

# CareFirst Formulary 2

---

## 2023

**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](https://carefirst.com).

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

# 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](http://carefirst.com/myaccount) and clicking on *Tools* and *Drug Pricing Tool* or by reviewing their annual summary of benefits.

<b>Tier 0: \$0 Drugs</b>	<ul style="list-style-type: none"> <li>■ 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.</li> <li>■ 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.</li> </ul>
<b>Tier 1: Generic Drugs \$</b>	<ul style="list-style-type: none"> <li>■ Generic drugs are the same as brand-name drugs in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.</li> <li>■ Generic drugs generally cost less than brand-name drugs.</li> </ul>
<b>Tier 2: Preferred Brand Drugs \$\$</b>	<ul style="list-style-type: none"> <li>■ 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.</li> </ul>
<b>Tier 3: Non-preferred Brand Drugs \$\$\$</b>	<ul style="list-style-type: none"> <li>■ Non-preferred brand drugs often have a generic or preferred brand drug option where your cost-share will be lower.</li> </ul>

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

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

1

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DEXEDRINE CAP 15MG CR	3	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 5 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 10 mg</i>	1	QL (150 caps every 30 days)
<i>dextroamphetamine sulfate cap er 24hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dextroamphetamine sulfate oral solution 5 mg/5ml</i>	1	QL (1440 mL every 30 days)
<i>dextroamphetamine sulfate tab 2.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 7.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 10 mg</i>	1	QL (150 tabs every 30 days)
<i>dextroamphetamine sulfate tab 15 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 20 mg</i>	1	QL (60 tabs every 30 days)
<i>dextroamphetamine sulfate tab 30 mg</i>	1	QL (30 tabs every 30 days)
<i>methamphetamine hcl tab 5 mg</i>	1	QL (180 tabs every 30 days)
VYVANSE CAP 10MG	3	QL (60 caps every 30 days)
VYVANSE CAP 20MG	3	QL (60 caps every 30 days)
VYVANSE CAP 30MG	3	QL (60 caps every 30 days)
VYVANSE CAP 40MG	3	QL (30 caps every 30 days)
VYVANSE CAP 50MG	3	QL (30 caps every 30 days)
VYVANSE CAP 60MG	3	QL (30 caps every 30 days)

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

2

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

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

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

3

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diethylpropion hcl tab 25 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>diethylpropion hcl tab er 24hr 75 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>orlistat cap 120 mg</i>	1	PA; Coverage is subject to your plan/benefits
PHENDIMETRAZ CAP 105MG ER	1	PA; Coverage is subject to your plan/benefits
<i>phendimetrazine tartrate tab 35 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 15 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 30 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl cap 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
<i>phentermine hcl tab 37.5 mg</i>	1	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 3.75-23	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 7.5-46MG	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 11.25-69	2	PA; Coverage is subject to your plan/benefits
QSYMIA CAP 15-92MG	2	PA; Coverage is subject to your plan/benefits
<b>ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS</b>		
<i>atomoxetine hcl cap 10 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 18 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 25 mg (base equiv)</i>	1	QL (150 caps every 30 days)
<i>atomoxetine hcl cap 40 mg (base equiv)</i>	1	QL (60 caps every 30 days)

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

4

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>atomoxetine hcl cap 60 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 80 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>atomoxetine hcl cap 100 mg (base equiv)</i>	1	QL (30 caps every 30 days)
<i>clonidine hcl tab er 12hr 0.1 mg</i>	1	
<i>guanfacine hcl tab er 24hr 1 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 2 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 3 mg (base equiv)</i>	1	
<i>guanfacine hcl tab er 24hr 4 mg (base equiv)</i>	1	
KAPVAY TAB 0.1 MG	3	
QELBREE CAP 200MG ER	2	
STRATTERA CAP 10MG	3	QL (150 caps every 30 days)
STRATTERA CAP 18MG	3	QL (150 caps every 30 days)
STRATTERA CAP 25MG	3	QL (150 caps every 30 days)
STRATTERA CAP 40MG	3	QL (60 caps every 30 days)
STRATTERA CAP 60MG	3	QL (30 caps every 30 days)
STRATTERA CAP 80MG	3	QL (30 caps every 30 days)
STRATTERA CAP 100MG	3	QL (30 caps every 30 days)
<b>DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS)</b>		
SUNOSI TAB 75MG	2	
SUNOSI TAB 150MG	2	
<b>HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS</b>		
WAKIX TAB 4.45MG	2	PA, QL (60 TABLETS PER 30 DAYS)
WAKIX TAB 17.8MG	2	PA, QL (60 TABLETS PER 30 DAYS)

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

5

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>STIMULANTS - MISC.</b>		
<i>armodafinil tab 50 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>armodafinil tab 150 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>armodafinil tab 200 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>armodafinil tab 250 mg</i>	1	PA, QL (30 tabs every 30 days)
AZSTARYS CAP 26.1-5.2	2	
AZSTARYS CAP 39.2-7.8	2	
AZSTARYS CAP 52.3-10.	2	
<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>	1	QL (60 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>	1	QL (30 caps every 30 days)
<i>dexmethylphenidate hcl tab 2.5 mg</i>	1	QL (150 tabs every 30 days)
<i>dexmethylphenidate hcl tab 5 mg</i>	1	QL (150 tabs every 30 days)
<i>dexmethylphenidate hcl tab 10 mg</i>	1	QL (60 tabs every 30 days)
FOCALIN TAB 2.5MG	3	QL (150 tabs every 30 days)

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

6

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FOCALIN TAB 5MG	3	QL (150 tabs every 30 days)
FOCALIN TAB 10MG	3	QL (60 tabs every 30 days)
METHYLIN SOL 5MG/5ML	3	QL (2160 mL every 30 days)
METHYLIN SOL 10MG/5ML	3	QL (1080 mL every 30 days)
METHYLPHENID TAB 72MG ER	3	QL (30 tabs every 30 days)
<i>methylphenidate hcl cap er 10 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 20 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	1	QL (30 caps every 30 days)

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

7

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl cap er 30 mg (cd)</i>	1	QL (60 caps every 30 days)
<i>methylphenidate hcl cap er 40 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 50 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl cap er 60 mg (cd)</i>	1	QL (30 caps every 30 days)
<i>methylphenidate hcl chew tab 2.5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl chew tab 5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl chew tab 10 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl soln 5 mg/5ml</i>	1	QL (2160 mL every 30 days)
<i>methylphenidate hcl soln 10 mg/5ml</i>	1	QL (1080 mL every 30 days)
<i>methylphenidate hcl tab 5 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl tab 10 mg</i>	1	QL (210 tabs every 30 days)
<i>methylphenidate hcl tab 20 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 10 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 20 mg</i>	1	QL (120 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 18 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er 24hr 36 mg</i>	1	QL (60 tabs every 30 days); MNPA
<i>methylphenidate hcl tab er 24hr 54 mg</i>	1	QL (30 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 18 mg</i>	1	QL (60 tabs every 30 days)

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

8

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methylphenidate hcl tab er osmotic release (osm) 27 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 36 mg</i>	1	QL (60 tabs every 30 days)
<i>methylphenidate hcl tab er osmotic release (osm) 54 mg</i>	1	QL (30 tabs every 30 days)
<i>modafinil tab 100 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>modafinil tab 200 mg</i>	1	PA, QL (60 tabs every 30 days)
RITALIN LA CAP 10MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 20MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 30MG	3	QL (60 caps every 30 days)
RITALIN LA CAP 40MG	3	QL (30 caps every 30 days)
RITALIN TAB 5MG	3	QL (210 tabs every 30 days)
RITALIN TAB 10MG	3	QL (210 tabs every 30 days)
RITALIN TAB 20MG	3	QL (120 tabs every 30 days)

**ALLERGENIC EXTRACTS/BIOLOGICALS MISC****ALLERGENIC EXTRACTS**

GRASTEK SUB 2800BAU	2	
RAGWITEK SUB	2	

**AMINOGLYCOSIDES****AMINOGLYCOSIDES**

ARIKAYCE SUS	3	PA
<i>neomycin sulfate tab 500 mg</i>	1	
<i>paromomycin sulfate cap 250 mg</i>	1	
<i>tobramycin nebu soln 300 mg/4ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)

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

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tobramycin nebu soln 300 mg/5ml</i>	1	PA, QL (56 AMPULES PER 28 DAYS)

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

ADALIMU-ADAZ INJ 40/0.4ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
ADALIMU-ADAZ INJ 40/0.4ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
AMJEVITA INJ 10/0.2ML	3	PA, QL (2 syringes per 28 days)
AMJEVITA INJ 20/0.4ML	3	PA, QL (4 SYRINGES PER 28 DAYS)
AMJEVITA INJ 40/0.8ML	3	PA, QL (4 PENS PER 28 DAYS); Loading dose: 8 per 14 days
AMJEVITA INJ 40/0.8ML	3	PA, QL (4 SYRINGES PER 28 DAYS); Loading dose: 8 per 14 days
HUMIRA INJ 10/0.1ML	2	PA, QL (2 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

10

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA INJ 20/0.2ML	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA INJ 40/0.4ML	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA KIT 40MG/0.8	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEDIA INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 2 syringes per 28 days.

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

11

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEDIA INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 3 syringes per 28 days.
HUMIRA PEN INJ 40/0.4ML	2	PA, QL (4.5 pens every 28 days); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HUMIRA PEN INJ 40MG/0.8	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 INJ 80/0.8ML	2	PA, QL (2 PENS PER 28 DAYS); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

12

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEN INJ CD/UC/HS	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 6 pens per 28 days.
HUMIRA PEN INJ PS/UV	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 4 pens per 28 days.
HUMIRA PEN KIT CD/UC/HS	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. Loading dose: 3 pens per 28 days.
HUMIRA PEN KIT PED UC	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

13

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HUMIRA PEN KIT PS/UV	2	PA, QL (NOT FOR DAILY USE); Preferred for all approved indications ; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
HYRIMOZ	2	PA, QL (2 NOT FOR DAILY USEpens PER 28 days); LOADING DOSE: 3 pens per 28 days
HYRIMOZ INJ 10/0.1ML	2	PA, QL (2 syringes per 28 days)
HYRIMOZ INJ 20/0.2ML	2	PA, QL (4 syringes per 28 days)
HYRIMOZ INJ 40/0.4ML	2	PA, QL (4 pens per 28 days); LOADING DOSE: 8 pens per 14 days
HYRIMOZ INJ 40/0.4ML	2	PA, QL (4 syringes per 28 days); LOADING DOSE: 8 syringes per 14 days
HYRIMOZ INJ 40/0.8ML	2	PA, QL (4 pen autoinjectors per 28 days)
HYRIMOZ INJ 40/0.8ML	2	PA, QL (4 syringes per 28 days)
HYRIMOZ INJ 80/0.8ML	2	PA, QL (2 pens PER 28 days); LOADING DOSE: 4 pens per 14 days
HYRIMOZ-PED INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 2 syringes per 28 days
HYRIMOZ-PED INJ CROHNS	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days

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

14

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
HYRIMOZ-PLAQ INJ PSORIASI	2	PA, QL (NOT FOR DAILY USE); LOADING DOSE: 3 pens per 28 days
<b>ANTIRHEUMATIC - ENZYME INHIBITORS</b>		
RINVOQ TAB 15MG ER	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits.
RINVOQ TAB 30MG ER	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits.
RINVOQ TAB 45MG ER	2	PA, QL (NOT FOR DAILY USE); referred agent for Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Ulcerative Colitis and Crohn's Disease; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 84 tablets per 84 days

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

15

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XELJANZ SOL 1MG/ML	2	PA, QL (240ML PER 24 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ TAB 5MG	2	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ TAB 10MG	2	PA, QL (60 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

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

16

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XELJANZ XR TAB 11MG	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
XELJANZ XR TAB 22MG	2	PA, QL (30 TABLETS PER 30 DAYS); Preferred agent for Rheumatoid Arthritis and Ulcerative colitis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.

#### **ANTIRHEUMATIC ANTIMETABOLITES**

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 PENS PER 28 DAYS)
RASUVO INJ 22.5MG	2	PA, QL (4 INJ PER 28 DAYS)

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

17

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RASUVO INJ 25MG	2	PA, QL (4 INJ PER 28 DAYS)
RASUVO INJ 30MG	2	PA, QL (4 INJ PER 28 DAYS)
<b>GOLD COMPOUNDS</b>		
RIDAURA CAP 3MG	3	
<b>INTERLEUKIN-6 RECEPTOR INHIBITORS</b>		
KEVZARA INJ 150/1.14	2	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
KEVZARA INJ 200/1.14	2	PA, QL (2 SYRINGES PER 4 WEEKS); Preferred agent for Rheumatoid Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
<b>NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)</b>		
<i>celecoxib cap 50 mg</i>	1	
<i>celecoxib cap 100 mg</i>	1	
<i>celecoxib cap 200 mg</i>	1	
<i>celecoxib cap 400 mg</i>	1	
DAYPRO TAB 600MG	3	
<i>diclofenac potassium tab 50 mg</i>	1	
<i>diclofenac sodium tab delayed release 25 mg</i>	1	
<i>diclofenac sodium tab delayed release 50 mg</i>	1	
<i>diclofenac sodium tab delayed release 75 mg</i>	1	
<i>diclofenac sodium tab er 24hr 100 mg</i>	1	

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

18

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i>	1	
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i>	1	
DUEXIS TAB 800-26.6	3	
EC-NAPROSYN TAB 375MG	3	
EC-NAPROSYN TAB 500MG	3	
<i>etodolac cap 200 mg</i>	1	
<i>etodolac cap 300 mg</i>	1	
<i>etodolac tab 400 mg</i>	1	
<i>etodolac tab 500 mg</i>	1	
<i>etodolac tab er 24hr 400 mg</i>	1	
<i>etodolac tab er 24hr 500 mg</i>	1	
<i>etodolac tab er 24hr 600 mg</i>	1	
FELDENE CAP 10MG	3	
FELDENE CAP 20MG	3	
<i>flurbiprofen tab 50 mg</i>	1	
<i>flurbiprofen tab 100 mg</i>	1	
<i>ibuprofen tab 400 mg</i>	1	
<i>ibuprofen tab 600 mg</i>	1	
<i>ibuprofen tab 800 mg</i>	1	
<i>indomethacin cap 25 mg</i>	1	
<i>indomethacin cap 50 mg</i>	1	
<i>indomethacin cap er 75 mg</i>	1	
<i>ketoprofen cap 50 mg</i>	1	
<i>ketoprofen cap 75 mg</i>	1	
<i>ketorolac tromethamine tab 10 mg</i>	1	
<i>meclofenamate sodium cap 50 mg</i>	1	
<i>meclofenamate sodium cap 100 mg</i>	1	
<i>mefenamic acid cap 250 mg</i>	1	
<i>meloxicam tab 7.5 mg</i>	1	
<i>meloxicam tab 15 mg</i>	1	
MOBIC TAB 7.5MG	3	
MOBIC TAB 15MG	3	
<i>nabumetone tab 500 mg</i>	1	

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

19

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nabumetone tab 750 mg</i>	1	
NALFON CAP 400MG	3	
NALFON TAB 600MG	3	
NAPROSYN SUS 125/5ML	3	
NAPROSYN TAB 500MG	3	
<i>naproxen sodium tab 275 mg</i>	1	
<i>naproxen sodium tab 550 mg</i>	1	
<i>naproxen tab 250 mg</i>	1	
<i>naproxen tab 375 mg</i>	1	
<i>naproxen tab 500 mg</i>	1	
<i>naproxen tab ec 375 mg</i>	1	
<i>naproxen tab ec 500 mg</i>	1	
<i>oxaprozin tab 600 mg</i>	1	
<i>piroxicam cap 10 mg</i>	1	
<i>piroxicam cap 20 mg</i>	1	
<i>sulindac tab 150 mg</i>	1	
<i>sulindac tab 200 mg</i>	1	
<i>tolmetin sodium cap 400 mg</i>	1	
<i>tolmetin sodium tab 600 mg</i>	1	
VIMOVO TAB 375-20MG	3	
VIMOVO TAB 500-20MG	3	
ZIPSOR CAP 25MG	3	
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS</b>		
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.

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

20

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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.
<b>PYRIMIDINE SYNTHESIS INHIBITORS</b>		
ARAVA TAB 10MG	2	
ARAVA TAB 20MG	2	
leflunomide tab 10 mg	1	
leflunomide tab 20 mg	1	
<b>SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS</b>		
ENBREL INJ 25/0.5ML	2	PA, QL (8 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. Approved quantity may be less than the listed limit.
ENBREL INJ 50MG/ML	2	PA, QL (4 SYRINGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. <b>LOADING DOSE:8 SYRINGES PER 28 DAYS</b>

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

21

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ENBREL MINI INJ 50MG/ML	2	PA, QL (4 CARTRIDGES PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:8 CARTRIDGES PER 28 DAYS
ENBREL SRCLK INJ 50MG/ML	2	PA, QL (4 INJ PER 28 DAYS); Preferred agent for all FDA approved indications except psoriasis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:8 INJECTORS PER 28 DAYS

**ANALGESICS - NONNARCOTIC****ANALGESIC COMBINATIONS**

<i>butalbital-acetaminophen tab 50-325 mg</i>	1	
<i>butalbital-acetaminophen-caffeine tab 50-325-40 mg</i>	1	
<i>butalbital-aspirin-caffeine cap 50-325-40 mg</i>	1	
ESGIC TAB	3	

**SALICYLATES**

<i>aspirin chew tab 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>aspirin tab delayed release 81 mg</i>	0	OTC; \$0 copay-age and gender restrictions apply
<i>diflunisal tab 500 mg</i>	1	
<i>salsalate tab 500 mg</i>	1	
<i>salsalate tab 750 mg</i>	1	

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

22

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANALGESICS - OPIOID</b>		
<b>OPIOID AGONISTS</b>		
ACTIQ LOZ 200MCG	3	PA
ACTIQ LOZ 400MCG	3	PA
ACTIQ LOZ 600MCG	3	PA
ACTIQ LOZ 800MCG	3	PA
ACTIQ LOZ 1200MCG	3	PA
ACTIQ LOZ 1600MCG	3	PA
CODEINE SULF TAB 15MG	3	PA, QL (42 tabs every 30 days)
CODEINE SULF TAB 60MG	3	PA, QL (42 tabs every 30 days)
<i>codeine sulfate tab 30 mg</i>	1	PA, QL (42 tabs every 30 days)
CONZIP CAP 100MG	3	PA, QL (30 caps every 30 days)
CONZIP CAP 200MG	3	PA, QL (30 caps every 30 days)
CONZIP CAP 300MG	3	PA, QL (30 caps every 30 days)
DILAUDID LIQ 1MG/ML	3	PA, QL (16 mL per day)
DILAUDID TAB 2MG	3	PA, QL (180 tabs every 30 days)
DILAUDID TAB 4MG	3	PA, QL (4 tabs per day)
DILAUDID TAB 8MG	3	PA, QL (60 tabs every 30 days)
DURAGESIC DIS 12MCG/HR	3	PA, QL (10 patches every 30 days)
DURAGESIC DIS 25MCG/HR	3	PA, QL (10 patches every 30 days)
DURAGESIC DIS 50MCG/HR	3	PA
DURAGESIC DIS 75MCG/HR	3	PA
DURAGESIC DIS 100MCG/H	3	PA, QL (10 patches every 30 days)
<i>fentanyl citrate buccal tab 100 mcg (base equiv)</i>	1	PA

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

23

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fentanyl citrate buccal tab 200 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 400 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 600 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate buccal tab 800 mcg (base equiv)</i>	1	PA
<i>fentanyl citrate lozenge on a handle 200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 400 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 600 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 800 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1200 mcg</i>	1	PA
<i>fentanyl citrate lozenge on a handle 1600 mcg</i>	1	PA
<i>fentanyl td patch 72hr 12 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 25 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 37.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 50 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 62.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 75 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 87.5 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
<i>fentanyl td patch 72hr 100 mcg/hr</i>	1	PA, QL (10 patches every 25 days)
FENTORA TAB 100MCG	3	PA
FENTORA TAB 200MCG	3	PA
FENTORA TAB 400MCG	3	PA
FENTORA TAB 600MCG	3	PA
FENTORA TAB 800MCG	3	PA

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

24

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydrocodone bitartrate cap er 12hr 10 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 15 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 20 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 30 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 40 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate cap er 12hr 50 mg</i>	1	PA, QL (60 caps every 30 days)
<i>hydrocodone bitartrate tab er 24hr deter 20 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 30 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 40 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 60 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 80 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 100 mg</i>	1	PA, QL (30 tabs every 25 days)
<i>hydrocodone bitartrate tab er 24hr deter 120 mg</i>	1	PA, QL (30 tabs every 25 days)
<b>HYDROMORPHON SUP 3MG</b>	3	PA, QL (120 supp every 30 days)
<i>hydromorphone hcl liqd 1 mg/ml</i>	1	PA, QL (16 mL per day)
<i>hydromorphone hcl tab 2 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydromorphone hcl tab 4 mg</i>	1	PA, QL (4 tabs per day)
<i>hydromorphone hcl tab 8 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 8 mg</i>	1	PA, QL (30 tabs every 30 days)

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

25

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydromorphone hcl tab er 24hr 12 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 16 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>hydromorphone hcl tab er 24hr 32 mg</i>	1	PA
<i>meperidine hcl oral soln 50 mg/5ml</i>	1	PA
<i>meperidine hcl tab 50 mg</i>	1	PA
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (1.5 mL per day)
<i>methadone hcl conc 10 mg/ml</i>	1	PA, QL (60 mL every 30 days)
<i>methadone hcl soln 5 mg/5ml</i>	1	PA, QL (450 mL every 30 days)
<i>methadone hcl soln 10 mg/5ml</i>	1	PA, QL (300 mL every 30 days)
<i>methadone hcl tab 5 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>methadone hcl tab 10 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>methadone hcl tab for oral susp 40 mg</i>	1	
METHADOSE CON 10MG/ML	3	QL (60 mL every 30 days)
METHADOSE SF CON 10MG/ML	3	QL (60 mL every 30 days)
<i>morphine sulfate beads cap er 24hr 30 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 45 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 75 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 90 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate beads cap er 24hr 120 mg</i>	1	PA
<i>morphine sulfate cap er 24hr 10 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 20 mg</i>	1	PA, QL (60 caps every 30 days)

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

26

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>morphine sulfate cap er 24hr 30 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 40 mg</i>	1	PA, QL (60 caps every 30 days)
<i>morphine sulfate cap er 24hr 50 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 60 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 80 mg</i>	1	PA, QL (30 caps every 30 days)
<i>morphine sulfate cap er 24hr 100 mg</i>	1	PA
<i>morphine sulfate oral soln 10 mg/5ml</i>	1	PA, QL (900 mL every 30 days)
<i>morphine sulfate oral soln 20 mg/5ml</i>	1	PA, QL (675 mL every 30 days)
<i>morphine sulfate oral soln 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (135 mL every 30 days)
<i>morphine sulfate suppos 5 mg</i>	1	PA, QL (180 supp every 30 days)
<i>morphine sulfate suppos 10 mg</i>	1	PA, QL (180 supp every 30 days)
<i>morphine sulfate suppos 20 mg</i>	1	PA, QL (120 supp every 30 days)
<i>morphine sulfate suppos 30 mg</i>	1	PA, QL (90 supp every 30 days)
<i>morphine sulfate tab 15 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>morphine sulfate tab 30 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 15 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 30 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>morphine sulfate tab er 60 mg</i>	1	PA
<i>morphine sulfate tab er 100 mg</i>	1	PA
<i>morphine sulfate tab er 200 mg</i>	1	PA

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

27

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MS CONTIN TAB 15MG ER	3	PA, QL (90 tabs every 30 days)
MS CONTIN TAB 30MG ER	3	PA, QL (90 tabs every 30 days)
MS CONTIN TAB 60MG ER	3	PA
MS CONTIN TAB 100MG ER	3	PA
MS CONTIN TAB 200MG ER	3	PA
<i>oxycodone hcl cap 5 mg</i>	1	PA, QL (180 caps every 30 days)
<i>oxycodone hcl conc 100 mg/5ml (20 mg/ml)</i>	1	PA, QL (90 mL every 30 days)
<i>oxycodone hcl soln 5 mg/5ml</i>	1	PA, QL (900 mL every 30 days)
<i>oxycodone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone hcl tab 10 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone hcl tab 15 mg</i>	1	PA, QL (120 tabs every 30 days)
<i>oxycodone hcl tab 20 mg</i>	1	PA, QL (90 tabs every 30 days)
<i>oxycodone hcl tab 30 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 10 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 15 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 20 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 30 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 40 mg</i>	1	PA, QL (120 tabs every 30 days)
<i>oxycodone hcl tab er 12hr deter 60 mg</i>	1	PA, QL (60 tabs every 30 days)

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

28

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxycodone hcl tab er 12hr deter 80 mg</i>	1	PA, QL (60 tabs every 30 days)
<i>oxymorphone hcl tab 5 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxymorphone hcl tab 10 mg</i>	1	PA, QL (90 tabs every 30 days)
ROXICODONE TAB 5MG	3	PA, QL (180 tabs every 30 days)
ROXICODONE TAB 15MG	3	PA, QL (120 tabs every 30 days)
ROXICODONE TAB 30MG	3	PA, QL (60 tabs every 30 days)
<i>tramadol hcl tab 50 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>tramadol hcl tab er 24hr 100 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr 200 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr 300 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>tramadol hcl tab er 24hr biphasic release 100 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 200 mg</i>	1	PA
<i>tramadol hcl tab er 24hr biphasic release 300 mg</i>	1	PA
ULTRAM TAB 50MG	3	PA, QL (180 tabs every 30 days)
XTAMPZA ER CAP 9MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 13.5MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 18MG	2	PA, QL (60 caps every 30 days)
XTAMPZA ER CAP 27MG	2	PA, QL (60 caps every 30 days)

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

29

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
XTAMPZA ER CAP 36MG	2	PA, QL (60 caps every 30 days)

**OPIOID COMBINATIONS**

<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i>	1	PA, QL (2700 mL every 30 days)
<i>acetaminophen w/ codeine tab 300-15 mg</i>	1	PA, QL (390 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-30 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>acetaminophen w/ codeine tab 300-60 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i>	1	PA, QL (300 caps every 30 days)
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i>	1	PA, QL (300 tabs every 30 days)
<i>butalbital-acetaminophen-caff w/ cod cap 50-300-40-30 mg</i>	1	
<i>butalbital-acetaminophen-caff w/ cod cap 50-325-40-30 mg</i>	1	
<i>butalbital-aspirin-caff w/ codeine cap 50-325-40-30 mg</i>	1	
FIORICET CAP CODEINE	3	
<i>hydrocodone-acetaminophen soln 7.5-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen soln 10-325 mg/15ml</i>	1	PA, QL (2700 mL every 30 days)
<i>hydrocodone-acetaminophen tab 5-300 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-300 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 7.5-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-acetaminophen tab 10-300 mg</i>	1	PA, QL (180 tabs every 30 days)

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

30

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>hydrocodone-acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 7.5-200 mg</i>	1	PA, QL (150 tabs every 30 days)
<i>hydrocodone-ibuprofen tab 10-200 mg</i>	1	PA, QL (150 tabs every 30 days)
LORTAB ELX 10-300MG	3	PA, QL (2040 mL every 30 days)
<i>oxycodone w/ acetaminophen tab 2.5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 5-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 7.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
<i>oxycodone w/ acetaminophen tab 10-325 mg</i>	1	PA, QL (180 tabs every 30 days)
<i>oxycodone-aspirin tab 4.8355-325 mg</i>	1	PA, QL (360 tabs every 30 days)
<i>tramadol-acetaminophen tab 37.5-325 mg</i>	1	PA, QL (240 tabs every 30 days)
ULTRACET TAB 37.5-325	3	PA, QL (240 tabs every 30 days)
<b>OPIOID PARTIAL AGONISTS</b>		
BELBUCA MIS 75MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 150MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 300MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 450MCG	2	PA, QL (60 films every 30 days)
BELBUCA MIS 600MCG	2	PA
BELBUCA MIS 750MCG	2	PA
BELBUCA MIS 900MCG	2	PA

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

31

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BUNAVAIL MIS 4.2-0.7	3	
BUNAVAIL MIS 6.3-1MG	3	
<i>buprenorphine hcl sl tab 2 mg (base equiv)</i>	0	
<i>buprenorphine hcl sl tab 8 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl film 2-0.5 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i>	1	
<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i>	0	
<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i>	0	
<i>buprenorphine td patch weekly 5 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 7.5 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 10 mcg/hr</i>	1	PA, QL (4 patches every 30 days)
<i>buprenorphine td patch weekly 15 mcg/hr</i>	1	PA
<i>buprenorphine td patch weekly 20 mcg/hr</i>	1	PA
<i>butorphanol tartrate nasal soln 10 mg/ml</i>	1	QL (2.4 bottles every 30 days)
<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	1	PA
ZUBSOLV SUB 0.7-0.18	2	
ZUBSOLV SUB 1.4-0.36	2	
ZUBSOLV SUB 2.9-0.71	2	
ZUBSOLV SUB 5.7-1.4	2	
ZUBSOLV SUB 8.6-2.1	2	
ZUBSOLV SUB 11.4-2.9	2	

