobalamin inj 1000 mcg/ml	1	PA
NASCOBAL SPR 500MCG	3	
FOLIC ACID/FOLATES		
folic acid cap 0.8 mg	0	$0 copay for women younger than 55
folic acid tab 1 mg	1	
folic acid tab 400 mcg	0	$0 copay for women younger than 55
folic acid tab 800 mcg	0	$0 copay for women younger than 55
HEMATOPOIETIC GROWTH FACTORS		
ARANESP INJ 10MCG	3	PA
ARANESP INJ 25MCG	3	PA
ARANESP INJ 40MCG	3	PA
ARANESP INJ 60MCG	3	PA
ARANESP INJ 100MCG	3	PA
ARANESP INJ 150MCG	3	PA
ARANESP INJ 200MCG	3	PA
ARANESP INJ 300MCG	3	PA
ARANESP INJ 500MCG	3	PA
DOPTELET TAB 20MG	3	PA, QL (90 tabs every month)
EPOGEN INJ 2000/ML	3	PA
EPOGEN INJ 3000/ML	3	PA
EPOGEN INJ 4000/ML	3	PA
EPOGEN INJ 10000/ML	3	PA
EPOGEN INJ 20000/ML	3	PA
FULPHILA INJ 6/0.6ML	3	PA, QL (2 SYRINGES PER 28 DAYS)
FYLNETRA INJ 6MG/0.6	3	PA, QL (2 PFS PER 28 DAYS)
GRANIX INJ 300/0.5	2	PA
GRANIX INJ 480/0.8	2	PA
LEUKINE INJ 250MCG	3	PA
MIRCERA INJ 30MCG	3	PA

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

Drug Name	Drug Tier	Requirements/Limits
MIRCERA INJ 50MCG	3	PA
MIRCERA INJ 75MCG	3	PA
MIRCERA INJ 100MCG	3	PA
MIRCERA INJ 150MCG	3	PA
MIRCERA INJ 200MCG	3	PA
MULPLETA TAB 3MG	3	PA, QL (7 TABLETS PER 14 DAYS)
NEULASTA INJ 6MG/0.6M	2	PA, QL (2 SYRINGES PER 28 DAYS)
NEULASTA KIT 6MG/0.6M	2	PA, QL (2 SYRINGES PER 28 DAYS)
NEUPOGEN INJ 300/0.5	2	PA
NEUPOGEN INJ 300MCG	2	PA
NEUPOGEN INJ 480/0.8	2	PA
NEUPOGEN INJ 480MCG	2	PA
NIVESTYM INJ 300/0.5	2	PA
NIVESTYM INJ 300MCG	2	PA
NIVESTYM INJ 480/0.8	2	PA
NIVESTYM INJ 480MCG	2	PA
NYVEPRIA INJ 6/0.6ML	3	PA, QL (2 SYRINGES PER 28 DAYS)
PROCRIT INJ 2000/ML	2	PA
PROCRIT INJ 3000/ML	2	PA
PROCRIT INJ 4000/ML	2	PA
PROCRIT INJ 10000/ML	2	PA
PROCRIT INJ 20000/ML	2	PA
PROCRIT INJ 40000/ML	2	PA
PROMACTA PAK 25MG	2	PA, QL (180 PACKETS PER 30 DAYS)
PROMACTA POW 12.5MG	2	PA, QL (120 PACKETS PER 30 DAYS)
PROMACTA TAB 12.5MG	2	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 25MG	2	PA, QL (30 TABLETS PER 30 DAYS)
PROMACTA TAB 50MG	2	PA, QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
PROMACTA TAB 75MG	2	PA, QL (60 TABLETS PER 30 DAYS)
RETACRIT INJ 2000UNIT	2	PA
RETACRIT INJ 3000UNIT	2	PA
RETACRIT INJ 4000UNIT	2	PA
RETACRIT INJ 10000UNT	2	PA
RETACRIT INJ 20000UNI	2	PA
RETACRIT INJ 40000UNT	2	PA
UDENYCA INJ 6MG/.6ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
ZARXIO INJ 300/0.5	2	PA
ZARXIO INJ 480/0.8	2	PA
ZIEXTENZO INJ 6/0.6ML	2	PA, QL (2 SYRINGES PER 28 DAYS)
HEMATOPOIETIC MIXTURES		
FERIVA TAB 21/7	3	PA; MNPA
folic acid-cholecalciferol tab 1 mg-3775 unit	1	PA; MNPA
ORTHO DF CAP 1-3775IU	3	PA; MNPA
TALIVA CAP	3	PA; MNPA
HEMOSTATICS		
HEMOSTATICS - SYSTEMIC		
AMICAR SOL 0.25/ML	3	
AMICAR TAB 500MG	3	
AMICAR TAB 1000MG	3	
aminocaproic acid oral soln 0.25 gm/ml	1	
aminocaproic acid tab 500 mg	1	
aminocaproic acid tab 1000 mg	1	
LYSTEDA TAB 650MG	3	
tranexamic acid tab 650 mg	1	
HEMOSTATICS - TOPICAL		
ARTISS SOL 2ML	3	
ARTISS SOL 4ML	3	
ARTISS SOL 10ML	3	
TACHOSIL PAD 4.8X4.8	3	
TACHOSIL PAD 9.5X4.8	3	
TISSEEL KIT 2ML	3	

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

Drug Name	Drug Tier	Requirements/Limits
TISSEEL KIT 4ML	3	
TISSEEL KIT 10ML	3	
TISSEEL SOL 2ML	3	
TISSEEL SOL 4ML	3	
TISSEEL SOL 10ML	3	
HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS		
BARBITURATE HYPNOTICS		
phenobarbital elixir 20 mg/5ml	1	
phenobarbital tab 15 mg	1	
phenobarbital tab 16.2 mg	1	
phenobarbital tab 30 mg	1	
phenobarbital tab 32.4 mg	1	
phenobarbital tab 60 mg	1	
phenobarbital tab 64.8 mg	1	
phenobarbital tab 97.2 mg	1	
phenobarbital tab 100 mg	1	
HYPNOTICS - TRICYCLIC AGENTS		
doxepin hcl (sleep) tab 3 mg (base equiv)	1	
doxepin hcl (sleep) tab 6 mg (base equiv)	1	
SILENOR TAB 3MG	3	
SILENOR TAB 6MG	3	
NON-BARBITURATE HYPNOTICS		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	
EDLUAR SUB 5MG	3	
EDLUAR SUB 10MG	3	
estazolam tab 1 mg	1	
estazolam tab 2 mg	1	
eszopiclone tab 1 mg	1	
eszopiclone tab 2 mg	1	
eszopiclone tab 3 mg	1	
flurazepam hcl cap 15 mg	1	
flurazepam hcl cap 30 mg	1	
HALCION TAB 0.25MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
IGALMI MIS 120MCG	3	
IGALMI MIS 180MCG	3	
LUNESTA TAB 1MG	3	
LUNESTA TAB 2MG	3	
LUNESTA TAB 3MG	3	
quazepam tab 15 mg	1	PA; MNPA
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	
RESTORIL CAP 22.5MG	3	
RESTORIL CAP 30MG	3	
temazepam cap 7.5 mg	1	
temazepam cap 15 mg	1	
temazepam cap 22.5 mg	1	
temazepam cap 30 mg	1	
triazolam tab 0.25 mg	1	
triazolam tab 0.125 mg	1	
zaleplon cap 5 mg	1	
zaleplon cap 10 mg	1	
zolpidem tartrate sl tab 1.75 mg	1	PA; MNPA
zolpidem tartrate sl tab 3.5 mg	1	PA; MNPA
zolpidem tartrate tab 5 mg	1	
zolpidem tartrate tab 10 mg	1	
zolpidem tartrate tab er 6.25 mg	1	
zolpidem tartrate tab er 12.5 mg	1	
ZOLPIMIST SPR 5MG	3	PA
OREXIN RECEPTOR ANTAGONISTS		
BELSOMRA TAB 5MG	2	
BELSOMRA TAB 10MG	2	
BELSOMRA TAB 15MG	2	
BELSOMRA TAB 20MG	2	
DAYVIGO TAB 5MG	3	
DAYVIGO TAB 10MG	3	
SELECTIVE MELATONIN RECEPTOR AGONISTS		
HETLIOZ CAP 20MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	3	PA, QL (150 ML PER MONTH)

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

Drug Name	Drug Tier	Requirements/Limits
ramelteon tab 8 mg	1	
ROZEREM TAB 8MG	3	
LAXATIVES		
LAXATIVE COMBINATIONS		
bisacodyl tab & peg 3350-kcl-sod bicarb-nacl for soln kit	0	$0 copay for members age 50 through 74
CLENPIQ SOL	0	$0 copay for members age 45 through 75
GOLYTELY SOL	3	
MOVIPREP SOL	0	
NULYTELY SOL LMN/LIME	3	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm	1	
peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm	1	
peg 3350-kcl-nacl-na sulfate-na ascorbate-c for soln 100 gm	0	
peg 3350-kcl-sod bicarb-nacl for soln 420 gm	1	
peg-prep kit	0	$0 copay for members age 50 through 74
PLENVU SOL	0	
SUPREP BOWEL SOL PREP KIT	0	
SUTAB TAB	0	
LAXATIVES - MISCELLANEOUS		
KRISTALOSE PAK 10GM	3	
KRISTALOSE PAK 20GM	3	
LACTULOSE PAK 10GM	3	PA; MNPA
lactulose solution 10 gm/15ml	1	
SALINE LAXATIVES		
OSMOPREP TAB 1.5GM	3	
STIMULANT LAXATIVES		
CASCARA EXT SAGRADA	3	
MACROLIDES		
AZITHROMYCIN		
azithromycin for susp 100 mg/5ml	1	
azithromycin for susp 200 mg/5ml	1	

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

Drug Name	Drug Tier	Requirements/Limits
azithromycin powd pack for susp 1 gm	1	
azithromycin tab 250 mg	1	
azithromycin tab 500 mg	1	
azithromycin tab 600 mg	1	
ZITHROMAX POW 1GM PAK	3	
ZITHROMAX SUS 100/5ML	3	
ZITHROMAX SUS 200/5ML	3	
ZITHROMAX TAB 250MG	3	
ZITHROMAX TAB 500MG	3	
ZITHROMAX TAB TRI-PAK	3	
ZITHROMAX TAB Z-PAK	3	
CLARITHROMYCIN		
clarithromycin for susp 125 mg/5ml	1	
clarithromycin for susp 250 mg/5ml	1	
clarithromycin tab 250 mg	1	
clarithromycin tab 500 mg	1	
clarithromycin tab er 24hr 500 mg	1	
ERYTHROMYCINS		
E.E.S. GRAN SUS 200/5ML	3	PA; MNPA
ERYPED SUS 200/5ML	3	PA; MNPA
ERYPED SUS 400/5ML	3	PA; MNPA
erythromycin ethylsuccinate for susp 200 mg/5ml	1	MNPA
erythromycin ethylsuccinate for susp 400 mg/5ml	1	MNPA
erythromycin ethylsuccinate tab 400 mg	1	
erythromycin stearate tab 250 mg	1	
erythromycin tab 250 mg	1	
erythromycin tab 500 mg	1	
erythromycin tab delayed release 250 mg	1	
erythromycin tab delayed release 333 mg	1	
erythromycin tab delayed release 500 mg	1	
erythromycin w/ delayed release particles cap 250 mg	1	
FIDAXOMICIN		
DIFICID SUS	2	
DIFICID TAB 200MG	2	

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

Drug Name	Drug Tier	Requirements/Limits
MEDICAL DEVICES AND SUPPLIES		
CONTRACEPTIVES		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 condoms per month)
FC FEMALE MIS CONDOM	0	QL (12 condoms per month)
FEMCAP MIS 22MM	0	QL (1 each every 300 days)
FEMCAP MIS 26MM	0	QL (1 each every 300 days)
FEMCAP MIS 30MM	0	QL (1 each every 300 days)
OMNIFLEX DPR	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 60	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 65	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 70	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 75	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 80	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 85	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 90	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 95	0	QL (1 each every 300 days)
DIABETIC SUPPLIES		
ACCU-CHEK KIT FASTCLIX	0	
ACCU-CHEK KIT SOFTCLIX	0	
ACCU-CHEK LIQ GUIDE	0	
ACCU-CHEK LIQ SMART	0	
ACCU-CHEK MIS MLTICLIX	0	

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

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

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
CVS LANCETS MIS 30G	0	
CVS LANCETS MIS 33G	0	
CVS LANCETS MIS ORIGINAL	0	
CVS LANCETS MIS THIN 26G	0	
CVS LANCETS MIS THIN 30G	0	
CVS LANCETS MIS THIN 33G	0	
CVS LANCING MIS DEVICE	0	
DEXCOM G5 MIS RECEIVER	2	QL (1 each every year)
DEXCOM G5 MIS TRANSMIT	2	QL (1 box every 75 days)
DEXCOM G6 MIS RECEIVER	2	QL (1 each every year)
DEXCOM G6 MIS SENSOR	2	QL (3 sensors per month)
DEXCOM G6 MIS TRANSMIT	2	QL (1 box every 75 days)
DIATHRIVE LIQ CONTROL	0	
DIATHRIVE MIS LANCETS	0	
DIATHRIVE MIS LANCING	0	
DIATHRIVE MIS UT 30G	0	
DIATRUE CONT SOL LEVEL 1	0	
DIATRUE CONT SOL LEVEL 2	0	
DIATRUE CONT SOL LEVEL 3	0	
DROPLET LANC MIS 30G	0	
DROPLET LANC MIS DEVICE	0	
DROPLET PERS MIS LANC 30G	0	
DUO-CARE LIQ LEVEL1/2	0	
E-Z JECT MIS 21G	0	
E-Z JECT MIS 21G COLR	0	
E-Z JECT MIS 30G	0	
E-Z JECT MIS 32G COLR	0	
E-Z JECT MIS LANC 21G	0	
E-Z JECT MIS THIN 26G	0	
E-ZJECT LANC MIS 33G	0	
EASY COMFORT MIS 30G	0	
EASY COMFORT MIS LANC/30G	0	
EASY COMFORT MIS TWIST	0	
EASY MINI MIS	0	

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

Drug Name	Drug Tier	Requirements/Limits
EASY MINI MIS EJECT	0	
EASY PLUS II SOL HIGH	0	
EASY PLUS II SOL LOW	0	
EASY TALK SOL HIGH	0	
EASY TALK SOL LOW	0	
EASY TALK SOL NORMAL	0	
EASY TOUCH MIS	0	
EASY TOUCH MIS LANC/21G	0	
EASY TOUCH MIS LANC/23G	0	
EASY TOUCH MIS LANC/26G	0	
EASY TOUCH MIS LANC/28G	0	
EASY TOUCH MIS LANC/30G	0	
EASY TOUCH MIS LANC/32G	0	
EASY TOUCH MIS LANC/33G	0	
EASY TOUCH SOL CONTROL	0	
EASY TOUCH SOL HIGH/LOW	0	
EASY TRAK II LIQ NORMAL	0	
EASY TRAK SOL HIGH	0	
EASY TRAK SOL LOW	0	
EASY TRAK SOL NORMAL	0	
EASYGLUCO SOL PLUS	0	
EASYMAX 15 LIQ LEVEL2-3	0	
EASYMAX 15 SOL LEVEL 2	0	
EASYMAX LIQ NORM/HIG	0	
EASYMAX SOL NORMAL	0	
EASYSTEP HGH SOL CONTROL	0	
EASYSTEP LOW SOL CONTROL	0	
ELEMENT CONT LIQ NORMAL	0	
ELEMENT LIQ HIGH	0	
ELEMENT LIQ LOW	0	
ELEMNT COMPA SOL LEVEL 2	0	
ELEMNT COMPA SOL LEVEL 3	0	
EMBRACE CNTR LIQ HIGH	0	
EMBRACE EVO LIQ LEVEL 1	0	
EMBRACE LANC MIS /EJECTOR	0	
EMBRACE LANC MIS THIN 30G	0	
EMBRACE PRO LIQ GLUCOSE	0	