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

32

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANDROGENS-ANABOLIC</b>		
<b>ANABOLIC STEROIDS</b>		
<i>oxandrolone tab 2.5 mg</i>	1	
<i>oxandrolone tab 10 mg</i>	1	
<b>ANDROGENS</b>		
ANDRODERM DIS 2MG/24HR	3	PA
ANDRODERM DIS 4MG/24HR	3	PA
<i>danazol cap 50 mg</i>	1	
<i>danazol cap 100 mg</i>	1	
<i>danazol cap 200 mg</i>	1	
METHITEST TAB 10MG	3	
<i>methyltestosterone cap 10 mg</i>	1	
NATESTO GEL 5.5MG	2	PA
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	1	PA
<i>testosterone cypionate im inj in oil 100 mg/ml</i>	3	PA
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	1	PA
<i>testosterone cypionate im inj in oil 200 mg/ml</i>	3	PA
<i>testosterone enanthate im inj in oil 200 mg/ml</i>	1	PA
<i>testosterone td gel 10mg/act (2%)</i>	1	PA
<i>testosterone td gel 12.5 mg/act (1%)</i>	1	PA
<i>testosterone td gel 20.25 mg/1.25gm (1.62%)</i>	1	PA
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	1	PA
<i>testosterone td gel 25 mg/2.5gm (1%)</i>	1	PA
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i>	1	PA
<i>testosterone td gel 50 mg/5gm (1%)</i>	1	PA
<i>testosterone td soln 30 mg/act</i>	1	
XYOSTED INJ 50/0.5	3	PA
XYOSTED INJ 75/0.5	3	PA
XYOSTED INJ 100/0.5	3	PA
<b>ANORECTAL AND RELATED PRODUCTS</b>		
<b>INTRARECTAL STEROIDS</b>		
CORTENEMA ENE 100MG	3	
CORTIFOAM AER 90MG	2	
<i>hydrocortisone enema 100 mg/60ml</i>	1	
UCERIS AER 2MG/ACT	3	

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

33

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>RECTAL COMBINATIONS</b>		
ANALPRAM-HC CRE 1-1%	3	
ANALPRAM-HC LOT 2.5%	3	
<i>hydrocortisone acetate w/ pramoxine perianal cream 1-1%</i>	1	
PROCORT CRE	3	
PROCTOFOAM AER HC 1%	2	
<b>RECTAL STEROIDS</b>		
ANUSOL-HC CRE 2.5%	2	
<i>hydrocortisone acetate suppos 25 mg</i>	1	
<i>hydrocortisone perianal cream 1%</i>	1	
<i>hydrocortisone perianal cream 2.5%</i>	1	
PROCTOCORT CRE 1%	3	
PROCTOCORT SUP 30MG	3	
<b>VASODILATING AGENTS</b>		
RECTIV OIN 0.4%	3	
<b>ANTHELMINTICS</b>		
<b>ANTHELMINTICS</b>		
<i>albendazole tab 200 mg</i>	1	QL (336 tabs every year)
ALBENZA TAB 200MG	3	QL (336 tabs every year)
BENZNIDAZOLE TAB 12.5MG	3	
BENZNIDAZOLE TAB 100MG	3	
BILTRICIDE TAB 600MG	3	QL (24 tabs every year)
EMVERM CHW 100MG	2	QL (12 ea every year)
<i>ivermectin tab 3 mg</i>	1	PA, QL (9 tabs every 90 days)
<i>praziquantel tab 600 mg</i>	1	QL (24 tabs every year)
STROMECTOL TAB 3MG	3	PA, QL (9 tabs every 90 days)
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
<b>ANTI-INFECTIVE AGENTS - MISC.</b>		
AEMCOLO TAB 194MG	3	
FLAGYL CAP 375MG	3	
FLAGYL TAB 500MG	3	
IMPAVIDO CAP 50MG	3	
<b>PA</b> - Prior Authorization <b>QL</b> - Quantity Limits <b>ST</b> - Step Therapy		34

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>metronidazole cap 375 mg</i>	1	
<i>metronidazole tab 250 mg</i>	1	
<i>metronidazole tab 500 mg</i>	1	
PRIMSOL SOL 50MG/5ML	3	
<i>tinidazole tab 250 mg</i>	1	
<i>tinidazole tab 500 mg</i>	1	
<i>trimethoprim tab 100 mg</i>	1	
XIFAXAN TAB 200MG	3	QL (9 tabs every 25 days)
XIFAXAN TAB 550MG	2	PA
<b>ANTI-INFECTIVE MISC. - COMBINATIONS</b>		
BACTRIM DS TAB 800-160	3	
BACTRIM TAB 400-80MG	3	
<i>methenamine-hyos-meth blue-sod phos-phen sal tab 81.6 mg</i>	1	
<i>sulfamethoxazole-trimethoprim susp 200-40 mg/5ml</i>	1	
<i>sulfamethoxazole-trimethoprim tab 400-80 mg</i>	1	
<i>sulfamethoxazole-trimethoprim tab 800-160 mg</i>	1	
<b>ANTIPROTOZOAL AGENTS</b>		
ALINIA SUS 100/5ML	3	
ALINIA TAB 500MG	3	
<i>atovaquone susp 750 mg/5ml</i>	1	
LAMPIT TAB 30MG	3	
LAMPIT TAB 120MG	3	
MEPRON SUS	3	
<i>nitazoxanide tab 500 mg</i>	1	
<b>GLYCOPEPTIDES</b>		
VANCOCIN CAP 125MG	2	QL (80 caps every 10 days)
VANCOCIN CAP 250MG	2	QL (80 caps every 10 days)
<i>vancomycin hcl cap 125 mg (base equivalent)</i>	1	QL (80 caps every 10 days)
<i>vancomycin hcl cap 250 mg (base equivalent)</i>	1	QL (80 caps every 10 days)
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i>	3	QL (450 mL every 10 days)

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

35

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>LEPROSTATICS</b>		
<i>dapsone tab 25 mg</i>	1	
<i>dapsone tab 100 mg</i>	1	
<b>LINCOSAMIDES</b>		
CLEOCIN CAP 75MG	2	
CLEOCIN CAP 150MG	2	
CLEOCIN CAP 300MG	2	
CLEOCIN PED SOL 75MG/5ML	2	
<i>clindamycin hcl cap 75 mg</i>	1	
<i>clindamycin hcl cap 150 mg</i>	1	
<i>clindamycin hcl cap 300 mg</i>	1	
<i>clindamycin palmitate hcl for soln 75 mg/5ml (base equiv)</i>	1	
<b>OXAZOLIDINONES</b>		
<i>linezolid for susp 100 mg/5ml</i>	1	PA
<i>linezolid tab 600 mg</i>	1	PA
SIVEXTRO TAB 200MG	3	
ZYVOX SUS 100MG/5M	3	PA
ZYVOX TAB 600MG	3	PA
<b>PLEUROMUTILINS</b>		
XENLETA TAB 600MG	3	
<b>URINARY ANTI-INFECTIVES</b>		
<i>fosfomycin tromethamine powd pack 3 gm (base equivalent)</i>	1	
HIPREX TAB 1GM	3	
MACROBID CAP 100MG	2	
<i>methenamine hippurate tab 1 gm</i>	1	
<i>methenamine mandelate tab 0.5 gm</i>	1	
<i>methenamine mandelate tab 1 gm</i>	1	
MONUROL PAK GRANULES	3	
<i>nitrofurantoin macrocrystalline cap 25 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	1	
<i>nitrofurantoin macrocrystalline cap 100 mg</i>	1	
<i>nitrofurantoin monohydrate macrocrystalline cap 100 mg</i>	1	

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

36

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nitrofurantoin susp 25 mg/5ml</i>	1	
<b>ANTIANGINAL AGENTS</b>		
<b>ANTIANGINALS-OTHER</b>		
RANEXA TAB 500MG	3	
RANEXA TAB 1000MG	3	
<i>ranolazine tab er 12hr 500 mg</i>	1	
<i>ranolazine tab er 12hr 1000 mg</i>	1	
<b>NITRATES</b>		
DILATRATE SR CAP 40MG	3	
ISORDIL TAB 5MG	3	
ISORDIL TAB 40MG	3	
<i>isosorbide dinitrate tab 5 mg</i>	1	
<i>isosorbide dinitrate tab 10 mg</i>	1	
<i>isosorbide dinitrate tab 20 mg</i>	1	
<i>isosorbide dinitrate tab 30 mg</i>	1	
<i>isosorbide mononitrate tab 10 mg</i>	1	
<i>isosorbide mononitrate tab 20 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 30 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 60 mg</i>	1	
<i>isosorbide mononitrate tab er 24hr 120 mg</i>	1	
NITRO-BID OIN 2%	3	
NITRO-DUR DIS 0.1MG/HR	2	
NITRO-DUR DIS 0.2MG/HR	2	
NITRO-DUR DIS 0.3MG/HR	2	
NITRO-DUR DIS 0.4MG/HR	2	
NITRO-DUR DIS 0.6MG/HR	2	
NITRO-DUR DIS 0.8MG/HR	2	
<i>nitroglycerin sl tab 0.3 mg</i>	1	
<i>nitroglycerin sl tab 0.4 mg</i>	1	
<i>nitroglycerin sl tab 0.6 mg</i>	1	
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i>	1	
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i>	1	

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

37

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nitroglycerin tl soln 0.4 mg/spray (400 mcg/spray)</i>	1	
NITROLINGUAL SPR PUMPSRA	3	
NITROMIST AER 400MCG	3	
NITROSTAT SUB 0.3MG	3	
NITROSTAT SUB 0.4MG	3	
NITROSTAT SUB 0.6MG	3	

**ANTIAXIETY AGENTS****ANTIAXIETY AGENTS - MISC.**

<i>buspirone hcl tab 5 mg</i>	1	
<i>buspirone hcl tab 7.5 mg</i>	1	
<i>buspirone hcl tab 10 mg</i>	1	
<i>buspirone hcl tab 15 mg</i>	1	
<i>buspirone hcl tab 30 mg</i>	1	
<i>hydroxyzine hcl syrup 10 mg/5ml</i>	1	
<i>hydroxyzine hcl tab 10 mg</i>	1	
<i>hydroxyzine hcl tab 25 mg</i>	1	
<i>hydroxyzine hcl tab 50 mg</i>	1	
<i>hydroxyzine pamoate cap 25 mg</i>	1	
<i>hydroxyzine pamoate cap 50 mg</i>	1	
<i>hydroxyzine pamoate cap 100 mg</i>	1	
<i>meprobamate tab 200 mg</i>	1	
<i>meprobamate tab 400 mg</i>	1	
VISTARIL CAP 25MG	3	
VISTARIL CAP 50MG	3	

**BENZODIAZEPINES**

ALPRAZOLAM CON 1 MG/ML	3	
<i>alprazolam orally disintegrating tab 0.5 mg</i>	1	
<i>alprazolam orally disintegrating tab 0.25 mg</i>	1	
<i>alprazolam orally disintegrating tab 1 mg</i>	1	
<i>alprazolam orally disintegrating tab 2 mg</i>	1	
<i>alprazolam tab 0.5 mg</i>	1	
<i>alprazolam tab 0.25 mg</i>	1	
<i>alprazolam tab 1 mg</i>	1	
<i>alprazolam tab 2 mg</i>	1	

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

38

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>alprazolam tab er 24hr 0.5 mg</i>	1	
<i>alprazolam tab er 24hr 1 mg</i>	1	
<i>alprazolam tab er 24hr 2 mg</i>	1	
<i>alprazolam tab er 24hr 3 mg</i>	1	
<i>chlordiazepoxide hcl cap 5 mg</i>	1	
<i>chlordiazepoxide hcl cap 10 mg</i>	1	
<i>chlordiazepoxide hcl cap 25 mg</i>	1	
<i>clorazepate dipotassium tab 3.75 mg</i>	1	
<i>clorazepate dipotassium tab 7.5 mg</i>	1	
<i>clorazepate dipotassium tab 15 mg</i>	1	
<i>diazepam conc 5 mg/ml</i>	1	
<i>diazepam oral soln 1 mg/ml</i>	1	
<i>diazepam tab 2 mg</i>	1	
<i>diazepam tab 5 mg</i>	1	
<i>diazepam tab 10 mg</i>	1	
<i>lorazepam conc 2 mg/ml</i>	1	
<i>lorazepam tab 0.5 mg</i>	1	
<i>lorazepam tab 1 mg</i>	1	
<i>lorazepam tab 2 mg</i>	1	
<i>oxazepam cap 10 mg</i>	1	
<i>oxazepam cap 15 mg</i>	1	
<i>oxazepam cap 30 mg</i>	1	
TRANXENE T TAB 7.5MG	3	
VALIUM TAB 2MG	3	
VALIUM TAB 5MG	3	
VALIUM TAB 10MG	3	

**ANTIARRHYTHMICS****ANTIARRHYTHMICS TYPE I-A**

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

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

39

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTIARRHYTHMICS TYPE I-B</b>		
<i>mexiletine hcl cap 150 mg</i>	1	
<i>mexiletine hcl cap 200 mg</i>	1	
<i>mexiletine hcl cap 250 mg</i>	1	
<b>ANTIARRHYTHMICS TYPE I-C</b>		
<i>flecainide acetate tab 50 mg</i>	1	
<i>flecainide acetate tab 100 mg</i>	1	
<i>flecainide acetate tab 150 mg</i>	1	
<i>propafenone hcl cap er 12hr 225 mg</i>	1	
<i>propafenone hcl cap er 12hr 325 mg</i>	1	
<i>propafenone hcl cap er 12hr 425 mg</i>	1	
<i>propafenone hcl tab 150 mg</i>	1	
<i>propafenone hcl tab 225 mg</i>	1	
<i>propafenone hcl tab 300 mg</i>	1	
RYTHMOL SR CAP 225MG	2	
RYTHMOL SR CAP 325MG	2	
RYTHMOL SR CAP 425MG	2	
<b>ANTIARRHYTHMICS TYPE III</b>		
<i>amiodarone hcl tab 100 mg</i>	1	
<i>amiodarone hcl tab 200 mg</i>	1	
<i>amiodarone hcl tab 400 mg</i>	1	
<i>dofetilide cap 125 mcg (0.125 mg)</i>	1	PA
<i>dofetilide cap 250 mcg (0.25 mg)</i>	1	PA
<i>dofetilide cap 500 mcg (0.5 mg)</i>	1	PA
TIKOSYN CAP 125MCG	3	PA
TIKOSYN CAP 250MCG	3	PA
TIKOSYN CAP 500MCG	3	PA
<b>ANTIASTHMATIC AND BRONCHODILATOR AGENTS</b>		
<b>ANTI-INFLAMMATORY AGENTS</b>		
<i>cromolyn sodium soln nebu 20 mg/2ml</i>	1	QL (240 mL every 30 days)
<b>ANTIASTHMATIC - MONOCLONAL ANTIBODIES</b>		
DUPIXENT INJ 100/0.67	2	PA, QL (2 SYRINGES PER 28 DAYS)

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

40

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DUPIXENT INJ 200/1.14	2	PA, QL (2 PFS PER 28 DAYS); LOADING DOSE:2 PFS PER 14 DAYS
FASENRA PEN INJ 30MG/ML	2	PA, QL (1 PENS PER 56 DAYS); LOADING DOSE: 3 PENS PER 84 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)
TEZSPIRE INJ 210MG	2	PA, QL (1 PEN PER 28 DAYS)

**BRONCHODILATORS - ANTICHOLINERGICS**

ATROVENT HFA AER 17MCG	3	QL (2 packages every 25 days)
<i>ipratropium bromide inhal soln 0.02%</i>	1	QL (120 vials every 30 days)
SPIRIVA AER 1.25MCG	2	QL (1 package every 25 days)
SPIRIVA CAP HANDIHLR	2	QL (30 caps every 30 days)
SPIRIVA SPR 2.5MCG	2	QL (1 package every 25 days)
YUPELRI SOL	2	QL (90 mL every 30 days)

**LEUKOTRIENE MODULATORS**

ACCOLATE TAB 10MG	3	
ACCOLATE TAB 20MG	3	
<i>montelukast sodium chew tab 4 mg (base equiv)</i>	1	
<i>montelukast sodium chew tab 5 mg (base equiv)</i>	1	
<i>montelukast sodium oral granules packet 4 mg (base equiv)</i>	1	
<i>montelukast sodium tab 10 mg (base equiv)</i>	1	

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

41

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>zafirlukast tab 10 mg</i>	1	
<i>zafirlukast tab 20 mg</i>	1	
ZYFLO TAB 600MG	3	

**STEROID INHALANTS**

<i>budesonide inhalation susp 0.5 mg/2ml</i>	1	QL (2 mL every 25 days)
<i>budesonide inhalation susp 0.25 mg/2ml</i>	1	QL (3 mL every 25 days)
<i>budesonide inhalation susp 1 mg/2ml</i>	1	QL (1 mL every 25 days)
FLOVENT HFA AER 44MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 110MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
FLOVENT HFA AER 220MCG	2	QL (2 packages every 25 days); Covered for member 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 110 mcg/act (125/valve)</i>	1	QL (2 packages every 25 days); Covered for members 6 years of age and younger
<i>fluticasone propionate hfa inhal aer 220 mcg/act (250/valve)</i>	1	QL (2 packages every 25 days); Covered for members 6 years of age and younger
<i>fluticasone propionate hfa inhal aero 44 mcg/act (50/valve)</i>	1	QL (2 packages every 25 days); Covered for members 6 years of age and younger
PULMICORT INH 90MCG	2	QL (3 inhalers every 25 days)
PULMICORT INH 180MCG	2	QL (2 inhalers every 25 days)
PULMICORT SUS 0.5MG/2	3	QL (3 mL every 25 days)

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

42

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PULMICORT SUS 0.25MG/2	3	QL (2 mL every 25 days)
PULMICORT SUS 1MG/2ML	3	QL (1 mL every 25 days)
QVAR REDIIHA AER 80MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger
QVAR REDIIHAL AER 40MCG	2	QL (2 packages every 25 days); Covered for members 6 years of age and younger

**SYMPATHOMIMETICS**

ADVAIR DISKU AER 100/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR DISKU AER 250/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR DISKU AER 500/50	1	QL (60 inhalations every 30 days); Tier 1 with DAW9
ADVAIR HFA AER 45/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 115/21	2	QL (1 package every 25 days)
ADVAIR HFA AER 230/21	2	QL (1 package every 25 days)
AIRSUPRA AER 90-80MCG	2	QL (3 packages per 30 days)
<i>albuterol sulfate inhal aero 108 mcg/act (90mcg base equiv)</i>	1	QL (2 packages every 25 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (120 ea every 30 days)
<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i>	1	QL (60 mL every 30 days)
<i>albuterol sulfate soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 0.083% (2.5 mg/3ml)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (360 mL every 30 days)
<i>albuterol sulfate syrup 2 mg/5ml</i>	1	

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

43

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>albuterol sulfate tab 2 mg</i>	1	
<i>albuterol sulfate tab 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 4 mg</i>	1	
<i>albuterol sulfate tab er 12hr 8 mg</i>	1	
ANORO ELLIPT AER 62.5-25	2	QL (60 blisters every 30 days)
<i>arformoterol tartrate soln nebu 15 mcg/2ml (base equiv)</i>	1	QL (120 mL every 30 days)
BREO ELLIPTA INH 50-25MCG	2	QL (60 blisters every 30 days)
BREO ELLIPTA INH 100-25	2	QL (60 blisters every 30 days)
BREO ELLIPTA INH 200-25	2	QL (60 blisters every 30 days)
BREZTRI AERO AER SPHERE	2	QL (1 inhaler every 25 days)
BROVANA NEB 15MCG	3	QL (120 mL every 30 days)
COMBIVENT AER 20-100	3	QL (2 packages every 25 days)
<i>formoterol fumarate soln nebu 20 mcg/2ml</i>	1	QL (60 mL every 30 days)
<i>ipratropium-albuterol nebu soln 0.5-2.5(3) mg/3ml</i>	1	QL (540 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.31 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 0.63 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu 1.25 mg/3ml (base equiv)</i>	1	QL (300 mL every 30 days)
<i>levalbuterol hcl soln nebu conc 1.25 mg/0.5ml (base equiv)</i>	1	QL (90 ea every 30 days)
<i>levalbuterol tartrate inhal aerosol 45 mcg/act (base equiv)</i>	1	QL (2 inhalers every 30 days)
PERFOROMIST NEB 20MCG	3	QL (120 mL every 30 days)
SEREVENT DIS AER 50MCG	2	QL (60 inhalations every 30 days)

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

44

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STIOLTO AER 2.5-2.5	2	QL (1 package every 25 days)
STRIVERDI AER 2.5MCG	2	QL (1 package every 25 days)
SYMBICORT AER 80-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
SYMBICORT AER 160-4.5	2	QL (3 packages every 25 days); Tier 2 with DAW9
<i>terbutaline sulfate tab 2.5 mg</i>	1	
<i>terbutaline sulfate tab 5 mg</i>	1	
TRELEGY AER 100MCG	2	QL (1 inhaler every 30 days)
TRELEGY AER 200MCG	2	QL (1 inhaler every 30 days)
XOPENEX CONC NEB 1.25/0.5	3	QL (90 ea every 30 days)
XOPENEX NEB 0.31MG	3	QL (300 mL every 30 days)
XOPENEX NEB 0.63MG	3	QL (300 mL every 30 days)
XOPENEX NEB 1.25/3ML	3	QL (300 mL every 30 days)

**XANTHINES**

<i>theophylline elixir 80 mg/15ml</i>	1	
<i>theophylline elixir 80 mg/15ml</i>	3	
<i>theophylline tab er 12hr 300 mg</i>	1	
<i>theophylline tab er 12hr 450 mg</i>	1	
<i>theophylline tab er 24hr 400 mg</i>	1	
<i>theophylline tab er 24hr 600 mg</i>	1	

**ANTICOAGULANTS****COUMARIN ANTICOAGULANTS**

<i>warfarin sodium tab 1 mg</i>	1	
<i>warfarin sodium tab 2 mg</i>	1	
<i>warfarin sodium tab 2.5 mg</i>	1	
<i>warfarin sodium tab 3 mg</i>	1	
<i>warfarin sodium tab 4 mg</i>	1	
<i>warfarin sodium tab 5 mg</i>	1	
<i>warfarin sodium tab 6 mg</i>	1	
<i>warfarin sodium tab 7.5 mg</i>	1	

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

45

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

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

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

46

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>fondaparinux sodium subcutaneous inj 10 mg/0.8ml</i>	1	
FRAGMIN INJ 2500/0.2	2	
FRAGMIN INJ 5000/0.2	2	
FRAGMIN INJ 7500/0.3	2	
FRAGMIN INJ 10000/ML	2	
FRAGMIN INJ 12500UNT	2	
FRAGMIN INJ 15000UNT	2	
FRAGMIN INJ 18000UNT	2	
FRAGMIN INJ 95000UNT	2	
<i>heparin sodium (porcine) inj 1000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 5000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 10000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) inj 20000 unit/ml</i>	1	PA
<i>heparin sodium (porcine) pf inj 5000 unit/0.5ml</i>	1	PA
LOVENOX INJ 30/0.3ML	3	
LOVENOX INJ 40/0.4ML	3	
LOVENOX INJ 60/0.6ML	3	
LOVENOX INJ 80/0.8ML	3	
LOVENOX INJ 100MG/ML	3	
LOVENOX INJ 120/0.8	3	
LOVENOX INJ 150MG/ML	3	
LOVENOX INJ 300/3ML	3	

**ANTICONVULSANTS****AMPA GLUTAMATE RECEPTOR ANTAGONISTS**

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

**ANTICONVULSANTS - BENZODIAZEPINES**

<i>clobazam suspension 2.5 mg/ml</i>	1	
<i>clobazam tab 10 mg</i>	1	

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

47

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>clobazam tab 20 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.5 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.25 mg</i>	1	
<i>clonazepam orally disintegrating tab 0.125 mg</i>	1	
<i>clonazepam orally disintegrating tab 1 mg</i>	1	
<i>clonazepam orally disintegrating tab 2 mg</i>	1	
<i>clonazepam tab 0.5 mg</i>	1	
<i>clonazepam tab 1 mg</i>	1	
<i>clonazepam tab 2 mg</i>	1	
DIASTAT ACDL GEL 5-10MG	3	
DIASTAT ACDL GEL 12.5-20	3	
DIASTAT PED GEL 2.5M GEL	3	
<i>diazepam rectal gel delivery system 2.5 mg</i>	1	
<i>diazepam rectal gel delivery system 10 mg</i>	1	
<i>diazepam rectal gel delivery system 20 mg</i>	1	
KLONOPIN TAB 0.5MG	3	
KLONOPIN TAB 1MG	3	
KLONOPIN TAB 2MG	3	
NAYZILAM SPR 5MG	2	PA, QL (10 bottles every 25 days)
VALTOCO SPR 5MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 10MG	2	PA, QL (5 sprays every 25 days)
VALTOCO SPR 15MG	2	PA, QL (5 ea every 25 days)
VALTOCO SPR 20MG	2	PA, QL (5 ea every 25 days)
<b>ANTICONVULSANTS - MISC.</b>		
APTIOM TAB 200MG	2	
APTIOM TAB 400MG	2	
APTIOM TAB 600MG	2	
APTIOM TAB 800MG	2	
BRIVIACT SOL 10MG/ML	3	
BRIVIACT TAB 10MG	3	

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

48

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BRIVIACT TAB 25MG	3	
BRIVIACT TAB 50MG	3	
BRIVIACT TAB 75MG	3	
BRIVIACT TAB 100MG	3	
<i>carbamazepine cap er 12hr 100 mg</i>	1	
<i>carbamazepine cap er 12hr 200 mg</i>	1	
<i>carbamazepine cap er 12hr 300 mg</i>	1	
<i>carbamazepine chew tab 100 mg</i>	1	
<i>carbamazepine susp 100 mg/5ml</i>	1	
<i>carbamazepine tab 200 mg</i>	1	
<i>carbamazepine tab er 12hr 100 mg</i>	1	
<i>carbamazepine tab er 12hr 200 mg</i>	1	
<i>carbamazepine tab er 12hr 400 mg</i>	1	
CARBATROL CAP 100MG	3	
CARBATROL CAP 200MG	3	
CARBATROL CAP 300MG	3	
EPIDIOLEX SOL 100MG/ML	3	PA, QL (800 ML PER 30 DAYS)
<i>gabapentin cap 100 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 300 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin cap 400 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin oral soln 250 mg/5ml</i>	1	
<i>gabapentin oral soln 250 mg/5ml</i>	1	QL (72 mL per day)
<i>gabapentin tab 600 mg</i>	1	QL (180 capsules per 30 days)
<i>gabapentin tab 800 mg</i>	1	QL (120 tablets per 30 days)
<i>lacosamide oral solution 10 mg/ml</i>	1	
<i>lacosamide tab 50 mg</i>	1	
<i>lacosamide tab 100 mg</i>	1	
<i>lacosamide tab 150 mg</i>	1	
<i>lacosamide tab 200 mg</i>	1	

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

49

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>lamotrigine orally disintegrating tab 25 mg</i>	1	
<i>lamotrigine orally disintegrating tab 50 mg</i>	1	
<i>lamotrigine orally disintegrating tab 100 mg</i>	1	
<i>lamotrigine orally disintegrating tab 200 mg</i>	1	
<i>lamotrigine tab 25 mg</i>	1	
<i>lamotrigine tab 25 mg (42) &amp; 100 mg (7) starter kit</i>	1	
<i>lamotrigine tab 35 x 25 mg starter kit</i>	1	
<i>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg starter kit</i>	1	
<i>lamotrigine tab 100 mg</i>	1	
<i>lamotrigine tab 150 mg</i>	1	
<i>lamotrigine tab 200 mg</i>	1	
<i>lamotrigine tab chewable dispersible 5 mg</i>	1	
<i>lamotrigine tab chewable dispersible 25 mg</i>	1	
<i>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp; 100 mg (7) kit</i>	1	
<i>lamotrigine tab er 24hr 25 mg</i>	1	
<i>lamotrigine tab er 24hr 50 mg</i>	1	
<i>lamotrigine tab er 24hr 100 mg</i>	1	
<i>lamotrigine tab er 24hr 200 mg</i>	1	
<i>lamotrigine tab er 24hr 250 mg</i>	1	
<i>lamotrigine tab er 24hr 300 mg</i>	1	
<i>levetiracetam oral soln 100 mg/ml</i>	1	
<i>levetiracetam tab 250 mg</i>	1	
<i>levetiracetam tab 500 mg</i>	1	
<i>levetiracetam tab 750 mg</i>	1	
<i>levetiracetam tab 1000 mg</i>	1	
<i>levetiracetam tab er 24hr 500 mg</i>	1	
<i>levetiracetam tab er 24hr 750 mg</i>	1	
MYSOLINE TAB 50MG	3	
MYSOLINE TAB 250MG	3	
NEURONTIN CAP 100MG	3	QL (180 capsules per 30 days)

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

50

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NEURONTIN CAP 300MG	3	QL (180 capsules per 30 days)
NEURONTIN CAP 400MG	3	QL (180 capsules per 30 days)
NEURONTIN SOL 250/5ML	3	QL (72 mL per day)
NEURONTIN TAB 600MG	3	QL (180 tablets per 30 days)
NEURONTIN TAB 800MG	3	QL (120 tablets per 30 days)
<i>oxcarbazepine susp 300 mg/5ml (60 mg/ml)</i>	1	
<i>oxcarbazepine tab 150 mg</i>	1	
<i>oxcarbazepine tab 300 mg</i>	1	
<i>oxcarbazepine tab 600 mg</i>	1	
OXTELLAR XR TAB 150MG	2	
OXTELLAR XR TAB 300MG	2	
OXTELLAR XR TAB 600MG	2	
<i>pregabalin cap 25 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 50 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 75 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 100 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 150 mg</i>	1	QL (120 caps every 30 days)
<i>pregabalin cap 200 mg</i>	1	QL (90 caps every 30 days)
<i>pregabalin cap 225 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin cap 300 mg</i>	1	QL (60 caps every 30 days)
<i>pregabalin soln 20 mg/ml</i>	1	QL (1080 mL every 30 days)
<i>primidone tab 50 mg</i>	1	
<i>primidone tab 250 mg</i>	1	

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

51

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
QUDEXY XR CAP 25/24HR	3	
QUDEXY XR CAP 50/24HR	3	
QUDEXY XR CAP 100/24HR	3	
QUDEXY XR CAP 150/24HR	3	
QUDEXY XR CAP 200/24HR	3	
<i>rufinamide susp 40 mg/ml</i>	1	
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	
<i>topiramate cap er 24hr 200 mg</i>	1	
<i>topiramate sprinkle cap 15 mg</i>	1	
<i>topiramate sprinkle cap 25 mg</i>	1	
<i>topiramate tab 25 mg</i>	1	
<i>topiramate tab 50 mg</i>	1	
<i>topiramate tab 100 mg</i>	1	
<i>topiramate tab 200 mg</i>	1	
TROKENDI XR CAP 25MG	2	
TROKENDI XR CAP 50MG	2	
TROKENDI XR CAP 100MG	2	
TROKENDI XR CAP 200MG	2	
<i>zonisamide cap 25 mg</i>	1	
<i>zonisamide cap 50 mg</i>	1	
<i>zonisamide cap 100 mg</i>	1	
<b>CARBAMATES</b>		
<i>felbamate susp 600 mg/5ml</i>	1	
<i>felbamate tab 400 mg</i>	1	
<i>felbamate tab 600 mg</i>	1	
FELBATOL SUS 600/5ML	3	
FELBATOL TAB 400MG	3	
FELBATOL TAB 600MG	3	
XCOPRI PAK 12.5-25	2	
XCOPRI PAK 50-100MG	2	

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

52

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

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

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

53

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VALPROIC ACID</b>		
<i>divalproex sodium cap delayed release sprinkle 125 mg</i>	1	
<i>divalproex sodium tab delayed release 125 mg</i>	1	
<i>divalproex sodium tab delayed release 250 mg</i>	1	
<i>divalproex sodium tab delayed release 500 mg</i>	1	
<i>divalproex sodium tab er 24 hr 250 mg</i>	1	
<i>divalproex sodium tab er 24 hr 500 mg</i>	1	
<i>valproate sodium oral soln 250 mg/5ml (base equiv)</i>	1	
<i>valproic acid cap 250 mg</i>	1	

**ANTIDEPRESSANTS****ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS)**

<i>mirtazapine orally disintegrating tab 15 mg</i>	1	
<i>mirtazapine orally disintegrating tab 30 mg</i>	1	
<i>mirtazapine orally disintegrating tab 45 mg</i>	1	
<i>mirtazapine tab 7.5 mg</i>	1	
<i>mirtazapine tab 15 mg</i>	1	
<i>mirtazapine tab 30 mg</i>	1	
<i>mirtazapine tab 45 mg</i>	1	
REMERON SLTB TAB 15MG	3	
REMERON SLTB TAB 30MG	3	
REMERON SLTB TAB 45MG	3	
REMERON TAB 15MG	3	
REMERON TAB 30MG	3	

**ANTIDEPRESSANTS - MISC.**

APLENZIN TAB 174MG	3	
APLENZIN TAB 348MG	3	
APLENZIN TAB 522MG	3	
<i>bupropion hcl tab 75 mg</i>	1	
<i>bupropion hcl tab 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 100 mg</i>	1	
<i>bupropion hcl tab er 12hr 150 mg</i>	1	
<i>bupropion hcl tab er 12hr 200 mg</i>	1	
<i>bupropion hcl tab er 24hr 150 mg</i>	1	

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

54

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



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

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

55

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>escitalopram oxalate tab 5 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 10 mg (base equiv)</i>	1	
<i>escitalopram oxalate tab 20 mg (base equiv)</i>	1	
<i>fluoxetine hcl cap 10 mg</i>	1	
<i>fluoxetine hcl cap 20 mg</i>	1	
<i>fluoxetine hcl cap 40 mg</i>	1	
<i>fluoxetine hcl cap delayed release 90 mg</i>	1	
<i>fluoxetine hcl solution 20 mg/5ml</i>	1	
<i>fluoxetine hcl tab 10 mg</i>	1	
<i>fluoxetine hcl tab 20 mg</i>	1	
FLUOXETINE TAB 60MG	3	
<i>fluvoxamine maleate cap er 24hr 100 mg</i>	1	
<i>fluvoxamine maleate cap er 24hr 150 mg</i>	1	
<i>fluvoxamine maleate tab 25 mg</i>	1	
<i>fluvoxamine maleate tab 50 mg</i>	1	
<i>fluvoxamine maleate tab 100 mg</i>	1	
<i>paroxetine hcl tab 10 mg</i>	1	
<i>paroxetine hcl tab 20 mg</i>	1	
<i>paroxetine hcl tab 30 mg</i>	1	
<i>paroxetine hcl tab 40 mg</i>	1	
<i>paroxetine hcl tab er 24hr 12.5 mg</i>	1	
<i>paroxetine hcl tab er 24hr 25 mg</i>	1	
<i>paroxetine hcl tab er 24hr 37.5 mg</i>	1	
<i>sertraline hcl oral concentrate for solution 20 mg/ml</i>	1	
<i>sertraline hcl tab 25 mg</i>	1	
<i>sertraline hcl tab 50 mg</i>	1	
<i>sertraline hcl tab 100 mg</i>	1	
<b>SEROTONIN MODULATORS</b>		
<i>nefazodone hcl tab 50 mg</i>	1	
<i>nefazodone hcl tab 100 mg</i>	1	
<i>nefazodone hcl tab 150 mg</i>	1	
<i>nefazodone hcl tab 200 mg</i>	1	
<i>nefazodone hcl tab 250 mg</i>	1	
<i>trazodone hcl tab 50 mg</i>	1	

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

56

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>trazodone hcl tab 100 mg</i>	1	
<i>trazodone hcl tab 150 mg</i>	1	
<i>trazodone hcl tab 300 mg</i>	1	
TRINTELLIX TAB 5MG	2	
TRINTELLIX TAB 10MG	2	
TRINTELLIX TAB 20MG	2	
<i>vilazodone hcl tab 10 mg</i>	1	
<i>vilazodone hcl tab 20 mg</i>	1	
<i>vilazodone hcl tab 40 mg</i>	1	
<b>SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)</b>		
DESVENLAFAX TAB 50MG ER	3	
DESVENLAFAX TAB 100MG ER	3	
<i>desvenlafaxine succinate tab er 24hr 25 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 50 mg (base equiv)</i>	1	
<i>desvenlafaxine succinate tab er 24hr 100 mg (base equiv)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 20 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 30 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 40 mg (base eq)</i>	1	
<i>duloxetine hcl enteric coated pellets cap 60 mg (base eq)</i>	1	
FETZIMA CAP 20MG	3	
FETZIMA CAP 40MG	3	
FETZIMA CAP 80MG	3	
FETZIMA CAP 120MG	3	
FETZIMA CAP TITRATIO	3	
<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i>	1	

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

57

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 25 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 50 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 75 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab 100 mg (base equivalent)</i>	1	
<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i>	1	

**TRICYCLIC AGENTS**

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

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

58

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

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

**ANTIDIABETICS****ALPHA-GLUCOSIDASE INHIBITORS**

<i>acarbose tab 25 mg</i>	1	
<i>acarbose tab 50 mg</i>	1	
<i>acarbose tab 100 mg</i>	1	
<i>miglitol tab 25 mg</i>	1	
<i>miglitol tab 50 mg</i>	1	
<i>miglitol tab 100 mg</i>	1	

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

59

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

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

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

60

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 every 30 days)
<b>BIGUANIDES</b>		
<i>metformin hcl oral soln 500 mg/5ml</i>	1	
<i>metformin hcl tab 500 mg</i>	1	
<i>metformin hcl tab 850 mg</i>	1	
<i>metformin hcl tab 1000 mg</i>	1	
<i>metformin hcl tab er 24hr 500 mg</i>	1	
<i>metformin hcl tab er 24hr 750 mg</i>	1	
<b>DIABETIC OTHER</b>		
BAQSIMI ONE POW 3MG/DOSE	2	
BAQSIMI TWO POW 3MG/DOSE	2	
<i>diazoxide susp 50 mg/ml</i>	1	
<i>glucagon (rdna) for inj kit 1 mg</i>	1	
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	
PROGLYCEM SUS 50MG/ML	3	
ZEGALOGUE INJ 0.6/0.6	2	
<b>DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS</b>		
JANUVIA TAB 25MG	2	ST
JANUVIA TAB 50MG	2	ST
JANUVIA TAB 100MG	2	ST

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

61

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC</b>		
CYCLOSET TAB 0.8MG	3	
<b>INCRETIN MIMETIC AGENTS</b>		
OZEMPIC INJ 2MG/3ML	2	ST, QL (1 pen every 30 days)
<b>INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS)</b>		
MOUNJARO INJ 2.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 5MG/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 7.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 12.5/0.5	2	ST, QL (4 pens every 30 days)
MOUNJARO INJ 15MG/0.5	2	ST, QL (4 pens every 30 days)
OZEMPIC INJ 2/1.5ML	2	ST, QL (1 pen every 30 days); Starter Pen
OZEMPIC INJ 4MG/3ML	2	ST, QL (1 pen every 30 days)
OZEMPIC INJ 8MG/3ML	2	ST, QL (1 pen every 25 days)
RYBELSUS TAB 3MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 7MG	2	ST, QL (30 tabs every 30 days)
RYBELSUS TAB 14MG	2	ST, QL (30 tabs every 30 days)
TRULICITY INJ 0.75/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 1.5/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 3/0.5	2	ST, QL (4 pens every 30 days)
TRULICITY INJ 4.5/0.5	2	ST, QL (4 pens every 30 days)

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

62

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VICTOZA INJ 18MG/3ML	2	ST, QL (3 pens every 30 days)
<b>INSULIN</b>		
BASAGLAR INJ 100UNIT	2	
FIASP FLEX INJ TOUCH	2	
FIASP INJ 100/ML	2	
FIASP PENFIL INJ U-100	2	
HUMULIN R INJ U-500	2	
LEVEMIR INJ	2	
LEVEMIR INJ FLEXPEN	2	
LEVEMIR INJ FLEXTOUC	2	
NOVOLIN INJ 70/30	2	
NOVOLIN INJ 70/30 FP	2	
NOVOLIN N INJ 100 UNIT	2	
NOVOLIN N INJ U-100	2	
NOVOLIN R INJ 100 UNIT	2	
NOVOLIN R INJ U-100	2	
NOVOLOG INJ 100/ML	2	
NOVOLOG INJ FLEXPEN	2	
NOVOLOG INJ PENFILL	2	
NOVOLOG MIX INJ 70/30	2	
NOVOLOG MIX INJ FLEXPEN	2	
TOUJEO MAX INJ 300IU/ML	2	
TOUJEO SOLO INJ 300IU/ML	2	
TRESIBA FLEX INJ 100UNIT	2	
TRESIBA FLEX INJ 200UNIT	2	
TRESIBA INJ 100UNIT	2	
<b>INSULIN SENSITIZING AGENTS</b>		
AVANDIA TAB 2MG	3	
AVANDIA TAB 4MG	3	
<i>pioglitazone hcl tab 15 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 30 mg (base equiv)</i>	1	
<i>pioglitazone hcl tab 45 mg (base equiv)</i>	1	
<b>MEGLITINIDE ANALOGUES</b>		
<i>nateglinide tab 60 mg</i>	1	

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

63

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nateglinide tab 120 mg</i>	1	
<i>repaglinide tab 0.5 mg</i>	1	
<i>repaglinide tab 1 mg</i>	1	
<i>repaglinide tab 2 mg</i>	1	
STARLIX TAB 120MG	3	
<b>SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS</b>		
FARXIGA TAB 5MG	2	ST
FARXIGA TAB 10MG	2	ST
JARDIANCE TAB 10MG	2	ST
JARDIANCE TAB 25MG	2	ST
<b>SULFONYLUREAS</b>		
AMARYL TAB 1MG	3	
AMARYL TAB 2MG	3	
AMARYL TAB 4MG	3	
<i>glimepiride tab 1 mg</i>	1	
<i>glimepiride tab 2 mg</i>	1	
<i>glimepiride tab 4 mg</i>	1	
<i>glipizide tab 5 mg</i>	1	
<i>glipizide tab 10 mg</i>	1	
<i>glipizide tab er 24hr 2.5 mg</i>	1	
<i>glipizide tab er 24hr 5 mg</i>	1	
<i>glipizide tab er 24hr 10 mg</i>	1	
GLUCOTROL TAB 10MG	3	
GLUCOTROL XL TAB 2.5MG	3	
GLUCOTROL XL TAB 5MG	3	
GLUCOTROL XL TAB 10MG	3	
<i>glyburide micronized tab 1.5 mg</i>	1	
<i>glyburide micronized tab 3 mg</i>	1	
<i>glyburide micronized tab 6 mg</i>	1	
<i>glyburide tab 1.25 mg</i>	1	
<i>glyburide tab 2.5 mg</i>	1	
<i>glyburide tab 5 mg</i>	1	
GLYNASE TAB 1.5MG	3	
GLYNASE TAB 3MG	3	
GLYNASE TAB 6MG	3	

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

64

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>tolbutamide tab 500 mg</i>	1	
<b>ANTIDIARRHEAL/PROBIOTIC AGENTS</b>		
<b>ANTIDIARRHEAL/PROBIOTIC COMBINATIONS</b>		
RESTORA RX CAP 60-1.25	3	
<b>ANTIPERISTALTIC AGENTS</b>		
<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i>	1	
<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i>	1	
LOMOTIL TAB 2.5MG	2	
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<b>ANTIDOTES - CHELATING AGENTS</b>		
CHEMET CAP 100MG	3	
<i>deferasirox granules packet 90 mg</i>	1	PA
<i>deferasirox granules packet 180 mg</i>	1	PA
<i>deferasirox granules packet 360 mg</i>	1	PA
<i>deferasirox tab 90 mg</i>	1	PA
<i>deferasirox tab 180 mg</i>	1	PA
<i>deferasirox tab 360 mg</i>	1	PA
<i>deferasirox tab for oral susp 125 mg</i>	1	PA
<i>deferasirox tab for oral susp 250 mg</i>	1	PA
<i>deferasirox tab for oral susp 500 mg</i>	1	PA
<i>deferiprone tab 500 mg</i>	1	PA
<b>ANTIDOTES AND SPECIFIC ANTAGONISTS</b>		
<i>deferoxamine mesylate for inj 2 gm</i>	1	PA
RADIOGARDASE CAP 0.5GM	3	
VISTOGARD PAK 10GM	2	QL (20 PACKETS PER 5 DAYS)
<b>OPIOID ANTAGONISTS</b>		
KLOXXADO SPR 8MG	3	
<i>naloxone hcl inj 0.4 mg/ml</i>	1	
<i>naloxone hcl inj 4 mg/10ml</i>	1	
<i>naloxone hcl nasal spray 4 mg/0.1ml</i>	1	
<i>naloxone hcl soln cartridge 0.4 mg/ml</i>	1	
<i>naloxone hcl soln prefilled syringe 2 mg/2ml</i>	1	
<i>naltrexone hcl tab 50 mg</i>	0	

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

65

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NARCAN SPR 4MG	3	
<b>ANTIEMETICS</b>		
<b>5-HT3 RECEPTOR ANTAGONISTS</b>		
ANZEMET TAB 50MG	3	QL (6 tabs every 21 days)
ANZEMET TAB 100MG	3	QL (6 tabs every 21 days)
<i>granisetron hcl tab 1 mg</i>	1	QL (12 tabs every 21 days)
<i>ondansetron hcl oral soln 4 mg/5ml</i>	1	QL (200 mL every 21 days)
<i>ondansetron hcl tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 8 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron hcl tab 24 mg</i>	1	QL (2 ea every 21 days)
<i>ondansetron orally disintegrating tab 4 mg</i>	1	QL (18 tabs every 21 days)
<i>ondansetron orally disintegrating tab 8 mg</i>	1	QL (18 tabs every 21 days)
SANCUSO DIS 3.1MG	2	QL (2 patches every 21 days)
ZOFRAN TAB 4MG	3	QL (18 tabs every 21 days)
<b>ANTIEMETICS - ANTICHOLINERGIC</b>		
<i>scopolamine td patch 72hr 1 mg/3days</i>	1	
TIGAN CAP 300MG	3	
<i>trimethobenzamide hcl cap 300 mg</i>	1	
<b>ANTIEMETICS - MISCELLANEOUS</b>		
AKYNZEO CAP 300-0.5	3	QL (2 caps every 21 days)
BONJESTA TAB 20-20MG	3	
DICLEGIS TAB 10-10MG	3	
<i>doxylamine-pyridoxine tab delayed release 10-10 mg</i>	1	
<i>dronabinol cap 2.5 mg</i>	1	
<i>dronabinol cap 5 mg</i>	1	
<i>dronabinol cap 10 mg</i>	1	
MARINOL CAP 2.5MG	3	
MARINOL CAP 5MG	3	
MARINOL CAP 10MG	3	
<b>SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS</b>		
<i>aprepitant capsule 40 mg</i>	1	QL (3 caps every 180 days)
<i>aprepitant capsule 80 mg</i>	1	QL (4 caps every 21 days)
<i>aprepitant capsule 125 mg</i>	1	QL (2 ea every 21 days)

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

66

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

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

**ANTIFUNGALS****ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS)**

BREXAFEMME TAB 150MG	3	ST, QL (4 tabs every 7 days)
----------------------	---	------------------------------

**ANTIFUNGALS**

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

**IMIDAZOLE-RELATED ANTIFUNGALS**

DIFLUCAN SUS 10MG/ML	3	
DIFLUCAN SUS 40MG/ML	3	
DIFLUCAN TAB 50MG	3	
DIFLUCAN TAB 100MG	3	
DIFLUCAN TAB 150MG	3	
DIFLUCAN TAB 200MG	3	
<i>fluconazole for susp 10 mg/ml</i>	1	
<i>fluconazole for susp 40 mg/ml</i>	1	
<i>fluconazole tab 50 mg</i>	1	
<i>fluconazole tab 100 mg</i>	1	
<i>fluconazole tab 150 mg</i>	1	
<i>fluconazole tab 200 mg</i>	1	

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

67

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>itraconazole cap 100 mg</i>	1	
<i>itraconazole oral soln 10 mg/ml</i>	1	
<i>ketoconazole tab 200 mg</i>	1	
<i>posaconazole susp 40 mg/ml</i>	1	
SPORANOX CAP 100MG	3	
SPORANOX CAP PULSEPAK	3	
SPORANOX SOL 10MG/ML	3	
VFEND SUS 40MG/ML	2	PA
VFEND TAB 50MG	2	PA
VFEND TAB 200MG	2	PA
VIVJOA CAP 150MG	3	PA
<i>voriconazole for susp 40 mg/ml</i>	1	PA
<i>voriconazole tab 50 mg</i>	1	PA
<i>voriconazole tab 200 mg</i>	1	PA

**ANTI-HISTAMINES****ANTI-HISTAMINES - ETHANOLAMINES**

<i>carbinoxamine maleate soln 4 mg/5ml</i>	1	
<i>carbinoxamine maleate tab 4 mg</i>	1	
<i>clemastine fumarate tab 2.68 mg</i>	1	
KARBINAL ER SUS 4MG/5ML	3	

**ANTI-HISTAMINES - NON-SEDATING**

CLARINEX TAB 5MG	3	
<i>desloratadine tab 5 mg</i>	1	
<i>desloratadine tab orally disintegrating 2.5 mg</i>	1	
<i>desloratadine tab orally disintegrating 5 mg</i>	1	
<i>levocetirizine dihydrochloride soln 2.5 mg/5ml (0.5 mg/ml)</i>	1	

**ANTI-HISTAMINES - PHENOTHIAZINES**

<i>promethazine hcl suppos 12.5 mg</i>	1	
<i>promethazine hcl suppos 25 mg</i>	1	
<i>promethazine hcl suppos 50 mg</i>	1	
<i>promethazine hcl syrup 6.25 mg/5ml</i>	1	
<i>promethazine hcl tab 12.5 mg</i>	1	
<i>promethazine hcl tab 25 mg</i>	1	
<i>promethazine hcl tab 50 mg</i>	1	

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

68

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTI-HISTAMINES - PIPERIDINES</b>		
<i>cyproheptadine hcl syrup 2 mg/5ml</i>	1	
<i>cyproheptadine hcl tab 4 mg</i>	1	
<b>ANTIHYPERLIPIDEMICS</b>		
<b>ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS</b>		
NEXLETOL TAB 180MG	2	PA
<b>ANTIHYPERLIPIDEMICS - COMBINATIONS</b>		
<i>ezetimibe-simvastatin tab 10-10 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-20 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-40 mg</i>	1	
<i>ezetimibe-simvastatin tab 10-80 mg</i>	1	
NEXLIZET TAB 180/10MG	2	PA
VYTORIN TAB 10-10MG	3	
VYTORIN TAB 10-20MG	3	
VYTORIN TAB 10-40MG	3	
VYTORIN TAB 10-80MG	3	
<b>ANTIHYPERLIPIDEMICS - MISC.</b>		
<i>omega-3-acid ethyl esters cap 1 gm</i>	1	PA
VASCEPA CAP 0.5GM	1	PA; Tier 1 with DAW9
VASCEPA CAP 1GM	1	PA; Tier 1 with DAW9
<b>BILE ACID SEQUESTRANTS</b>		
<i>cholestyramine light powder 4 gm/dose</i>	1	
<i>cholestyramine light powder packets 4 gm</i>	1	
<i>cholestyramine powder 4 gm/dose</i>	1	
<i>cholestyramine powder packets 4 gm</i>	1	
<i>colesevelam hcl packet for susp 3.75 gm</i>	1	
<i>colesevelam hcl tab 625 mg</i>	1	
COLESTID FLA GRA 5/7.5GM	3	
COLESTID FLA GRA 5GM	3	
COLESTID GRA 5GM	3	
COLESTID POW 5GM	3	
COLESTID TAB 1GM	3	
<i>colestipol hcl granule packets 5 gm</i>	1	
<i>colestipol hcl granules 5 gm</i>	1	

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

69

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>colestipol hcl tab 1 gm</i>	1	
QUESTRAN POW 4GM	3	
QUESTRAN POW 4GM LITE	3	
WELCHOL PAK 3.75GM	3	
WELCHOL TAB 625MG	3	
<b>FIBRIC ACID DERIVATIVES</b>		
ANTARA CAP 30MG	3	
ANTARA CAP 90MG	3	
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i>	1	
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i>	1	
<i>fenofibrate cap 150 mg</i>	1	
<i>fenofibrate micronized cap 43 mg</i>	1	
<i>fenofibrate micronized cap 67 mg</i>	1	
<i>fenofibrate micronized cap 134 mg</i>	1	
<i>fenofibrate micronized cap 200 mg</i>	1	
<i>fenofibrate tab 48 mg</i>	1	
<i>fenofibrate tab 54 mg</i>	1	
<i>fenofibrate tab 145 mg</i>	1	
<i>fenofibrate tab 160 mg</i>	1	
<i>fenofibric acid tab 35 mg</i>	1	
<i>fenofibric acid tab 105 mg</i>	1	
FENOGLIDE TAB 40MG	3	
FIBRICOR TAB 35MG	3	
FIBRICOR TAB 105MG	3	
<i>gemfibrozil tab 600 mg</i>	1	
LIPOFEN CAP 50MG	3	
LIPOFEN CAP 150MG	3	
LOPID TAB 600MG	3	
TRILIPIX CAP 45MG	3	
TRILIPIX CAP 135MG	3	
<b>HMG COA REDUCTASE INHIBITORS</b>		
<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	0	\$0 copay for members age 40 through 75

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

70

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



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

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

71

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>simvastatin tab 20 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 40 mg</i>	0	\$0 copay for members age 40 through 75
<i>simvastatin tab 80 mg</i>	1	
ZOCOR TAB 10MG	3	
ZOCOR TAB 20MG	3	
ZOCOR TAB 40MG	3	
ZOCOR TAB 80MG	3	
<b>INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS</b>		
<i>ezetimibe tab 10 mg</i>	1	
<b>NICOTINIC ACID DERIVATIVES</b>		
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	1	
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>	1	
NIASPAN TAB 500MG ER	3	
NIASPAN TAB 750MG ER	3	
NIASPAN TAB 1000 ER	3	
<b>PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS</b>		
REPATHA INJ 140MG/ML	2	PA, QL (3 SYRINGES PER 28 DAYS)
REPATHA PUSH INJ 420/3.5	2	PA, QL (1 CARTRIDGES PER 28 DAYS)
REPATHA SURE INJ 140MG/ML	2	PA, QL (3 PENS PER 28 DAYS)
<b>ANTIHYPERTENSIVES</b>		
<b>ACE INHIBITORS</b>		
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	

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

72

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

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

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

73

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>quinapril hcl tab 40 mg</i>	1	
<i>ramipril cap 1.25 mg</i>	1	
<i>ramipril cap 2.5 mg</i>	1	
<i>ramipril cap 5 mg</i>	1	
<i>ramipril cap 10 mg</i>	1	
<i>trandolapril tab 1 mg</i>	1	
<i>trandolapril tab 2 mg</i>	1	
<i>trandolapril tab 4 mg</i>	1	
VASOTEC TAB 2.5MG	3	
VASOTEC TAB 5MG	3	
VASOTEC TAB 10MG	3	
VASOTEC TAB 20MG	3	
ZESTRIL TAB 2.5MG	3	
ZESTRIL TAB 5MG	3	
ZESTRIL TAB 10MG	3	
ZESTRIL TAB 20MG	3	
ZESTRIL TAB 30MG	3	
ZESTRIL TAB 40MG	3	
<b>AGENTS FOR PHEOCHROMOCYTOMA</b>		
DEMSER CAP 250MG	3	
DIBENZYLINE CAP 10MG	3	
<i>metyrosine cap 250 mg</i>	1	
<i>phenoxybenzamine hcl cap 10 mg</i>	1	
<b>ANGIOTENSIN II RECEPTOR ANTAGONISTS</b>		
AVAPRO TAB 75MG	3	
AVAPRO TAB 150MG	3	
AVAPRO TAB 300MG	3	
<i>candesartan cilexetil tab 4 mg</i>	1	
<i>candesartan cilexetil tab 8 mg</i>	1	
<i>candesartan cilexetil tab 16 mg</i>	1	
<i>candesartan cilexetil tab 32 mg</i>	1	
<i>irbesartan tab 75 mg</i>	1	
<i>irbesartan tab 150 mg</i>	1	
<i>irbesartan tab 300 mg</i>	1	
<i>losartan potassium tab 25 mg</i>	1	

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

74

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>losartan potassium tab 50 mg</i>	1	
<i>losartan potassium tab 100 mg</i>	1	
<i>olmesartan medoxomil tab 5 mg</i>	1	
<i>olmesartan medoxomil tab 20 mg</i>	1	
<i>olmesartan medoxomil tab 40 mg</i>	1	
<i>telmisartan tab 20 mg</i>	1	
<i>telmisartan tab 40 mg</i>	1	
<i>telmisartan tab 80 mg</i>	1	
<i>valsartan tab 40 mg</i>	1	
<i>valsartan tab 80 mg</i>	1	
<i>valsartan tab 160 mg</i>	1	
<i>valsartan tab 320 mg</i>	1	
<b>ANTIADRENERGIC ANTIHYPERTENSIVES</b>		
CARDURA TAB 1MG	3	
CARDURA TAB 2MG	3	
CARDURA TAB 4MG	3	
CARDURA TAB 8MG	3	
CATAPRES-TTS DIS 0.1/24HR	2	
CATAPRES-TTS DIS 0.2/24HR	2	
CATAPRES-TTS DIS 0.3/24HR	2	
<i>clonidine hcl tab 0.1 mg</i>	1	
<i>clonidine hcl tab 0.2 mg</i>	1	
<i>clonidine hcl tab 0.3 mg</i>	1	
<i>clonidine td patch weekly 0.1 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.2 mg/24hr</i>	1	
<i>clonidine td patch weekly 0.3 mg/24hr</i>	1	
<i>doxazosin mesylate tab 1 mg</i>	1	
<i>doxazosin mesylate tab 2 mg</i>	1	
<i>doxazosin mesylate tab 4 mg</i>	1	
<i>doxazosin mesylate tab 8 mg</i>	1	
<i>guanfacine hcl tab 1 mg</i>	1	
<i>guanfacine hcl tab 2 mg</i>	1	
<i>methyldopa tab 250 mg</i>	1	
<i>methyldopa tab 500 mg</i>	1	
MINIPRESS CAP 1MG	3	