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

Drug Name	Drug Tier	Requirements/Limits
EMBRACE SOL LOW	0	
EMBRACE TALK SOL HIGH/L2	0	
EMBRACE TALK SOL LOW/L1	0	
EQL LANCETS MIS 21G COLR	0	
EQL LANCETS MIS 33G COLR	0	
EQL LANCETS MIS THIN 26G	0	
EQL LANCETS MIS THIN 30G	0	
EVENCAR MINI SOL NORMAL	0	
EVENCARE G2 SOL LOW/HIGH	0	
EVENCARE G3 SOL LOW/HIGH	0	
EVENCARE SOL LIQ LOW/HIGH	0	
EVOLUTION SOL NORMAL	0	
EZ-LETS 21G MIS LANCETS	0	
EZ-LETS 26G MIS LANCETS	0	
EZ-LETS 28G MIS LANCETS	0	
EZ-LETS 30G MIS LANCETS	0	
FASTCLIX MIS LANCETS	0	
FIFTY50 SAFE MIS LANCETS	0	
FINE 30 MIS	0	
FINGERSTIX MIS LANCETS	0	
FORA CONTROL SOL HIGH	0	
FORA CONTROL SOL LOW	0	
FORA CONTROL SOL NORMAL	0	
FORA LANCETS MIS 30G	0	
FORA MIS LANCETS	0	
FORA MIS LANCING	0	
FORACARE GDH SOL HIGH	0	
FORACARE GDH SOL LOW	0	
FORACARE GDH SOL NORMAL	0	
FORTISCARE SOL CNTL HI	0	
FORTISCARE SOL CNTL LOW	0	
FORTISCARE SOL CNTL NML	0	
FREESTY LIBR KIT 2 SENSOR	2	QL (3 sensors per month)
FREESTY LIBR MIS 2 READER	2	QL (1 each every year); FREESTYLE LIBRE

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

Drug Name	Drug Tier	Requirements/Limits
FREESTYLE KIT SENSOR	2	QL (3 sensors per month)
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS READER	2	QL (1 each every year); FREESTYLE LIBRE
FREESTYLE MIS UNISTICK	0	
G4 PLAT PED MIS RVC/SHAR	2	QL (1 each every year)
G4 PLATINUM MIS PEDIATRC	2	QL (1 each every year)
G4 PLATINUM MIS RCV/SHAR	2	QL (1 each every year)
G4 PLATINUM MIS RECEIVER	2	QL (1 each every year)
G4 PLATINUM MIS TRANSMIT	2	QL (1 box every 75 days)
G4 SENSOR MIS	2	QL (3 sensors per month)
G5/G4 MIS SENSOR	2	QL (3 sensors per month)
GE100 CONTRL SOL NORMAL	0	
GENTEEL LANC KIT BLUE	0	
GENTEEL MIS LANCETS	0	
GENTEEL MIS NOZZLES	0	
GENTEEL PLUS MIS BLACK	0	
GENTEEL PLUS MIS BLUE	0	
GENTEEL PLUS MIS PINK	0	
GENTEEL PLUS MIS PURPLE	0	
GENTEEL PLUS MIS WHITE	0	
GENTEEL TIPS MIS BLUE	0	
GENTEEL TIPS MIS CLEAR	0	
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	
GENTEEL TIPS MIS YELLOW	0	
GENTLE-LET MIS 26G	0	
GENTLE-LET MIS 28G	0	
GENTLE-LET MIS LANCETS	0	
GENTLE-LET MIS PLATFORM	0	
GLOBAL 28G MIS LANCETS	0	

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
LANCETS MIS THIN	0	
LANCETS MIS THIN 26G	0	
LANCETS MIS THIN 30G	0	
LANCETS SUPR MIS THIN 28G	0	
LANCETS THIN MIS	0	
LANCETS THIN MIS 26G	0	
LANCETS ULTR MIS THIN	0	
LANCING DEVI MIS	0	
LANCING DEVI MIS 25G	0	
LANCING DEVI MIS 30G	0	
LANCING MIS DEVICE	0	
LANZO MIS LANCING	0	
LB LANCET MIS 28G	0	
LB LANCING MIS DEVICE	0	
LIFESCAN MIS UNISTIK2	0	
LITE TOUCH MIS LANC PEN	0	
LITE TOUCH MIS LANCETS	0	
LITETOUCH MIS LANCETS	0	
LONGS LANCET MIS STANDARD	0	
LONGS LANCET MIS THIN	0	
LONGS LANCET MIS ULTRA TH	0	
MEDICHOICE MIS LANCET	0	
MEDISENSE LIQ GLUC-KET	0	
MEDISENSE LIQ GLUC/KET	0	
MEDLANCE MIS 30G PLUS	0	
MEDLANCE MIS EXTR 21G	0	
MEDLANCE MIS LITE 25G	0	
MEDLANCE MIS PLUS	0	
MEDLANCE MIS PLUS 30G	0	
MEDLANCE MIS UNV 21G	0	
MEDLANCE PLS MIS 0.8MM	0	
MEDLANCE PLS MIS EXTR 21G	0	
MEDLANCE PLS MIS LITE 25G	0	
MEDLANCE PLS MIS UNIV 21G	0	
MEIJER LANCE MIS COLOR	0	
MEIJER LANCE MIS UNIV 21G	0	
MEIJER LANCE MIS UNIV 30G	0	

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

Drug Name	Drug Tier	Requirements/Limits
MEIJER LANCE MIS UNIVERSA	0	
MEIJER MIS LANCETS	0	
MICRO THIN MIS LANC 33G	0	
MICRODOT CON SOL HIGH/LOW	0	
MICROLET MIS LANCETS	0	
MICROLET MIS NEXT	0	
MINI LANCING MIS DEVICE	0	
MM LANCING MIS DEVICE	0	
MM TWIST MIS LANCETS	0	
MOBILE LANCE MIS 30G	0	
MONOLET MIS LANCETS	0	
MONOLET OPD MIS LANCETS	0	
MONOLETTOR MIS LANCETS	0	
MPD SFTY LAN MIS 21G	0	
MPD SFTY LAN MIS 23G	0	
MPD SFTY LAN MIS 28G	0	
MPD SFTY LAN MIS 30G	0	
MULTI-LANCET KIT DEVICE	0	
MULTI-LANCET MIS DEVICE	0	
MYGLUCOHEALT MIS LANC 30G	0	
MYGLUCOHEALT SOL LO/NL/HI	0	
NEUTEK 2TEK SOL CONTROL	0	
NOVA MAX GLU LIQ /KET CON	0	
NOVA SAFETY MIS LANC 23G	0	
NOVA SAFETY MIS LANC 28G	0	
NOVA SURE MIS LANCETS	0	
NOVA SUREFLX MIS LANC DEV	0	
OMNIPOD 5 G6 KIT INTRO	2	QL (1 kit per year)
OMNIPOD 5 G6 MIS PODS	2	QL (30 per month)
OMNIPOD MIS CLASSIC	2	QL (30 boxes every month)
OMNIPOD PDM KIT CLASSIC	2	QL (1 kit per year)
ON-THE-GO MIS LANC 30G	0	
ONETOUCH DEL MIS LANC DEV	0	
ONETOUCH DEL MIS PLUS 30G	0	
ONETOUCH DEL MIS PLUS 33G	0	
ONETOUCH FP MIS LANCETS	0	

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

Drug Name	Drug Tier	Requirements/Limits
ONETOUCH MIS 30G	0	
ONETOUCH MIS LANC DEV	0	
ONETOUCH MIS LANCETS	0	
ONETOUCH SOL KIT COMPLETE	0	
ONETOUCH SOL KIT FIT	0	
ONETOUCH SOL KIT REFILL	0	
ONETOUCH SOL ULT CONT	0	
ONETOUCH SOL VERIO	0	
ONETOUCH SOL VERIO-HI	0	
ONETOUCH US MIS LANCETS	0	
PC LANCETS MIS 30G	0	
PENLET II KIT BLOOD	0	
PENLET II MIS REPL CAP	0	
PERFECT 28G MIS LANCETS	0	
PERFECT 30G MIS LANCETS	0	
PHARMACY COU MIS LANCETS	0	
PIP LANCETS MIS 28G	0	
PIP LANCETS MIS 30G	0	
POCKETCHEM SOL EZ	0	
PRECISION LIQ CONTROL	0	
PRECISION LIQ GLUC/KET	0	
PRECISION LIQ NRML/MID	0	
PRESSURE ACT MIS LANCET	0	
PRESSURE ACT MIS LANCETS	0	
PRO COMFORT MIS 31G	0	
PRO COMFORT MIS LANCETS	0	
PRODIGY MIS 26G	0	
PRODIGY MIS 28G	0	
PRODIGY MIS LANC DEV	0	
PRODIGY SOL HIGH	0	
PRODIGY SOL LOW	0	
PSS SAFE LAN MIS	0	
PSS SEL LANC MIS	0	
PSS SEL PLAT MIS	0	
PX LANCETS MIS 28G	0	
PX LANCETS MIS ULT THIN	0	
QC LANCETS MIS 28G	0	

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

Drug Name	Drug Tier	Requirements/Limits
QC LANCETS MIS 30G	0	
QC LANCING MIS DEVICE	0	
QUICKTEK LIQ SOLUTION	0	
QUINTET CONT SOL HGH/NORM	0	
RA E-ZJECT MIS 28G	0	
RA E-ZJECT MIS THIN 26G	0	
RA E-ZJECT MIS THIN 28G	0	
RA E-ZJECT MIS ULT THIN	0	
RAPID-SAFE MIS LANCING	0	
READYLANCE MIS 21G	0	
READYLANCE MIS 23G	0	
READYLANCE MIS 26G	0	
READYLANCE MIS 28G	0	
READYLANCE MIS 30G	0	
REALITY MIS LANCETS	0	
REALITY TRIG MIS LANCETS	0	
REFUAH PLUS SOL CONTROL	0	
RELION KIT LANCING	0	
RELION LANCE MIS THIN 26G	0	
RELION LANCE MIS THIN 30G	0	
RELION LANCI MIS DEVICE	0	
RELION MICRO MIS THIN 33G	0	
RELION ULTRA MIS THIN 30G	0	
RELION ULTRA MIS THIN PLS	0	
RIGHTEST ALT MIS ADAPTOR	0	
RIGHTEST LIQ HIGH CON	0	
RIGHTEST LIQ NORM CON	0	
RIGHTEST MIS GD500	0	
RIGHTEST MIS GL300	0	
SAFE-T-LANCE MIS 21G	0	
SAFE-T-LANCE MIS 25G	0	
SAFE-T-LANCE MIS HI FLOW	0	
SAFE-T-LANCE MIS LOW FLOW	0	
SAFE-T-LANCE MIS NOR FLOW	0	
SAFE-T-PRO MIS LANCETS	0	
SAFE-T-PRO MIS PLUS	0	
SAFETY 21G MIS LANCETS	0	

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

Drug Name	Drug Tier	Requirements/Limits
SAFETY 23G MIS LANCETS	0	
SAFETY 28G MIS LANCETS	0	
SAFETY 30G MIS LANCETS	0	
SAFETY MIS LANCETS	0	
SAPS HEALTH MIS TWIST	0	
SAPS TWIST MIS 30G	0	
SAPSCARE MIS TWIST	0	
SB LANCETS MIS THIN	0	
SB LANCETS MIS ULTR THN	0	
SELECT-LITE KIT DEV/LANC	0	
SELECT-LITE MIS LANC DEV	0	
SHOPKO LANC MIS DEVICE	0	
SIDE BUTTON MIS SAFETY	0	
SIMPLE DIAG MIS LANCING	0	
SINGLE-LET MIS 23G	0	
SM LANCETS MIS 33G	0	
SM TRUEDRAW MIS LANC DEV	0	
SMART SENSE MIS LANC 21G	0	
SMART SENSE MIS LANC 26G	0	
SMART SENSE MIS LANC 30G	0	
SMART SENSE MIS LANC 33G	0	
SMARTEST MIS LANCETS	0	
SMARTEST SOL CONTROL	0	
SOFTCLIX MIS LANCETS	0	
SOLUS V2 MIS LANC 28G	0	
SOLUS V2 MIS LANC 30G	0	
SOLUS V2 MIS LANC DEV	0	
SOLUS V2 SOL HIGH	0	
SOLUS V2 SOL LOW	0	
STERILANCE MIS 1.8MM	0	
STERILANCE MIS TL 28G	0	
STERILANCE MIS TL 30G	0	
STERILANCE MIS TL 32G	0	
SUPER THIN MIS LANC 28G	0	
SUPER THIN MIS LANCETS	0	
SUPREME II LIQ HIGH/LOW	0	
SURE COMFORT MIS LANC 18G	0	

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

Drug Name	Drug Tier	Requirements/Limits
SURE COMFORT MIS LANC 21G	0	
SURE COMFORT MIS LANC 23G	0	
SURE COMFORT MIS LANC 30G	0	
SURE COMFORT MIS LANC PEN	0	
SURE COMFORT MIS LANCETS	0	
SURE-LANCE MIS 26G	0	
SURE-LANCE MIS LANCETS	0	
SURE-PEN MIS	0	
SURE-TOUCH MIS UNV LANC	0	
SUREFLEX MIS LANCETS	0	
SURELITE MIS LANCETS	0	
SURESTEP GLU SOL	0	
SURESTEP GLU SOL HIGH/LOW	0	
SURESTEP PRO TES HIGH CON	0	
SURESTEP PRO TES LOW CON	0	
SURESTEP PRO TES NORM CON	0	
SURESTEP SOL CONTROL	0	
TAI DOC SOL NORM CON	0	
TECHLITE AST MIS LANCETS	0	
TECHLITE MIS LANC 30G	0	
TECHLITE MIS LANCETS	0	
TGT LANCET MIS 26G	0	
TGT LANCET MIS 30G	0	
TGT LANCET MIS 33G	0	
TGT LANCING MIS DEVICE	0	
THIN LANCETS MIS	0	
THIN LANCETS MIS 26G	0	
THIN LANCETS MIS 30G	0	
THINLETS GP MIS 26G	0	
TOPCARE MIS LANC 33G	0	
TRAVEL LANCE MIS 30G	0	
TRAVEL LANCE MIS ADV 28G	0	
TRUE METRIX SOL LEVEL 1	0	
TRUE METRIX SOL LEVEL 2	0	
TRUE METRIX SOL LEVEL 3	0	
TRUECONTROL LIQ LEVEL 0	0	
TRUECONTROL LIQ LEVEL 1	0	

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

Drug Name	Drug Tier	Requirements/Limits
TRUEDRAW MIS LANC DEV	0	
TRUPLUS LANC MIS 26G	0	
TRUPLUS LANC MIS 28G	0	
TRUPLUS LANC MIS 30G	0	
TRUPLUS LANC MIS 33G	0	
TWIST LANCET MIS 30G MULT	0	
ULTI-LANCE MIS CLR TIP	0	
ULTILET MIS 26G	0	
ULTILET MIS 28G	0	
ULTILET MIS 30G	0	
ULTILET MIS 33G	0	
ULTILET MIS LANCETS	0	
ULTILET MIS SAFETY	0	
ULTILET SAFE MIS 21G	0	
ULTRA THIN MIS 28G	0	
ULTRA THIN MIS 30G	0	
ULTRA THIN MIS 31G	0	
ULTRA THIN MIS 33G	0	
ULTRA THIN MIS LAN 31G	0	
ULTRA THIN MIS LANC 28G	0	
ULTRA THIN MIS LANC 30G	0	
ULTRA THIN MIS LANCETS	0	
UNILET CMFR MIS TCH 28G	0	
UNILET CMFR MIS TCH 30G	0	
UNILET EX II MIS 28G	0	
UNILET EXCEL MIS 23G	0	
UNILET G.P MIS SUPR 23G	0	
UNILET G.P. MIS 21G	0	
UNILET GP 28 MIS ULT THIN	0	
UNILET LANC MIS 33G	0	
UNILET LANCE MIS 21G	0	
UNILET LANCE MIS 28G	0	
UNILET LANCE MIS 33G	0	
UNILET LANCT MIS 28G	0	
UNILET LANCT MIS 30G	0	
UNILET LANCT MIS 33G	0	
UNILET MICRO MIS 33G	0	

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

Drug Name	Drug Tier	Requirements/Limits
UNILET MIS 21G	0	
UNILET SUPER MIS 23G	0	
UNILET SUPER MIS G.P. 23G	0	
UNISTIK 1 MIS 2.4MM	0	
UNISTIK 1 MIS 3.0MM	0	
UNISTIK 2 MIS	0	
UNISTIK 2 MIS 1.8MM	0	
UNISTIK 2 MIS 2.4MM	0	
UNISTIK 2 MIS COMFORT	0	
UNISTIK 2 MIS EXTRA	0	
UNISTIK 2 MIS NEONATAL	0	
UNISTIK 2 MIS NORMAL	0	
UNISTIK 2 MIS SUPER	0	
UNISTIK 3 MIS 1.8MM	0	
UNISTIK 3 MIS COMFORT	0	
UNISTIK 3 MIS EXTRA	0	
UNISTIK 3 MIS GENT 30G	0	
UNISTIK 3 MIS NEONATAL	0	
UNISTIK 3 MIS NORMAL	0	
UNISTIK 3 MIS XTR 21G	0	
UNISTIK CZT MIS COMFORT	0	
UNISTIK CZT MIS NORMAL	0	
UNISTIK II MIS LANCETS	0	
UNISTIK PRO MIS LANC 21G	0	
UNISTIK PRO MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 30G	0	
UNISTIK TOUC MIS LANC 21G	0	
UNISTIK TOUC MIS LANC 23G	0	
UNISTIK TOUC MIS LANC 28G	0	
UNISTIK TOUC MIS LANC 30G	0	
UNITSTIK PRO MIS LANC 25G	0	
UNIVERSAL 1 MIS 33G	0	
UNIVERSAL 1 MIS LANC 26G	0	
UNIVERSAL 1 MIS LANC 30G	0	
V-GO 20 KIT	2	QL (1 kit every month)
V-GO 30 KIT	2	QL (1 kit every month)