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

75

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

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

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

76

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

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

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

77

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

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

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

78

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



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

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

79

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

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

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

80

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSPRA TAB 25MG	2	
INSPRA TAB 50MG	2	
<b>VASODILATORS</b>		
<i>hydralazine hcl tab 10 mg</i>	1	
<i>hydralazine hcl tab 25 mg</i>	1	
<i>hydralazine hcl tab 50 mg</i>	1	
<i>hydralazine hcl tab 100 mg</i>	1	
<i>minoxidil tab 2.5 mg</i>	1	
<i>minoxidil tab 10 mg</i>	1	
<b>ANTIMALARIALS</b>		
<b>ANTIMALARIAL COMBINATIONS</b>		
<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	1	
<i>atovaquone-proguanil hcl tab 250-100 mg</i>	1	
COARTEM TAB 20-120MG	3	
MALARONE TAB 62.5-25	2	
MALARONE TAB 250-100	2	
<b>ANTIMALARIALS</b>		
<i>chloroquine phosphate tab 250 mg</i>	1	
<i>chloroquine phosphate tab 500 mg</i>	1	
<i>hydroxychloroquine sulfate tab 200 mg</i>	1	
<i>mefloquine hcl tab 250 mg</i>	1	
PLAQUENIL TAB 200MG	2	
<i>primaquine phosphate tab 26.3 mg (15 mg base)</i>	1	
PRIMAQUINE TAB 26.3MG	3	
<i>pyrimethamine tab 25 mg</i>	1	PA
QUALAQUIN CAP 324MG	3	
<i>quinine sulfate cap 324 mg</i>	1	
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
<b>ANTIMYASTHENIC/CHOLINERGIC AGENTS</b>		
FIRDAPSE TAB 10MG	3	PA, QL (240 TABLETS PER 30 DAYS)
GUANIDINE TAB 125MG	3	
MESTINON SOL 60MG/5ML	3	
MESTINON TAB 60MG	3	

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

81

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MESTINON TAB TIMESPAN	3	
<i>pyridostigmine bromide oral soln 60 mg/5ml</i>	1	
<i>pyridostigmine bromide tab 60 mg</i>	1	
<i>pyridostigmine bromide tab er 180 mg</i>	1	
RUZURGI TAB 10MG	3	PA, QL (300 TABLETS PER 30 DAYS)

**ANTIMYCOBACTERIAL AGENTS****ANTIMYCOBACTERIAL AGENTS**

<i>cycloserine cap 250 mg</i>	1	
<i>ethambutol hcl tab 100 mg</i>	1	
<i>ethambutol hcl tab 400 mg</i>	1	
<i>isoniazid syrup 50 mg/5ml</i>	1	
<i>isoniazid tab 100 mg</i>	1	
<i>isoniazid tab 300 mg</i>	1	
MYAMBUTOL TAB 400MG	2	
MYCOBUTIN CAP 150MG	3	
PASER GRA 4GM	3	
PRETOMANID TAB 200MG	3	
PRIFTIN TAB 150MG	3	
<i>pyrazinamide tab 500 mg</i>	1	
<i>rifabutin cap 150 mg</i>	1	
<i>rifampin cap 150 mg</i>	1	
<i>rifampin cap 300 mg</i>	1	
SIRTURO TAB 20MG	3	
SIRTURO TAB 100MG	3	
TRECTOR TAB 250MG	3	

**ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES****ALKYLATING AGENTS**

ALKERAN TAB 2MG	0	
CYCLOPHOSPH TAB 25MG	0	
CYCLOPHOSPH TAB 50MG	0	
<i>cyclophosphamide cap 25 mg</i>	0	
<i>cyclophosphamide cap 50 mg</i>	0	
GLEOSTINE CAP 10MG	0	
GLEOSTINE CAP 40MG	0	

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

82

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GLEOSTINE CAP 100MG	0	
LEUKERAN TAB 2MG	0	
<i>melfalan tab 2 mg</i>	0	
MYLERAN TAB 2MG	0	
TEMODAR CAP 100MG	0	PA
TEMODAR CAP 140MG	0	PA
TEMODAR CAP 180MG	0	PA
TEMODAR CAP 250MG	0	PA
<i>temozolomide cap 5 mg</i>	0	PA
<i>temozolomide cap 20 mg</i>	0	PA
<i>temozolomide cap 100 mg</i>	0	PA
<i>temozolomide cap 140 mg</i>	0	PA
<i>temozolomide cap 180 mg</i>	0	PA
<i>temozolomide cap 250 mg</i>	0	PA
<b>ANTIMETABOLITES</b>		
<i>azacitidine for inj 100 mg</i>	1	PA
<i>capecitabine tab 150 mg</i>	0	PA
<i>capecitabine tab 500 mg</i>	0	PA
<i>mercaptopurine tab 50 mg</i>	0	
<i>methotrexate sodium for inj 1 gm</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 50 mg/2ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj 250 mg/10ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 50 mg/2ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 250 mg/10ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium inj pf 1000 mg/40ml (25 mg/ml)</i>	1	\$0 copay based on your plan/benefit
<i>methotrexate sodium tab 2.5 mg (base equiv)</i>	0	\$0 copay based on your plan/benefit
ONUREG TAB 200MG	0	PA, QL (14 TABLETS PER 28 DAYS)

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

83

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 tabs every 30 days)
XELODA TAB 500MG	0	PA, QL (300 tabs every 30 days)
<b>ANTINEOPLASTIC - ANGIOGENESIS INHIBITORS</b>		
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)

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

84

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTINEOPLASTIC - ANTI-HER2 AGENTS</b>		
TUKYSA TAB 50MG	0	PA, QL (120 TABLETS PER 30 DAYS)
TUKYSA TAB 150MG	0	PA, QL (120 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTIC - BCL-2 INHIBITORS</b>		
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)
<b>ANTINEOPLASTIC - EGFR INHIBITORS</b>		
<i>erlotinib hcl tab 25 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 100 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>erlotinib hcl tab 150 mg (base equivalent)</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
GILOTRIF TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IRESSA TAB 250MG	0	PA, QL (30 TABLETS PER 30 DAYS)
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)

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

85

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TARCEVA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
TARCEVA TAB 150MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS</b>		
ERIVEDGE CAP 150MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
ODOMZO CAP 200MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
<b>ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS</b>		
<i>abiraterone acetate tab 250 mg</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>abiraterone acetate tab 500 mg</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
<i>anastrozole tab 1 mg</i>	0	
ARIMIDEX TAB 1MG	0	
AROMASIN TAB 25MG	0	
<i>bicalutamide tab 50 mg</i>	0	
CASODEX TAB 50MG	0	
EMCYT CAP 140MG	0	
ERLEADA TAB 60MG	0	PA, QL (120 TABLETS PER 30 DAYS)
ERLEADA TAB 240MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>exemestane tab 25 mg</i>	0	
FARESTON TAB 60MG	0	
FEMARA TAB 2.5MG	0	
<i>flutamide cap 125 mg</i>	0	
<i>letrozole tab 2.5 mg</i>	0	
<i>leuprolide acetate inj kit 1 mg/0.2ml (5 mg/ml)</i>	1	PA
LUPRON DEPOT INJ 3.75MG	3	PA
LUPRON DEPOT INJ 11.25MG	3	PA
LYSODREN TAB 500MG	0	
<i>megestrol acetate susp 40 mg/ml</i>	0	
<i>megestrol acetate tab 20 mg</i>	0	

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

86

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



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

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

87

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTINEOPLASTIC - XPO1 INHIBITORS</b>		
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
<b>ANTINEOPLASTIC COMBINATIONS</b>		
INQOVI TAB 35-100MG	0	PA, QL (5 TABLETS PER 28 DAYS)
KISQALI 200 PAK FEMARA	0	PA, QL (49 TABLETS PER 28 DAYS)
KISQALI 400 PAK FEMARA	0	PA, QL (70 TABLETS PER 28 DAYS)
KISQALI 600 PAK FEMARA	0	PA, QL (91 TABLETS PER 28 DAYS)
LONSURF TAB 15-6.14	0	PA, QL (100 TABLETS 28 DAYS)
LONSURF TAB 20-8.19	0	PA, QL (80 TABLETS 28 DAYS)

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

88

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTINEOPLASTIC ENZYME INHIBITORS</b>		
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)
BRUKINSA CAP 80MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
CABOMETYX TAB 20MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 40MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CABOMETYX TAB 60MG	0	PA, QL (30 TABLETS PER 30 DAYS)
CALQUENCE CAP 100MG	0	PA, QL (60 caps every 30 days)

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

89

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
<i>everolimus tab 2.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>everolimus tab 7.5 mg</i>	0	PA, QL (30 TABLETS PER 30 DAYS)
GAVRETO CAP 100MG	0	PA, QL (120 CAPSULES 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)

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

90

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ICLUSIG TAB 30MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IDHIFA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 100 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
<i>imatinib mesylate tab 400 mg (base equivalent)</i>	0	PA, QL (60 TABLETS PER 30 DAYS)
IMBRUVICA CAP 70MG	0	PA, QL (30 CAPSULES PER 30 DAYS)
IMBRUVICA CAP 140MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
IMBRUVICA SUS 70MG/ML	0	PA, QL (216 ML PER 36 DAYS)
IMBRUVICA TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 280MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 420MG	0	PA, QL (30 TABLETS PER 30 DAYS)
IMBRUVICA TAB 560MG	0	PA, QL (30 TABLETS PER 30 DAYS)
JAKAFI TAB 5MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 10MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 15MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 20MG	0	PA, QL (60 TABLETS PER 30 DAYS)
JAKAFI TAB 25MG	0	PA, QL (60 TABLETS PER 30 DAYS)
KISQALI TAB 200DOSE	0	PA, QL (21 TABLETS PER 28 DAYS)

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

91

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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)
KRAZATI TAB 200MG	0	PA, QL (180 TABLETS PER 30 DAYS)
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>	0	PA, QL (180 TABLETS PER 30 DAYS)
LORBRENA TAB 25MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LORBRENA TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
LUMAKRAS TAB 120MG	0	PA, QL (240 TABS PER 30 DAYS)
LUMAKRAS TAB 320MG	0	PA, QL (90 TABLETS PER 30 DAYS)
LYNPARZA TAB 100MG	0	PA, QL (120 TABLETS PER 30 DAYS)
LYNPARZA TAB 150MG	0	PA, QL (120 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)

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

92

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PIQRAY 200MG TAB DOSE	0	PA, QL (28 TABLETS PER 28 DAYS)
PIQRAY 250MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
PIQRAY 300MG TAB DOSE	0	PA, QL (56 TABLETS PER 28 DAYS)
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)
RYDAPT CAP 25MG	0	PA, QL (224 CAPSULES PER 28 DAYS)
<i>sorafenib tosylate tab 200 mg (base equivalent)</i>	0	PA, QL (120 TABLETS PER 30 DAYS)
SPRYCEL TAB 20MG	0	PA, QL (90 TABLETS PER 30 DAYS)
SPRYCEL TAB 50MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 70MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 80MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 100MG	0	PA, QL (30 TABLETS PER 30 DAYS)
SPRYCEL TAB 140MG	0	PA, QL (30 TABLETS PER 30 DAYS)
STIVARGA TAB 40MG	0	PA, QL (84 TABLETS PER 28 DAYS)
<i>sunitinib malate cap 12.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 25 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)

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

93

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sunitinib malate cap 37.5 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
<i>sunitinib malate cap 50 mg (base equivalent)</i>	0	PA, QL (30 CAPSULES PER 30 DAYS)
TIBSOVO TAB 250MG	0	PA, QL (60 TABLETS PER 30 DAYS)
TYKERB TAB 250MG	0	PA, QL (180 TABLETS PER 30 DAYS)
VERZENIO TAB 50MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 100MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 150MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VERZENIO TAB 200MG	0	PA, QL (56 TABLETS PER 28 DAYS)
VITRAKVI CAP 25MG	0	PA, QL (180 CAPSULES PER 30 DAYS)
VITRAKVI CAP 100MG	0	PA, QL (60 CAPSULES PER 30 DAYS)
VITRAKVI SOL 20MG/ML	0	PA, QL (300 ML PER 30 DAYS)
VONJO CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
XOSPATA TAB 40MG	0	PA, QL (90 TABLETS PER 30 DAYS)
ZEJULA CAP 100MG	0	PA, QL (90 CAPSULES PER 30 DAYS)
ZEJULA TAB 100MG	0	PA, QL (30 TABS PER 30 DAYS)
ZEJULA TAB 200MG	0	PA, QL (30 TABS PER 30 DAYS)
ZEJULA TAB 300MG	0	PA, QL (30 TABS PER 30 DAYS)
ZELBORAF TAB 240MG	0	PA, QL (240 TABLETS PER 30 DAYS)

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

94

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZOLINZA CAP 100MG	0	PA, QL (120 CAPSULES PER 30 DAYS)
ZYDELIG TAB 100MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYDELIG TAB 150MG	0	PA, QL (60 TABLETS PER 30 DAYS)
ZYKADIA TAB 150MG	0	PA, QL (90 TABLETS PER 30 DAYS)
<b>ANTINEOPLASTICS MISC.</b>		
ACTIMMUNE INJ 2MU/0.5	3	PA
BESREMI SOL 500MCG	3	PA, QL (2 PFS PER 28 DAYS)
<i>bexarotene cap 75 mg</i>	0	PA
HYDREA CAP 500MG	0	
<i>hydroxyurea cap 500 mg</i>	0	
INTRON A INJ 10MU	3	PA
INTRON A INJ 18MU	3	PA
INTRON A INJ 25MU	3	PA
INTRON A INJ 50MU	3	PA
MATULANE CAP 50MG	0	
<i>tretinoin cap 10 mg</i>	0	
<b>CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS</b>		
<i>leucovorin calcium tab 5 mg</i>	0	
<i>leucovorin calcium tab 10 mg</i>	0	
<i>leucovorin calcium tab 15 mg</i>	0	
<i>leucovorin calcium tab 25 mg</i>	0	
MESNEX TAB 400MG	0	
<b>MITOTIC INHIBITORS</b>		
<i>etoposide cap 50 mg</i>	0	
<b>TOPOISOMERASE I INHIBITORS</b>		
HYCAMTIN CAP 0.25MG	0	PA
HYCAMTIN CAP 1MG	0	PA
<b>ANTIPARKINSON AND RELATED THERAPY AGENTS</b>		
<b>ANTIPARKINSON ADJUNCTIVE THERAPY</b>		
<i>carbidopa tab 25 mg</i>	1	

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

95

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

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

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

96

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carbidopa-levodopa-entacapone tabs 18.75-75-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 25-100-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 31.25-125-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 37.5-150-200 mg</i>	1	
<i>carbidopa-levodopa-entacapone tabs 50-200-200 mg</i>	1	
INBRIJA CAP 42MG	2	PA, QL (300 CAPSULES PER 30 DAYS)
MIRAPEX ER TAB 0.75MG	3	
MIRAPEX ER TAB 0.375MG	3	
MIRAPEX ER TAB 1.5MG	3	
MIRAPEX ER TAB 2.25MG	3	
MIRAPEX ER TAB 3.75MG	3	
MIRAPEX ER TAB 3MG	3	
MIRAPEX ER TAB 4.5MG	3	
MIRAPEX TAB 0.5MG	3	
MIRAPEX TAB 0.75MG	3	
MIRAPEX TAB 0.125MG	3	
MIRAPEX TAB 1MG	3	
NEUPRO DIS 1MG/24HR	2	
NEUPRO DIS 2MG/24HR	2	
NEUPRO DIS 3MG/24HR	2	
NEUPRO DIS 4MG/24HR	2	
NEUPRO DIS 6MG/24HR	2	
NEUPRO DIS 8MG/24HR	2	
PARLODEL CAP 5MG	3	
PARLODEL TAB 2.5MG	3	
<i>pramipexole dihydrochloride tab 0.5 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.25 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab 0.125 mg</i>	1	

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

97

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pramipexole dihydrochloride tab 1 mg</i>	1	
<i>pramipexole dihydrochloride tab 1.5 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 0.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 0.375 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 1.5 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 2.25 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 3 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 3.75 mg</i>	1	
<i>pramipexole dihydrochloride tab er 24hr 4.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.5 mg</i>	1	
<i>ropinirole hydrochloride tab 0.25 mg</i>	1	
<i>ropinirole hydrochloride tab 1 mg</i>	1	
<i>ropinirole hydrochloride tab 2 mg</i>	1	
<i>ropinirole hydrochloride tab 3 mg</i>	1	
<i>ropinirole hydrochloride tab 4 mg</i>	1	
<i>ropinirole hydrochloride tab 5 mg</i>	1	
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i>	1	
<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i>	1	
<b>RYTARY CAP 95MG</b>	2	
<b>RYTARY CAP 145MG</b>	2	
<b>RYTARY CAP 195MG</b>	2	
<b>RYTARY CAP 245MG</b>	2	
<b>SINEMET TAB 10-100MG</b>	3	
<b>SINEMET TAB 25-100MG</b>	3	

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

98

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
STALEVO 50 TAB	3	
STALEVO 75 TAB	3	
STALEVO 100 TAB	3	
STALEVO 125 TAB	3	
STALEVO 150 TAB	3	
STALEVO 200 TAB	3	
<b>ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS</b>		
AZILECT TAB 0.5MG	3	
AZILECT TAB 1MG	3	
<i>rasagiline mesylate tab 0.5 mg (base equiv)</i>	1	
<i>rasagiline mesylate tab 1 mg (base equiv)</i>	1	
<i>selegiline hcl cap 5 mg</i>	1	
<i>selegiline hcl tab 5 mg</i>	1	
ZELAPAR TAB 1.25MG	3	
<b>ANTIPSYCHOTICS/ANTIMANIC AGENTS</b>		
<b>ANTIMANIC AGENTS</b>		
<i>lithium carbonate cap 150 mg</i>	1	
<i>lithium carbonate cap 300 mg</i>	1	
<i>lithium carbonate cap 600 mg</i>	1	
<i>lithium carbonate tab 300 mg</i>	1	
<i>lithium carbonate tab er 300 mg</i>	1	
<i>lithium carbonate tab er 450 mg</i>	1	
LITHIUM SOL 8MEQ/5ML	3	
LITHOBID TAB 300MG CR	2	
<b>ANTIPSYCHOTICS - MISC.</b>		
CAPLYTA CAP 10.5MG	3	
CAPLYTA CAP 21MG	3	
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	

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

99

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GEODON INJ 20MG	3	
<i>lurasidone hcl tab 20 mg</i>	1	
<i>lurasidone hcl tab 40 mg</i>	1	
<i>lurasidone hcl tab 60 mg</i>	1	
<i>lurasidone hcl tab 80 mg</i>	1	
<i>lurasidone hcl tab 120 mg</i>	1	
NUPLAZID CAP 34MG	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	
<i>ziprasidone hcl cap 20 mg</i>	1	
<i>ziprasidone hcl cap 40 mg</i>	1	
<i>ziprasidone hcl cap 60 mg</i>	1	
<i>ziprasidone hcl cap 80 mg</i>	1	
<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i>	1	
<b>BENZISOXAZOLES</b>		
INVEGA SUST INJ 39/0.25	3	
INVEGA SUST INJ 78/0.5ML	3	
INVEGA SUST INJ 117/0.75	3	
INVEGA SUST INJ 156MG/ML	3	
INVEGA SUST INJ 234/1.5	3	
INVEGA TAB 1.5MG	3	
INVEGA TAB 3MG	3	
INVEGA TAB 6MG	3	
INVEGA TAB 9MG	3	
<i>paliperidone tab er 24hr 1.5 mg</i>	1	
<i>paliperidone tab er 24hr 3 mg</i>	1	
<i>paliperidone tab er 24hr 6 mg</i>	1	
<i>paliperidone tab er 24hr 9 mg</i>	1	

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

100

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PERSERIS INJ 90MG	2	
PERSERIS INJ 120MG	2	
RISPERDAL INJ 12.5MG	3	
RISPERDAL INJ 25MG	3	
RISPERDAL INJ 37.5MG	3	
RISPERDAL INJ 50MG	3	
RISPERDAL SOL 1MG/ML	3	
RISPERDAL TAB 0.5MG	3	
RISPERDAL TAB 1MG	3	
RISPERDAL TAB 2MG	3	
RISPERDAL TAB 3MG	3	
RISPERDAL TAB 4MG	3	
<i>risperidone orally disintegrating tab 0.5 mg</i>	1	
<i>risperidone orally disintegrating tab 0.25 mg</i>	1	
<i>risperidone orally disintegrating tab 1 mg</i>	1	
<i>risperidone orally disintegrating tab 2 mg</i>	1	
<i>risperidone orally disintegrating tab 3 mg</i>	1	
<i>risperidone orally disintegrating tab 4 mg</i>	1	
<i>risperidone soln 1 mg/ml</i>	1	
<i>risperidone tab 0.5 mg</i>	1	
<i>risperidone tab 0.25 mg</i>	1	
<i>risperidone tab 1 mg</i>	1	
<i>risperidone tab 2 mg</i>	1	
<i>risperidone tab 3 mg</i>	1	
<i>risperidone tab 4 mg</i>	1	
<b>BUTYROPHENONES</b>		
HALDOL DECAN INJ 50MG/ML	3	
HALDOL DECAN INJ 100MG/ML	3	
HALDOL INJ 5MG/ML	3	
<i>haloperidol decanoate im soln 50 mg/ml</i>	1	
<i>haloperidol decanoate im soln 100 mg/ml</i>	1	
<i>haloperidol lactate inj 5 mg/ml</i>	1	
<i>haloperidol lactate oral conc 2 mg/ml</i>	1	
<i>haloperidol tab 0.5 mg</i>	1	
<i>haloperidol tab 1 mg</i>	1	

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

101

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>haloperidol tab 2 mg</i>	1	
<i>haloperidol tab 5 mg</i>	1	
<i>haloperidol tab 10 mg</i>	1	
<i>haloperidol tab 20 mg</i>	1	
<b>DIBENZAPINES</b>		
ADASUVE INH 10MG	3	
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	1	
<i>asenapine maleate sl tab 10 mg (base equiv)</i>	1	
<i>clozapine orally disintegrating tab 12.5 mg</i>	1	
<i>clozapine orally disintegrating tab 25 mg</i>	1	
<i>clozapine orally disintegrating tab 100 mg</i>	1	
<i>clozapine orally disintegrating tab 150 mg</i>	1	
<i>clozapine orally disintegrating tab 200 mg</i>	1	
<i>clozapine tab 25 mg</i>	1	
<i>clozapine tab 50 mg</i>	1	
<i>clozapine tab 100 mg</i>	1	
<i>clozapine tab 200 mg</i>	1	
CLOZARIL TAB 25MG	3	
CLOZARIL TAB 50MG	3	
CLOZARIL TAB 100MG	3	
CLOZARIL TAB 200MG	3	
<i>loxapine succinate cap 5 mg</i>	1	
<i>loxapine succinate cap 10 mg</i>	1	
<i>loxapine succinate cap 25 mg</i>	1	
<i>loxapine succinate cap 50 mg</i>	1	
<i>olanzapine for im inj 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 5 mg</i>	1	
<i>olanzapine orally disintegrating tab 10 mg</i>	1	
<i>olanzapine orally disintegrating tab 15 mg</i>	1	
<i>olanzapine orally disintegrating tab 20 mg</i>	1	
<i>olanzapine tab 2.5 mg</i>	1	
<i>olanzapine tab 5 mg</i>	1	
<i>olanzapine tab 7.5 mg</i>	1	
<i>olanzapine tab 10 mg</i>	1	

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

102

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



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

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

103

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZYPREXA ZYDI TAB 15MG	3	
ZYPREXA ZYDI TAB 20MG	3	
<b>DIHYDROINDOLONES</b>		
<i>molindone hcl tab 5 mg</i>	1	
<i>molindone hcl tab 10 mg</i>	1	
<i>molindone hcl tab 25 mg</i>	1	
<b>PHENOTHIAZINES</b>		
<i>chlorpromazine hcl inj 25 mg/ml</i>	1	
<i>chlorpromazine hcl inj 50 mg/2ml</i>	1	
<i>chlorpromazine hcl tab 10 mg</i>	1	
<i>chlorpromazine hcl tab 25 mg</i>	1	
<i>chlorpromazine hcl tab 50 mg</i>	1	
<i>chlorpromazine hcl tab 100 mg</i>	1	
<i>chlorpromazine hcl tab 200 mg</i>	1	
<i>fluphenazine decanoate inj 25 mg/ml</i>	1	
<i>fluphenazine hcl elixir 2.5 mg/5ml</i>	1	
<i>fluphenazine hcl inj 2.5 mg/ml</i>	1	
<i>fluphenazine hcl oral conc 5 mg/ml</i>	1	
<i>fluphenazine hcl tab 1 mg</i>	1	
<i>fluphenazine hcl tab 2.5 mg</i>	1	
<i>fluphenazine hcl tab 5 mg</i>	1	
<i>fluphenazine hcl tab 10 mg</i>	1	
<i>perphenazine tab 2 mg</i>	1	
<i>perphenazine tab 4 mg</i>	1	
<i>perphenazine tab 8 mg</i>	1	
<i>perphenazine tab 16 mg</i>	1	
<i>prochlorperazine edisylate inj 10 mg/2ml</i>	1	
<i>prochlorperazine edisylate inj 50 mg/10ml</i>	1	
<i>prochlorperazine maleate tab 5 mg (base equivalent)</i>	1	
<i>prochlorperazine maleate tab 10 mg (base equivalent)</i>	1	
<i>prochlorperazine suppos 25 mg</i>	1	
<i>thioridazine hcl tab 10 mg</i>	1	
<i>thioridazine hcl tab 25 mg</i>	1	

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

104

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>thioridazine hcl tab 50 mg</i>	1	
<i>thioridazine hcl tab 100 mg</i>	1	
<i>trifluoperazine hcl tab 1 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 2 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 5 mg (base equivalent)</i>	1	
<i>trifluoperazine hcl tab 10 mg (base equivalent)</i>	1	
<b>QUINOLINONE DERIVATIVES</b>		
ABILIFY MAIN INJ 300MG	2	
ABILIFY MAIN INJ 400MG	2	
<i>aripiprazole oral solution 1 mg/ml</i>	1	
<i>aripiprazole orally disintegrating tab 10 mg</i>	1	
<i>aripiprazole orally disintegrating tab 15 mg</i>	1	
<i>aripiprazole tab 2 mg</i>	1	
<i>aripiprazole tab 5 mg</i>	1	
<i>aripiprazole tab 10 mg</i>	1	
<i>aripiprazole tab 15 mg</i>	1	
<i>aripiprazole tab 20 mg</i>	1	
<i>aripiprazole tab 30 mg</i>	1	
ARISTADA INJ 441MG/1.	3	
ARISTADA INJ 662MG/2	3	
ARISTADA INJ 882MG/3	3	
ARISTADA INJ 1064MG	3	QL (23.077 injections every year)
ARISTADA INJ INITIO	3	
REXULTI TAB 0.5MG	3	
REXULTI TAB 0.25MG	3	
REXULTI TAB 1MG	3	
REXULTI TAB 2MG	3	
REXULTI TAB 3MG	3	
REXULTI TAB 4MG	3	
<b>THIOXANTHENES</b>		
<i>thiothixene cap 1 mg</i>	1	
<i>thiothixene cap 2 mg</i>	1	
<i>thiothixene cap 5 mg</i>	1	
<i>thiothixene cap 10 mg</i>	1	

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

105

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTISEPTICS &amp; DISINFECTANTS</b>		
<b>ANTISEPTICS &amp; DISINFECTANTS</b>		
<i>formaldehyde solution 10%</i>	1	
GLUTARALDEHY SOL 25%	3	
<i>hydrogen peroxide soln 30%</i>	1	
<b>CHLORINE ANTISEPTICS</b>		
BENZALKONIUM SOL NF	3	
CHLORHEX GLU SOL 20%	3	
<b>ANTIVIRALS</b>		
<b>ANTIRETROVIRALS</b>		
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i>	1	QL (900 ML PER 30 DAYS)
<i>abacavir sulfate tab 300 mg (base equiv)</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine tab 600-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>atazanavir sulfate cap 150 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 200 mg (base equiv)</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>atazanavir sulfate cap 300 mg (base equiv)</i>	1	QL (30 CAPSULES PER 30 DAYS)
BIKTARVY TAB	2	QL (30 TABLETS PER 30 DAYS)
CIMDUO TAB 300-300	2	QL (30 TABLETS PER 30 DAYS)
COMBIVIR TAB 150-300	3	QL (60 TABLETS PER 30 DAYS)
CRIXIVAN CAP 400MG	3	QL (180 CAPSULES PER 30 DAYS)

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

106

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DESCOVY TAB 120-15MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis
DESCOVY TAB 200/25MG	2	PA, QL (30 TABLETS PER 30 DAYS); Exception process available for \$0 copay when medically necessary for pre-exposure prophylaxis
DOVATO TAB 50-300MG	2	QL (30 TABLETS PER 30 DAYS)
EDURANT TAB 25MG	2	QL (60 TABLETS PER 30 DAYS)
<i>efavirenz cap 50 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz cap 200 mg</i>	1	QL (90 CAPSULES PER 30 DAYS)
<i>efavirenz tab 600 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-emtricitabine-tenofovir df tab 600-200-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 400-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>efavirenz-lamivudine-tenofovir df tab 600-300-300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine caps 200 mg</i>	1	QL (30 CAPSULES PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 100-150 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 133-200 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>emtricitabine-tenofovir disoproxil fumarate tab 167-250 mg</i>	1	QL (30 TABLETS PER 30 DAYS)

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

107

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>emtricitabine-tenofovir disoproxil fumarate tab 200-300 mg</i>	0	QL (30 TABLETS PER 30 DAYS); \$0 copay for pre exposure prophylaxis
EMTRIVA CAP 200MG	2	QL (30 CAPSULES PER 30 DAYS)
EMTRIVA SOL 10MG/ML	2	QL (680 ML PER 28 DAYS)
EPIVIR SOL 10MG/ML	3	QL (960 ML PER 30 DAYS)
EPIVIR TAB 150MG	3	QL (60 TABLETS PER 30 DAYS)
EPIVIR TAB 300MG	3	QL (30 TABLETS PER 30 DAYS)
EPZICOM TAB 600-300	3	QL (30 TABLETS PER 30 DAYS)
<i>etravirine tab 100 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>etravirine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
EVOTAZ TAB 300-150	2	QL (30 TABLETS PER 30 DAYS)
<i>fosamprenavir calcium tab 700 mg (base equiv)</i>	1	QL (120 TABLETS PER 30 DAYS)
FUZEON INJ 90MG	2	PA, QL (60 VIALS PER 30 DAYS)
GENVOYA TAB	2	QL (30 TABLETS PER 30 DAYS)
INTELENCE TAB 25MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 100MG	2	QL (120 TABLETS PER 30 DAYS)
INTELENCE TAB 200MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS CHW 25MG	2	QL (180 TABLETS PER 30 DAYS)
ISENTRESS CHW 100MG	2	QL (180 TABLETS PER 30 DAYS)

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

108

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ISENTRESS HD TAB 600MG	2	QL (60 TABLETS PER 30 DAYS)
ISENTRESS POW 100MG	2	QL (60 PACKETS PER 30 DAYS)
ISENTRESS TAB 400MG	2	QL (120 TABLETS PER 30 DAYS)
JULUCA TAB 50-25MG	3	QL (30 TABLETS PER 30 DAYS)
KALETRA SOL	3	QL (480 ML PER 30 DAYS)
KALETRA TAB 100-25MG	3	QL (240 TABLETS PER 30 DAYS)
KALETRA TAB 200-50MG	3	QL (120 TABLETS PER 30 DAYS)
<i>lamivudine oral soln 10 mg/ml</i>	1	QL (960 ML PER 30 DAYS)
<i>lamivudine tab 150 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lamivudine tab 300 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
<i>lamivudine-zidovudine tab 150-300 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir soln 400-100 mg/5ml (80-20 mg/ml)</i>	1	QL (480 ML PER 30 DAYS)
<i>lopinavir-ritonavir tab 100-25 mg</i>	1	QL (240 TABLETS PER 30 DAYS)
<i>lopinavir-ritonavir tab 200-50 mg</i>	1	QL (120 TABLETS PER 30 DAYS)
<i>nevirapine susp 50 mg/5ml</i>	1	QL (1200 ML PER 30 ML DAYS)
<i>nevirapine tab 200 mg</i>	1	QL (60 TABLETS PER 30 DAYS)
<i>nevirapine tab er 24hr 100 mg</i>	1	QL (90 TABLETS PER 30 DAYS)
<i>nevirapine tab er 24hr 400 mg</i>	1	QL (30 TABLETS PER 30 DAYS)
NORVIR POW 100MG	2	QL (360 PACKETS PER 30 DAYS)

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

109

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NORVIR SOL 80MG/ML	2	QL (480 ML PER 30 DAYS)
NORVIR TAB 100MG	2	QL (360 TABLETS PER 30 DAYS)
ODEFSEY TAB	2	QL (30 TABLETS PER 30 DAYS)
PREZCOBIX TAB 800-150	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA SUS 100MG/ML	2	QL (400 ML PER 30 DAYS)
PREZISTA TAB 75MG	2	QL (300 TABLETS PER 30 DAYS)
PREZISTA TAB 150MG	2	QL (180 TABLETS PER 30 DAYS)
PREZISTA TAB 600MG	2	QL (30 TABLETS PER 30 DAYS)
PREZISTA TAB 800MG	2	QL (60 TABLETS PER 30 DAYS)
RETROVIR CAP 100MG	3	QL (180 CAPSULES PER 30 DAYS)
RETROVIR SYP 50MG/5ML	3	QL (1920 ML PER 30 DAYS)
REYATAZ CAP 150MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ CAP 200MG	3	QL (60 CAPSULES PER 30 DAYS)
REYATAZ CAP 300MG	3	QL (30 CAPSULES PER 30 DAYS)
REYATAZ POW 50MG	3	QL (180 PACKETS PER 30 DAYS)
<i>ritonavir tab 100 mg</i>	1	QL (360 TABLETS PER 30 DAYS)
RUKOBIA TAB 600MG ER	3	PA, QL (60 TABLETS PER 30 DAYS)
<i>stavudine cap 15 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)
<i>stavudine cap 20 mg</i>	1	QL (60 CAPSULES PER 30 DAYS)

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

110

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



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

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

111

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

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

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

112

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

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

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

113

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SOVALDI PAK 150MG	3	PA, QL (28 PELLETS PER 28 DAYS)
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)
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)

**HERPES AGENTS**

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

**INFLUENZA AGENTS**

<i>oseltamivir phosphate cap 30 mg (base equiv)</i>	1	QL (28 caps every 90 days)
<i>oseltamivir phosphate cap 45 mg (base equiv)</i>	1	QL (14 caps every 90 days)
<i>oseltamivir phosphate cap 75 mg (base equiv)</i>	1	QL (14 caps every 90 days)

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

114

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oseltamivir phosphate for susp 6 mg/ml (base equiv)</i>	1	QL (180 mL every 90 days)
RELENZA MIS DISKHALE	2	QL (2 inhalers every 90 days)
<i>rimantadine hydrochloride tab 100 mg</i>	1	
TAMIFLU CAP 30MG	3	QL (28 caps every 90 days)
TAMIFLU CAP 45MG	3	QL (14 caps every 90 days)
TAMIFLU CAP 75MG	3	QL (14 caps every 90 days)
TAMIFLU SUS 6MG/ML	3	QL (180 mL every 90 days)
<b>MISC. ANTIVIRALS</b>		
FAVIPIRAVIR TAB 200MG	3	
LAGEVRIO CAP 200MG	3	QL (40 caps every 30 days)
TEMBEXA SUS 10MG/ML	3	
TEMBEXA TAB 100MG	3	
TPOXX CAP 200MG	3	
TPOXX INJ	3	
<b>BETA BLOCKERS</b>		
<b>ALPHA-BETA BLOCKERS</b>		
<i>carvedilol phosphate cap er 24hr 10 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 20 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 40 mg</i>	1	
<i>carvedilol phosphate cap er 24hr 80 mg</i>	1	
<i>carvedilol tab 3.125 mg</i>	1	
<i>carvedilol tab 6.25 mg</i>	1	
<i>carvedilol tab 12.5 mg</i>	1	
<i>carvedilol tab 25 mg</i>	1	
COREG TAB 3.125MG	3	
COREG TAB 6.25MG	3	
COREG TAB 12.5MG	3	
COREG TAB 25MG	3	
<i>labetalol hcl tab 100 mg</i>	1	
<i>labetalol hcl tab 200 mg</i>	1	
<i>labetalol hcl tab 300 mg</i>	1	

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

115

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>BETA BLOCKERS CARDIO-SELECTIVE</b>		
<i>acebutolol hcl cap 200 mg</i>	1	
<i>acebutolol hcl cap 400 mg</i>	1	
<i>atenolol tab 25 mg</i>	1	
<i>atenolol tab 50 mg</i>	1	
<i>atenolol tab 100 mg</i>	1	
<i>betaxolol hcl tab 10 mg</i>	1	
<i>betaxolol hcl tab 20 mg</i>	1	
<i>bisoprolol fumarate tab 5 mg</i>	1	
<i>bisoprolol fumarate tab 10 mg</i>	1	
LOPRESSOR TAB 50MG	3	
LOPRESSOR TAB 100MG	3	
<i>metoprolol succinate tab er 24hr 25 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 50 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 100 mg (tartrate equiv)</i>	1	
<i>metoprolol succinate tab er 24hr 200 mg (tartrate equiv)</i>	1	
<i>metoprolol tartrate tab 25 mg</i>	1	
<i>metoprolol tartrate tab 37.5 mg</i>	1	
<i>metoprolol tartrate tab 50 mg</i>	1	
<i>metoprolol tartrate tab 75 mg</i>	1	
<i>metoprolol tartrate tab 100 mg</i>	1	
<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 5 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 10 mg (base equivalent)</i>	1	
<i>nebivolol hcl tab 20 mg (base equivalent)</i>	1	
TENORMIN TAB 25MG	3	
TENORMIN TAB 50MG	3	
TENORMIN TAB 100MG	3	
<b>BETA BLOCKERS NON-SELECTIVE</b>		
CORGARD TAB 20MG	3	
CORGARD TAB 40MG	3	

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

116

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CORGARD TAB 80MG	3	
HEMANGEOL SOL 4.28/ML	3	
<i>nadolol tab 20 mg</i>	1	
<i>nadolol tab 40 mg</i>	1	
<i>nadolol tab 80 mg</i>	1	
<i>pindolol tab 5 mg</i>	1	
<i>pindolol tab 10 mg</i>	1	
<i>propranolol hcl cap er 24hr 60 mg</i>	1	
<i>propranolol hcl cap er 24hr 80 mg</i>	1	
<i>propranolol hcl cap er 24hr 120 mg</i>	1	
<i>propranolol hcl cap er 24hr 160 mg</i>	1	
<i>propranolol hcl oral soln 20 mg/5ml</i>	1	
<i>propranolol hcl oral soln 40 mg/5ml</i>	1	
<i>propranolol hcl tab 10 mg</i>	1	
<i>propranolol hcl tab 20 mg</i>	1	
<i>propranolol hcl tab 40 mg</i>	1	
<i>propranolol hcl tab 60 mg</i>	1	
<i>propranolol hcl tab 80 mg</i>	1	
<i>sotalol hcl (afib/afI) tab 80 mg</i>	1	
<i>sotalol hcl (afib/afI) tab 120 mg</i>	1	
<i>sotalol hcl (afib/afI) tab 160 mg</i>	1	
<i>sotalol hcl tab 80 mg</i>	1	
<i>sotalol hcl tab 120 mg</i>	1	
<i>sotalol hcl tab 160 mg</i>	1	
<i>sotalol hcl tab 240 mg</i>	1	
SOTYLIZE SOL 5MG/ML	3	
<i>timolol maleate tab 5 mg</i>	1	
<i>timolol maleate tab 10 mg</i>	1	
<i>timolol maleate tab 20 mg</i>	1	

**CALCIUM CHANNEL BLOCKERS****CALCIUM CHANNEL BLOCKERS**

<i>amlodipine besylate tab 2.5 mg (base equivalent)</i>	1	
<i>amlodipine besylate tab 5 mg (base equivalent)</i>	1	

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

117

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

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

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

118

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>isradipine cap 2.5 mg</i>	1	
<i>isradipine cap 5 mg</i>	1	
<i>nicardipine hcl cap 20 mg</i>	1	
<i>nicardipine hcl cap 30 mg</i>	1	
<i>nifedipine cap 10 mg</i>	1	
<i>nifedipine cap 20 mg</i>	1	
<i>nifedipine tab er 24hr 30 mg</i>	1	
<i>nifedipine tab er 24hr 60 mg</i>	1	
<i>nifedipine tab er 24hr 90 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 30 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 60 mg</i>	1	
<i>nifedipine tab er 24hr osmotic release 90 mg</i>	1	
<i>nimodipine cap 30 mg</i>	1	
<i>nisoldipine tab er 24hr 8.5 mg</i>	1	
<i>nisoldipine tab er 24hr 17 mg</i>	1	
<i>nisoldipine tab er 24hr 20 mg</i>	1	
<i>nisoldipine tab er 24hr 25.5 mg</i>	1	
<i>nisoldipine tab er 24hr 30 mg</i>	1	
<i>nisoldipine tab er 24hr 34 mg</i>	1	
<i>nisoldipine tab er 24hr 40 mg</i>	1	
NYMALIZE SOL	3	
PROCARDIA CAP 10MG	3	
PROCARDIA XL TAB 30MG CR	3	
PROCARDIA XL TAB 60MG CR	3	
PROCARDIA XL TAB 90MG CR	3	
SULAR TAB 8.5MG	3	
SULAR TAB 17MG	3	
SULAR TAB 34MG	3	
TIAZAC CAP 120MG/24	3	
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	
<i>verapamil hcl cap er 24hr 100 mg</i>	1	

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

119

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>verapamil hcl cap er 24hr 120 mg</i>	1	
<i>verapamil hcl cap er 24hr 180 mg</i>	1	
<i>verapamil hcl cap er 24hr 200 mg</i>	1	
<i>verapamil hcl cap er 24hr 240 mg</i>	1	
<i>verapamil hcl cap er 24hr 300 mg</i>	1	
<i>verapamil hcl cap er 24hr 360 mg</i>	1	
<i>verapamil hcl tab 40 mg</i>	1	
<i>verapamil hcl tab 80 mg</i>	1	
<i>verapamil hcl tab 120 mg</i>	1	
<i>verapamil hcl tab er 120 mg</i>	1	
<i>verapamil hcl tab er 180 mg</i>	1	
<i>verapamil hcl tab er 240 mg</i>	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**

<i>digoxin oral soln 0.05 mg/ml</i>	1	
<i>digoxin tab 125 mcg (0.125 mg)</i>	1	
<i>digoxin tab 250 mcg (0.25 mg)</i>	1	
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)

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

120

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>CARDIOVASCULAR AGENTS MISC. - COMBINATIONS</b>		
<i>amlodipine besylate-atorvastatin calcium tab 2.5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 2.5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 5-80 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-10 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-20 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-40 mg</i>	1	
<i>amlodipine besylate-atorvastatin calcium tab 10-80 mg</i>	1	
BIDIL TAB	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	

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

121

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>IMPOTENCE AGENTS</b>		
CAVERJECT IM KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
CAVERJECT INJ 40MCG	3	QL (6 vials every 30 days); Coverage is subject to your plan/benefits
CAVERJECT KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 10MCG	3	QL (6 each every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 20MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
EDEX KIT 40MCG	3	QL (6 kits every 30 days); Coverage is subject to your plan/benefits
LEVITRA TAB 10MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
LEVITRA TAB 20MG	3	QL (6 tabs every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 125MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 250MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits
MUSE SUP 500MCG	2	QL (6 sup every 30 days); Coverage is subject to your plan/benefits

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

122

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

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

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

123

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

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

**PROSTAGLANDIN VASODILATORS**

ORENITRAM TAB 0.25MG	2	PA
ORENITRAM TAB 0.125MG	2	PA
ORENITRAM TAB 1MG	2	PA
ORENITRAM TAB 2.5MG	2	PA
ORENITRAM TAB 5MG	2	PA
ORENITRAM TAB MONTH 1	2	PA
ORENITRAM TAB MONTH 2	2	PA
ORENITRAM TAB MONTH 3	2	PA
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**

<i>ambrisentan tab 5 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<i>ambrisentan tab 10 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<i>bosentan tab 62.5 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>bosentan tab 125 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
OPSUMIT TAB 10MG	2	PA, QL (30 TABLETS PER 30 DAYS)

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

124

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS</b>		
<i>sildenafil citrate for suspension 10 mg/ml</i>	1	PA, QL (784 ML PER 30 DAYS)
<i>sildenafil citrate tab 20 mg</i>	1	PA, QL (360 TABLETS PER 30 DAYS)
<i>tadalafil tab 20 mg (pah)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
TADLIQ SUS 20MG/5ML	3	PA, QL (300 ML PER 30 DAYS)
<b>PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST</b>		
UPTRAVI PACK TAB 200/800	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)
<b>PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR</b>		
ADEMPAS TAB 0.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1.5MG	2	PA, QL (90 TABLETS PER 30 DAYS)
ADEMPAS TAB 1MG	2	PA, QL (90 TABLETS PER 30 DAYS)

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

125

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

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

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

126

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>cefaclor for susp 375 mg/5ml</i>	1	
<i>cefprozil for susp 125 mg/5ml</i>	1	
<i>cefprozil for susp 250 mg/5ml</i>	1	
<i>cefprozil tab 250 mg</i>	1	
<i>cefprozil tab 500 mg</i>	1	
<i>cefuroxime axetil tab 250 mg</i>	1	
<i>cefuroxime axetil tab 500 mg</i>	1	
<b>CEPHALOSPORINS - 3RD GENERATION</b>		
<i>cefdinir cap 300 mg</i>	1	
<i>cefdinir for susp 125 mg/5ml</i>	1	
<i>cefdinir for susp 250 mg/5ml</i>	1	
<i>cefixime cap 400 mg</i>	1	
<i>cefixime for susp 100 mg/5ml</i>	1	
<i>cefixime for susp 200 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 50 mg/5ml</i>	1	
<i>cefpodoxime proxetil for susp 100 mg/5ml</i>	1	
<i>cefpodoxime proxetil tab 100 mg</i>	1	
<i>cefpodoxime proxetil tab 200 mg</i>	1	
SUPRAX CAP 400MG	2	
SUPRAX CHW 100MG	2	
SUPRAX CHW 200MG	2	
SUPRAX SUS 100/5ML	2	
SUPRAX SUS 200/5ML	2	
SUPRAX SUS 500/5ML	2	
<b>CONTRACEPTIVES</b>		
<b>COMBINATION CONTRACEPTIVES - ORAL</b>		
<i>desogest-eth estrad &amp; eth estrad tab 0.15-0.02/0.01 mg(21/5)</i>	0	
<i>desogest-ethin est tab 0.1-0.025/0.125-0.025/0.15-0.025mg-mg</i>	0	
<i>desogestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.02-0.451 mg</i>	0	

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

127

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>drospirenone-ethinyl estrad-levomefolate tab 3-0.03-0.451 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.02 mg</i>	0	
<i>drospirenone-ethinyl estradiol tab 3-0.03 mg</i>	0	
ESTROSTEP FE TAB	0	
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</i>	0	
<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</i>	0	
GENERESS FE CHW	0	
<i>levonor-eth est tab 0.15-0.02/0.025/0.03 mg &amp; eth est 0.01 mg</i>	0	
<i>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth est tab 0.01mg(7)</i>	0	
<i>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth est tab 0.01mg(7)</i>	0	
<i>levonorgestrel &amp; ethinyl estradiol (91-day) tab 0.15-0.03 mg</i>	0	
<i>levonorgestrel &amp; ethinyl estradiol tab 0.1 mg-20 mcg</i>	0	
<i>levonorgestrel &amp; ethinyl estradiol tab 0.15 mg-30 mcg</i>	0	
<i>levonorgestrel-eth estra tab 0.05-30/0.075-40/0.125-30mg-mcg</i>	0	
<i>levonorgestrel-ethinyl estradiol (continuous) tab 90-20 mcg</i>	0	
LO LOESTRIN TAB 1-10-10	0	
MIRCETTE TAB 28 DAY	0	
NATAZIA TAB	0	
<i>norethindrone &amp; ethinyl estradiol tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol tab 0.5 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol tab 1 mg-35 mcg</i>	0	

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

128

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>norethindrone &amp; ethinyl estradiol-fe chew tab 0.4 mg-35 mcg</i>	0	
<i>norethindrone &amp; ethinyl estradiol-fe chew tab 0.8 mg-25 mcg</i>	0	
<i>norethindrone ac-ethinyl estrad-fe tab 1-20/1-30/1-35 mg-mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1 mg-20 mcg</i>	0	
<i>norethindrone ace &amp; ethinyl estradiol-fe tab 1.5 mg-30 mcg</i>	0	
<i>norethindrone ace-eth estradiol-fe chew tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe cap 1 mg-20 mcg (24)</i>	0	
<i>norethindrone ace-ethinyl estradiol-fe tab 1 mg-20 mcg (24)</i>	0	
<i>norethindrone-eth estradiol tab 0.5-35/0.75-35/1-35 mg-mcg</i>	0	
<i>norethindrone-eth estradiol tab 0.5-35/1-35/0.5-35 mg-mcg</i>	0	
<i>norgestimate &amp; ethinyl estradiol tab 0.25 mg-35 mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-25/0.215-25/0.25-25 mg-mcg</i>	0	
<i>norgestimate-eth estrad tab 0.18-35/0.215-35/0.25-35 mg-mcg</i>	0	
<i>norgestrel &amp; ethinyl estradiol tab 0.3 mg-30 mcg</i>	0	
SAFYRAL TAB	0	
<b>COMBINATION CONTRACEPTIVES - TRANSDERMAL</b>		
<i>norelgestromin-ethinyl estradiol td ptwk 150-35 mcg/24hr</i>	0	

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

129

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>COMBINATION CONTRACEPTIVES - VAGINAL</b>		
ANNOVERA MIS	0	QL (1 ring every 300 days)
NUVARING MIS	0	QL (13 rings every 300 days); Tier 1 with DAW9
<b>EMERGENCY CONTRACEPTIVES</b>		
ELLA TAB 30MG	0	
levonorgestrel tab 1.5 mg	0	
<b>PROGESTIN CONTRACEPTIVES - INJECTABLE</b>		
DEPO-PROVERA INJ 150MG/ML	0	QL (1 injection every 59 days)
DEPO-SQ PROV INJ 104	0	QL (6.154 injections every 300 days)
medroxyprogesterone acetate im susp 150 mg/ml	0	QL (4 injections every 300 days)
medroxyprogesterone acetate im susp prefilled syr 150 mg/ml	0	QL (4 injections every 300 days)
<b>PROGESTIN CONTRACEPTIVES - ORAL</b>		
norethindrone tab 0.35 mg	0	
ORTHO MICRON TAB 0.35MG	0	
<b>CORTICOSTEROIDS</b>		
<b>GLUCOCORTICOSTEROIDS</b>		
budesonide delayed release particles cap 3 mg	1	
CORTEF TAB 5MG	3	
CORTEF TAB 10MG	3	
CORTEF TAB 20MG	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	

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

130

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>dexamethasone tab therapy pack 1.5 mg (21)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (35)</i>	1	
<i>dexamethasone tab therapy pack 1.5 mg (51)</i>	1	
ENTOCORT EC CAP 3MG DR	3	
<i>hydrocortisone tab 5 mg</i>	1	
<i>hydrocortisone tab 10 mg</i>	1	
<i>hydrocortisone tab 20 mg</i>	1	
MEDROL TAB 2MG	3	
MEDROL TAB 4MG	3	
MEDROL TAB 8MG	3	
MEDROL TAB 16MG	3	
MEDROL TAB 32MG	3	
<i>methylprednisolone tab 4 mg</i>	1	
<i>methylprednisolone tab 8 mg</i>	1	
<i>methylprednisolone tab 16 mg</i>	1	
<i>methylprednisolone tab 32 mg</i>	1	
<i>methylprednisolone tab therapy pack 4 mg (21)</i>	1	
ORAPRED ODT TAB 10MG	3	
ORAPRED ODT TAB 15MG	3	
ORAPRED ODT TAB 30MG	3	
PEDIAPRED SOL 5MG/5ML	3	
<i>prednisolone sod phos orally disintegr tab 10 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 15 mg (base eq)</i>	1	
<i>prednisolone sod phos orally disintegr tab 30 mg (base eq)</i>	1	
<i>prednisolone sod phosph oral soln 6.7 mg/5ml (5 mg/5ml base)</i>	1	
<i>prednisolone sod phosphate oral soln 15 mg/5ml (base equiv)</i>	1	
<i>prednisolone sodium phosphate oral soln 25 mg/5ml (base eq)</i>	1	
<i>prednisolone soln 15 mg/5ml</i>	1	
PREDNISON CON 5MG/ML	3	

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

131

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>prednisone oral soln 5 mg/5ml</i>	1	
<i>prednisone tab 1 mg</i>	1	
<i>prednisone tab 2.5 mg</i>	1	
<i>prednisone tab 5 mg</i>	1	
<i>prednisone tab 10 mg</i>	1	
<i>prednisone tab 20 mg</i>	1	
<i>prednisone tab 50 mg</i>	1	
<i>prednisone tab therapy pack 5 mg (21)</i>	1	
<i>prednisone tab therapy pack 5 mg (48)</i>	1	
<i>prednisone tab therapy pack 10 mg (21)</i>	1	
<i>prednisone tab therapy pack 10 mg (48)</i>	1	
SOLU-CORTEF INJ 100MG	3	PA
SOLU-CORTEF INJ 250MG	3	PA
SOLU-CORTEF INJ 500MG	3	PA
SOLU-CORTEF INJ 1000MG	3	PA
UCERIS TAB 9MG	1	Tier 1 with DAW9
<b>MINERALOCORTICOIDS</b>		
<i>fludrocortisone acetate tab 0.1 mg</i>	1	
<b>COUGH/COLD/ALLERGY</b>		
<b>ANTITUSSIVES</b>		
<i>benzonatate cap 100 mg</i>	1	
<i>benzonatate cap 150 mg</i>	1	
<i>benzonatate cap 200 mg</i>	1	
<i>hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg</i>	1	QL (6 tabs every 7 days)
TESSALON PER CAP 100MG	2	
<b>COUGH/COLD/ALLERGY COMBINATIONS</b>		
CLARINEX-D TAB 2.5-120	3	
<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i>	1	QL (45 mL every 7 days)
<i>guaifenesin-codeine soln 100-10 mg/5ml</i>	1	QL (60 mL every 7 days)
<i>hydrocod polst-chlorphen polst er susp 10-8 mg/5ml</i>	1	QL (10 mL every 7 days)
MAR-COF CG LIQ 225-7.5	3	QL (45 mL every 7 days)

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

132

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NEOTUSS PLUS LIQ	3	
<i>promethazine &amp; phenylephrine syrup 6.25-5 mg/5ml</i>	1	
<i>promethazine w/ codeine syrup 6.25-10 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	1	
<i>promethazine-phenylephrine-codeine syrup 6.25-5-10 mg/5ml</i>	1	QL (30 mL every 7 days)
<i>pseudoephed-bromphen-dm syrup 30-2-10 mg/5ml</i>	1	
TUSSICAPS CAP 10-8MG	3	QL (2 caps every 7 days)
TUZISTRA XR SUS	3	QL (20 mL every 7 days)
<b>MISC. RESPIRATORY INHALANTS</b>		
HYPERSAL NEB 3.5%	3	
HYPERSAL NEB 7%	3	
<i>sodium chloride soln nebu 0.9%</i>	1	
<i>sodium chloride soln nebu 3%</i>	1	
<i>sodium chloride soln nebu 7%</i>	1	
<i>sodium chloride soln nebu 10%</i>	1	
<b>MUCOLYTICS</b>		
<i>acetylcysteine inhal soln 10%</i>	1	
<i>acetylcysteine inhal soln 20%</i>	1	
<b>DERMATOLOGICALS</b>		
<b>ACNE PRODUCTS</b>		
ABSORICA CAP 10MG	3	
ABSORICA CAP 20MG	3	
ABSORICA CAP 25MG	3	
ABSORICA CAP 30MG	3	
ABSORICA CAP 35MG	3	
ABSORICA CAP 40MG	3	
<i>adapalene cream 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.1%</i>	1	PA
<i>adapalene gel 0.3%</i>	1	PA
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i>	1	PA