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

Drug Name	Drug Tier	Requirements/Limits
V-GO 40 KIT	2	QL (1 kit every month)
VANTAGE LANC MIS DEVICE	0	
VERASENS LIQ LEVEL 1	0	
VIVAGUARD LIQ CONTROL	0	
VIVAGUARD MIS 28G	0	
VIVAGUARD MIS 30G	0	
VIVAGUARD MIS LANCING	0	
MISC. DEVICES		
ALCOH-GLOVE PAD CONTOURE	0	
ALCOHOL PAD	0	
ALCOHOL PAD 70%	0	
ALCOHOL PAD PREP	0	
ALCOHOL PAD SWABSTIC	0	
ALCOHOL PREP PAD	0	
ALCOHOL PREP PAD 70%	0	
ALCOHOL PREP PAD MED 70%	0	
ALCOHOL PREP PAD PADS 70%	0	
ALCOHOL SWAB PAD	0	
ALCOHOL SWAB PAD 70%	0	
ALCOHOL SWAB PAD EX-THICK	0	
ALCOHOL WIPE PAD	0	
APLICARE ALC PAD SWABSTIC	0	
BD SWAB BFLY PAD SNGL USE	0	
CARETOUCH PAD ALCOHOL	0	
CURITY PREP PAD ALCOHOL	0	
CURITY SWABS PAD ALCOHOL	0	QL (2 packages every 25 days)
EASY COMFORT PAD ALCOHOL	0	
FIFTY50 PREP PAD PADS	0	
GLOBAL PREP PAD PADS	0	
GNP ALCOHOL PAD SWABS	0	
HM STERILE PAD ALCHOL	0	
INCONTROL PAD ALCOHOL	0	
PREP PADS PAD	0	
PRO COMFORT PAD ALCOHOL	0	
PURE COMFORT PAD	0	
QC ALCOHOL PAD SWABS	0	

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

Drug Name	Drug Tier	Requirements/Limits
REALITY SWAB PAD	0	
SAPS CARE PAD ALCOHOL	0	
SAPS HEALTH PAD ALCOHOL	0	
SB ALCOHOL PAD PREP	0	
SM ALCOHOL PAD PREP	0	
ULTICARE PAD ALCOHOL	0	
ULTILET PAD ALCOHOL	0	
WEBCOL PREP PAD LARGE	0	
WEBCOL PREP PAD MEDIUM	0	
PARENTERAL THERAPY SUPPLIES		
BD U-500 MIS 31GX6MM	0	
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
CEQUR SIMPL KIT PATCH 2U	3	
COMFORT EZ MIS 31GX5/16	0	
HM INSULIN S MIS 0.3/31G	0	
HM INSULIN S MIS 1ML/30G	0	
INPEN 100EL MIS BLUE-HUM	3	
INSULIN SRYG MIS 1ML/32G	0	
SYRINGE MIS 0.5/30G	0	
1ML SYRINGE MIS 29G	0	
1ML SYRINGE MIS 30G	0	
RESPIRATORY THERAPY SUPPLIES		
AERCHMBR PLS MIS FLOW-VU	3	
AERCHMBR PLS MIS LRG MASK	3	
AERCHMBR PLS MIS MED MASK	3	
AERCHMBR PLS MIS SM MASK	3	
AERCHMBR Z- MIS STAT PLS	3	
AEROCHAMBER KIT ACTION	3	
AEROCHAMBER MIS CHAMBER	3	
AEROCHAMBER MIS FLOSIGNA	3	
AEROCHAMBER MIS MV	3	
AEROCHAMBER MIS PLUS	3	
AEROVENT MIS PLUS	3	
BREATHE EASE MIS LG MASK	3	

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

Drug Name	Drug Tier	Requirements/Limits
BREATHE EASE MIS MED MASK	3	
BREATHE EASE MIS SM MASK	3	
COMPACT SPAC MIS CHAMBER	3	
COMPACT SPAC MIS LG MASK	3	
COMPACT SPAC MIS MD MASK	3	
COMPACT SPAC MIS SM MASK	3	
EASIVENT MIS	3	
EASIVENT MIS MASK LG	3	
EASIVENT MIS MASK MED	3	
EASIVENT MIS MASK SM	3	
FLEXICHAMBER MIS	3	
FLEXICHAMBER MIS MASK LRG	3	
FLEXICHAMBER MIS MASK SM	3	
HOLD CHAMBER MIS ADLT LG	3	
HOLD CHAMBER MIS MEDIUM	3	
HOLD CHAMBER MIS SMALL	3	
INSPIRACHAMB MIS LARGE	3	
INSPIRACHAMB MIS MEDIUM	3	
INSPIRACHAMB MIS MOUTHPCE	3	
INSPIRACHAMB MIS SMALL	3	
INSPIREASE MIS DD SYST	3	
INSPIREASE MIS RES BAG	3	
MICROCHAMBER MIS	3	
OPTICHAMBER MIS DIA MD	3	
OPTICHAMBER MIS DIA SM	3	
OPTICHAMBER MIS DIAMOND	3	
POCKET CHAMB MIS	3	
POCKET SPACE MIS	3	
RITEFLO MIS	3	
TRUZONE PEAK MIS FLOW MTR	3	

MIGRAINE PRODUCTS

CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG

AIMOVIG INJ 70MG/ML	2	ST, QL (2 pens every month)
AIMOVIG INJ 140MG/ML	2	ST, QL (1 pen every month)

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

Drug Name	Drug Tier	Requirements/Limits
AJOVY INJ 225/1.5	2	ST, QL (3 pens every 75 days)
EMGALITY INJ 100MG/ML	2	ST, QL (3 syringes every month)
EMGALITY INJ 120MG/ML	2	ST, QL (2 pens every 25 days); Loading Dose: 2 injectors per month; Maintenance Dose: 1 injector per month
EMGALITY INJ 120MG/ML	2	ST, QL (2 syringes every 25 days); Loading Dose: 2 syringes per month; Maintenance Dose: 1 syringe per month
NURTEC TAB 75MG ODT	2	PA, QL (16 tablets per month)
QULIPTA TAB 10MG	3	ST, QL (30 tablets per month)
QULIPTA TAB 30MG	3	ST, QL (30 tablets per month)
QULIPTA TAB 60MG	3	ST, QL (30 tablets per month)
UBRELVY TAB 50MG	2	PA, QL (16 tablets per month)
UBRELVY TAB 100MG	2	PA, QL (16 tablets per month)
MIGRAINE COMBINATIONS		
CAFERGOT TAB 1-100MG	3	PA; MNPA
ergotamine w/ caffeine suppos 2-100 mg	1	PA; MNPA
ergotamine w/ caffeine tab 1-100 mg	1	PA; MNPA
sumatriptan-naproxen sodium tab 85-500 mg	1	PA, QL (9 tabs per month); MNPA
TREXIMET TAB 85-500MG	3	PA, QL (9 tabs per month)
MIGRAINE PRODUCTS		
dihydroergotamine mesylate nasal spray 4 mg/ml	1	PA, QL (8 per month); MNPA
ERGOMAR SUB 2MG	3	
MIGRANAL SPR 4MG/ML	3	QL (8 per month)

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

Drug Name	Drug Tier	Requirements/Limits
TRUDHESA AER 0.725MG	3	
MIGRAINE PRODUCTS - NSAIDS		
CAMBIA POW 50MG	3	
SEROTONIN AGONISTS		
almotriptan malate tab 6.25 mg	1	QL (12 TABS PER MONTH)
almotriptan malate tab 12.5 mg	1	QL (12 TABS PER MONTH)
AMERGE TAB 1MG	3	QL (12 TABS PER MONTH)
AMERGE TAB 2.5MG	3	QL (12 TABS PER MONTH)
eletriptan hydrobromide tab 20 mg (base equivalent)	1	QL (12 TABS PER MONTH)
eletriptan hydrobromide tab 40 mg (base equivalent)	1	QL (12 TABS PER MONTH)
FROVA TAB 2.5MG	3	QL (18 tablets per month)
frovatriptan succinate tab 2.5 mg (base equivalent)	1	QL (18 tablets per month)
IMITREX INJ 4MG/0.5	3	QL (18 syringes per month)
IMITREX INJ 4MG/0.5	3	QL (6 UNITS PER MONTH)
IMITREX INJ 6MG/0.5	3	QL (12 cartridges per month)
IMITREX INJ 6MG/0.5	3	QL (6 UNITS PER MONTH)
IMITREX SPR 5MG/ACT	3	QL (4 packages per month)
IMITREX SPR 20MG/ACT	3	QL (12 UNITS PER MONTH)
IMITREX TAB 25MG	3	QL (12 TABS PER MONTH)
IMITREX TAB 50MG	3	QL (12 TABS PER MONTH)
IMITREX TAB 100MG	3	QL (12 TABS PER MONTH)

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

Drug Name	Drug Tier	Requirements/Limits
MAXALT TAB 10MG	3	QL (18 tabs every month)
MAXALT-MLT TAB 10MG	3	QL (18 tabs every month)
naratriptan hcl tab 1 mg (base equiv)	1	QL (12 TABS PER MONTH)
naratriptan hcl tab 2.5 mg (base equiv)	1	QL (12 TABS PER MONTH)
ONZETRA XSAI MIS 11MG	2	QL (16 nosepieces every month)
RELPAX TAB 20MG	3	QL (12 TABS PER MONTH)
RELPAX TAB 40MG	3	QL (12 TABS PER MONTH)
REYVOW TAB 50MG	3	ST, QL (4 tablets per month)
REYVOW TAB 100MG	3	ST, QL (8 tablets per month)
rizatriptan benzoate oral disintegrating tab 5 mg (base eq)	1	QL (18 tabs every month)
rizatriptan benzoate oral disintegrating tab 10 mg (base eq)	1	QL (18 tabs every month)
rizatriptan benzoate tab 5 mg (base equivalent)	1	QL (18 tablets per month)
rizatriptan benzoate tab 10 mg (base equivalent)	1	QL (18 tabs every month)
sumatriptan nasal spray 5 mg/act	1	QL (4 packages per month)
sumatriptan nasal spray 20 mg/act	1	QL (12 UNITS PER MONTH)
sumatriptan succinate inj 6 mg/0.5ml	1	QL (6 UNITS PER MONTH)
sumatriptan succinate solution auto-injector 4 mg/0.5ml	1	QL (6 UNITS PER MONTH)
sumatriptan succinate solution auto-injector 6 mg/0.5ml	1	QL (6 UNITS PER MONTH)
sumatriptan succinate solution cartridge 4 mg/0.5ml	1	QL (18 syringes per month)

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

Drug Name	Drug Tier	Requirements/Limits
sumatriptan succinate solution cartridge 6 mg/0.5ml	1	QL (12 cartridges per month)
sumatriptan succinate solution prefilled syringe 6 mg/0.5ml	1	QL (12 syringes per month)
sumatriptan succinate tab 25 mg	1	QL (12 TABS PER MONTH)
sumatriptan succinate tab 50 mg	1	QL (12 TABS PER MONTH)
sumatriptan succinate tab 100 mg	1	QL (12 TABS PER MONTH)
TOSYMRA SOL 10MG	3	QL (3 packages per month)
ZEMBRACE SYM INJ 3/0.5ML	2	QL (24 injections every month)
zolmitriptan nasal spray 2.5 mg/spray unit	1	QL (12 UNITS PER MONTH)
zolmitriptan nasal spray 5 mg/spray unit	1	QL (12 UNITS PER MONTH)
zolmitriptan orally disintegrating tab 2.5 mg	1	QL (12 TABS PER MONTH)
zolmitriptan orally disintegrating tab 5 mg	1	QL (12 TABS PER MONTH)
zolmitriptan tab 2.5 mg	1	QL (12 TABS PER MONTH)
zolmitriptan tab 5 mg	1	QL (12 TABS PER MONTH)
ZOMIG SPR 2.5MG	2	QL (12 UNITS PER MONTH)
ZOMIG SPR 5MG	2	QL (12 UNITS PER MONTH)
ZOMIG TAB 2.5MG	3	QL (12 TABS PER MONTH)
ZOMIG TAB 5MG	3	QL (12 TABS PER MONTH)
ZOMIG ZMT TAB 2.5 MG	3	QL (12 TABS PER MONTH)
ZOMIG ZMT TAB 5MG ODT	3	QL (12 TABS PER MONTH)

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

Drug Name	Drug Tier	Requirements/Limits
MINERALS & ELECTROLYTES		
POTASSIUM		
K-TAB TAB 8MEQ CR	3	
K-TAB TAB 10MEQ CR	2	
K-TAB TAB 20MEQ	3	
potassium chloride cap er 8 meq	1	
potassium chloride cap er 10 meq	1	
potassium chloride microencapsulated crys er tab 10 meq	1	
potassium chloride microencapsulated crys er tab 15 meq	1	
potassium chloride microencapsulated crys er tab 20 meq	1	
potassium chloride oral soln 10% (20 meq/15ml)	1	
potassium chloride oral soln 20% (40 meq/15ml)	1	
potassium chloride powder packet 20 meq	1	
potassium chloride tab er 8 meq (600 mg)	1	
potassium chloride tab er 10 meq	1	
potassium chloride tab er 20 meq (1500 mg)	1	
POTASSIUM POW CHLORIDE	3	
MISCELLANEOUS THERAPEUTIC CLASSES		
CHELATING AGENTS		
CUPRIMINE CAP 250MG	3	
DEPEN TITRA TAB 250MG	3	
penicillamine cap 250 mg	1	
penicillamine tab 250 mg	1	
SYPRINE CAP 250MG	3	
trientine hcl cap 250 mg	1	
IMMUNOMODULATORS		
lenalidomide cap 5 mg	0	PA, QL (28 CAPSULES PER 28 DAYS)
lenalidomide cap 10 mg	0	PA, QL (28 CAPSULES PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
lenalidomide cap 15 mg	0	PA, QL (28 CAPSULES PER 28 DAYS)
lenalidomide cap 25 mg	0	PA, QL (21 CAPSULES PER 28 DAYS)
REVLIMID CAP 2.5MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 5MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 10MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 15MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
REVLIMID CAP 20MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
REVLIMID CAP 25MG	0	PA, QL (21 CAPSULES PER 28 DAYS)
THALOMID CAP 50MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
THALOMID CAP 100MG	0	PA, QL (28 CAPSULES PER 28 DAYS)
THALOMID CAP 150MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
THALOMID CAP 200MG	0	PA, QL (56 CAPSULES PER 28 DAYS)
IMMUNOSUPPRESSIVE AGENTS		
ASTAGRAF XL CAP 0.5MG	3	
ASTAGRAF XL CAP 1MG	3	
ASTAGRAF XL CAP 5MG	3	
azathioprine tab 50 mg	1	
AZATHIOPRINE TAB 75 MG	2	
AZATHIOPRINE TAB 100 MG	2	
CELLCEPT CAP 250MG	3	
CELLCEPT SUS 200MG/ML	3	
CELLCEPT TAB 500MG	3	
cyclosporine cap 25 mg	1	
cyclosporine cap 100 mg	1	
cyclosporine modified cap 25 mg	1	
cyclosporine modified cap 50 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
cyclosporine modified cap 100 mg	1	
cyclosporine modified oral soln 100 mg/ml	1	
ENSPRYNG INJ	2	PA, QL (1 PFS PER 28 DAYS)
ENVARSUS XR TAB 0.75MG	3	
ENVARSUS XR TAB 1MG	3	
ENVARSUS XR TAB 4MG	3	
everolimus tab 0.5 mg	1	
everolimus tab 0.25 mg	1	
everolimus tab 0.75 mg	1	
IMURAN TAB 50MG	2	
LUPKYNIS CAP 7.9MG	3	PA, QL (180 CAPS PER MONTH)
mycophenolate mofetil cap 250 mg	1	
mycophenolate mofetil for oral susp 200 mg/ml	1	
mycophenolate mofetil tab 500 mg	1	
mycophenolate sodium tab dr 180 mg (mycophenolic acid equiv)	1	
mycophenolate sodium tab dr 360 mg (mycophenolic acid equiv)	1	
MYFORTIC TAB 180MG	3	
MYFORTIC TAB 360MG	3	
NEORAL CAP 25MG	3	
NEORAL CAP 100MG	3	
NEORAL SOL 100MG/ML	3	
PROGRAF CAP 0.5MG	3	
PROGRAF CAP 1MG	3	
PROGRAF CAP 5MG	3	
PROGRAF GRA 0.2MG	3	
PROGRAF GRA 1MG	3	
RAPAMUNE SOL 1MG/ML	3	
RAPAMUNE TAB 0.5MG	3	
RAPAMUNE TAB 1MG	3	
RAPAMUNE TAB 2MG	3	
REZUROCK TAB 200MG	3	PA, QL (30 tablets per month)
SANDIMMUNE CAP 25MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
SANDIMMUNE CAP 100MG	3	
SANDIMMUNE SOL 100MG/ML	3	
sirolimus oral soln 1 mg/ml	1	
sirolimus tab 0.5 mg	1	
sirolimus tab 1 mg	1	
sirolimus tab 2 mg	1	
tacrolimus cap 0.5 mg	1	
tacrolimus cap 1 mg	1	
tacrolimus cap 5 mg	1	
ZORTRESS TAB 0.5MG	3	
ZORTRESS TAB 0.25MG	3	
ZORTRESS TAB 0.75MG	3	
ZORTRESS TAB 1MG	3	
PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS		
VIJOICE TAB 50MG	3	QL (1 Carton per 28 days)
VIJOICE TAB 125MG	3	QL (1 Carton per 28 days)
VIJOICE TAB 250MG	3	QL (1 Carton per 28 days)
POTASSIUM REMOVING AGENTS		
LOKELMA PAK 5GM	2	
LOKELMA PAK 10GM	2	
sodium polystyrene sulfonate oral susp 15 gm/60ml	1	
sodium polystyrene sulfonate powder*	1	
VELTASSA POW 8.4GM	2	
VELTASSA POW 16.8GM	2	
VELTASSA POW 25.2GM	2	
PROGERIA TREATMENT AGENTS		
ZOKINVY CAP 50MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS		
BENLYSTA INJ 200MG/ML	3	PA, QL (4 INJ PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
MOUTH/THROAT/DENTAL AGENTS		
ANESTHETICS TOPICAL ORAL		
lidocaine hcl laryngotracheal soln 4%	1	
lidocaine hcl viscous soln 2%	1	
ANTI-INFECTIVES - THROAT		
clotrimazole troche 10 mg	1	QL (90 troches per month)
nystatin susp 100000 unit/ml	1	
ORAVIG TAB 50MG	3	
ANTISEPTICS - MOUTH/THROAT		
chlorhexidine gluconate soln 0.12%	1	
PERIDEX SOL 0.12%	3	
DENTAL PRODUCTS		
NAFRINSE DLY SOL /NEUTRAL	3	
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
sodium fluoride gel 1.1% (0.5% f)	1	
STEROIDS - MOUTH/THROAT/DENTAL		
triamcinolone acetonide dental paste 0.1%	1	
THROAT PRODUCTS - MISC.		
cevimeline hcl cap 30 mg	1	
EVOXAC CAP 30MG	2	
ORAFATE PST 10%	3	
pilocarpine hcl tab 5 mg	1	
pilocarpine hcl tab 7.5 mg	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	2	
SALAGEN TAB 7.5MG	2	
MULTIVITAMINS		
B-COMPLEX W/ FOLIC ACID		
b-complex w/ c & folic acid tab 1 mg**	1	PA; MNPA
b-complex w/ c & folic acid tab 5 mg**	1	PA; MNPA
b-complex w/ c & folic acid tab**	1	PA; MNPA
FOLIC-K CAP	3	PA; MNPA
MULTIPLE VITAMINS W/ MINERALS		
multiple vitamins w/ minerals cap*	1	PA; MNPA