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

133

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i>	1	PA
AKLIEF CRE 0.005%	2	PA
ARAZLO LOT 0.045%	2	PA
ATRALIN GEL 0.05%	3	PA
BENZAMYCIN GEL 5-3%	3	QL (47 gm every 25 days)
<i>benzoyl peroxide foam 9.8%</i>	1	
<i>benzoyl peroxide liq 7%</i>	1	
<i>benzoyl peroxide-erythromycin gel 5-3%</i>	1	QL (47 gm every 25 days)
<i>benzoyl peroxide-hydrocortisone lotion 5-0.5%</i>	1	
CLEOCIN-T LOT 1%	3	QL (60 mL every 30 days)
CLINDAGEL GEL 1%	3	QL (60 mL every 30 days)
<i>clindamycin phosph-benzoyl peroxide (refrig) gel 1.2 (1)-5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate foam 1%</i>	1	
<i>clindamycin phosphate gel 1%</i>	1	QL (60 gm every 30 days)
<i>clindamycin phosphate lotion 1%</i>	1	QL (60 mL every 30 days)
<i>clindamycin phosphate soln 1%</i>	1	QL (60 mL every 30 days)
<i>clindamycin phosphate swab 1%</i>	1	
<i>clindamycin phosphate-benzoyl peroxide gel 1-5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate-benzoyl peroxide gel 1.2-2.5%</i>	1	QL (50 gm every 25 days)
<i>clindamycin phosphate-tretinoin gel 1.2-0.025%</i>	1	PA
<i>dapsone gel 5%</i>	1	
<i>dapsone gel 7.5%</i>	1	
DIFFERIN CRE 0.1%	3	PA
DIFFERIN GEL 0.1%	3	PA
DIFFERIN GEL 0.3%	3	PA
EPIDUO FORTE GEL 0.3-2.5%	2	PA
EPIDUO GEL 0.1-2.5%	2	PA
ERYGEL GEL 2%	3	QL (60 gm every 30 days)
<i>erythromycin gel 2%</i>	1	QL (60 gm every 30 days)
<i>erythromycin pads 2%</i>	1	
<i>erythromycin soln 2%</i>	1	QL (60 mL every 30 days)

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

134

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EVOCLIN AER 1%	3	
<i>isotretinoin cap 10 mg</i>	1	
<i>isotretinoin cap 20 mg</i>	1	
<i>isotretinoin cap 30 mg</i>	1	
<i>isotretinoin cap 40 mg</i>	1	
KLARON LOT 10%	3	
ONEXTON GEL 1.2-3.75	2	QL (50 gm every 25 days)
PR BENZOYL LIQ 7% WASH	1	
RETIN-A CRE 0.1%	3	PA
RETIN-A CRE 0.05%	3	PA
RETIN-A CRE 0.025%	3	PA
RETIN-A GEL 0.01%	3	PA
RETIN-A GEL 0.025%	3	PA
RETIN-A MICR GEL 0.1%	3	PA
RETIN-A MICR GEL 0.1%PUMP	3	PA
RETIN-A MICR GEL 0.04%	3	PA
RETIN-A MICR GEL 0.04%PMP	3	PA
RETIN-A MICR GEL 0.06%	3	PA
RETIN-A MICR GEL 0.08%	3	PA
RIAX AER 5.5%	3	
RIAX AER 9.5%	3	
<i>sulfacetamide sodium lotion 10% (acne)</i>	1	
<i>sulfacetamide sodium w/ sulfur cleansing pad 10-4%</i>	1	
<i>sulfacetamide sodium w/ sulfur emulsion 10-1%</i>	1	
<i>tretinoin cream 0.1%</i>	1	PA
<i>tretinoin cream 0.05%</i>	1	PA
<i>tretinoin cream 0.025%</i>	1	PA
<i>tretinoin gel 0.01%</i>	1	PA
<i>tretinoin gel 0.05%</i>	1	PA
<i>tretinoin gel 0.025%</i>	1	PA
<i>tretinoin microsphere gel 0.1%</i>	1	PA
<i>tretinoin microsphere gel 0.04%</i>	1	PA
TWYNEO CRE 0.1-3%	2	PA
WINLEVI CRE 1%	2	PA

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

135

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZACLIR LOT 8%	3	
<b>ANTI-INFLAMMATORY AGENTS - TOPICAL</b>		
<i>diclofenac epolamine patch 1.3%</i>	1	
<i>diclofenac sodium soln 1.5%</i>	1	PA, QL (150 mL every 21 days)
FLECTOR DIS 1.3%	3	
<b>ANTIBIOTICS - TOPICAL</b>		
ALTABAX OIN 1%	3	
CENTANY OIN 2%	3	QL (30 gm every 25 days)
<i>gentamicin sulfate cream 0.1%</i>	1	QL (120 gm every 25 days)
<i>gentamicin sulfate oint 0.1%</i>	1	QL (120 gm every 25 days)
<i>mupirocin oint 2%</i>	1	QL (30 gm every 25 days)
XEPI CRE 1%	3	PA
<b>ANTIFUNGALS - TOPICAL</b>		
<i>ciclopirox gel 0.77%</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine cream 0.77% (base equiv)</i>	1	QL (120 gm every 25 days)
<i>ciclopirox olamine susp 0.77% (base equiv)</i>	1	QL (120 mL every 25 days)
<i>ciclopirox shampoo 1%</i>	1	QL (120 mL every 25 days)
<i>ciclopirox solution 8%</i>	1	
<i>clotrimazole w/ betamethasone cream 1-0.05%</i>	1	
<i>clotrimazole w/ betamethasone lotion 1-0.05%</i>	1	
<i>econazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
ECOZA AER 1%	3	QL (70 gm every 25 days)
ERTACZO CRE 2%	3	QL (60 gm every 25 days)
EXELDERM CRE 1%	3	QL (60 gm every 25 days)
EXELDERM SOL 1%	3	QL (60 mL every 25 days)
EXODERM LOT 25-1%	3	
EXTINA AER 2%	3	QL (100 gm every 25 days)
<i>iodoquinol-hc cream 1-1%</i>	1	
<i>iodoquinol-hydrocortisone in aloe vehicle cream 1-1.9%</i>	1	
JUBLIA SOL 10%	3	PA, QL (4 mL every 21 days)
KERYDIN SOL 5%	3	PA, QL (4 mL every 21 days)

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

136

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>ketoconazole cream 2%</i>	1	QL (120 gm every 25 days)
<i>ketoconazole shampoo 2%</i>	1	QL (120 mL every 25 days)
LOPROX SHA 1%	3	QL (120 mL every 25 days)
LUZU CRE 1%	3	QL (60 gm every 25 days)
<i>miconazole-zinc oxide-white petrolatum oint 0.25-15-81.35%</i>	1	QL (100 gm every 25 days)
<i>naftifine hcl cream 1%</i>	1	QL (60 gm every 25 days)
<i>naftifine hcl cream 2%</i>	1	QL (60 gm every 25 days)
<i>naftifine hcl gel 1%</i>	1	QL (120 gm every 25 days)
NAFTIN GEL 1%	2	QL (120 gm every 25 days)
NAFTIN GEL 2%	2	QL (60 gm every 25 days)
<i>nystatin cream 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin oint 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin topical powder 100000 unit/gm</i>	1	QL (120 gm every 25 days)
<i>nystatin-triamcinolone cream 100000-0.1 unit/gm-%</i>	1	
<i>nystatin-triamcinolone oint 100000-0.1 unit/gm-%</i>	1	
<i>oxiconazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
OXISTAT CRE 1%	3	QL (60 gm every 25 days)
OXISTAT LOT 1%	3	QL (60 mL every 25 days)
<i>sulconazole nitrate cream 1%</i>	1	QL (60 gm every 25 days)
<i>sulconazole nitrate solution 1%</i>	1	QL (60 mL every 25 days)
VUSION OIN	3	QL (100 gm every 25 days)

**ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL**

<i>diclofenac sodium (actinic keratoses) gel 3%</i>	1	PA
EFUDEX CRE 5%	3	
FLUOROPLEX CRE 1%	3	
<i>fluorouracil cream 5%</i>	1	
<i>fluorouracil soln 2%</i>	1	
<i>fluorouracil soln 5%</i>	1	
LEVULAN KERA SOL 20%	3	
PANRETIN GEL 0.1%	3	
PICATO GEL 0.05%	2	
PICATO GEL 0.015%	2	

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

137

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
VALCHLOR GEL 0.016%	3	PA, QL (2 TUBES PER 30 DAYS)
<b>ANTIPRURITICS - TOPICAL</b>		
PRUDOXIN CRE 5%	3	ST, QL (90 gm every 25 days)
ZONALON CRE 5%	3	ST, QL (90 gm every 25 days)
<b>ANTIPSORIATICS</b>		
<i>acitretin cap 10 mg</i>	1	
<i>acitretin cap 17.5 mg</i>	1	
<i>acitretin cap 25 mg</i>	1	
<i>calcipotriene oint 0.005%</i>	1	PA
<i>calcipotriene soln 0.005% (50 mcg/ml)</i>	1	PA
COSENTYX INJ 75MG/0.5	2	PA, QL (1 SYRINGE PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE:5 SYRINGES PER 35 DAYS
COSENTYX INJ 150MG/ML	2	PA, QL (1 SYRINGES PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis dependent

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

138

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COSENTYX INJ 300DOSE	2	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
COSENTYX PEN INJ 150MG/ML	2	PA, QL (1 PENS PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
COSENTYX PEN INJ 300DOSE	2	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent

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

139

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
COSENTYX UNO INJ 300/2ML	2	PA, QL (300 MG (2 ML) PER 28 DAYS); Preferred agent for Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis and Psoriatic Arthritis. Quantity Limits are consistent with maximum FDA approved dosing limits.
DOVONEX CRE 0.005%	3	PA
<i>methoxsalen rapid cap 10 mg</i>	1	
OXSORALEN-UL CAP 10MG	3	
SKYRIZI INJ 150DOSE	2	PA, QL (2 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 4 SYRINGES PER 28 DAYS
SKYRIZI INJ 150MG/ML	2	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS
SKYRIZI PEN INJ 150MG/ML	2	PA, QL (1 SYRINGES PER 84 DAYS); Preferred for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 SYRINGES PER 28 DAYS

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

140

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SORIATANE CAP 10MG	3	
SORIATANE CAP 25MG	3	
SOTYKTU TAB 6MG	2	PA, QL (30 TABLETS PER 30 DAYS)
STELARA INJ 45MG/0.5	2	PA, QL (1 SYRINGES PER 12 WEEKS (84 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
STELARA INJ 45MG/0.5	2	PA, QL (1 VIALS PER 12 WEEKS); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
STELARA INJ 90MG/ML	2	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for all FDA approved indications; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: Diagnosis Dependent
tazarotene cream 0.1%	1	PA

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

141

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TREMFYA INJ 100MG/ML	2	PA, QL (1 PENS PER 8 WEEKS); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
TREMFYA INJ 100MG/ML	2	PA, QL (1 PFS PER 8 WEEKS (56 DAYS)); Preferred agent for Psoriasis, Psoriatic Arthritis; Quantity Limits are consistent with maximum FDA approved dosing limits. LOADING DOSE: 2 INJ PER 28 DAYS
VTAMA CRE 1%	2	PA
ZORYVE CRE 0.3%	2	ST, PA, QL (60 gms per 25 days)

**ANTISEBORRHEIC PRODUCTS**

<i>selenium sulfide lotion 2.5%</i>	1	
SODIUM SULFA LIQ 10% WASH	3	

**ANTIVIRALS - TOPICAL**

<i>acyclovir oint 5%</i>	1	
DENAVIR CRE 1%	3	
<i>penciclovir cream 1%</i>	1	
XERESE CRE 5-1%	3	
ZOVIRAX CRE 5%	3	
ZOVIRAX OIN 5%	3	

**BURN PRODUCTS**

<i>mafenide acetate packet for topical soln 5% (50 gm)</i>	1	
SILVADENE CRE 1%	2	
<i>silver sulfadiazine cream 1%</i>	1	
SULFAMYLON CRE 85MG/GM	3	

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

142

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SULFAMYLON PAK 5%	3	
<b>CORTICOSTEROIDS - TOPICAL</b>		
<i>alclometasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>alclometasone dipropionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>amcinonide cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>amcinonide lotion 0.1%</i>	1	QL (120 mL every 30 days)
<i>amcinonide oint 0.1%</i>	3	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate augmented lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone dipropionate augmented oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>betamethasone dipropionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate aerosol foam 0.12%</i>	1	QL (120 gm every 30 days)
<i>betamethasone valerate cream 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
<i>betamethasone valerate lotion 0.1% (base equivalent)</i>	1	QL (120 mL every 30 days)
<i>betamethasone valerate oint 0.1% (base equivalent)</i>	1	QL (120 gm every 30 days)
BRYHALI LOT 0.01%	2	QL (120 gm every 30 days)
CAPEX SHA 0.01%	2	QL (120 mL every 30 days)
<i>clobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate emollient base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate foam 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>clobetasol propionate shampoo 0.05%</i>	1	QL (120 mL every 30 days)
<i>clobetasol propionate soln 0.05%</i>	1	QL (120 mL every 30 days)

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

143

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CLOBEX LOT 0.05%	2	QL (120 mL every 30 days)
CLOBEX SHA 0.05%	2	QL (120 mL every 30 days)
CLODERM CRE 0.1%	3	QL (120 gm every 30 days)
CUTIVATE LOT 0.05%	3	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS BODY	2	QL (120 mL every 30 days)
DERMA-SMOOTH OIL /FS SCLP	2	QL (120 mL every 30 days)
DESONATE GEL 0.05%	3	QL (120 gm every 30 days)
<i>desonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desonide lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>desonide oint 0.05%</i>	1	QL (120 gm every 30 days)
DESOWEN CRE 0.05%	3	QL (120 gm every 30 days)
<i>desoximetasone cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone cream 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone oint 0.25%</i>	1	QL (120 gm every 30 days)
<i>desoximetasone spray 0.25%</i>	1	QL (120 mL every 30 days)
DIPROLENE AF CRE 0.05%	3	QL (120 gm every 30 days)
DIPROLENE OIN 0.05%	3	QL (120 gm every 30 days)
ENSTILAR AER	2	PA
EPIFOAM AER 1%	3	
<i>fluocinolone acetonide cream 0.01%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide cream 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide oil 0.01% (body oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>	1	QL (120 mL every 30 days)
<i>fluocinolone acetonide oint 0.025%</i>	1	QL (120 gm every 30 days)
<i>fluocinolone acetonide soln 0.01%</i>	1	QL (120 mL every 30 days)
<i>fluocinonide cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide emulsified base cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide gel 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide oint 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluocinonide soln 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate cream 0.05%</i>	1	QL (120 gm every 30 days)
<i>fluticasone propionate lotion 0.05%</i>	1	QL (120 mL every 30 days)
<i>fluticasone propionate oint 0.005%</i>	1	QL (120 gm every 30 days)
<i>halobetasol propionate cream 0.05%</i>	1	QL (120 gm every 30 days)

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

144

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>halobetasol propionate oint 0.05%</i>	1	QL (120 gm every 30 days)
HC/PRAMOXINE CRE 1-2.35%	3	
<i>hydrocortisone butyrate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone butyrate soln 0.1%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone cream 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone lotion 2.5%</i>	1	QL (120 mL every 30 days)
<i>hydrocortisone oint 2.5%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate cream 0.2%</i>	1	QL (120 gm every 30 days)
<i>hydrocortisone valerate oint 0.2%</i>	1	QL (120 gm every 30 days)
KENALOG AER SPRAY	3	QL (120 gm every 30 days)
LOCOID LIPO CRE 0.1%	3	QL (120 gm every 30 days)
LOCOID LOT 0.1%	3	QL (120 mL every 30 days)
LUXIQ AER 0.12%	3	QL (120 gm every 30 days)
<i>mometasone furoate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>mometasone furoate solution 0.1% (lotion)</i>	1	QL (120 mL every 30 days)
OLUX AER 0.05%	3	QL (120 gm every 30 days)
PANDEL CRE 0.1%	3	QL (120 gm every 30 days)
PRAMOSONE CRE 1-1%	3	
PRAMOSONE LOT 1%	3	
PRAMOSONE LOT 2.5%	3	
<i>prednicarbate cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>prednicarbate oint 0.1%</i>	1	QL (120 gm every 30 days)
SERNIVO SPR	3	QL (120 mL every 30 days)
SERNIVO SPR 0.05%	3	QL (120 mL every 30 days)
SYNALAR CRE 0.025%	3	QL (120 gm every 30 days)
SYNALAR OIN 0.025%	3	QL (120 gm every 30 days)
SYNALAR SOL 0.01%	3	QL (120 mL every 30 days)
TACLONEX OIN	3	PA
TACLONEX SUS	3	PA
TEMOVATE CRE 0.05%	2	QL (120 gm every 30 days)
TEMOVATE OIN 0.05%	2	QL (120 gm every 30 days)
TEXACORT SOL 2.5%	2	QL (120 mL every 30 days)
TOPICORT CRE 0.05%	3	QL (120 gm every 30 days)

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

145

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TOPICORT CRE 0.25%	3	QL (120 gm every 30 days)
TOPICORT GEL 0.05%	3	QL (120 gm every 30 days)
TOPICORT OIN 0.05%	3	QL (120 gm every 30 days)
TOPICORT OIN 0.25%	3	QL (120 gm every 30 days)
TOPICORT SPR 0.25%	3	QL (120 mL every 30 days)
<i>triamcinolone acetonide cream 0.1%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide cream 0.5%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide cream 0.025%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide lotion 0.1%</i>	1	QL (120 mL every 30 days)
<i>triamcinolone acetonide lotion 0.025%</i>	1	QL (120 mL every 30 days)
<i>triamcinolone acetonide oint 0.1%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide oint 0.5%</i>	1	QL (120 gm every 30 days)
<i>triamcinolone acetonide oint 0.025%</i>	1	QL (120 gm every 30 days)
TRIDESILON CRE 0.05%	3	QL (120 gm every 30 days)
VANOS CRE 0.1%	3	QL (120 gm every 30 days)
VERDESO AER 0.05%	3	QL (120 gm every 30 days)
<b>ECZEMA AGENTS</b>		
ADBRY INJ 150MG/ML	2	PA, QL (4 SYRINGES PER 28 DAYS); LOADING DOSE: 4 SYRINGES PER 14 DAYS
CIBINQO TAB 50MG	2	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 100MG	2	PA, QL (30 TABLETS PER 30 DAYS)
CIBINQO TAB 200MG	2	PA, QL (30 TABLETS PER 30 DAYS)
DUPIXENT INJ 200MG	2	PA, QL (2 PENS (400 MG) PER 28 DAYS); LOADING DOSE: 2 PENS (400 MG) PER 14 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

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

146

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>EMOLLIENT/KERATOLYTIC AGENTS</b>		
<i>urea cream 39%</i>	1	
<i>urea lotion 40%</i>	1	
<b>EMOLLIENTS</b>		
LACTIC ACID LOT 10%	3	
<b>ENZYMES - TOPICAL</b>		
SANTYL OIN 250/GM	3	
<b>HAIR GROWTH AGENTS</b>		
LITFULO CAP 50MG	3	PA, QL (28 caps per 28 days)
<b>IMMUNOMODULATING AGENTS - TOPICAL</b>		
ALDARA CRE 5%	3	QL (21 ea every 25 days)
<i>imiquimod cream 3.75%</i>	1	
<i>imiquimod cream 5%</i>	1	QL (21 ea every 25 days)
ZYCLARA CRE 3.75%	2	
ZYCLARA PUMP CRE 2.5%	2	
ZYCLARA PUMP CRE 3.75%	2	
<b>IMMUNOSUPPRESSIVE AGENTS - TOPICAL</b>		
<i>pimecrolimus cream 1%</i>	1	ST
PROTOPIC OIN 0.1%	3	ST
PROTOPIC OIN 0.03%	3	ST
<i>tacrolimus oint 0.1%</i>	1	ST
<i>tacrolimus oint 0.03%</i>	1	ST
<b>KERATOLYTIC/ANTIMITOTIC AGENTS</b>		
CONDYLOX GEL 0.5%	2	
GORDOFILM SOL	3	
<i>podofilox soln 0.5%</i>	1	
PYROGALL ACD OIN	3	
SALIMEZ FORT CRE 10%	3	
<b>LINIMENTS</b>		
TURPENTINE SOL SPIRITS	3	
<b>LOCAL ANESTHETICS - TOPICAL</b>		
ANACAINE OIN	3	
ETHYL CHLOR AER FINE PIN	3	

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

147

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ETHYL CHLOR AER FN STRM	3	
ETHYL CHLOR AER MED JET	3	
ETHYL CHLOR AER MED STRM	3	
ETHYL CHLOR AER MIST	3	
<i>ethyl chloride aerosol spray</i>	1	
<i>lidocaine hcl soln 4%</i>	1	QL (50 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel 2%</i>	1	QL (60 mL every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (10 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (12 injections every 25 days)
<i>lidocaine hcl urethral/mucosal gel prefilled syringe 2%</i>	1	QL (3 injections every 25 days)
<i>lidocaine oint 5%</i>	1	QL (50 gm every 25 days)
<i>lidocaine patch 5%</i>	1	QL (90 ea every 30 days)
<i>lidocaine-prilocaine cream 2.5-2.5%</i>	1	QL (30 gm every 25 days)
LIDODERM DIS 5%	2	QL (90 ea every 30 days)
SYNERA DIS 70-70MG	3	QL (2 patches every 25 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 ea every 30 days)
ZTLIDO PAD 1.8%	3	PA, QL (90 patches every 30 days)
<b>MISC. TOPICAL</b>		
ARNICA TIN FLOWER	3	
DRYSOL SOL 20%	3	
QBREXZA PAD 2.4%	3	
XERAC-AC SOL 6.25%	3	
<b>PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL</b>		
EUCRISA OIN 2%	2	
<b>ROSACEA AGENTS</b>		
<i>azelaic acid gel 15%</i>	1	PA
FINACEA AER 15%	2	PA
METROCREAM CRE 0.75%	3	
METROGEL GEL 1%	3	

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

148

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
METROLOTION LOT 0.75%	3	
<i>metronidazole cream 0.75%</i>	1	
<i>metronidazole gel 0.75%</i>	1	
<i>metronidazole gel 1%</i>	1	
<i>metronidazole lotion 0.75%</i>	1	
ORACEA CAP 40MG	1	Tier 1 with DAW9
RHOFADE CRE 1%	2	PA
SOOLANTRA CRE 1%	1	Tier 1 with DAW9
<b>SCABICIDES &amp; PEDICULICIDES</b>		
<i>crotamiton lotion 10%</i>	1	
ELIMITE CRE 5%	2	
<i>ivermectin lotion 0.5%</i>	1	
<i>lindane shampoo 1%</i>	1	
<i>malathion lotion 0.5%</i>	1	
NATROBA SUS 0.9%	3	
OVIDE LOT 0.5%	2	
<i>permethrin cream 5%</i>	1	
<i>spinosad susp 0.9%</i>	1	
SULF LIME SOL	3	
<b>TAR PRODUCTS</b>		
<i>coal tar soln 20%</i>	1	
<b>WOUND CARE PRODUCTS</b>		
REGRANEX GEL 0.01%	3	
<b>DIAGNOSTIC PRODUCTS</b>		
<b>DIAGNOSTIC TESTS</b>		
ACCU-CHEK GUIDE	0	QL (150 strips every 30 days)
ACCU-CHEK TES AVIVA PL	0	QL (150 strips every 30 days)
ACCU-CHEK TES COMPACT	0	QL (150 strips every 30 days)
ACCU-CHEK TES SMART	0	QL (150 strips every 30 days)
ASSURE PRISM TES MULTI	0	PA, QL (150 strips every 30 days)

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

149

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

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

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

CAMINO PRO LIQ 15PE	3	Coverage is subject to your plan/benefits
COMPLEAT LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
COMPLEAT PED LIQ ORG BLND	3	PA; Coverage is subject to your plan/benefits
CRUCIAL LIQ UNFLAVOR	3	PA; Coverage is subject to your plan/benefits
DIABETIC TF LIQ	3	PA; Coverage is subject to your plan/benefits

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

150

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
DIABETISOURC LIQ	3	PA; Coverage is subject to your plan/benefits
EAA SUPPLEME POW TROPICAL	3	Coverage is subject to your plan/benefits
ENSURE PLANT LIQ CHOCOLAT	3	Coverage is subject to your plan/benefits
EO28 SPLASH LIQ ORANGE	3	PA; Coverage is subject to your plan/benefits
F.A.A. LIQ	3	PA; Coverage is subject to your plan/benefits
FIBERSOUR HN LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
FIBERSOURCE LIQ CLS SYS	3	PA; Coverage is subject to your plan/benefits
GLUCERNA 1.0 LIQ CARB VAN	3	PA; Coverage is subject to your plan/benefits
GLUCERNA LIQ 1.2 CAL	3	PA; Coverage is subject to your plan/benefits
GLUCERNA SEL LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
GLYTACTIN PAK BTMK/DLT	3	Coverage is subject to your plan/benefits
GLYTACTIN POW BETMLK15	3	Coverage is subject to your plan/benefits
GLYTACTIN POW RST LT10	3	Coverage is subject to your plan/benefits
GLYTROL LIQ PREBIO1	3	PA; Coverage is subject to your plan/benefits
HCU EXP20 PAK UNFLAVOR	3	Coverage is subject to your plan/benefits
HCU EXPRESS PAK	3	Coverage is subject to your plan/benefits
HOMACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
ISOSOURCE HN LIQ	3	PA; Coverage is subject to your plan/benefits

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

151

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

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

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

152

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

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

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

153

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PHENACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
PHLEXY-10 POW	3	PA; Coverage is subject to your plan/benefits
PIVOT LIQ 1.5 CAL	3	PA; Coverage is subject to your plan/benefits
PKU EXPLORE5 POW UNFLAVOR	3	Coverage is subject to your plan/benefits
PPA/MMA POW EXPRESS	3	Coverage is subject to your plan/benefits
PRO-PHREE POW	3	Coverage is subject to your plan/benefits
PROMACTIN AA SUS PLUS	3	Coverage is subject to your plan/benefits
PROMOTE 1.0 LIQ W/ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROMOTE W/FB LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
PROMOTE/ LIQ FIBER	3	PA; Coverage is subject to your plan/benefits
PROSOURCE LIQ TF	3	PA; Coverage is subject to your plan/benefits
REPLETE FIBE LIQ 1 CAL	3	PA; Coverage is subject to your plan/benefits
REPLETE LIQ ULTRAPAK	3	PA; Coverage is subject to your plan/benefits
RESOURCE DIA LIQ TF	3	PA; Coverage is subject to your plan/benefits
S.O.S. 20 POW	3	Coverage is subject to your plan/benefits
S.O.S. 25 POW	3	Coverage is subject to your plan/benefits

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

154

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
SUPLINA LIQ VANILLA	3	PA; Coverage is subject to your plan/benefits
TOLEREX POW	3	PA; Coverage is subject to your plan/benefits
TWOCAL HN LIQ	3	PA; Coverage is subject to your plan/benefits
TYLACTIN POW BLD 20PE	3	Coverage is subject to your plan/benefits
ULTRACAL HN LIQ PLUS	3	PA; Coverage is subject to your plan/benefits
ULTRACAL LIQ	3	PA; Coverage is subject to your plan/benefits
ULTRIENT 1.5 LIQ SAFE-T	3	PA; Coverage is subject to your plan/benefits
VILACTIN AA LIQ PLUS	3	Coverage is subject to your plan/benefits
VITAL HN POW	3	PA; Coverage is subject to your plan/benefits
VIVONEX RTF LIQ	3	PA; Coverage is subject to your plan/benefits

**DIGESTIVE AIDS*****DIGESTIVE ENZYMES***

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

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

155

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PERTZYE CAP 16000U	3	
PERTZYE CAP 24000U	3	
SUCRAID SOL 8500/ML	3	PA
SUCRAID SOL 8500/ML	3	PA
VIOKACE TAB 10440	2	
VIOKACE TAB 20880	2	
ZENPEP CAP 3000UNIT	2	
ZENPEP CAP 5000UNIT	2	
ZENPEP CAP 10000UNT	2	
ZENPEP CAP 15000UNT	2	
ZENPEP CAP 20000UNT	2	
ZENPEP CAP 25000UNT	2	
ZENPEP CAP 40000UNT	2	

**DIURETICS****CARBONIC ANHYDRASE INHIBITORS**

<i>acetazolamide cap er 12hr 500 mg</i>	1	
<i>acetazolamide tab 125 mg</i>	1	
<i>acetazolamide tab 250 mg</i>	1	
<i>dichlorphenamide tab 50 mg</i>	1	PA, QL (120 tabs every 30 days)
KEVEYIS TAB 50MG	3	PA, QL (120 TABLETS PER 30 DAYS)
<i>methazolamide tab 25 mg</i>	1	
<i>methazolamide tab 50 mg</i>	1	

**DIURETIC COMBINATIONS**

ALDACTAZIDE TAB 25/25	3	
ALDACTAZIDE TAB 50/50	3	
<i>amiloride &amp; hydrochlorothiazide tab 5-50 mg</i>	1	
MAXZIDE TAB 75-50	3	
MAXZIDE-25 TAB	3	
<i>spironolactone &amp; hydrochlorothiazide tab 25-25 mg</i>	1	
<i>triamterene &amp; hydrochlorothiazide cap 37.5-25 mg</i>	1	