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

Drug Name	Drug Tier	Requirements/Limits
NICAZEL TAB	3	PA
NICAZEL TAB FORTE	3	PA
PRENATAL VITAMINS		
ATABEX EC TAB 29-1MG	3	
ATABEX OB TAB 29-1MG	3	
AZESCHEW CHW 13-1MG	3	
AZESCO TAB 13-1MG	3	PA; MNPA
C-NATE DHA CAP 28-1-200	3	
CITRANATAL CAP HARMONY	3	
CITRANATAL CAP MEDLEY	3	
CITRANATAL MIS	3	
CITRANATAL MIS 90 DHA	3	
CITRANATAL MIS B-CALM	3	
CITRANATAL PAK ASSURE	3	
CITRANATAL PAK DHA	3	
CITRANATAL TAB BLOOM	3	
CITRANATAL TAB RX	3	
CO-NATAL FA TAB 29-1MG	3	
CONCEPT DHA CAP	3	
CONCEPT OB CAP	3	
DUET DHA 400 MIS 25-1-400	3	
DUET DHA MIS BALANCED	3	
ENBRACE HR CAP	3	
JENLIVA CAP	3	
KOSHR PRENAT TAB 30-1MG	3	
M-NATAL PLUS TAB	3	
MYNATAL CAP	3	
MYNATAL PLUS TAB	3	
MYNATAL-Z TAB	3	
NATACHEW CHW	3	
NATALVIT TAB 75-1MG	3	
NEEVO DHA CAP 27-1.13	3	
NEONATAL 19 TAB	3	
NEONATAL FE TAB	3	
NEONATAL PLS TAB 27-1MG	3	
NEONATAL TAB COMPLETE	3	
NEONATAL TAB COMPLTE	3	

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

Drug Name	Drug Tier	Requirements/Limits
NEONATAL/DHA MIS	3	
NESTABS DHA PAK	3	
NESTABS ONE CAP	3	
NESTABS TAB	3	
NIVA-PLUS TAB	3	
O-CAL TAB PRENATAL	3	
OB COMPLETE CAP ONE	3	
OB COMPLETE CAP PETITE	3	
OB COMPLETE TAB	3	
OB COMPLETE TAB PREMIER	3	
OB COMPLETE/ CAP DHA	3	
OBSTETRIX EC TAB	3	
OBSTETRIX PAK DHA	3	
OBSTETRX ONE CAP 38-1-225	3	
ONE VITE TAB 1MG PLUS	3	
PNV TAB 20-1 TAB	3	
PNV TABS TAB 29-1MG	3	
PNV-DHA CAP DOCUSATE	3	
PNV-OMEGA CAP	3	
PREGEN DHA CAP	3	
PREGENNA TAB	3	
PREMESISRX TAB	3	
PRENA1 CHW	3	
PRENA1 PEARL CAP	3	
PRENA 1 TRUE MIS	3	
PRENAISSANCE CAP	3	
PRENAISSANCE CAP PLUS	3	
PRENARA CAP PRENATAL	3	
prenat w/o a w/fefum-methfol-fa-dha cap 27-0.6-0.4-300 mg*	1	
PRENATAL 19 CHW 29-1MG	3	
PRENATAL 19 TAB 29-1MG	3	
PRENATAL TAB 27-1MG	3	
PRENATAL VIT TAB LOW IRON	3	
prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg**	1	

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

Drug Name	Drug Tier	Requirements/Limits
prenatal vit w/ fe fum-methylfolate-fa tab 27-0.6-0.4 mg**	1	
prenatal vit w/ fe fumarate-fa chew tab 29-1 mg**	1	
prenatal vit w/ fe fumarate-fa tab 28-1 mg**	1	
prenatal vit w/ iron carbonyl-fa tab 29-1 mg**	1	
PRENATAL+FE TAB 29-1MG	3	
PRENATAL-U CAP 106.5-1	3	
PRENATE AM TAB 1MG	3	
PRENATE CAP ENHANCE	3	
PRENATE CAP ESSENT	3	
PRENATE CAP PIXIE	3	
PRENATE CAP RESTORE	3	
PRENATE CHW 0.6-0.4	3	
PRENATE DHA CAP	3	
PRENATE MINI CAP	3	
PRENATE TAB ELITE	3	
PRENATRIX TAB	3	
PRENATRYL TAB	3	
PRENATVITE TAB COMPLETE	3	
PRENATVITE TAB PLUS	3	
PRENATVITE TAB RX	3	
PREPLUS TAB 27-1MG	3	
PRETAB TAB 29-1MG	3	
PRIMACARE CAP	3	
PROVIDA OB CAP	3	
REDICHEW RX CHW	3	
RELNATE DHA CAP	3	
SE-NATAL 19 CHW	3	
SE-NATAL 19 TAB	3	
SELECT-OB CHW	3	
SELECT-OB+ PAK DHA	3	
TARON-PREX CAP	3	
THRIVITE RX TAB 29-1MG	3	
TRICARE PRE CAP 27-1-500	3	
TRICARE TAB PRENATAL	3	

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

Drug Name	Drug Tier	Requirements/Limits
TRINAZ TAB 12-1MG	3	PA
TRISTART CAP FREE	3	
TRISTART DHA CAP	3	
TRISTART ONE CAP 35-1-215	3	
VINATE DHA CAP 27-1.13	3	
VINATE II TAB	3	
VINATE ONE TAB	3	
VIRT-C DHA CAP	3	
VIRT-NATE CAP DHA	3	
VIRT-PN DHA CAP	3	
VIRT-PN PLUS CAP	3	
VITAFOL CAP ULTRA	3	
VITAFOL CHW GUMMIES	3	
VITAFOL FE+ CAP	3	
VITAFOL STRP MIS 1MG	3	
VITAFOL-NANO TAB	3	
VITAFOL-OB PAK +DHA	3	
VITAFOL-OB TAB 65-1MG	3	
VITAFOL-ONE CAP	3	
VITAMEDMD CAP ONE RX	3	
VITAPEARL CAP	3	
VITATHELY TAB	3	
VITATRUE MIS	3	
VIVA DHA CAP	3	
VP-PNV-DHA CAP	3	
WESTAB PLUS TAB 27-1MG	3	
WESTGEL DHA CAP	3	
ZALVIT TAB 13-1MG	3	PA; MNPA
VITAMIN MIXTURES		
NICOMIDE TAB	3	PA; MNPA
MUSCULOSKELETAL THERAPY AGENTS		
CENTRAL MUSCLE RELAXANTS		
AMRIX CAP 15MG	3	PA; MNPA
AMRIX CAP 30MG	3	PA; MNPA
baclofen tab 5 mg	1	
baclofen tab 10 mg	1	
baclofen tab 20 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
carisoprodol tab 250 mg	1	PA, QL (84 tabs every month); MNPA
carisoprodol tab 350 mg	1	QL (84 tabs every month)
CHLORZOXAZONE TAB 250 MG	3	PA; MNPA
chlorzoxazone tab 375 mg	1	PA; MNPA
chlorzoxazone tab 500 mg	1	
chlorzoxazone tab 500 mg	1	PA; MNPA
chlorzoxazone tab 750 mg	1	PA
chlorzoxazone tab 750 mg	1	PA; MNPA
cyclobenzaprine hcl cap er 24hr 15 mg	1	PA; MNPA
cyclobenzaprine hcl cap er 24hr 30 mg	1	PA; MNPA
cyclobenzaprine hcl tab 5 mg	1	
cyclobenzaprine hcl tab 7.5 mg	1	PA; MNPA
cyclobenzaprine hcl tab 10 mg	1	
metaxalone tab 400 mg	1	PA; MNPA
metaxalone tab 800 mg	1	
methocarbamol tab 500 mg	1	
methocarbamol tab 500 mg	1	PA; MNPA
methocarbamol tab 750 mg	1	
methocarbamol tab 750 mg	1	PA
orphenadrine citrate tab er 12hr 100 mg	1	
OZOBAX SOL 5MG/5ML	3	
SKELAXIN TAB 800MG	2	
SOMA TAB 250MG	3	QL (84 tabs every month)
SOMA TAB 350MG	3	QL (84 tabs every month)
tizanidine hcl cap 2 mg (base equivalent)	1	
tizanidine hcl cap 4 mg (base equivalent)	1	
tizanidine hcl cap 6 mg (base equivalent)	1	
tizanidine hcl tab 2 mg (base equivalent)	1	
tizanidine hcl tab 4 mg (base equivalent)	1	
ZANAFLEX CAP 2MG	3	
ZANAFLEX CAP 4MG	3	
ZANAFLEX CAP 6MG	3	
ZANAFLEX TAB 4MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
DIRECT MUSCLE RELAXANTS		
DANTRIUM CAP 25MG	2	
DANTRIUM CAP 50MG	2	
dantrolene sodium cap 25 mg	1	
dantrolene sodium cap 50 mg	1	
dantrolene sodium cap 100 mg	1	
MUSCLE RELAXANT COMBINATIONS		
carisoprodol w/ aspirin & codeine tab 200-325-16 mg	1	QL (90 tablets per month)
NORGESIC TAB FORTE	3	PA; MNPA
orphenadrine w/ aspirin & caffeine tab 50-770-60 mg	1	PA; MNPA
NASAL AGENTS - SYSTEMIC AND TOPICAL		
NASAL AGENT COMBINATIONS		
azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act	1	
DYMISTA SPR 137-50	3	
NASAL AGENTS - MISC.		
NOZIN NASAL MIS SANITIZE	0	
NASAL ANESTHETICS		
COCAINE HCL SOL 40MG/ML	3	
GOPRELTO SOL 40MG/ML	3	
NUMBRINO SOL 40MG/ML	3	
NASAL ANTIALLERGY		
azelastine hcl nasal spray 0.1% (137 mcg/spray)	1	
azelastine hcl nasal spray 0.15% (205.5 mcg/spray)	1	
olopatadine hcl nasal soln 0.6%	1	
PATANASE SPR 0.6%	3	
NASAL ANTICHOLINERGICS		
ipratropium bromide nasal soln 0.03% (21 mcg/spray)	1	
ipratropium bromide nasal soln 0.06% (42 mcg/spray)	1	
NASAL STEROIDS		
BECONASE AQ SUS 0.042%	3	

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

Drug Name	Drug Tier	Requirements/Limits
flunisolide nasal soln 25 mcg/act (0.025%)	1	
fluticasone propionate nasal susp 50 mcg/act	1	
mometasone furoate nasal susp 50 mcg/act	1	
NASONEX SPR 50MCG/AC	3	
OMNARIS SPR	3	
QNASL AER 80MCG	3	
QNASL CHILD SPR 40MCG	3	
XHANCE MIS 93MCG	3	
ZETONNA AER 37MCG	3	
SYMPATHOMIMETIC DECONGESTANTS		
ADRENALIN SOL 1:1000	3	
NEUROMUSCULAR AGENTS		
ALS AGENTS		
RADICAVA ORS SUS 105/5ML	3	PA, QL (50ml (1 bottle) for 28 days)
RADICAVA ORS SUS STARTER	3	PA, QL (70ml (2 bottles) for 28 days)
RILUTEK TAB 50MG	3	
riluzole tab 50 mg	1	
TIGLUTIK SUS 50/10ML	3	
SPINAL MUSCULAR ATROPHY AGENTS (SMA)		
EVRYSDI SOL	3	PA, QL (2 bottles (120 mg) per 24 days)
NUTRIENTS		
LIPIDS		
DOJOLVI LIQ 100%	3	PA
OPHTHALMIC AGENTS		
ARTIFICIAL TEARS AND LUBRICANTS		
LACRISERT MIS 5MG OP	3	
BETA-BLOCKERS - OPHTHALMIC		
betaxolol hcl ophth soln 0.5%	1	
BETIMOL SOL 0.5%	2	
BETIMOL SOL 0.25%	2	
BETOPTIC-S SUS 0.25% OP	2	

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

Drug Name	Drug Tier	Requirements/Limits
brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%	1	
carteolol hcl ophth soln 1%	1	
COMBIGAN SOL 0.2/0.5%	2	
COSOPT PF SOL 2%-0.5%	3	
COSOPT SOL 22.3-6.8	3	
dorzolamide hcl-timolol maleate ophth sol 22.3-6.8 mg/ml pf	1	
dorzolamide hcl-timolol maleate ophth soln 22.3-6.8 mg/ml	1	
ISTALOL SOL 0.5% OP	3	
levobunolol hcl ophth soln 0.5%	1	
TIM/BRIM/DOR SOL	3	
TIM/DORZ/LAT SOL	3	
TIMOL/BRIM SOL DORZ/LAT	3	
TIMOL/LATAN SOL	3	
timolol maleate ophth gel forming soln 0.5%	1	
timolol maleate ophth gel forming soln 0.25%	1	
timolol maleate ophth soln 0.5%	1	
timolol maleate ophth soln 0.5% (once-daily)	1	
timolol maleate ophth soln 0.25%	1	
timolol maleate preservative free ophth soln 0.5%	1	
timolol maleate preservative free ophth soln 0.25%	1	
TIMOPTIC OCU SOL 0.5% OP	3	
TIMOPTIC OCU SOL 0.25% OP	3	
TIMOPTIC SOL 0.5% OP	3	
TIMOPTIC SOL 0.25% OP	3	
TIMOPTIC-XE SOL 0.5% OP	3	
TIMOPTIC-XE SOL 0.25% OP	3	
CHOLINERGIC AGONISTS		
TYRVAYA SOL 0.03MG	3	PA
CYCLOPLEGIC MYDRIATICS		
ATROPINE SUL SOL 0.01%	3	