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

156

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

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

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

157

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>chlorthalidone tab 50 mg</i>	1	
DIURIL SUS 250/5ML	3	
<i>hydrochlorothiazide cap 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 12.5 mg</i>	1	
<i>hydrochlorothiazide tab 25 mg</i>	1	
<i>hydrochlorothiazide tab 50 mg</i>	1	
<i>indapamide tab 1.25 mg</i>	1	
<i>indapamide tab 2.5 mg</i>	1	
<i>metolazone tab 2.5 mg</i>	1	
<i>metolazone tab 5 mg</i>	1	
<i>metolazone tab 10 mg</i>	1	

**ENDOCRINE AND METABOLIC AGENTS - MISC.****BONE DENSITY REGULATORS**

ACTONEL TAB 35MG	3	
ACTONEL TAB 150MG	3	
<i>alendronate sodium oral soln 70 mg/75ml</i>	1	
<i>alendronate sodium tab 5 mg</i>	1	
<i>alendronate sodium tab 10 mg</i>	1	
<i>alendronate sodium tab 35 mg</i>	1	
<i>alendronate sodium tab 70 mg</i>	1	
AELVIA TAB	3	
BINOSTO TAB 70MG	3	
BONIVA TAB 150MG	3	
<i>calcitonin (salmon) nasal soln 200 unit/act</i>	1	
FORTEO INJ 600/2.4	2	PA, QL (1 PENS FOR 28 DAYS)
FOSAMAX + D TAB 70-2800	3	
FOSAMAX + D TAB 70-5600	3	
FOSAMAX TAB 70MG	3	
<i>ibandronate sodium tab 150 mg (base equivalent)</i>	1	
NATPARA INJ 25MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 50MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)

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

158

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NATPARA INJ 75MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
NATPARA INJ 100MCG	3	PA, QL (2 CARTRIDGES PER 28 DAYS)
<i>risedronate sodium tab 5 mg</i>	1	
<i>risedronate sodium tab 30 mg</i>	1	
<i>risedronate sodium tab 35 mg</i>	1	
<i>risedronate sodium tab 150 mg</i>	1	
<i>risedronate sodium tab delayed release 35 mg</i>	1	
TYMLOS INJ	2	PA, QL (1 PEN PER 30 DAYS)
<b>CORTICOTROPIN</b>		
ACTHAR INJ 80UNIT	3	PA, QL (35ML PER 21 DAYS)
CORTROPHIN GEL 80UNIT	3	PA, QL (35ML PER 21 DAYS)
<b>FERTILITY REGULATORS</b>		
<i>clomiphene citrate tab 50 mg</i>	1	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
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

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

159

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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 CARTRIDGES PER 28 DAYS); Coverage is subject to your plan/benefits
MENOPUR INJ 75UNIT	2	PA; Coverage is subject to your plan/benefits
OVIDREL INJ	2	PA; Coverage is subject to your plan/benefits
<b>GNRH/LHRH ANTAGONISTS</b>		
CETROTIDE KIT 0.25MG	2	PA
GANIRELIX AC INJ 250/0.5	3	PA
<i>ganirelix acetate soln prefilled syringe 250 mcg/0.5ml</i>	1	PA
ORLISSA TAB 150MG	2	PA
ORLISSA TAB 200MG	2	PA
<b>GROWTH HORMONE RELEASING HORMONES (GHRH)</b>		
EGRIFTA SV INJ 2MG	3	PA, QL (30 VIALS PER 30 DAYS)
<b>GROWTH HORMONES</b>		
GENOTROPIN INJ 0.2MG	2	PA
GENOTROPIN INJ 0.4MG	2	PA
GENOTROPIN INJ 0.6MG	2	PA
GENOTROPIN INJ 0.8MG	2	PA
GENOTROPIN INJ 1.2MG	2	PA
GENOTROPIN INJ 1.4MG	2	PA
GENOTROPIN INJ 1.6MG	2	PA
GENOTROPIN INJ 1.8MG	2	PA
GENOTROPIN INJ 1MG	2	PA
GENOTROPIN INJ 2MG	2	PA
GENOTROPIN INJ 5MG	2	PA
GENOTROPIN INJ 12MG	2	PA

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

160

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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
SEROSTIM INJ 4MG	3	PA
SEROSTIM INJ 5MG	3	PA
SEROSTIM INJ 6MG	3	PA
SOGROYA INJ 5MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 10MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
SOGROYA INJ 15MG/1.5	2	PA, QL (4 PENS PER 28 DAYS)
ZORBTIVE INJ 8.8MG	3	PA
<b>HORMONE RECEPTOR MODULATORS</b>		
EVISTA TAB 60MG	0	
<i>raloxifene hcl tab 60 mg</i>	0	
<b>INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS)</b>		
INCRELEX INJ 40MG/4ML	3	PA
<b>LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS</b>		
SYNAREL SOL 2MG/ML	3	
<b>METABOLIC MODIFIERS</b>		
<i>calcitriol cap 0.5 mcg</i>	1	
<i>calcitriol cap 0.25 mcg</i>	1	
<i>calcitriol oral soln 1 mcg/ml</i>	1	
<i>carglumic acid soluble tab 200 mg</i>	1	PA
<i>cinacalcet hcl tab 30 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 60 mg (base equiv)</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>cinacalcet hcl tab 90 mg (base equiv)</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
<i>doxercalciferol cap 0.5 mcg</i>	1	
<i>doxercalciferol cap 1 mcg</i>	1	
<i>doxercalciferol cap 2.5 mcg</i>	1	

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

161

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
GALAFOLD CAP 123MG	3	PA, QL (14 CAPSULES PER 28 DAYS)
<i>levocarnitine oral soln 1 gm/10ml (10%)</i>	1	
<i>levocarnitine tab 330 mg</i>	1	
MYALEPT INJ 11.3MG	3	PA, QL (30 VIALS PER 30 DAYS)
<i>nitisinone cap 2 mg</i>	1	PA
<i>nitisinone cap 5 mg</i>	1	PA
<i>nitisinone cap 10 mg</i>	1	PA
ORFADIN CAP 2MG	2	PA
ORFADIN CAP 5MG	2	PA
ORFADIN CAP 10MG	2	PA
ORFADIN CAP 20MG	2	PA
ORFADIN SUS 4MG/ML	2	PA
<i>paricalcitol cap 1 mcg</i>	1	
<i>paricalcitol cap 2 mcg</i>	1	
<i>paricalcitol cap 4 mcg</i>	1	
PHEBURANE MIS 483/GM	3	PA, QL (672 GRAMS (8 BOTTLES) PER 30 DAYS)
REVCOSI INJ 1.6MG/ML	3	
ROCALTROL CAP 0.5MCG	2	
ROCALTROL CAP 0.25MCG	2	
ROCALTROL SOL 1MCG/ML	2	
<i>sapropterin dihydrochloride powder packet 100 mg</i>	1	PA
<i>sapropterin dihydrochloride powder packet 500 mg</i>	1	PA
<i>sapropterin dihydrochloride tab 100 mg</i>	1	PA
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)
<i>sodium phenylbutyrate oral powder 3 gm/teaspoonful</i>	1	PA, QL (798 GRAMS PER 30 DAYS)

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

162

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
<b>MINERALOCORTICOID RECEPTOR ANTAGONISTS</b>		
KERENDIA TAB 10MG	2	PA
KERENDIA TAB 20MG	2	PA
<b>NATRIURETIC PEPTIDES</b>		
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)
<b>POSTERIOR PITUITARY HORMONES</b>		
DDAVP SOL 0.01%	3	
DDAVP TAB 0.1MG	3	
DDAVP TAB 0.2MG	3	
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
<b>PROGESTERONE RECEPTOR ANTAGONISTS</b>		
MIFEPREX TAB 200MG	3	
mifepristone tab 200 mg	1	\$0 copay based on your plan/benefit

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

163

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PROLACTIN INHIBITORS</b>		
<i>cabergoline tab 0.5 mg</i>	1	
<b>SOMATOSTATIC AGENTS</b>		
<i>octreotide acetate inj 50 mcg/ml (0.05 mg/ml)</i>	1	PA, QL (90 vials every 30 days)
<i>octreotide acetate inj 100 mcg/ml (0.1 mg/ml)</i>	1	PA, QL (90 VIALS PER 30 DAYS)
<i>octreotide acetate inj 200 mcg/ml (0.2 mg/ml)</i>	1	PA, QL (45 VIALS (45,000 UNITS) PER 30 DAYS)
<i>octreotide acetate inj 500 mcg/ml (0.5 mg/ml)</i>	1	PA, QL (90 AMPULES PER 30 DAYS)
<i>octreotide acetate inj 1000 mcg/ml (1 mg/ml)</i>	1	PA, QL (9 VIALS (45,000) PER 30 DAYS)
SANDOSTATIN INJ 50MCG/ML	3	PA, QL (90 ampules every 30 days)
SANDOSTATIN INJ 100MCG	3	PA, QL (90 VIALS 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)
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)
<b>VASOPRESSIN RECEPTOR ANTAGONISTS</b>		
SAMSCA TAB 15MG	3	PA, QL (60 TABLETS PER 30 DAYS)
SAMSCA TAB 30MG	3	PA, QL (30 TABLETS PER 30 DAYS)
<i>tolvaptan tab 30 mg</i>	1	PA, QL (30 TABLETS PER 30 DAYS)
<b>ESTROGENS</b>		
<b>ESTROGEN COMBINATIONS</b>		
ACTIVELLA TAB 1-0.5MG	3	

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

164

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
FEMHRT TAB 0.5-2.5	3	
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	
<b>ESTROGENS</b>		
ALORA DIS 0.1MG	3	
ALORA DIS 0.05MG	3	
ALORA DIS 0.025MG	3	
ALORA DIS 0.075MG	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	

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

165

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ELESTRIN GEL 0.06%	3	
ESTRACE TAB 0.5MG	3	
ESTRACE TAB 1MG	3	
ESTRACE TAB 2MG	3	
<i>estradiol tab 0.5 mg</i>	1	
<i>estradiol tab 1 mg</i>	1	
<i>estradiol tab 2 mg</i>	1	
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i>	1	
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i>	1	
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i>	1	
<i>estradiol td gel 1 mg/gm (0.1%)</i>	1	
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i>	1	
<i>estradiol td patch twice weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.025 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.1 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.05 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.06 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.025 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.075 mg/24hr</i>	1	
<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i>	1	
<i>estradiol valerate im in oil 20 mg/ml</i>	1	PA
<i>estradiol valerate im in oil 40 mg/ml</i>	1	PA
ESTROGEL GEL	3	
EVAMIST SPR 1.53MG	2	
MENOSTAR DIS 14MCG	3	
PREMARIN INJ 25MG	3	PA

**FLUROQUINOLONES****FLUROQUINOLONES**

BAXDELA TAB 450MG	3	
CIPRO (5%) SUS 250MG/5	3	
CIPRO (10%) SUS 500MG/5	3	

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

166

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
CIPRO TAB 250MG	3	
CIPRO TAB 500MG	3	
<i>ciprofloxacin hcl tab 100 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 250 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 500 mg (base equiv)</i>	1	
<i>ciprofloxacin hcl tab 750 mg (base equiv)</i>	1	
<i>levofloxacin oral soln 25 mg/ml</i>	1	
<i>levofloxacin tab 250 mg</i>	1	
<i>levofloxacin tab 500 mg</i>	1	
<i>levofloxacin tab 750 mg</i>	1	
<i>moxifloxacin hcl tab 400 mg (base equiv)</i>	1	
<i>ofloxacin tab 300 mg</i>	1	
<i>ofloxacin tab 400 mg</i>	1	
<b>GASTROINTESTINAL AGENTS - MISC.</b>		
<b>AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC)</b>		
TRULANCE TAB 3MG	3	
<b>BILE ACID SYNTHESIS DISORDER AGENTS</b>		
CHOLBAM CAP 50MG	3	PA
CHOLBAM CAP 250MG	3	PA
<b>FARNESOID X RECEPTOR (FXR) AGONISTS</b>		
OCALIVA TAB 5MG	3	PA, QL (30 TABLETS PER 30 DAYS)
OCALIVA TAB 10MG	3	PA, QL (30 TABLETS PER 30 DAYS)
<b>GALLSTONE SOLUBILIZING AGENTS</b>		
CHENODAL TAB 250MG	3	
URSO 250 TAB 250MG	2	
URSO FORTE TAB 500MG	2	
<i>ursodiol cap 300 mg</i>	1	
<i>ursodiol tab 250 mg</i>	1	
<i>ursodiol tab 500 mg</i>	1	
<b>GASTROINTESTINAL ANTIALLERGY AGENTS</b>		
<i>cromolyn sodium oral conc 100 mg/5ml</i>	1	
GASTROCROM CON 100/5ML	3	

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

167

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS</b>		
<i>lubiprostone cap 8 mcg</i>	1	
<i>lubiprostone cap 24 mcg</i>	1	
<b>GASTROINTESTINAL STIMULANTS</b>		
METOCLOPRAMI TAB 10MG ODT	3	
<i>metoclopramide hcl orally disintegrating tab 5 mg (base eq)</i>	1	
<i>metoclopramide hcl soln 5 mg/5ml (10 mg/10ml) (base equiv)</i>	1	
<i>metoclopramide hcl tab 5 mg (base equivalent)</i>	1	
<i>metoclopramide hcl tab 10 mg (base equivalent)</i>	1	
REGLAN TAB 5MG	3	
REGLAN TAB 10MG	3	
<b>INFLAMMATORY BOWEL AGENTS</b>		
APRISO CAP 0.375GM	3	
AZULFIDINE TAB 500MG	3	
AZULFIDINE TAB 500MG EN	3	
<i>balsalazide disodium cap 750 mg</i>	1	
CANASA SUP 1000MG	3	
DIPENTUM CAP 250MG	3	
<i>mesalamine cap dr 400 mg</i>	1	
<i>mesalamine cap er 24hr 0.375 gm</i>	1	
<i>mesalamine cap er 500 mg</i>	1	
<i>mesalamine enema 4 gm</i>	1	
<i>mesalamine rectal enema 4 gm &amp; cleanser wipe kit</i>	1	
<i>mesalamine suppos 1000 mg</i>	1	
<i>mesalamine tab delayed release 1.2 gm</i>	1	
<i>mesalamine tab delayed release 800 mg</i>	1	
ROWASA KIT 4GM	3	
SFROWASA ENE 4GM	3	

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

168

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

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

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

169

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PERIPHERAL OPIOID RECEPTOR ANTAGONISTS</b>		
<i>alvimopan cap 12 mg</i>	1	
ENTEREG CAP 12MG	3	
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
<b>PHOSPHATE BINDER AGENTS</b>		
AURYXIA TAB 210MG	2	
<i>calcium acetate (phosphate binder) cap 667 mg (169 mg ca)</i>	1	
PHOSLYRA SOL	3	
RENAGEL TAB 800MG	3	
<i>sevelamer carbonate packet 0.8 gm</i>	1	
<i>sevelamer carbonate packet 2.4 gm</i>	1	
<i>sevelamer carbonate tab 800 mg</i>	1	
<i>sevelamer hcl tab 400 mg</i>	1	
<i>sevelamer hcl tab 800 mg</i>	1	
VELPHORO CHW 500MG	2	
<b>SHORT BOWEL SYNDROME (SBS) AGENTS</b>		
GATTEX KIT 5MG	3	PA, QL (ONE 30-VIAL KIT PER 30 DAYS)
<b>TRYPTOPHAN HYDROXYLASE INHIBITORS</b>		
XERMELO TAB 250MG	3	PA, QL (90 TABLETS PER 30 DAYS)
<b>GENITOURINARY AGENTS - MISCELLANEOUS</b>		
<b>ACIDIFIERS</b>		
K-PHOS TAB NO 2	3	
<b>ALKALINIZERS</b>		
ORACIT SOL	3	
<i>pot &amp; sod citrates w/ cit ac soln 550-500-334 mg/5ml</i>	1	
<i>potassium citrate &amp; citric acid powder pack 3300-1002 mg</i>	1	

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

170

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>potassium citrate &amp; citric acid soln 1100-334 mg/5ml</i>	1	
<i>potassium citrate tab er 5 meq (540 mg)</i>	1	
<i>potassium citrate tab er 10 meq (1080 mg)</i>	1	
<i>potassium citrate tab er 15 meq (1620 mg)</i>	1	
<i>sodium citrate &amp; citric acid soln 500-334 mg/5ml</i>	1	
UROCIT-K 5 TAB	2	
UROCIT-K 10 TAB	2	
UROCIT-K 15 TAB	2	
<b>CYSTITINOSIS AGENTS</b>		
CYSTAGON CAP 50MG	2	PA
CYSTAGON CAP 150MG	2	PA
<b>PROSTATIC HYPERTROPHY AGENTS</b>		
<i>alfuzosin hcl tab er 24hr 10 mg</i>	1	
AVODART CAP 0.5MG	3	
CARDURA XL TAB 4MG	3	
CARDURA XL TAB 8MG	3	
<i>dutasteride cap 0.5 mg</i>	1	
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	1	
<i>finasteride tab 5 mg</i>	1	
FLOMAX CAP 0.4MG	3	
PROSCAR TAB 5MG	3	
<i>silodosin cap 4 mg</i>	1	
<i>silodosin cap 8 mg</i>	1	
<i>tamsulosin hcl cap 0.4 mg</i>	1	
<b>URINARY ANALGESICS</b>		
<i>phenazopyridine hcl tab 200 mg</i>	1	
<b>URINARY STONE AGENTS</b>		
<i>tiopronin tab 100 mg</i>	1	PA
<b>GOUT AGENTS</b>		
<b>GOUT AGENT COMBINATIONS</b>		
<i>colchicine w/ probenecid tab 0.5-500 mg</i>	1	

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

171

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>GOUT AGENTS</b>		
<i>allopurinol tab 100 mg</i>	1	
<i>allopurinol tab 300 mg</i>	1	
<i>colchicine tab 0.6 mg</i>	1	QL (120 tabs per 30 days)
<i>febuxostat tab 40 mg</i>	1	
<i>febuxostat tab 80 mg</i>	1	
MITIGARE CAP 0.6MG	1	QL (60 caps per 30 days); Tier 1 with DAW9
ZYLOPRIM TAB 100MG	3	
ZYLOPRIM TAB 300MG	3	
<b>URICOSURICS</b>		
<i>probenecid tab 500 mg</i>	1	
<b>HEMATOLOGICAL AGENTS - MISC.</b>		
<b>ANTIHEMOPHILIC PRODUCTS</b>		
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
<b>BRADYKININ B2 RECEPTOR ANTAGONISTS</b>		
<i>icatibant acetate subcutaneous soln pref syr 30 mg/3ml</i>	1	PA, QL (45 syringes every 90 days)
<b>COMPLEMENT INHIBITORS</b>		
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)
<b>HEMATAOLOGIC - TYROSINE KINASE INHIBITORS</b>		
TAVALISSE TAB 100MG	2	PA, QL (60 TABLETS PER 30 DAYS)
TAVALISSE TAB 150MG	2	PA, QL (60 TABLETS PER 30 DAYS)
<b>HEMATORHEOLOGIC AGENTS</b>		
<i>pentoxifylline tab er 400 mg</i>	1	
<b>PA</b> - Prior Authorization <b>QL</b> - Quantity Limits <b>ST</b> - Step Therapy		172

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

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

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

173

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ZAVESCA CAP 100MG	3	PA, QL (90 CAPSULES PER 30 DAYS)
<b>AGENTS FOR SICKLE CELL DISEASE</b>		
DROXIA CAP 200MG	3	
DROXIA CAP 300MG	3	
DROXIA CAP 400MG	3	
ENDARI POW 5GM	2	PA, QL (180 PACKETS PER 30 DAYS)
SIKLOS TAB 100MG	2	
SIKLOS TAB 1000MG	2	
<b>COBALAMINS</b>		
<i>cyanocobalamin inj 1000 mcg/ml</i>	1	PA
NASCOBAL SPR 500MCG	3	
<b>FOLIC ACID/FOLATES</b>		
<i>folic acid cap 0.8 mg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 1 mg</i>	1	
<i>folic acid tab 400 mcg</i>	0	\$0 copay for women younger than 55
<i>folic acid tab 800 mcg</i>	0	\$0 copay for women younger than 55
<b>HEMATOPOIETIC GROWTH FACTORS</b>		
ARANESP INJ 10MCG	2	PA
ARANESP INJ 25MCG	2	PA
ARANESP INJ 40MCG	2	PA
ARANESP INJ 60MCG	2	PA
ARANESP INJ 100MCG	2	PA
ARANESP INJ 150MCG	2	PA
ARANESP INJ 200MCG	2	PA
ARANESP INJ 300MCG	2	PA
ARANESP INJ 500MCG	2	PA
DOPTELET TAB 20MG	2	PA, QL (60 tabs every 30 days)
DOPTELET TAB 20MG	2	PA, QL (90 tabs every 30 days)

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

174

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FYLNETRA INJ 6MG/0.6	2	PA, QL (2 SYRINGES PER 28 DAYS)
MULPLETA TAB 3MG	3	PA, QL (7 TABLETS PER 14 DAYS)
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	2	PA, QL (2 SYRINGES PER 28 DAYS)
PROCRIT INJ 2000/ML	2	PA; MNPA
PROCRIT INJ 3000/ML	2	PA; MNPA
PROCRIT INJ 4000/ML	2	PA; MNPA
PROCRIT INJ 10000/ML	2	PA; MNPA
PROCRIT INJ 20000/ML	2	PA; MNPA
PROCRIT INJ 40000/ML	2	PA; MNPA
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)
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

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

175

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

Drug Name	Drug Tier	Requirements/Limits
-----------	-----------	---------------------

**HEMOSTATICS****HEMOSTATICS - SYSTEMIC**

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

**HEMOSTATICS - TOPICAL**

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

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

<i>phenobarbital elixir 20 mg/5ml</i>	1	
<i>phenobarbital tab 15 mg</i>	1	
<i>phenobarbital tab 16.2 mg</i>	1	
<i>phenobarbital tab 30 mg</i>	1	
<i>phenobarbital tab 32.4 mg</i>	1	
<i>phenobarbital tab 60 mg</i>	1	
<i>phenobarbital tab 64.8 mg</i>	1	
<i>phenobarbital tab 97.2 mg</i>	1	
<i>phenobarbital tab 100 mg</i>	1	

**HYPNOTICS - TRICYCLIC AGENTS**

<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i>	1	
--	---	--

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

176

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i>	1	
<b>NON-BARBITURATE HYPNOTICS</b>		
AMBIEN CR TAB 6.25MG	3	
AMBIEN CR TAB 12.5MG	3	
AMBIEN TAB 5MG	3	
AMBIEN TAB 10MG	3	
DORAL TAB 15MG	3	
<i>estazolam tab 1 mg</i>	1	
<i>estazolam tab 2 mg</i>	1	
<i>eszopiclone tab 1 mg</i>	1	
<i>eszopiclone tab 2 mg</i>	1	
<i>eszopiclone tab 3 mg</i>	1	
<i>flurazepam hcl cap 15 mg</i>	1	
<i>flurazepam hcl cap 30 mg</i>	1	
HALCION TAB 0.25MG	3	
RESTORIL CAP 7.5MG	3	
RESTORIL CAP 15MG	3	
RESTORIL CAP 22.5MG	3	
RESTORIL CAP 30MG	3	
<i>temazepam cap 7.5 mg</i>	1	
<i>temazepam cap 15 mg</i>	1	
<i>temazepam cap 22.5 mg</i>	1	
<i>temazepam cap 30 mg</i>	1	
<i>triazolam tab 0.25 mg</i>	1	
<i>triazolam tab 0.125 mg</i>	1	
<i>zaleplon cap 5 mg</i>	1	
<i>zaleplon cap 10 mg</i>	1	
<i>zolpidem tartrate tab 5 mg</i>	1	
<i>zolpidem tartrate tab 10 mg</i>	1	
<i>zolpidem tartrate tab er 6.25 mg</i>	1	
<i>zolpidem tartrate tab er 12.5 mg</i>	1	
<b>OREXIN RECEPTOR ANTAGONISTS</b>		
BELSOMRA TAB 5MG	2	
BELSOMRA TAB 10MG	2	
BELSOMRA TAB 15MG	2	

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

177

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BELSOMRA TAB 20MG	2	
DAYVIGO TAB 5MG	2	
DAYVIGO TAB 10MG	2	
QUVIVIQ TAB 25MG	2	
QUVIVIQ TAB 50MG	2	
<b>SELECTIVE MELATONIN RECEPTOR AGONISTS</b>		
HETLIOZ CAP 20MG	3	PA, QL (30 CAPSULES PER 30 DAYS)
HETLIOZ LQ SUS 4MG/ML	3	PA, QL (5 ML PER DAY)
<i>ramelteon tab 8 mg</i>	1	
<i>tasimelteon capsule 20 mg</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
<b>LAXATIVES</b>		
<b>LAXATIVE COMBINATIONS</b>		
<i>bisacodyl tab &amp; peg 3350-kcl-sod bicarb-nacl for soln kit</i>	0	\$0 copay for members age 45 through 75
CLENPIQ SOL	0	\$0 copay for members age 45 through 75
NULYTELY SOL LMN/LIME	3	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 236 gm</i>	1	
<i>peg 3350-kcl-na bicarb-nacl-na sulfate for soln 240 gm</i>	1	
<i>peg 3350-kcl-sod bicarb-nacl for soln 420 gm</i>	1	
PEG-PREP KIT	0	\$0 copay for members age 45 through 75
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-3.13-1.6 gm/177ml</i>	0	\$0 copay for members age 45 through 75
<b>LAXATIVES - MISCELLANEOUS</b>		
KRISTALOSE PAK 10GM	3	
KRISTALOSE PAK 20GM	3	
<i>lactulose solution 10 gm/15ml</i>	1	
<b>STIMULANT LAXATIVES</b>		
CASCARA EXT SAGRADA	3	

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

178

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>MACROLIDES</b>		
<b>AZITHROMYCIN</b>		
<i>azithromycin for susp 100 mg/5ml</i>	1	
<i>azithromycin for susp 200 mg/5ml</i>	1	
<i>azithromycin powd pack for susp 1 gm</i>	1	
<i>azithromycin tab 250 mg</i>	1	
<i>azithromycin tab 500 mg</i>	1	
<i>azithromycin tab 600 mg</i>	1	
ZITHROMAX POW 1GM PAK	3	
ZITHROMAX SUS 100/5ML	3	
ZITHROMAX SUS 200/5ML	3	
ZITHROMAX TAB 250MG	3	
ZITHROMAX TAB 500MG	3	
ZITHROMAX TAB TRI-PAK	3	
ZITHROMAX TAB Z-PAK	3	
<b>CLARITHROMYCIN</b>		
<i>clarithromycin for susp 125 mg/5ml</i>	1	
<i>clarithromycin for susp 250 mg/5ml</i>	1	
<i>clarithromycin tab 250 mg</i>	1	
<i>clarithromycin tab 500 mg</i>	1	
<i>clarithromycin tab er 24hr 500 mg</i>	1	
<b>ERYTHROMYCINS</b>		
<i>erythromycin ethylsuccinate for susp 200 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate for susp 400 mg/5ml</i>	1	
<i>erythromycin ethylsuccinate tab 400 mg</i>	1	
<i>erythromycin stearate tab 250 mg</i>	1	
<i>erythromycin tab 250 mg</i>	1	
<i>erythromycin tab 500 mg</i>	1	
<i>erythromycin tab delayed release 250 mg</i>	1	
<i>erythromycin tab delayed release 333 mg</i>	1	
<i>erythromycin tab delayed release 500 mg</i>	1	
<i>erythromycin w/ delayed release particles cap 250 mg</i>	1	

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

179

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>FIDAXOMICIN</b>		
DIFICID SUS	2	
DIFICID TAB 200MG	2	
<b>MEDICAL DEVICES AND SUPPLIES</b>		
<b>CONTRACEPTIVES</b>		
CAYA DPR	0	QL (1 each every 300 days)
FC2 FEMALE MIS CONDOM	0	QL (12 boxes every 25 days); OTC
FC FEMALE MIS CONDOM	0	QL (12 boxes every 25 days); OTC
FEMCAP MIS 22MM	0	QL (1 each every 300 days)
FEMCAP MIS 26MM	0	QL (1 each every 300 days)
FEMCAP MIS 30MM	0	QL (1 each every 300 days)
OMNIFLEX DPR	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 60	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 65	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 70	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 75	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 80	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 85	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 90	0	QL (1 each every 300 days)
WIDE-SEAL DPR KIT 95	0	QL (1 each every 300 days)
<b>DIABETIC SUPPLIES</b>		
ACCU-CHEK KIT FASTCLIX	0	
ACCU-CHEK KIT SOFTCLIX	0	
ACCU-CHEK LIQ GUIDE	0	
ACCU-CHEK LIQ SMART	0	
ACCU-CHEK MIS MLTICLIX	0	
ACCU-CHEK SOL	0	
ACCU-CHEK SOL COMPACT	0	
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	

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

180

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

181

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
CARESENS SOL CONTROL	0	
CARETOUCH MIS EJECTOR	0	
CARETOUCH MIS LANC 26G	0	