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

Drug Name	Drug Tier	Requirements/Limits
ATROPINE SUL SOL 1% OP	3	
CYCLOGYL SOL 0.5% OP	3	
CYCLOGYL SOL 1% OP	3	
CYCLOGYL SOL 2% OP	3	
CYCLOMYDRIL SOL OP	3	
cyclopentolate hcl ophth soln 0.5%	1	
cyclopentolate hcl ophth soln 1%	1	
cyclopentolate hcl ophth soln 2%	1	
ISOPTO ATROP SOL 1% OP	3	
phenylephrine hcl ophth soln 2.5%	1	
phenylephrine hcl ophth soln 10%	1	
TROP-CYC-PE DRO 1-1-2.5	3	
TROP-PHENYL SOL 1-2.5%	3	
TROP/CYC/PE/ SOL KETO/PRO	3	
TROP/CYC/PE/ SOL KETOROLA	3	
TROP/CYCL/PE SOL KETOROLA	3	
MIOTICS		
ISOPTO CARP SOL 1% OP	3	
ISOPTO CARP SOL 2% OP	3	
ISOPTO CARP SOL 4% OP	3	
PHOSPHOLINE SOL 0.125%OP	3	
pilocarpine hcl ophth soln 1%	1	
pilocarpine hcl ophth soln 2%	1	
pilocarpine hcl ophth soln 4%	1	
OPHTHALMIC ADRENERGIC AGENTS		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
apraclonidine hcl ophth soln 0.5% (base equivalent)	1	
BRIMO/DORZO SOL 0.15-2%	3	
brimonidine tartrate ophth soln 0.2%	1	
brimonidine tartrate ophth soln 0.15%	1	
IOPIDINE SOL 1% OP	3	
SIMBRINZA SUS 1-0.2%	2	
OPHTHALMIC ANTI-INFECTIVES		
AZASITE SOL 1%	3	
bacitracin ophth oint 500 unit/gm	1	

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

Drug Name	Drug Tier	Requirements/Limits
bacitracin-polymyxin b ophth oint	1	
BESIVANCE SUS 0.6%	2	
BETADINE SOL 5% OP	3	
BLEPH-10 SOL 10% OP	3	
CILOXAN OIN 0.3% OP	2	
CILOXAN SOL 0.3% OP	3	
ciprofloxacin hcl ophth soln 0.3% (base equivalent)	1	
erythromycin ophth oint 5 mg/gm	1	
gatifloxacin ophth soln 0.5%	1	
gentamicin sulfate ophth oint 0.3%	1	
gentamicin sulfate ophth soln 0.3%	1	QL (4 bottles per 25 days)
KLARITY-A DRO 1%	3	
levofloxacin ophth soln 0.5%	1	
MITOSOL KIT 0.2MG	3	
MOXEZA SOL 0.5%	3	
moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)	1	
moxifloxacin hcl ophth soln 0.5% (base equiv)	1	
MOXIFLOXACIN SOL 0.5%	3	
NATACYN SUS 5% OP	3	
neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin	1	
neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml	1	
OCUFLOX DRO 0.3% OP	3	
ofloxacin ophth soln 0.3%	1	
polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%	1	
POLYTRIM SOL OP	3	
POVIDONE IOD SOL 5%	3	
sulfacetamide sodium ophth oint 10%	1	
sulfacetamide sodium ophth soln 10%	1	
tobramycin ophth soln 0.3%	1	
TOBREX OIN 0.3% OP	3	
TOBREX SOL 0.3% OP	3	

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

Drug Name	Drug Tier	Requirements/Limits
trifluridine ophth soln 1%	1	
VANCOMYCIN SOL 10MG/ML	3	
VIGAMOX DRO 0.5%	3	
ZIRGAN GEL 0.15%	3	
ZYMAXID SOL 0.5%	3	
OPHTHALMIC IMMUNOMODULATORS		
CEQUA SOL 0.09%	3	PA
cyclosporine (ophth) emulsion 0.05%	1	
RESTASIS EMU 0.05% OP	2	PA
RESTASIS MUL EMU 0.05% OP	2	PA
OPHTHALMIC INTEGRIN ANTAGONISTS		
XIIDRA DRO 5%	2	PA
OPHTHALMIC KINASE INHIBITORS		
RHOPRESSA SOL 0.02%	2	
ROCKLATAN DRO	2	
OPHTHALMIC LOCAL ANESTHETICS		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
proparacaine hcl ophth soln 0.5%	1	
tetracaine hcl ophth soln 0.5%	1	
OPHTHALMIC NERVE GROWTH FACTORS		
OXERVATE SOL 20MCG/ML	3	PA, QL (16 CARTONS PER 56 days - ONE TIME TREATMENT)
OPHTHALMIC PHOTOENHANCERS		
PHOTREXA VIS SOL 0.146-20	3	
PHOTREXA/PHO SOL VISC KIT	3	
OPHTHALMIC STEROIDS		
ALREX SUS 0.2%	3	
bacitracin-polymyxin-neomycin-hc ophth oint 1%	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	
dexamethasone sodium phosphate ophth soln 0.1%	1	
difluprednate ophth emulsion 0.05%	1	

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

Drug Name	Drug Tier	Requirements/Limits
DUREZOL EMU 0.05%	3	
EYSUVIS DRO 0.25%	3	PA
FLAREX SUS 0.1% OP	3	
fluorometholone ophth susp 0.1%	1	
FML FORTE SUS 0.25% OP	2	
FML LIQUIFLM SUS 0.1% OP	3	PA; MNPA
FML OIN 0.1% OP	2	
INVELTYS SUS 1%	3	
KLARITY-L DRO 0.2%	3	
KLARITY-L DRO 0.5%	3	
LOTEMAX GEL 0.5%	3	
LOTEMAX OIN 0.5%	3	
LOTEMAX SM GEL 0.38%	3	
LOTEMAX SUS 0.5%	3	
loteprednol etabonate ophth gel 0.5%	1	
loteprednol etabonate ophth susp 0.5%	1	
MAXIDEX SUS 0.1% OP	2	
MAXITROL OIN 0.1% OP	3	
MAXITROL SUS 0.1% OP	3	
neomycin-polymyxin-dexamethasone ophth oint 0.1%	1	
neomycin-polymyxin-dexamethasone ophth susp 0.1%	1	
neomycin-polymyxin-hc ophth susp	1	
PRED FORTE SUS 1% OP	3	PA; MNPA
PRED MILD SUS 0.12% OP	2	PA; MNPA
PRED MOXIFLO SOL 1-0.5%	3	
PRED MOXIFLO SUS BROMFEN	3	
PRED SOD PHO SOL 1% OP	3	
PRED-G S.O.P OIN OP	3	
PRED-G SUS OP	3	
PRED-GATI SUS 1-0.5%	3	
PRED-GATIFL- SUS BROMFENA	3	
PRED/NEPAFEN DRO 1-0.1%	3	
PREDNI/MOXI/ DRO NEPAFENA	3	
PREDNI/MOXIF DRO 1-0.5%	3	
prednisolone acetate ophth susp 1%	1	

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

Drug Name	Drug Tier	Requirements/Limits
PREDNISOLONE SOL MOX-BROM	3	
PREDNISOLONE SUS 1%	3	
sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%	1	
TOBRADEX OIN 0.3-0.1%	2	
TOBRADEX ST SUS 0.3-0.05	2	
TOBRADEX SUS 0.3-0.1%	3	
tobramycin-dexamethasone ophth susp 0.3-0.1%	1	
ZYLET SUS 0.5-0.3%	3	
OPHTHALMIC SURGICAL AIDS		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
OPHTHALMICS - MISC.		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ACUVAIL SOL 0.45%	2	
ALOCRIL SOL 2%	3	
ALOMIDE SOL 0.1% OP	3	
azelastine hcl ophth soln 0.05%	1	
AZOPT SUS 1% OP	3	
BEPREVE DRO 1.5%	3	
brinzolamide ophth susp 1%	1	
bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)	1	
BROMSITE DRO 0.075%	3	
CHONDROITIN SOL	3	
cromolyn sodium ophth soln 4%	1	
CYSTADROPS SOL 0.37%	3	PA, QL (4 BOTTLES PER 28 DAYS)
CYSTARAN SOL 0.44%	3	PA, QL (4 BOTTLES PER 28 DAYS)
diclofenac sodium ophth soln 0.1%	1	
dorzolamide hcl ophth soln 2%	1	
DORZOLAMIDE SOL 2%	3	
epinastine hcl ophth soln 0.05%	1	

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

Drug Name	Drug Tier	Requirements/Limits
flurbiprofen sodium ophth soln 0.03%	1	
ILEVRO DRO 0.3% OP	2	
ketorolac tromethamine ophth soln 0.4%	1	
ketorolac tromethamine ophth soln 0.5%	1	
LASTACAFT SOL 0.25%	2	
NEVANAC SUS 0.1%	2	
PROLENSA SOL 0.07%	3	
TRUSOPT SOL 2% OP	3	
UPNEEQ SOL 0.1%	3	
ZERVIATE DRO 0.24%	2	
PROSTAGLANDINS - OPHTHALMIC		
bimatoprost ophth soln 0.03%	1	
latanoprost ophth soln 0.005%	1	
LUMIGAN SOL 0.01%	2	
TRAVATAN Z DRO 0.004%	3	
travoprost ophth soln 0.004% (benzalkonium free) (bak free)	1	
VYZULTA SOL 0.024%	3	
XALATAN SOL 0.005%	3	
XELPROS EMU 0.005%	3	
ZIOPTAN DRO 0.0015%	2	
OTIC AGENTS		
OTIC AGENTS - MISCELLANEOUS		
acetic acid otic soln 2%	1	
OTIC ANTI-INFECTIVES		
CETRAXAL SOL 0.2%	3	
ciprofloxacin hcl otic soln 0.2% (base equivalent)	1	
ofloxacin otic soln 0.3%	1	
OTIC COMBINATIONS		
CIPRO HC SUS OTIC	3	
CIPRODEX SUS 0.3-0.1%	3	
ciprofloxacin-dexamethasone otic susp 0.3-0.1%	1	
ciprofloxacin-fluocinolone aceton (pf) otic soln 0.3-0.025%	1	
CORTISPORIN SUS -TC OTIC	3	

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

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

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

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

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

Drug Name	Drug Tier	Requirements/Limits
progesterone im in oil 50 mg/ml	1	
PROMETRIUM CAP 100MG	3	PA; MNPA
PROMETRIUM CAP 200MG	3	PA; MNPA
PROVERA TAB 2.5MG	3	
PROVERA TAB 5MG	3	
PROVERA TAB 10MG	3	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
AGENTS FOR CHEMICAL DEPENDENCY		
acamprosate calcium tab delayed release 333 mg	1	
disulfiram tab 250 mg	1	
disulfiram tab 500 mg	1	
LUCEMYRA TAB 0.18MG	3	
ANTI-CATAPLECTIC AGENTS		
XYREM SOL 500MG/ML	3	PA, QL (540 ML PER 30 DAYS)
XYWAV SOL 0.5GM/ML	2	PA, QL (540 ML (270 GRAMS) PER 30 DAYS)
ANTIDEMENTIA AGENTS		
ADLARITY DIS 5MG/DAY	3	
ADLARITY DIS 10MG/DAY	3	
ARICEPT TAB 5MG	3	
ARICEPT TAB 10MG	3	
ARICEPT TAB 23MG	3	
donepezil hydrochloride orally disintegrating tab 5 mg	1	
donepezil hydrochloride orally disintegrating tab 10 mg	1	
donepezil hydrochloride tab 5 mg	1	
donepezil hydrochloride tab 10 mg	1	
donepezil hydrochloride tab 23 mg	1	
EXELON DIS 4.6MG/24	3	
EXELON DIS 9.5MG/24	3	QL (3 packages every 25 days)
EXELON DIS 13.3/24	3	
galantamine hydrobromide cap er 24hr 8 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
galantamine hydrobromide cap er 24hr 16 mg	1	
galantamine hydrobromide cap er 24hr 24 mg	1	
galantamine hydrobromide oral soln 4 mg/ml	1	
galantamine hydrobromide tab 4 mg	1	
galantamine hydrobromide tab 8 mg	1	
galantamine hydrobromide tab 12 mg	1	
memantine hcl cap er 24hr 7 mg	1	
memantine hcl cap er 24hr 14 mg	1	
memantine hcl cap er 24hr 21 mg	1	
memantine hcl cap er 24hr 28 mg	1	
memantine hcl oral solution 2 mg/ml	1	
memantine hcl tab 5 mg	1	
memantine hcl tab 10 mg	1	
memantine hcl tab 28 x 5 mg & 21 x 10 mg titration pack	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
NAMENDA XR CAP 7MG	3	
NAMENDA XR CAP 14MG	3	
NAMENDA XR CAP 21MG	3	
NAMENDA XR CAP 28MG	3	
NAMENDA XR CAP TITRATIO	3	
NAMZARIC CAP	2	
NAMZARIC CAP 7-10MG	2	
NAMZARIC CAP 14-10MG	2	
NAMZARIC CAP 21-10MG	2	
NAMZARIC CAP 28-10MG	2	
RAZADYNE ER CAP 8MG	3	
RAZADYNE ER CAP 16MG	3	
RAZADYNE ER CAP 24MG	3	
rivastigmine tartrate cap 1.5 mg (base equivalent)	1	
rivastigmine tartrate cap 3 mg (base equivalent)	1	

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

Drug Name	Drug Tier	Requirements/Limits
rivastigmine tartrate cap 4.5 mg (base equivalent)	1	
rivastigmine tartrate cap 6 mg (base equivalent)	1	
rivastigmine td patch 24hr 4.6 mg/24hr	1	
rivastigmine td patch 24hr 9.5 mg/24hr	1	
rivastigmine td patch 24hr 13.3 mg/24hr	1	
COMBINATION PSYCHOTHERAPEUTICS		
chlordiazepoxide-amitriptyline tab 5-12.5 mg	1	
chlordiazepoxide-amitriptyline tab 10-25 mg	1	
olanzapine-fluoxetine hcl cap 3-25 mg	1	
olanzapine-fluoxetine hcl cap 6-25 mg	1	
olanzapine-fluoxetine hcl cap 6-50 mg	1	
olanzapine-fluoxetine hcl cap 12-25 mg	1	
olanzapine-fluoxetine hcl cap 12-50 mg	1	
perphenazine-amitriptyline tab 2-10 mg	1	
perphenazine-amitriptyline tab 2-25 mg	1	
perphenazine-amitriptyline tab 4-10 mg	1	
perphenazine-amitriptyline tab 4-25 mg	1	
perphenazine-amitriptyline tab 4-50 mg	1	
SYMBYAX CAP 3-25MG	3	
SYMBYAX CAP 6-25MG	3	
SYMBYAX CAP 6-50MG	3	
SYMBYAX CAP 12-50MG	3	
FIBROMYALGIA AGENTS		
SAVELLA MIS TITR PAK	2	
SAVELLA TAB 12.5MG	2	
SAVELLA TAB 25MG	2	
SAVELLA TAB 50MG	2	
SAVELLA TAB 100MG	2	
HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS		
VYLEESI INJ 1.75/0.3	3	PA
MOVEMENT DISORDER DRUG THERAPY		
AUSTEDO TAB 6MG	2	PA, QL (60 TABLETS PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO TAB 9MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO TAB 12MG	2	PA, QL (120 TABLETS PER 30 DAYS)
INGREZZA CAP 40-80MG	2	PA
INGREZZA CAP 40MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 60MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 80MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
tetrabenazine tab 12.5 mg	1	PA, QL (120 TABLETS PER 30 DAYS)
tetrabenazine tab 25 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
XENAZINE TAB 12.5MG	3	PA, QL (120 TABLETS PER 30 DAYS)
XENAZINE TAB 25MG	3	PA, QL (60 TABLETS PER 30 DAYS)
MULTIPLE SCLEROSIS AGENTS		
AMPYRA TAB 10MG	3	PA, QL (60 TABLETS PER 30 DAYS)
AUBAGIO TAB 7MG	2	PA, QL (30 TABLETS PER 30 DAYS)
AUBAGIO TAB 14MG	2	PA, QL (30 TABLETS PER 30 DAYS)
AVONEX PEN KIT 30MCG	2	PA, QL (4 SYRINGES PER 28 DAYS)
AVONEX PREFL KIT 30MCG	2	PA, QL (4 SYRINGES PER 28 DAYS)
BAFIERTAM CAP 95MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
BETASERON INJ 0.3MG	2	PA, QL (14 KITS PER 28 DAYS)
COPAXONE INJ 20MG/ML	2	PA, QL (30 SYRINGES PER 30 DAYS)
COPAXONE INJ 40MG/ML	2	PA, QL (12 SYRINGES PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
dalfampridine tab er 12hr 10 mg	1	PA, QL (60 TABLETS PER 30 DAYS)
dimethyl fumarate capsule delayed release 120 mg	1	PA, QL (14 CAPSULES PER 28 DAYS)
dimethyl fumarate capsule delayed release 240 mg	1	PA, QL (60 CAPSULES PER 30 DAYS)
dimethyl fumarate capsule dr starter pack 120 mg & 240 mg	1	PA, QL (60 CAPSULES PER 30 DAYS)
EXTAVIA INJ 0.3MG	3	PA, QL (14 KITS PER 28 DAYS)
fingolimod hcl cap 0.5 mg (base equiv)	1	PA, QL (30 CAPSULES PER 30 DAYS)
GILENYA CAP 0.5MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
glatiramer acetate soln prefilled syringe 20 mg/ml	1	PA, QL (30 SYRINGES PER 30 DAYS)
glatiramer acetate soln prefilled syringe 40 mg/ml	1	PA, QL (12 SYRINGES PER 28 DAYS)
KESIMPTA INJ 20/.4ML	2	PA, QL (1 PEN PER 28 DAYS)
MAVENCLAD PAK 10MG(4)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(5)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(6)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(7)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(8)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(9)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAVENCLAD PAK 10MG(10)	3	PA, QL (20 TABLETS PER 9 MONTHS)
MAYZENT PAK STARTER	2	PA, QL (7 tablets per 4 days)
MAYZENT TAB 0.25MG	2	PA, QL (12 tablets per 5 days)

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

Drug Name	Drug Tier	Requirements/Limits
MAYZENT TAB 1MG	2	PA, QL (30 tablets per 30 days)
MAYZENT TAB 2MG	2	PA, QL (30 tablets per 30 days)
PLEGRIDY INJ	3	PA, QL (1 CARTON PER 28 DAYS)
PLEGRIDY INJ	3	PA, QL (1 KIT PER 28 DAYS)
PLEGRIDY INJ PEN	3	PA, QL (2 PENS PER 28 DAYS)
PLEGRIDY INJ STARTER	3	PA, QL (1 PACK PER 28 DAYS)
PLEGRIDY PEN INJ STARTER	3	PA, QL (1 PACK PER 28 DAYS)
PONVORY TAB 20MG	3	PA, QL (30 tabs per month)
PONVORY TAB STARTER	3	PA, QL (1 Pack (14 tabs) for 14 days)
REBIF INJ 22/0.5	2	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF INJ 44/0.5	2	PA, QL (12 SYRINGES PER 28 DAYS)
REBIF REBIDO INJ 22/0.5	2	PA, QL (12 INJ PER 28 DAYS)
REBIF REBIDO INJ 44/0.5	2	PA, QL (12 INJ PER 28 DAYS)
REBIF REBIDO INJ TITRATN	2	PA, QL (12 INJ PER 28 DAYS)
REBIF TITRTN INJ PACK	2	PA, QL (12 SYRINGES PER 28 DAYS)
TASCENSO ODT TAB 0.25MG	3	PA, QL (30 TABLETS PER 30 DAYS)
TECFIDERA CAP 120MG	3	PA, QL (14 CAPSULES PER 28 DAYS)
TECFIDERA CAP 240MG	3	PA, QL (60 CAPSULES PER 30 DAYS)
TECFIDERA MIS STARTER	3	PA, QL (60 CAPSULES PER 30 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
VUMERITY CAP 231MG	2	PA, QL (120 CAPSULES PER 30 DAYS)
ZEPOSIA 7DAY CAP STR PACK	2	PA, QL (7 TABLETS PER 7 DAYS)
ZEPOSIA CAP .92MG	2	PA, QL (30 TABLETS PER 30 DAYS)
ZEPOSIA CAP STR KIT	2	PA, QL (37 TABLETS PER 37 DAYS)
POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS		
GRALISE TAB 300MG	2	QL (150 tablets per month)
GRALISE TAB 600MG	2	QL (90 tablets per month)
LYRICA CR TAB 82.5MG	3	QL (60 tabs every month)
LYRICA CR TAB 165MG	3	QL (60 tabs every month)
LYRICA CR TAB 330MG	3	QL (60 tabs every month)
pregabalin tab er 24hr 82.5 mg	1	QL (60 TABLETS PER 30 DAYS)
pregabalin tab er 24hr 165 mg	1	QL (60 TABLETS PER 30 DAYS)
pregabalin tab er 24hr 330 mg	1	QL (60 TABLETS PER 30 DAYS)
PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS		
fluoxetine hcl (pmdd) tab 10 mg	1	PA; MNPA
fluoxetine hcl (pmdd) tab 20 mg	1	PA; MNPA
PSEUDOBULBAR AFFECT (PBA) AGENTS		
NUEDEXTA CAP 20-10MG	2	
PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.		
ergoloid mesylates tab 1 mg	1	
pimozide tab 1 mg	1	
pimozide tab 2 mg	1	
RESTLESS LEG SYNDROME (RLS) AGENTS		
HORIZANT TAB 300MG ER	3	QL (60 tablets per month)

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

Drug Name	Drug Tier	Requirements/Limits
HORIZANT TAB 600MG ER	3	QL (60 tablets per month)
SMOKING DETERRENTS		
bupropion hcl (smoking deterrent) tab er 12hr 150 mg	0	
CHANTIX PAK 1MG	0	
CHANTIX TAB 0.5& 1MG	0	
CHANTIX TAB 0.5MG	0	
CHANTIX TAB 1MG	0	
NICODERM CQ DIS 7MG/24HR	0	
NICODERM CQ DIS 14MG/24H	0	
NICODERM CQ DIS 21MG/24H	0	
NICORETTE GUM 2MG	0	
NICORETTE GUM 2MG CINN	0	
NICORETTE GUM 2MG MINT	0	
NICORETTE GUM 2MG ORIG	0	
NICORETTE GUM 2MGFRUIT	0	
NICORETTE GUM 4MG	0	
NICORETTE GUM 4MG CINN	0	
NICORETTE GUM 4MG MINT	0	
NICORETTE GUM 4MG ORIG	0	
NICORETTE GUM 4MGFRUIT	0	
NICORETTE LOZ 2MG MINT	0	
NICORETTE LOZ 4MG MINT	0	
NICORETTE ST GUM 2MG MINT	0	
NICORETTE ST GUM 2MG ORIG	0	
NICORETTE ST GUM 4MG ORIG	0	
nicotine polacrilex gum 2 mg	0	
nicotine polacrilex gum 2 mg	0	OTC; $0 limited to 2 treatment cycles/year
nicotine polacrilex gum 4 mg	0	
nicotine polacrilex gum 4 mg	0	OTC; $0 limited to 2 treatment cycles/year
nicotine polacrilex lozenge 2 mg	0	
nicotine polacrilex lozenge 2 mg	0	OTC; $0 limited to 2 treatment cycles/year
nicotine polacrilex lozenge 4 mg	0	

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

Drug Name	Drug Tier	Requirements/Limits
nicotine polacrilex lozenge 4 mg	0	OTC; $0 limited to 2 treatment cycles/year
nicotine td patch 24hr 7 mg/24hr	0	OTC; $0 limited to 2 treatment cycles/year
nicotine td patch 24hr 14 mg/24hr	0	OTC; $0 limited to 2 treatment cycles/year
nicotine td patch 24hr 21 mg/24hr	0	OTC; $0 limited to 2 treatment cycles/year
NICOTROL INH	0	
NICOTROL NS SPR 10MG/ML	0	
TRANSTHYRETIN AMYLOIDOSIS AGENTS		
TEGSEDI INJ 284/1.5	2	PA, QL (4 PFS PER 28 DAYS)
VASOMOTOR SYMPTOM AGENTS		
BRISDELLE CAP 7.5MG	3	
paroxetine mesylate cap 7.5 mg (base equiv)	1	PA; MNPA
RESPIRATORY AGENTS - MISC.		
CYSTIC FIBROSIS AGENTS		
BRONCHITOL CAP 40MG	3	PA, QL (600 caps every 30 days)
BRONCHITOL CAP TOL TEST	3	PA, QL (90 caps every 30 days)
KALYDECO PAK 25MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 50MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO PAK 75MG	3	PA, QL (56 PACKETS PER 28 DAYS)
KALYDECO TAB 150MG	3	QL (60 tablets per month)
ORKAMBI GRA 75-94MG	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 100-125	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 150-188	3	PA, QL (56 PACKETS PER 28 DAYS)

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

Drug Name	Drug Tier	Requirements/Limits
ORKAMBI TAB 100-125	3	PA, QL (112 TABLETS PER 28 DAYS)
ORKAMBI TAB 200-125	3	PA, QL (112 TABLETS PER 28 DAYS)
PULMOZYME SOL 1MG/ML	2	PA, QL (60 AMPULES PER 30 DAYS)
SYMDEKO TAB 50-75MG	3	PA, QL (56 TABLETS PER 28 DAYS)
SYMDEKO TAB 100-150	3	PA, QL (56 TABLETS PER 28 DAYS)
TRIKAFTA TAB	3	PA, QL (84 TABLETS PER 28 DAYS)
TRIKAFTA TAB	3	PA, QL (84 tablets per 28 days)
PULMONARY FIBROSIS AGENTS		
ESBRIET CAP 267MG	2	PA, QL (270 CAPSULES PER 30 DAYS)
ESBRIET TAB 267MG	2	PA, QL (270 TABLETS PER 30 DAYS)
ESBRIET TAB 801MG	2	PA, QL (90 TABLETS PER 30 DAYS)
OFEV CAP 100MG	2	PA, QL (60 CAPSULES PER 30 DAYS)
OFEV CAP 150MG	2	PA, QL (60 CAPSULES PER 30 DAYS)
pirfenidone tab 267 mg	1	
pirfenidone tab 801 mg	1	
SULFONAMIDES		
SULFONAMIDES		
SULFADIAZINE TAB 500 MG	3	
TETRACYCLINES		
AMINOMETHYLCYCLINES		
NUZYRA TAB 150MG	3	
TETRACYCLINES		
ACTICLATE TAB 75MG	3	MNPA
ACTICLATE TAB 150MG	3	MNPA
demeclocycline hcl tab 150 mg	1	
demeclocycline hcl tab 300 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
DORYX MPC TAB 120MG	3	
DORYX TAB 50MG	3	MNPA
DORYX TAB 80MG	3	
DORYX TAB 200MG	3	MNPA
doxycycline hyclate cap 50 mg	1	
doxycycline hyclate cap 100 mg	1	
doxycycline hyclate tab 20 mg	1	
doxycycline hyclate tab 50 mg	1	PA; MNPA
DOXYCYCLINE HYCLATE TAB 50 MG	3	MNPA
doxycycline hyclate tab 75 mg	1	MNPA
doxycycline hyclate tab 75 mg	1	PA; MNPA
doxycycline hyclate tab 100 mg	1	
doxycycline hyclate tab 150 mg	1	MNPA
doxycycline hyclate tab 150 mg	1	PA; MNPA
doxycycline hyclate tab delayed release 50 mg	1	PA; MNPA
doxycycline hyclate tab delayed release 75 mg	1	
doxycycline hyclate tab delayed release 80 mg	1	
doxycycline hyclate tab delayed release 100 mg	1	
doxycycline hyclate tab delayed release 150 mg	1	
doxycycline hyclate tab delayed release 200 mg	1	PA; MNPA
doxycycline monohydrate cap 50 mg	1	
doxycycline monohydrate cap 75 mg	1	PA; MNPA
doxycycline monohydrate cap 75 mg	1	PA, QL (3 packages every 25 days); MNPA
doxycycline monohydrate cap 100 mg	1	
doxycycline monohydrate cap 150 mg	1	PA; MNPA
doxycycline monohydrate for susp 25 mg/5ml	1	
doxycycline monohydrate tab 50 mg	1	
doxycycline monohydrate tab 75 mg	1	
doxycycline monohydrate tab 100 mg	1	
doxycycline monohydrate tab 150 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
minocycline hcl cap 50 mg	1	
minocycline hcl cap 75 mg	1	
minocycline hcl cap 100 mg	1	
minocycline hcl cap er 24hr 45 mg (base equivalent)	1	PA; MNPA
minocycline hcl cap er 24hr 90 mg (base equivalent)	1	PA; MNPA
minocycline hcl cap er 24hr 135 mg (base equivalent)	1	PA; MNPA
minocycline hcl tab 50 mg	1	
minocycline hcl tab 75 mg	1	
minocycline hcl tab 100 mg	1	
minocycline hcl tab er 24hr 45 mg	1	PA; MNPA
minocycline hcl tab er 24hr 55 mg	1	PA
minocycline hcl tab er 24hr 65 mg	1	PA; MNPA
minocycline hcl tab er 24hr 80 mg	1	PA
minocycline hcl tab er 24hr 90 mg	1	PA; MNPA
minocycline hcl tab er 24hr 105 mg	1	PA
minocycline hcl tab er 24hr 115 mg	1	PA; MNPA
minocycline hcl tab er 24hr 135 mg	1	PA; MNPA
MINOLIRA TAB 105MG	3	
MINOLIRA TAB 135MG	3	
SEYSARA TAB 60MG	3	
SEYSARA TAB 100MG	3	
SEYSARA TAB 150MG	3	
SOLODYN TAB 55MG	3	
SOLODYN TAB 65MG	3	MNPA
SOLODYN TAB 80MG	3	
SOLODYN TAB 105MG	3	
SOLODYN TAB 115MG	3	MNPA
tetracycline hcl cap 250 mg	1	QL (120 capsules per 25 days)
tetracycline hcl cap 500 mg	1	QL (120 capsules per 25 days)
VIBRAMYCIN CAP 100MG	3	
VIBRAMYCIN SUS 25MG/5ML	2	
VIBRAMYCIN SYP 50MG/5ML	2	
XIMINO CAP 45MG ER	3	MNPA

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

Drug Name	Drug Tier	Requirements/Limits
XIMINO CAP 90MG ER	3	MNPA
XIMINO CAP 135MG ER	3	MNPA
THYROID AGENTS		
ANTITHYROID AGENTS		
methimazole tab 5 mg	1	
methimazole tab 10 mg	1	
propylthiouracil tab 50 mg	1	
TAPAZOLE TAB 5MG	2	
TAPAZOLE TAB 10MG	2	
THYROID HORMONES		
ARMOUR THYRO TAB 15MG	3	
ARMOUR THYRO TAB 30MG	3	
ARMOUR THYRO TAB 60MG	3	
ARMOUR THYRO TAB 90MG	3	
ARMOUR THYRO TAB 120MG	3	
ARMOUR THYRO TAB 180MG	3	
ARMOUR THYRO TAB 240MG	3	
ARMOUR THYRO TAB 300MG	3	
CYTOMEL TAB 5MCG	3	
CYTOMEL TAB 25MCG	3	
CYTOMEL TAB 50MCG	3	
LEVOTHYROXINE SODIUM CAP 13 MCG	1	
LEVOTHYROXINE SODIUM CAP 25 MCG	1	
LEVOTHYROXINE SODIUM CAP 50 MCG	1	
LEVOTHYROXINE SODIUM CAP 75 MCG	1	
LEVOTHYROXINE SODIUM CAP 88 MCG	1	
LEVOTHYROXINE SODIUM CAP 100 MCG	1	
LEVOTHYROXINE SODIUM CAP 112 MCG	1	
LEVOTHYROXINE SODIUM CAP 125 MCG	1	
LEVOTHYROXINE SODIUM CAP 137 MCG	1	
LEVOTHYROXINE SODIUM CAP 150 MCG	1	
LEVOTHYROXINE SODIUM CAP 175 MCG	1	
LEVOTHYROXINE SODIUM CAP 200 MCG	1	
levothyroxine sodium tab 25 mcg	1	
levothyroxine sodium tab 50 mcg	1	
levothyroxine sodium tab 75 mcg	1	
levothyroxine sodium tab 88 mcg	1	

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

Drug Name	Drug Tier	Requirements/Limits
levothyroxine sodium tab 100 mcg	1	
levothyroxine sodium tab 112 mcg	1	
levothyroxine sodium tab 125 mcg	1	
levothyroxine sodium tab 137 mcg	1	
levothyroxine sodium tab 150 mcg	1	
levothyroxine sodium tab 175 mcg	1	
levothyroxine sodium tab 200 mcg	1	
levothyroxine sodium tab 300 mcg	1	
liothyronine sodium tab 5 mcg	1	
liothyronine sodium tab 25 mcg	1	
liothyronine sodium tab 50 mcg	1	
NATURE THROI TAB 162.5MG	3	
NATURE-THROI TAB 16.25MG	3	
NATURE-THROI TAB 32.5MG	3	
NATURE-THROI TAB 48.75MG	3	
NATURE-THROI TAB 65MG	3	
NATURE-THROI TAB 81.25MG	3	
NATURE-THROI TAB 97.5MG	3	
NATURE-THROI TAB 113.75MG	3	
NATURE-THROI TAB 130MG	3	
NATURE-THROI TAB 146.25MG	3	
NATURE-THROI TAB 195MG	3	
NATURE-THROI TAB 260MG	3	
NATURE-THROI TAB 325MG	3	
SYNTHROID TAB 25MCG	2	
SYNTHROID TAB 50MCG	2	
SYNTHROID TAB 75MCG	2	
SYNTHROID TAB 88MCG	2	
SYNTHROID TAB 100MCG	2	
SYNTHROID TAB 112MCG	2	
SYNTHROID TAB 125MCG	2	
SYNTHROID TAB 137MCG	2	
SYNTHROID TAB 150MCG	2	
SYNTHROID TAB 175MCG	2	
SYNTHROID TAB 200MCG	2	
SYNTHROID TAB 300MCG	2	
THYQUIDITY SOL 100MCG	3	

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

Drug Name	Drug Tier	Requirements/Limits
thyroid tab 15 mg (1/4 grain)	1	
thyroid tab 30 mg (1/2 grain)	1	
thyroid tab 60 mg (1 grain)	1	
thyroid tab 90 mg (1 1/2 grain)	1	
thyroid tab 120 mg (2 grain)	1	
TIROSINT CAP 13MCG	3	
TIROSINT CAP 25MCG	3	
TIROSINT CAP 50MCG	3	
TIROSINT CAP 75MCG	3	
TIROSINT CAP 88MCG	3	
TIROSINT CAP 100MCG	3	
TIROSINT CAP 112MCG	3	
TIROSINT CAP 125MCG	3	
TIROSINT CAP 137MCG	3	
TIROSINT CAP 150MCG	3	
TIROSINT CAP 175MCG	3	
TIROSINT CAP 200	3	
TIROSINT-SOL SOL 13MCG/ML	3	
TIROSINT-SOL SOL 25MCG/ML	3	
TIROSINT-SOL SOL 50MCG/ML	3	
TIROSINT-SOL SOL 75MCG/ML	3	
TIROSINT-SOL SOL 88MCG/ML	3	
TIROSINT-SOL SOL 100MCG	3	
TIROSINT-SOL SOL 112MCG	3	
TIROSINT-SOL SOL 125MCG	3	
TIROSINT-SOL SOL 137MCG	3	
TIROSINT-SOL SOL 150MCG	3	
TIROSINT-SOL SOL 175MCG	3	
TIROSINT-SOL SOL 200MCG	3	
WESTHROID TAB 32.5MG	3	
WESTHROID TAB 65MG	3	
WESTHROID TAB 97.5MG	3	
WESTHROID TAB 130MG	3	
WESTHROID TAB 195MG	3	
WP THYROID TAB 16.25MG	3	
WP THYROID TAB 32.5MG	3	
WP THYROID TAB 48.75MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
WP THYROID TAB 65MG	3	
WP THYROID TAB 81.25MG	3	
WP THYROID TAB 97.5MG	3	
WP THYROID TAB 113.75MG	3	
WP THYROID TAB 130MG	3	
ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS		
ANTISPASMODICS		
ANASPAZ TAB 0.125MG	2	
BELLA/OPIUM SUP 16.2-30	3	
BELLA/OPIUM SUP 16.2-60	3	
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg	1	
chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg	1	PA
CUVPOSA SOL 1MG/5ML	3	
dicyclomine hcl cap 10 mg	1	
dicyclomine hcl oral soln 10 mg/5ml	1	
dicyclomine hcl tab 20 mg	1	
GLYCATE TAB 1.5MG	3	
GLYCOPYRROL INJ 0.2MG/ML	3	
GLYCOPYRROL INJ 0.4/2ML	3	
GLYCOPYRROLA TAB 1.5MG	3	PA; MNPA
glycopyrrolate oral soln 1 mg/5ml	1	
glycopyrrolate tab 1 mg	1	
glycopyrrolate tab 2 mg	1	
hyoscyamine sulfate elixir 0.125 mg/5ml	1	
hyoscyamine sulfate sl tab 0.125 mg	1	
hyoscyamine sulfate soln 0.125 mg/ml	1	
hyoscyamine sulfate tab 0.125 mg	1	
hyoscyamine sulfate tab disint 0.125 mg	1	
hyoscyamine sulfate tab er 12hr 0.375 mg	1	PA; MNPA
LEVBID TAB 0.375 ER	3	
LEVSIN TAB 0.125MG	2	
LEVSIN/SL SUB 0.125MG	2	
LIBRAX CAP 5-2.5MG	3	
methscopolamine bromide tab 2.5 mg	1	
methscopolamine bromide tab 5 mg	1	

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

Drug Name	Drug Tier	Requirements/Limits
SYMAX DUOTAB TAB	3	
H-2 ANTAGONISTS		
cimetidine hcl soln 300 mg/5ml	1	
cimetidine tab 300 mg	1	
cimetidine tab 400 mg	1	
cimetidine tab 800 mg	1	
famotidine for susp 40 mg/5ml	1	
famotidine tab 40 mg	1	
nizatidine cap 150 mg	1	
nizatidine cap 300 mg	1	
nizatidine oral soln 15 mg/ml	1	
PEPCID TAB 40MG	3	
MISC. ANTI-ULCER		
CARAFATE SUS 1GM/10ML	3	
CARAFATE TAB 1GM	3	
sucralfate susp 1 gm/10ml	1	PA
sucralfate tab 1 gm	1	
PROTON PUMP INHIBITORS		
ACIPHEX SPR CAP 5MG	3	QL (90 caps every year)
ACIPHEX SPR CAP 10MG	3	QL (90 caps every year)
ACIPHEX TAB 20MG	3	QL (90 tabs every year)
DEXILANT CAP 30MG DR	3	QL (90 caps every year)
DEXILANT CAP 60MG DR	3	QL (90 caps every year)
dexlansoprazole cap delayed release 30 mg	1	QL (90 caps every year)
dexlansoprazole cap delayed release 60 mg	1	QL (90 caps every year)
ESOMEPRAZOLE CAP 49.3MG	3	QL (90 caps every year)
esomeprazole magnesium cap delayed release 20 mg (base eq)	1	QL (90 caps every year)
esomeprazole magnesium cap delayed release 40 mg (base eq)	1	QL (90 caps every year)
esomeprazole magnesium for delayed release susp packet 10 mg	1	QL (90 packets every year)
esomeprazole magnesium for delayed release susp packet 20 mg	1	QL (90 packets every year)
esomeprazole magnesium for delayed release susp packet 40 mg	1	QL (90 packets every year)
lansoprazole cap delayed release 15 mg	1	QL (90 caps every year)

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

Drug Name	Drug Tier	Requirements/Limits
lansoprazole cap delayed release 30 mg	1	QL (90 caps every year)
lansoprazole tab delayed release orally disintegrating 15 mg	1	QL (90 ea every year)
lansoprazole tab delayed release orally disintegrating 30 mg	1	QL (90 ea every year)
NEXIUM CAP 20MG	3	QL (90 caps every year)
NEXIUM CAP 40MG	3	QL (90 caps every year)
NEXIUM GRA 2.5MG DR	3	QL (90 packets every year)
NEXIUM GRA 5MG DR	3	QL (90 packets every year)
NEXIUM GRA 10MG DR	3	QL (90 packets every year)
NEXIUM GRA 20MG DR	3	QL (90 packets every year)
NEXIUM GRA 40MG DR	3	QL (90 packets every year)
omeprazole cap delayed release 10 mg	1	QL (90 caps every year)
omeprazole cap delayed release 20 mg	1	QL (90 caps every year)
omeprazole cap delayed release 40 mg	1	QL (90 caps every year)
pantoprazole sodium ec tab 20 mg (base equiv)	1	QL (90 tabs every year)
pantoprazole sodium ec tab 40 mg (base equiv)	1	QL (90 tabs every year)
pantoprazole sodium for delayed release susp packet 40 mg	1	PA, QL (90 packets every year); MNPA
pantoprazole sodium for iv soln 40 mg (base equiv)	1	QL (90 vials every year)
PREVACID CAP 15MG DR	3	QL (90 caps every year)
PREVACID CAP 30MG DR	3	QL (90 caps every year)
PREVACID TAB 15MG STB	3	QL (90 ea every year)
PREVACID TAB 30MG STB	3	QL (90 ea every year)
PRILOSEC POW 2.5MG	3	PA, QL (90 packets every year); MNPA
PRILOSEC POW 10MG	3	PA, QL (90 packets every year); MNPA
PROTONIX INJ 40MG	3	QL (90 vials every year)
PROTONIX PAK 40MG	3	QL (90 packets every year)

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

Drug Name	Drug Tier	Requirements/Limits
PROTONIX TAB 20MG	3	QL (90 tabs every year)
PROTONIX TAB 40MG	3	QL (90 tabs every year)
RABEPRAZOLE CAP 10MG DR	3	QL (90 caps every year)
rabeprazole sodium ec tab 20 mg	1	QL (90 tabs every year)
ULCER DRUGS - PROSTAGLANDINS		
CYTOTEC TAB 100MCG	2	
CYTOTEC TAB 200MCG	2	
misoprostol tab 100 mcg	1	
misoprostol tab 200 mcg	1	
ULCER THERAPY COMBINATIONS		
amoxicillin cap-clarithro tab-lansopraz cap dr therapy pack	1	
HELIDAC MIS THERAPY	3	
OMECLAMOX- MIS PAK	3	
omeprazole-sodium bicarbonate cap 20-1100 mg	1	PA, QL (90 caps every year); MNPA
omeprazole-sodium bicarbonate cap 40-1100 mg	1	PA, QL (90 caps every year); MNPA
omeprazole-sodium bicarbonate powd pack for susp 20-1680 mg	1	PA, QL (90 packets every year); MNPA
omeprazole-sodium bicarbonate powd pack for susp 40-1680 mg	1	PA, QL (90 packets every year); MNPA
PYLERA CAP	2	
TALICIA CAP	2	
VOQUEZNA PAK DUAL PAK	3	
VOQUEZNA PAK TRIP PK	3	
ZEGERID CAP 20-1100	3	PA, QL (90 caps every year); MNPA
ZEGERID CAP 40-1100	3	PA, QL (90 caps every year); MNPA
ZEGERID POW 20-1680	3	PA, QL (90 packets every year); MNPA
ZEGERID POW 40-1680	3	PA, QL (90 packets every year); MNPA

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

Drug Name	Drug Tier	Requirements/Limits
URINARY ANTISPASMODICS		
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)		
darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)	1	
darifenacin hydrobromide tab er 24hr 15 mg (base equiv)	1	
DETROL LA CAP 2MG	3	
DETROL LA CAP 4MG	3	
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
ENABLEX TAB 7.5MG	3	
fesoterodine fumarate tab er 24hr 4 mg	1	
fesoterodine fumarate tab er 24hr 8 mg	1	
GELNIQUE GEL 10%	3	
oxybutynin chloride syrup 5 mg/5ml	1	
oxybutynin chloride tab 5 mg	1	
oxybutynin chloride tab er 24hr 5 mg	1	
oxybutynin chloride tab er 24hr 10 mg	1	
oxybutynin chloride tab er 24hr 15 mg	1	
OXYTROL DIS 3.9MG/24	3	
solifenacin succinate tab 5 mg	1	
solifenacin succinate tab 10 mg	1	
tolterodine tartrate cap er 24hr 2 mg	1	
tolterodine tartrate cap er 24hr 4 mg	1	
tolterodine tartrate tab 1 mg	1	
tolterodine tartrate tab 2 mg	1	
TOVIAZ TAB 4MG	2	
TOVIAZ TAB 8MG	2	
trospium chloride cap er 24hr 60 mg	1	
trospium chloride tab 20 mg	1	
VESICARE LS SUS 5MG/5ML	3	
VESICARE TAB 5MG	3	
VESICARE TAB 10MG	3	

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

Drug Name	Drug Tier	Requirements/Limits
URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS		
GEMTESA TAB 75MG	3	
MYRBETRIQ SUS 8MG/ML	2	
MYRBETRIQ TAB 25MG	2	
MYRBETRIQ TAB 50MG	2	
URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS		
bethanechol chloride tab 5 mg	1	
bethanechol chloride tab 10 mg	1	
bethanechol chloride tab 25 mg	1	
bethanechol chloride tab 50 mg	1	
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS		
flavoxate hcl tab 100 mg	1	
VAGINAL AND RELATED PRODUCTS		
MISCELLANEOUS VAGINAL PRODUCTS		
INTRAROSA SUP 6.5MG	3	
SPERMICIDES		
ENCARE SUP 100MG	0	
GYNOL II GEL 3%	0	
SHUR-SEAL GEL 2%	0	
TODAY SPONGE MIS	0	
VCF VAGINAL AER CONTRACP	0	
vcf vaginal gel contrace	0	
VCF VAGINAL MIS CONTRACP	0	
VAGINAL ANTI-INFECTIVES		
CLEOCIN CRE 2% VAG	2	
CLEOCIN SUP 100MG	3	
clindamycin phosphate vaginal cream 2%	1	
CLINDESSE CRE 2%	3	
GYNAZOLE-1 CRE 2%	3	
metronidazole vaginal gel 0.75%	1	
miconazole nitrate vaginal suppos 200 mg	1	
NUVESSA GEL 1.3%	3	
terconazole vaginal cream 0.4%	1	
terconazole vaginal cream 0.8%	1	
terconazole vaginal suppos 80 mg	1	
vandazole gel 0.75%	1	

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

Drug Name	Drug Tier	Requirements/Limits
VAGINAL ESTROGENS		
ESTRACE VAG CRE 0.01%	3	
estradiol vaginal cream 0.1 mg/gm	1	
estradiol vaginal tab 10 mcg	1	
ESTRING MIS 2MG	2	
FEMRING MIS 0.1MG/24	3	
FEMRING MIS 0.05/24H	3	
IMVEXXY MAIN SUP 4MCG	3	
IMVEXXY MAIN SUP 10MCG	3	
IMVEXXY STRT SUP 4MCG	3	
IMVEXXY STRT SUP 10MCG	3	
PREMARIN VAG CRE 0.625MG	2	
VAGIFEM TAB 10MCG	3	
VAGINAL PROGESTINS		
CRINONE GEL 4% VAG	2	
CRINONE GEL 8% VAG	2	
ENDOMETRIN SUP 100MG	2	
VASOPRESSORS		
ANAPHYLAXIS THERAPY AGENTS		
ADRENALIN INJ 1MG/ML	3	
ADRENALIN INJ 30/30ML	3	
AUVI-Q INJ 0.1MG	2	QL (6 pens every 300 days)
AUVI-Q INJ 0.3MG	2	QL (6 pens every 300 days)
AUVI-Q INJ 0.15MG	2	QL (6 pens every 300 days)
EPINEPHR PRO KIT 1MG/ML	3	QL (6 kits every 300 days)
epinephrine inj 30 mg/30ml (1 mg/ml) (1:1000)	1	
EPINEPHRINE KIT 1MG/ML	3	QL (6 kits every 300 days)
epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)	1	QL (6 pens every 300 days)
epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)	1	QL (6 pens every 300 days)

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

Drug Name	Drug Tier	Requirements/Limits
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	1	QL (3 pens / 300 days)
epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)	1	QL (3 pens every 300 days)
EPINPHEPHRIN KIT SNAP-V	3	QL (6 kits every 300 days)
EPIPEN 2-PAK INJ 0.3MG	2	QL (6 pens every 300 days)
EPIPEN-JR INJ 0.15MG	2	QL (6 pens every 300 days)
SYMJEPI INJ 0.3MG	3	QL (3 syringes every 300 days)
SYMJEPI INJ 0.15MG	3	QL (6 syringes every 300 days)
NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS		
droxidopa cap 100 mg	1	PA, QL (90 CAPSULES PER 30 DAYS)
droxidopa cap 200 mg	1	PA, QL (180 CAPSULES PER 30 DAYS)
droxidopa cap 300 mg	1	PA, QL (180 CAPSULES PER 30 DAYS)
NORTHERA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS)
NORTHERA CAP 200MG	3	PA, QL (180 CAPSULES PER 30 DAYS)
NORTHERA CAP 300MG	3	PA, QL (180 CAPSULES PER 30 DAYS)
VASOPRESSORS		
EPINEPHRINE INJ 0.2MG	3	
midodrine hcl tab 2.5 mg	1	
midodrine hcl tab 5 mg	1	
midodrine hcl tab 10 mg	1	
VITAMINS		
OIL SOLUBLE VITAMINS		
DRISDOL CAP 50000UNT	3	
ergocalciferol cap 1.25 mg (50000 unit)	1	
MEPHYTON TAB 5MG	3	
phytonadione tab 5 mg	1	

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

Index

Generate the index.

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

10455 Mill Run Circle
Owings Mills, MD 21117

carefirst.com/rxgroup

SUM5464-1S (12/22) ■ For self-insured plans only

Notice of Nondiscrimination and Availability of Language Assistance Services

(UPDATED 8/5/19)

CareFirst BlueCross BlueShield, CareFirst BlueChoice, Inc., CareFirst Diversified Benefits and all of their corporate affiliates (CareFirst) comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability or sex. CareFirst does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

CareFirst:

- Provides free aid and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call 855-258-6518.

If you believe CareFirst has failed to provide these services, or discriminated in another way, on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our CareFirst Civil Rights Coordinator by mail, fax or email. If you need help filing a grievance, our CareFirst Civil Rights Coordinator is available to help you.

To file a grievance regarding a violation of federal civil rights, please contact the Civil Rights Coordinator as indicated below. Please do not send payments, claims issues, or other documentation to this office.

Civil Rights Coordinator, Corporate Office of Civil Rights

Mailing Address	P.O. Box 8894 Baltimore, Maryland 21224
Email Address	**civilrightscoordinator@carefirst.com**
Telephone Number	410-528-7820
Fax Number	410-505-2011

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Foreign Language Assistance

Attention (English): This notice contains information about your insurance coverage. It may contain key dates and you may need to take action by certain deadlines. You have the right to get this information and assistance in your language at no cost. Members should call the phone number on the back of their member identification card. All others may call 855-258-6518 *and wait through the dialogue until prompted to push* 0. *When an agent answers, state the language you need and you will be connected to an interpreter.*

አማርኛ(Amharic) ማሳሰቢያ፦ ይህ ማስታወቂያ ስለ መድን ሽፋንዎ መረጃ ይዟል። ከተወሰኑ ቀነ-ገደቦች በፊት ሊፈጽሟቸው የሚገቡ ነገሮች ሊኖሩ ስለሚችሉ እነዚህን ወሳኝ ቀናት ሊይዝ ይችላል። ይኽን መረጃ የማግኘት እና ያለምንም ክፍያ በቋንቋዎ እገዛ የማግኘት መብት አለዎት። አባል ከሆኑ ከመታወቂያ ካርድዎ በስተጀርባ ላይ ወደተጠቀሰው የስልክ ቁጥር መደወል ይችላሉ። አባል ካልሆኑ ደግሞ ወደ ስልክ ቁጥር 855-258-6518 ደውለው 0ን እንዲጫኑ እስኪነገርዎ ድረስ ንግግሩን መጠበቅ አለብዎ። አንድ ወኪል መልስ ሲሰጥዎ፣ የሚፈልጉትን ቋንቋ ያሳውቁ፣ ከዚያም ከተርጓሚ ጋር ይገናኛሉ።

Èdè Yorùbá (Yoruba) Ìtẹ́tíléko: Àkíyèsí yìí ní ìwífún nípa iṣẹ́ adójútòfò rẹ. Ó le ní àwọn déètì pàtó o sì le ní láti gbé ìgbésẹ̀ ní àwọn ọjọ́ gbèdéke kan. O ni ẹ̀tọ́ láti gba ìwífún yìí àti ìrànlọ́wọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Àwọn ọmọ-ẹgbẹ́ gbọ́dọ̀ pe nọ́mbà fóònù tó wà lẹ́yìn káàdì ìdánimọ̀ wọn. Àwọn míràn le pe 855-258-6518 kí o sì dúró nípasẹ̀ ìjíròrò tití a ó fi sọ fún ọ láti tẹ 0. Nígbàtí aṣojú kan bá dáhùn, sọ èdè tí o fẹ́ a ó sì so ọ́ pọ̀ mọ́ ògbufọ̀ kan.

Tiếng Việt (Vietnamese) Chú ý: Thông báo này chứa thông tin về phạm vi bảo hiểm của quý vị. Thông báo có thể chứa những ngày quan trọng và quý vị cần hành động trước một số thời hạn nhất định. Quý vị có quyền nhận được thông tin này và hỗ trợ bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Các thành viên nên gọi số điện thoại ở mặt sau của thẻ nhận dạng. Tất cả những người khác có thể gọi số 855-258-6518 và chờ hết cuộc đối thoại cho đến khi được nhắc nhấn phím 0. Khi một tổng đài viên trả lời, hãy nêu rõ ngôn ngữ quý vị cần và quý vị sẽ được kết nối với một thông dịch viên.

Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa nasasaklawan ng iyong insurance. Maaari itong maglaman ng mga pinakamahalagang petsa at maaaring kailangan mong gumawa ng aksyon ayon sa ilang deadline. May karapatan ka na makuha ang impormasyong ito at tulong sa iyong sariling wika nang walang gastos. Dapat tawagan ng mga Miyembro ang numero ng telepono na nasa likuran ng kanilang identification card. Ang lahat ng iba ay maaaring tumawag sa 855-258-6518 at maghintay hanggang sa dulo ng diyalogo hanggang sa diktahan na pindutin ang 0. Kapag sumagot ang ahente, sabihin ang wika na kailangan mo at ikokonekta ka sa isang interpreter.

Español (Spanish) Atención: Este aviso contiene información sobre su cobertura de seguro. Es posible que incluya fechas clave y que usted tenga que realizar alguna acción antes de ciertas fechas límite. Usted tiene derecho a obtener esta información y asistencia en su idioma sin ningún costo. Los asegurados deben llamar al número de teléfono que se encuentra al reverso de su tarjeta de identificación. Todos los demás pueden llamar al 855-258-6518 y esperar la grabación hasta que se les indique que deben presionar 0. Cuando un agente de seguros responda, indique el idioma que necesita y se le comunicará con un intérprete.

Русский (Russian) Внимание! Настоящее уведомление содержит информацию о вашем страховом обеспечении. В нем могут указываться важные даты, и от вас может потребоваться выполнить некоторые действия до определенного срока. Вы имеете право бесплатно получить настоящие сведения и сопутствующую помощь на удобном вам языке. Участникам следует обращаться по номеру телефона, указанному на тыльной стороне идентификационной карты. Все прочие абоненты могут звонить по номеру 855-258-6518 и ожидать, пока в голосовом меню не будет предложено нажать цифру «0». При ответе агента укажите желаемый язык общения, и вас свяжут с переводчиком.

हिन्दी (Hindi) ध्यान दें: इस सूचना में आपकी बीमा कवरेज के बारे में जानकारी दी गई है। हो सकता है कि इसमें मुख्य तिथियों का उल्लेख हो और आपके लिए किसी नियत समय-सीमा के भीतर काम करना ज़रूरी हो। आपको यह जानकारी और संबंधित सहायता अपनी भाषा में निःशुल्क पाने का अधिकार है। सदस्यों को अपने पहचान पत्र के पीछे दिए गए फ़ोन नंबर पर कॉल करना चाहिए। अन्य सभी लोग 855-258-6518 पर कॉल कर सकते हैं और जब तक 0 दबाने के लिए न कहा जाए, तब तक संवाद की प्रतीक्षा करें। जब कोई एजेंट उत्तर दे तो उसे अपनी भाषा बताएँ और आपको व्याख्याकार से कनेक्ट कर दिया जाएगा।

Bǎsɔ́ɔ̀-wùdù (Bassa) Tò Đùǔ Cáo! Bɔ̌ nìà kɛ ɓá nyɔ ɓě ké m̀ gbo kpá ɓó nì fǔà-fǘá-tìǐn nyɛɛ jè dyí. Bɔ̌ nìà kɛ ɓédɖé wé jɛ́ɛ́ ɓě ɓɛ́ m̀ ké dɛ wa mó m̀ ké nyuɛɛ nyu hwè ɓɛ́ wé ɓěa ké zi. Ɔ mò nì kpé ɓɛ́ m̀ ké bɔ̌ nìà kɛ kè gbo-kpá-kpá m̀ mɔ́ɛɛ dyé dɖé nì ɓídɖí-wùdù mú ɓɛ́ m̀ ké se wídɖí dɔ̀ pɛ́è. Kpooɔ̀ nyɔ ɓě mɛ dɖá fǔùn-nɔ̀ɓà nìà dɖé waà I.D. káàɔ̀ dɛín nyɛ. Nyɔ tɔ̀ɔ̀ séín mɛ dɖá nɔ̀ɓà nìà kɛ: 855-258-6518, ké m̀ mɛ fò tee ɓɛ́ wa kéɛ m̀ gbo cɛ̃ ɓɛ́ m̀ ké nɔ̀ɓà mɔà 0 kɛɛ dyi pàdɖàìn hwè. Ɔ jǔ ké nyɔ dɔ̀ dyi m̀ gɔ̌ jǔǐn, po wudu m̀ mɔ́ poɛ dyiɛ, ké nyɔ dɔ̀ mu ɓó nììn ɓé ɔ ké nì wuduɔ̀ mú zà.

বাংলা (Bengali) লক্ষ্য করুন: এই নোটিশে আপনার বিমা কভারেজ সম্পর্কে তথ্য রয়েছে। এর মধ্যে গুরুত্বপূর্ণ তারিখ থাকতে পারে এবং নির্দিষ্ট তারিখের মধ্যে আপনাকে পদক্ষেপ নিতে হতে পারে। বিনা খরচে নিজের ভাষায় এই তথ্য পাওয়ার এবং সহায়তা পাওয়ার অধিকার আপনার আছে। সদস্যদেরকে তাদের পরিচয়পত্রের পিছনে থাকা নম্বরে কল করতে হবে। অন্যেরা 855-258-6518 নম্বরে কল করে 0 টিপতে না বলা পর্যন্ত অপেক্ষা করতে পারেন। যখন কোনো এজেন্ট উত্তর দেবেন তখন আপনার নিজের ভাষার নাম বলুন এবং আপনাকে দোভাষীর সঙ্গে সংযুক্ত করা হবে।

اردو (Urdu) توجہ :یہ نوٹس آپ کے انشورینس کوریج سے متعلق معلومات پر مشتمل ہے۔ اس میں کلیدی تاریخیں ہو سکتی ہیں اور ممکن ہے کہ آپ کو مخصوص آخری تاریخوں تک کارروائی کرنے کی ضرورت پڑے۔ آپ کے پاس یہ معلومات حاصل کرنے اور بغیر خرچہ کیے اپنی زبان میں مدد حاصل کرنے کا حق ہے۔ ممبران کو اپنے شناختی کارڈ کی پشت پر موجود فون نمبر پر کال کرنی چاہیے۔ سبھی دیگر لوگ 855-258-6518پر کال کر سکتے ہیں اور 0 دبانے کو کہے جانے تک انتظار کریں۔ ایجنٹ کے جواب دینے پر اپنی مطلوبہ زبان بتائیں اور مترجم سے مربوط ہو جائیں گے۔

فارسی (Farsi) توجه: این اعلامیه حاوی اطلاعاتی درباره پوشش بیمه شما است. ممکن است حاوی تاریخ های مهمی باشد و لازم است تا تاریخ مقرر شده خاصی اقدام کنید. شما از این حق برخوردار هستید تا این اطلاعات و راهنمایی را به صورت رایگان به زبان خودتان دریافت کنید. اعضا باید با شماره درج شده در پشت کارت شناسایی‌شان تماس بگیرند. سایر افراد می توانند با شماره 855-258-6518تماس بگیرند و منتظر بمانند تا از آنها خواسته شود عدد 0 را فشار دهند. بعد از پاسخگویی توسط یکی از اپراتورها، زبان مورد نیاز را تنظیم کنید تا به مترجم مربوطه وصل شوید.

اللغة العربية (Arabic) تنبيه :يحتوي هذا الإخطار على معلومات بشأن تغطيتك التأمينية، وقد يحتوي على تواريخ مهمة، وقد تحتاج إلى اتخاذ إجراءات بحلول مواعيد نهائية محددة .يحق لك الحصول على هذه المساعدة والمعلومات بلغتك بدون تحمل أي تكلفة .ينبغي على الأعضاء الاتصال على رقم الهاتف المذكور في ظهر بطاقة تعريف الهوية الخاصة بهم .يمكن للآخرين الاتصال على الرقم 855-258-6518 والانتظار خلال المحادثة حتى يطلب منهم الضغط على رقم .0 عند إجابة أحد الوكلاء، اذكر اللغة التي تحتاج إلى التواصل بها وسيتم توصيلك بأحد المترجمين الفوريين.

中文繁体 (Traditional Chinese) 注意：本聲明包含關於您的保險給付相關資訊。本聲明可能包含重要日期及您在特定期限之前需要採取的行動。您有權利免費獲得這份資訊，以及透過您的母語提供的協助服務。會員請撥打印在身分識別卡背面的電話號碼。其他所有人士可撥打電話 855-258-6518，並等候直到對話提示按下按鍵 0。當接線生回答時，請說出您需要使用的語言，這樣您就能與口譯人員連線。

Igbo (Igbo) Nrụbama: Ọkwa a nwere ozi gbasara mkpuchi nchekwa onwe gị. Ọ nwere ike ịnwe ụbọchị ndị dị mkpa, ị nwere ike ịme ihe tupu ụfọdụ ụbọchị njedebe. Ị nwere ikike ịnweta ozi na enyemaka a n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ndị otu kwesịrị ịkpọ akara ekwentị dị n'azụ nke kaadị njirimara ha. Ndị ọzọ niile nwere ike ịkpọ 855-258-6518 wee chere ụbụbọ ahụ ruo mgbe amanyere ịpị 0. Mgbe onye nnọchite anya zara, kwuo asụsụ ị chọrọ, a ga-ejikọ gị na onye ọkọwa okwu.

Deutsch (German) Achtung: Diese Mitteilung enthält Informationen über Ihren Versicherungsschutz. Sie kann wichtige Termine beinhalten, und Sie müssen gegebenenfalls innerhalb bestimmter Fristen reagieren. Sie haben das Recht, diese Informationen und weitere Unterstützung kostenlos in Ihrer Sprache zu erhalten. Als Mitglied verwenden Sie bitte die auf der Rückseite Ihrer Karte angegebene Telefonnummer. Alle anderen Personen rufen bitte die Nummer 855-258-6518 an und warten auf die Aufforderung, die Taste 0 zu drücken. Geben Sie dem Mitarbeiter die gewünschte Sprache an, damit er Sie mit einem Dolmetscher verbinden kann.

Français (French) Attention: cet avis contient des informations sur votre couverture d'assurance. Des dates importantes peuvent y figurer et il se peut que vous deviez entreprendre des démarches avant certaines échéances. Vous avez le droit d'obtenir gratuitement ces informations et de l'aide dans votre langue. Les membres doivent appeler le numéro de téléphone figurant à l'arrière de leur carte d'identification. Tous les autres peuvent appeler le 855-258-6518 et, après avoir écouté le message, appuyer sur le 0 lorsqu'ils seront invités à le faire. Lorsqu'un(e) employé(e) répondra, indiquez la langue que vous souhaitez et vous serez mis(e) en relation avec un interprète.

한국어(Korean) 주의: 이 통지서에는 보험 커버리지에 대한 정보가 포함되어 있습니다. 주요 날짜 및 조치를 취해야 하는 특정 기한이 포함될 수 있습니다. 귀하에게는 사용 언어로 해당 정보와 지원을 받을 권리가 있습니다. 회원이신 경우 ID 카드의 뒷면에 있는 전화번호로 연락해 주십시오. 회원이 아니신 경우 855-258-6518 번으로 전화하여 0을 누르라는 메시지가 들릴 때까지 기다리십시오. 연결된 상담원에게 필요한 언어를 말씀하시면 통역 서비스에 연결해 드립니다.

Diné Bizaad *(Navajo)* Ge': Díí bee ił hane'ígíí bii' dahólǫ bee éédahózin béeso ách'ą́ąh naanil ník'ist'i'ígíí bá. Bii' dahólǫ́ǫ doo íiyisíí yoolkáálígíí dóó t'áádoo le'é ádadoolyíįlígíí da yókeedgo t'áá doo bee e'e'aahí ájiil'íįh. Bee ná ahóót'i' díí bee ił hane' dóó niká'ádoowoł t'áá nínizaad bee t'áá jiik'é. Atah danilínígíí béésh bee hane'é bee wółta'ígíí nitł'izgo bee nee hódolzinígíí bikéédęę' bikáá' bich'į' hodoonihjį'. Aadóó náánáła' éí kojį' dahódoolnih 855-258-6518 dóó yii diiłts'įįł yałtí'ígíí t'áá níléíjį ádóó éí bikéé'dóó naasbąąs bił adidiilchił. Áká'ánidaalwó'ígíí neidiitą́ągo, saad bee yániłt'i'ígíí yii diikił dóó ata' halne'é lá níká'ádoolwoł.