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

182

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



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

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

183

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

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

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

184

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
EASY COMFORT MIS TWIST	0	
EASY MINI MIS	0	
EASY MINI MIS EJECT	0	
EASY PLUS II SOL HIGH	0	
EASY PLUS II SOL LOW	0	
EASY TALK SOL HIGH	0	
EASY TALK SOL LOW	0	
EASY TALK SOL NORMAL	0	
EASY TOUCH MIS	0	
EASY TOUCH MIS LANC/21G	0	
EASY TOUCH MIS LANC/23G	0	
EASY TOUCH MIS LANC/26G	0	
EASY TOUCH MIS LANC/28G	0	
EASY TOUCH MIS LANC/30G	0	
EASY TOUCH MIS LANC/32G	0	
EASY TOUCH MIS LANC/33G	0	
EASY TOUCH SOL CONTROL	0	
EASY TOUCH SOL HIGH/LOW	0	
EASY TRAK II LIQ NORMAL	0	
EASY TRAK SOL HIGH	0	
EASY TRAK SOL LOW	0	
EASY TRAK SOL NORMAL	0	
EASYGLUCO SOL PLUS	0	
EASYMAX 15 LIQ LEVEL2-3	0	
EASYMAX 15 SOL LEVEL 2	0	
EASYMAX LIQ NORM/HIG	0	
EASYMAX SOL NORMAL	0	
EASYSSTEP HGH SOL CONTROL	0	
EASYSSTEP LOW SOL CONTROL	0	
ELEMENT CONT LIQ NORMAL	0	
ELEMENT LIQ HIGH	0	
ELEMENT LIQ LOW	0	
ELEMNT COMPA SOL LEVEL 2	0	
ELEMNT COMPA SOL LEVEL 3	0	
EMBRACE CNTR LIQ HIGH	0	

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

185

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

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

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

186

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
FORTISCARE SOL CNTL NML	0	
FREESTYLE LIQ CONTROL	0	
FREESTYLE MIS LANCETS	0	
FREESTYLE MIS UNISTICK	0	
G4 PLAT PED MIS RVC/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS PEDIATRC	0	QL (1 each every year)
G4 PLATINUM MIS RCV/SHAR	0	QL (1 each every year)
G4 PLATINUM MIS RECEIVER	0	
G4 PLATINUM MIS TRANSMIT	0	
G4 SENSOR MIS	0	QL (3 sensors per month)
G5/G4 MIS SENSOR	0	QL (3 sensors per month)
GE100 CONTRL SOL NORMAL	0	
GENTEEL LANC KIT BLUE	0	
GENTEEL MIS LANCETS	0	
GENTEEL MIS NOZZLES	0	
GENTEEL PLUS MIS BLACK	0	
GENTEEL PLUS MIS BLUE	0	
GENTEEL PLUS MIS PINK	0	
GENTEEL PLUS MIS PURPLE	0	
GENTEEL PLUS MIS WHITE	0	
GENTEEL TIPS MIS BLUE	0	
GENTEEL TIPS MIS CLEAR	0	
GENTEEL TIPS MIS GREEN	0	
GENTEEL TIPS MIS ORANGE	0	
GENTEEL TIPS MIS RAINBOW	0	
GENTEEL TIPS MIS VIOLET	0	
GENTEEL TIPS MIS YELLOW	0	
GENTLE-LET MIS 26G	0	
GENTLE-LET MIS 28G	0	
GENTLE-LET MIS LANCETS	0	
GENTLE-LET MIS PLATFORM	0	
GLOBAL 28G MIS LANCETS	0	
GLOBAL 30G MIS LANCETS	0	
GLOBAL LANC MIS DEVICE	0	
GLUC CONTROL LIQ NORMAL	0	

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

187

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
HC LANCING MIS DEVICE	0	

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

188

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	

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

189

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

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

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

190

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
MEIJER LANCE MIS COLOR	0	
MEIJER LANCE MIS UNIV 21G	0	
MEIJER LANCE MIS UNIV 30G	0	
MEIJER LANCE MIS UNIVERSA	0	
MEIJER MIS LANCETS	0	
MICRO THIN MIS LANC 33G	0	
MICRODOT CON SOL HIGH/LOW	0	
MICROLET MIS LANCETS	0	
MICROLET MIS NEXT	0	
MINI LANCING MIS DEVICE	0	
MM LANCING MIS DEVICE	0	
MM TWIST MIS LANCETS	0	
MOBILE LANCE MIS 30G	0	
MONOLET MIS LANCETS	0	
MONOLET OPD MIS LANCETS	0	
MONOLETTOR MIS LANCETS	0	
MPD SFTY LAN MIS 21G	0	
MPD SFTY LAN MIS 23G	0	
MPD SFTY LAN MIS 28G	0	
MPD SFTY LAN MIS 30G	0	
MULTI-LANCET KIT DEVICE	0	
MULTI-LANCET MIS DEVICE	0	
MYGLUCOHEALT MIS LANC 30G	0	
MYGLUCOHEALT SOL LO/NL/HI	0	
NEUTEK 2TEK SOL CONTROL	0	
NOVA MAX GLU LIQ /KET CON	0	
NOVA SAFETY MIS LANC 23G	0	
NOVA SAFETY MIS LANC 28G	0	
NOVA SURE MIS LANCETS	0	
NOVA SUREFLX MIS LANC DEV	0	
OMNIPOD 5 G6 KIT INTRO	0	PA, QL (1 kit per 999 days)
OMNIPOD 5 G6 MIS PODS	0	PA, QL (10 pods per month)
OMNIPOD MIS CLASSIC	0	PA, QL (10 pods per month)

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

191

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

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

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

192

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

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

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

193

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

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

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

194

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
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	

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

195

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TECHLITE MIS LANCETS	0	
TGT LANCET MIS 26G	0	
TGT LANCET MIS 30G	0	
TGT LANCET MIS 33G	0	
TGT LANCING MIS DEVICE	0	
THIN LANCETS MIS	0	
THIN LANCETS MIS 26G	0	
THIN LANCETS MIS 30G	0	
THINLETS GP MIS 26G	0	
TOPCARE MIS LANC 33G	0	
TRAVEL LANCE MIS 30G	0	
TRAVEL LANCE MIS ADV 28G	0	
TRUE METRIX SOL LEVEL 1	0	
TRUE METRIX SOL LEVEL 2	0	
TRUE METRIX SOL LEVEL 3	0	
TRUECONTROL LIQ LEVEL 0	0	
TRUECONTROL LIQ LEVEL 1	0	
TRUEDRAW MIS LANC DEV	0	
TRUPLUS LANC MIS 26G	0	
TRUPLUS LANC MIS 28G	0	
TRUPLUS LANC MIS 30G	0	
TRUPLUS LANC MIS 33G	0	
TWIST LANCET MIS 30G MULT	0	
ULTI-LANCE MIS CLR TIP	0	
ULTILET MIS 26G	0	
ULTILET MIS 28G	0	
ULTILET MIS 30G	0	
ULTILET MIS 33G	0	
ULTILET MIS LANCETS	0	
ULTILET MIS SAFETY	0	
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	

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

196

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

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

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

197

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
UNISTIK 3 MIS GENT 30G	0	
UNISTIK 3 MIS NEONATAL	0	
UNISTIK 3 MIS NORMAL	0	
UNISTIK 3 MIS XTR 21G	0	
UNISTIK CZT MIS COMFORT	0	
UNISTIK CZT MIS NORMAL	0	
UNISTIK II MIS LANCETS	0	
UNISTIK PRO MIS LANC 21G	0	
UNISTIK PRO MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 28G	0	
UNISTIK SAFE MIS LANC 30G	0	
UNISTIK TOUC MIS LANC 21G	0	
UNISTIK TOUC MIS LANC 23G	0	
UNISTIK TOUC MIS LANC 28G	0	
UNISTIK TOUC MIS LANC 30G	0	
UNITSTIK PRO MIS LANC 25G	0	
UNIVERSAL 1 MIS 33G	0	
UNIVERSAL 1 MIS LANC 26G	0	
UNIVERSAL 1 MIS LANC 30G	0	
V-GO 20 KIT	0	PA, QL (30 pumps per month)
V-GO 30 KIT	0	QL (30 pumps per month)
V-GO 40 KIT	0	QL (30 pumps per month)
VANTAGE LANC MIS DEVICE	0	
VERASENS LIQ LEVEL 1	0	
VIVAGUARD LIQ CONTROL	0	
VIVAGUARD MIS 28G	0	
VIVAGUARD MIS 30G	0	
VIVAGUARD MIS LANCING	0	
<b>MISC. DEVICES</b>		
ALCOH-GLOVE PAD CONTOURE	0	
ALCOH-WIPE MIS 12"X12"	3	
ALCOHOL PAD	0	
ALCOHOL PAD 70%	0	
ALCOHOL PAD PREP	0	

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

198

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ALCOHOL PAD SWABSTIC	0	
ALCOHOL PREP PAD	0	
ALCOHOL PREP PAD 70%	0	
ALCOHOL PREP PAD MED 70%	0	
ALCOHOL PREP PAD PADS 70%	0	
ALCOHOL SWAB PAD	0	
ALCOHOL SWAB PAD 70%	0	
ALCOHOL SWAB PAD EX-THICK	0	
ALCOHOL WIPE PAD	0	
APLICARE ALC PAD SWABSTIC	0	
BD SWAB BFLY PAD SNGL USE	0	
CARETOUCH PAD ALCOHOL	0	
CURITY PREP PAD ALCOHOL	0	
CURITY SWABS PAD ALCOHOL	0	
EASY COMFORT PAD ALCOHOL	0	
FIFTY50 PREP PAD PADS	0	
GLOBAL PREP PAD PADS	0	
GNP ALCOHOL PAD SWABS	0	
HM STERILE PAD ALCHOL	0	
INCONTROL PAD ALCOHOL	0	
PREP PADS PAD	0	
PRO COMFORT PAD ALCOHOL	0	
PURE COMFORT PAD	0	
QC ALCOHOL PAD SWABS	0	
REALITY SWAB PAD	0	
SAPS CARE PAD ALCOHOL	0	
SAPS HEALTH PAD ALCOHOL	0	
SB ALCOHOL PAD PREP	0	
SM ALCOHOL PAD PREP	0	
ULTICARE PAD ALCOHOL	0	
ULTILET PAD ALCOHOL	0	
WEBCOL PREP PAD LARGE	0	
WEBCOL PREP PAD MEDIUM	0	
<b>PARENTERAL THERAPY SUPPLIES</b>		
BD U-500 MIS 31GX6MM	0	

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

199

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BD ULTRAFINE INSULIN SYRINGES/NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
BD ULTRAFINE PEN NEEDLES	0	
CEQR SIMPL KIT PATCH 2U	0	
INPEN 100EL MIS BLUE-HUM	0	
<b>RESPIRATORY THERAPY SUPPLIES</b>		
AERCHMBR PLS MIS FLOW-VU	3	
AERCHMBR PLS MIS LRG MASK	3	
AERCHMBR PLS MIS MED MASK	3	
AERCHMBR PLS MIS SM MASK	3	
AERCHMBR Z- MIS STAT PLS	3	
AEROCHAMBER KIT ACTION	3	
AEROCHAMBER MIS CHAMBER	3	
AEROCHAMBER MIS FLOSIGNA	3	
AEROCHAMBER MIS MV	3	
AEROCHAMBER MIS PLUS	3	
AEROVENT MIS PLUS	3	
BREATHE EASE MIS LG MASK	3	
BREATHE EASE MIS MED MASK	3	
BREATHE EASE MIS SM MASK	3	
COMPACT SPAC MIS CHAMBER	3	
COMPACT SPAC MIS LG MASK	3	
COMPACT SPAC MIS MD MASK	3	
COMPACT SPAC MIS SM MASK	3	
EASIVENT MIS	3	
EASIVENT MIS MASK LG	3	
EASIVENT MIS MASK MED	3	
EASIVENT MIS MASK SM	3	
FLEXICHAMBER MIS	3	
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	

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

200

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INSPIRACHAMB MIS MEDIUM	3	
INSPIRACHAMB MIS MOUTHPC	3	
INSPIRACHAMB MIS SMALL	3	
INSPIREASE MIS DD SYST	3	
INSPIREASE MIS RES BAG	3	
MICROCHAMBER MIS	3	
OPTICHAMBER MIS DIA MD	3	
OPTICHAMBER MIS DIA SM	3	
OPTICHAMBER MIS DIAMOND	3	
POCKET CHAMB MIS	3	
POCKET SPACE MIS	3	
RITEFLO MIS	3	
TRUZONE PEAK MIS FLOW MTR	3	

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

AIMOVIG INJ 70MG/ML	2	ST, PA, QL (2 pens every 25 days)
AIMOVIG INJ 140MG/ML	2	ST, PA, QL (1 pen every 25 days)
AJOVY INJ 225/1.5	2	ST, QL (3 auto-injectors every 75 days)
AJOVY INJ 225/1.5	2	ST, QL (3 syringes every 75 days)
EMGALITY INJ 100MG/ML	2	ST, QL (3 syringes every 25 days)
EMGALITY INJ 120MG/ML	2	ST, QL (2 pens every 25 days); Loading Dose: 2 injectors per month; Maintenance Dose: 1 injector per month
EMGALITY INJ 120MG/ML	2	ST, QL (2 syringes every 25 days); Loading Dose: 2 syringes per month; Maintenance Dose: 1 syringe per month

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

201

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NURTEC TAB 75MG ODT	2	PA, QL (16 tabs every 25 days)
QULIPTA TAB 10MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 30MG	2	ST, QL (30 tabs every 25 days)
QULIPTA TAB 60MG	2	ST, QL (30 tabs every 25 days)
UBRELVY TAB 50MG	2	PA, QL (16 ea every 25 days)
UBRELVY TAB 100MG	2	PA, QL (16 ea every 25 days)
<b>MIGRAINE PRODUCTS</b>		
ERGOMAR SUB 2MG	3	
MIGRANAL SPR 4MG/ML	3	QL (8.01 mL every 30 days)
TRUDHESA AER 0.725MG	3	
<b>SEROTONIN AGONISTS</b>		
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 6.25 mg</i>	1	QL (12 tabs every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 ea every 30 days)
<i>almotriptan malate tab 12.5 mg</i>	1	QL (12 tabs every 30 days)
AMERGE TAB 1MG	3	QL (12 tabs every 30 days)
AMERGE TAB 2.5MG	3	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 20 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
<i>eletriptan hydrobromide tab 40 mg (base equivalent)</i>	1	QL (12 tabs every 30 days)
FROVA TAB 2.5MG	3	QL (30 tabs every 30 days)
<i>frovatriptan succinate tab 2.5 mg (base equivalent)</i>	1	QL (30 ea every 30 days)
IMITREX INJ 4MG/0.5	3	QL (12 injections every 30 days)
IMITREX INJ 4MG/0.5	3	QL (36 injections every 30 days)

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

202

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

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

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

203

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

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

**MINERALS & ELECTROLYTES****POTASSIUM**

K-TAB TAB 8MEQ CR	3
K-TAB TAB 10MEQ CR	2
K-TAB TAB 20MEQ	3
<i>potassium chloride cap er 8 meq</i>	1

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

204

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

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

**MISCELLANEOUS THERAPEUTIC CLASSES****CHELATING AGENTS**

DEPEN TITRA TAB 250MG	3	
<i>penicillamine cap 250 mg</i>	1	
<i>penicillamine tab 250 mg</i>	1	
<i>trientine hcl cap 250 mg</i>	1	

**IMMUNOMODULATORS**

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

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

205

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

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

**IMMUNOSUPPRESSIVE AGENTS**

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

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

206

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



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

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

207

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>sirolimus tab 0.5 mg</i>	1	
<i>sirolimus tab 1 mg</i>	1	
<i>sirolimus tab 2 mg</i>	1	
<i>tacrolimus cap 0.5 mg</i>	1	
<i>tacrolimus cap 1 mg</i>	1	
<i>tacrolimus cap 5 mg</i>	1	
ZORTRESS TAB 0.5MG	3	PA
ZORTRESS TAB 0.25MG	3	PA
ZORTRESS TAB 0.75MG	3	PA
ZORTRESS TAB 1MG	3	PA
<b>POTASSIUM REMOVING AGENTS</b>		
<i>sodium polystyrene sulfonate oral susp 15 gm/60ml</i>	1	
<i>sodium polystyrene sulfonate powder</i>	1	
VELTASSA POW 8.4GM	2	
VELTASSA POW 16.8GM	2	
VELTASSA POW 25.2GM	2	
<b>PROGERIA TREATMENT AGENTS</b>		
ZOKINVY CAP 50MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
ZOKINVY CAP 75MG	3	PA, QL (120 CAPSULES PER 30 DAYS)
<b>SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS</b>		
BENLYSTA INJ 200MG/ML	3	PA, QL (4 INJ PER 28 DAYS); LOADING DOSE: 8 SYR PER 28 DAYS
<b>MOUTH/THROAT/DENTAL AGENTS</b>		
<b>ANESTHETICS TOPICAL ORAL</b>		
<i>lidocaine hcl laryngotracheal soln 4%</i>	1	
<i>lidocaine hcl viscous soln 2%</i>	1	
<b>ANTI-INFECTIVES - THROAT</b>		
<i>clotrimazole troche 10 mg</i>	1	QL (90 ea every 25 days)
<i>nystatin susp 100000 unit/ml</i>	1	
ORAVIG TAB 50MG	3	

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

208

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>ANTISEPTICS - MOUTH/THROAT</b>		
<i>chlorhexidine gluconate soln 0.12%</i>	1	
PERIDEX SOL 0.12%	3	
<b>DENTAL PRODUCTS</b>		
NAFRINSE DLY SOL /NEUTRAL	3	
NAFRINSE SOL DAILY	3	
NAFRINSE WK SOL 0.2%	3	
<i>sodium fluoride gel 1.1% (0.5% f)</i>	1	
<b>STEROIDS - MOUTH/THROAT/DENTAL</b>		
<i>triamcinolone acetonide dental paste 0.1%</i>	1	
<b>THROAT PRODUCTS - MISC.</b>		
<i>cevimeline hcl cap 30 mg</i>	1	
EVOXAC CAP 30MG	2	
ORAFATE PST 10%	3	
<i>pilocarpine hcl tab 5 mg</i>	1	
<i>pilocarpine hcl tab 7.5 mg</i>	1	
PROTHELIAL PST 10%	3	
SALAGEN TAB 5MG	2	
SALAGEN TAB 7.5MG	2	
<b>MULTIVITAMINS</b>		
<b>PRENATAL VITAMINS</b>		
<i>prenat w/o a w/fefum-methfol-fa-dha cap 27-0.6-0.4-300 mg</i>	1	
<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1 mg</i>	1	
<i>prenatal vit w/ fe fum-methylfolate-fa tab 27-0.6-0.4 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa chew tab 29-1 mg</i>	1	
<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i>	1	
<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i>	1	
<b>MUSCULOSKELETAL THERAPY AGENTS</b>		
<b>CENTRAL MUSCLE RELAXANTS</b>		
<i>baclofen tab 5 mg</i>	1	
<i>baclofen tab 10 mg</i>	1	
<i>baclofen tab 20 mg</i>	1	

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

209

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>carisoprodol tab 350 mg</i>	1	QL (84 tabs every 25 days)
<i>chlorzoxazone tab 500 mg</i>	1	
<i>cyclobenzaprine hcl tab 5 mg</i>	1	
<i>cyclobenzaprine hcl tab 10 mg</i>	1	
LYVISPAH GRA 5MG	2	
LYVISPAH GRA 10MG	2	
LYVISPAH GRA 20MG	2	
<i>metaxalone tab 800 mg</i>	1	
<i>methocarbamol tab 500 mg</i>	1	
<i>methocarbamol tab 750 mg</i>	1	
<i>orphenadrine citrate tab er 12hr 100 mg</i>	1	
SKELAXIN TAB 800MG	2	
SOMA TAB 250MG	3	QL (84 tabs every 25 days)
SOMA TAB 350MG	3	QL (84 tabs every 25 days)
<i>tizanidine hcl cap 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 4 mg (base equivalent)</i>	1	
<i>tizanidine hcl cap 6 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	1	
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	1	
ZANAFLEX CAP 2MG	3	
ZANAFLEX CAP 4MG	3	
ZANAFLEX CAP 6MG	3	
ZANAFLEX TAB 4MG	3	
<b>DIRECT MUSCLE RELAXANTS</b>		
DANTRIUM CAP 25MG	2	
DANTRIUM CAP 50MG	2	
<i>dantrolene sodium cap 25 mg</i>	1	
<i>dantrolene sodium cap 50 mg</i>	1	
<i>dantrolene sodium cap 100 mg</i>	1	
<b>MUSCLE RELAXANT COMBINATIONS</b>		
<i>carisoprodol w/ aspirin &amp; codeine tab 200-325-16 mg</i>	1	QL (168 tabs every 25 days)

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

210

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>NASAL AGENTS - SYSTEMIC AND TOPICAL</b>		
<b>NASAL AGENT COMBINATIONS</b>		
<i>azelastine hcl-fluticasone prop nasal spray 137-50 mcg/act</i>	1	QL (1 package (23gm) per 25 days)
<b>NASAL AGENTS - MISC.</b>		
NOZIN NASAL MIS SANITIZE	0	
<b>NASAL ANTIALLERGY</b>		
<i>azelastine hcl nasal spray 0.1% (137 mcg/spray)</i>	1	
<i>azelastine hcl nasal spray 0.15% (205.5 mcg/spray)</i>	1	
<i>olopatadine hcl nasal soln 0.6%</i>	1	QL (1 package (30.5gm) per 25 days)
PATANASE SPR 0.6%	3	QL (1 package (30.5gm) per 25 days)
<b>NASAL ANTICHOLINERGICS</b>		
<i>ipratropium bromide nasal soln 0.03% (21 mcg/spray)</i>	1	
<i>ipratropium bromide nasal soln 0.06% (42 mcg/spray)</i>	1	
<b>NASAL STEROIDS</b>		
<i>flunisolide nasal soln 25 mcg/act (0.025%)</i>	1	QL (3 packages (25mL each) per 25 days)
<i>fluticasone propionate nasal susp 50 mcg/act</i>	1	QL (1 package (16gm) per 25 days)
<i>mometasone furoate nasal susp 50 mcg/act</i>	1	QL (2 packages (17gm each) per 25 days)
NASONEX SPR 50MCG/AC	3	QL (2 packages (17gm each) per 25 days)
XHANCE MIS 93MCG	3	PA, QL (2 packages (16mL each) per 25 days)
<b>NEUROMUSCULAR AGENTS</b>		
<b>ALS AGENTS</b>		
RADICAVA ORS SUS 105/5ML	3	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)

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

211

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
RADICAVA ORS SUS STARTER	3	PA, QL (50ML (1 BOTTLE) FOR 28 DAYS)
RILUTEK TAB 50MG	3	
<i>riluzole tab 50 mg</i>	1	
<b>SPINAL MUSCULAR ATROPHY AGENTS (SMA)</b>		
EVRYSDI SOL	3	PA, QL (2 BOTTLES (120 MG) PER 24 DAYS)
<b>NUTRIENTS</b>		
<b>MISC. NUTRITIONAL SUBSTANCES</b>		
ALTEMIA EMU	3	
<b>OPHTHALMIC AGENTS</b>		
<b>BETA-BLOCKERS - OPTHALMIC</b>		
<i>betaxolol hcl ophth soln 0.5%</i>	1	
BETOPTIC-S SUS 0.25% OP	2	
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i>	1	
<i>carteolol hcl ophth soln 1%</i>	1	
COSOPT PF SOL 2%-0.5%	3	
COSOPT SOL 2-0.5%OP	3	
<i>dorzolamide hcl-timolol maleate ophth soln 2-0.5%</i>	1	
<i>dorzolamide hcl-timolol maleate pf ophth soln 2-0.5%</i>	1	
ISTALOL SOL 0.5% OP	3	
<i>levobunolol hcl ophth soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.5%</i>	1	
<i>timolol maleate ophth gel forming soln 0.25%</i>	1	
<i>timolol maleate ophth soln 0.5%</i>	1	
<i>timolol maleate ophth soln 0.5% (once-daily)</i>	1	
<i>timolol maleate ophth soln 0.25%</i>	1	
<i>timolol maleate preservative free ophth soln 0.5%</i>	1	
TIMOPTIC SOL 0.5% OP	3	
TIMOPTIC SOL 0.25% OP	3	
TIMOPTIC-XE SOL 0.5% OP	3	

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

212

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
TIMOPTIC-XE SOL 0.25% OP	3	
<b>CYCLOPLEGIC MYDRIATICS</b>		
ATROPINE SUL SOL 1% OP	3	
CYCLOGYL SOL 0.5% OP	3	
CYCLOGYL SOL 1% OP	3	
CYCLOGYL SOL 2% OP	3	
CYCLOMYDRIL SOL OP	3	
<i>cyclopentolate hcl ophth soln 0.5%</i>	1	
<i>cyclopentolate hcl ophth soln 1%</i>	1	
<i>cyclopentolate hcl ophth soln 2%</i>	1	
ISOPTO ATROP SOL 1% OP	3	
<i>phenylephrine hcl ophth soln 2.5%</i>	1	
<i>phenylephrine hcl ophth soln 10%</i>	1	
<b>MIOTICS</b>		
ISOPTO CARP SOL 1% OP	3	
ISOPTO CARP SOL 2% OP	3	
ISOPTO CARP SOL 4% OP	3	
PHOSPHOLINE SOL 0.125%OP	3	
<i>pilocarpine hcl ophth soln 1%</i>	1	
<i>pilocarpine hcl ophth soln 2%</i>	1	
<i>pilocarpine hcl ophth soln 4%</i>	1	
<b>OPHTHALMIC ADRENERGIC AGENTS</b>		
ALPHAGAN P SOL 0.1%	2	
ALPHAGAN P SOL 0.15%	2	
<i>apraclonidine hcl ophth soln 0.5% (base equivalent)</i>	1	
<i>brimonidine tartrate ophth soln 0.2%</i>	1	
<i>brimonidine tartrate ophth soln 0.15%</i>	1	
IOPIDINE SOL 1% OP	3	
SIMBRINZA SUS 1-0.2%	2	
<b>OPHTHALMIC ANTI-INFECTIVES</b>		
<i>bacitracin ophth oint 500 unit/gm</i>	1	
<i>bacitracin-polymyxin b ophth oint</i>	1	
BESIVANCE SUS 0.6%	2	
BETADINE SOL 5% OP	3	

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

213

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
BLEPH-10 SOL 10% OP	3	
<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i>	1	
<i>erythromycin ophth oint 5 mg/gm</i>	1	
<i>gatifloxacin ophth soln 0.5%</i>	1	
<i>gentamicin sulfate ophth oint 0.3%</i>	1	
<i>gentamicin sulfate ophth soln 0.3%</i>	1	QL (4 mL every 25 days)
<i>levofloxacin ophth soln 0.5%</i>	1	
MITOSOL KIT 0.2MG	3	
MOXEZA SOL 0.5%	3	
<i>moxifloxacin hcl ophth soln 0.5% (base eq) (2 times daily)</i>	1	
<i>moxifloxacin hcl ophth soln 0.5% (base equiv)</i>	1	
NATACYN SUS 5% OP	3	
<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-400unt-10000unt op oin</i>	1	
<i>neomycin-polymy-gramicid op sol 1.75-10000-0.025mg-unt-mg/ml</i>	1	
OCUFLOX DRO 0.3% OP	3	
<i>ofloxacin ophth soln 0.3%</i>	1	
<i>polymyxin b-trimethoprim ophth soln 10000 unit/ml-0.1%</i>	1	
POLYTRIM SOL OP	3	
POVIDONE IOD SOL 5%	3	
<i>sulfacetamide sodium ophth oint 10%</i>	1	
<i>sulfacetamide sodium ophth soln 10%</i>	1	
<i>tobramycin ophth soln 0.3%</i>	1	
TOBEX OIN 0.3% OP	3	
TOBEX SOL 0.3% OP	3	
<i>trifluridine ophth soln 1%</i>	1	
VIGAMOX DRO 0.5%	3	
ZYMAXID SOL 0.5%	3	
<b>OPHTHALMIC IMMUNOMODULATORS</b>		
RESTASIS EMU 0.05% OP	1	PA; Tier 1 with DAW9
RESTASIS MUL EMU 0.05% OP	2	PA

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

214

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OPHTHALMIC INTEGRIN ANTAGONISTS</b>		
XIIDRA DRO 5%	2	PA
<b>OPHTHALMIC LOCAL ANESTHETICS</b>		
AKTEN GEL 3.5%	3	
ALCAINE SOL 0.5% OP	3	
<i>proparacaine hcl ophth soln 0.5%</i>	1	
<i>tetracaine hcl ophth soln 0.5%</i>	1	
<b>OPHTHALMIC NERVE GROWTH FACTORS</b>		
OXERVATE SOL 20MCG/ML	3	PA, QL (16 CARTONS PER 56 DAYS - ONE TIME TREATMENT)
<b>OPHTHALMIC STEROIDS</b>		
<i>bacitracin-polymyxin-neomycin-hc ophth oint 1%</i>	1	
BLEPHAMIDE OIN S.O.P.	3	
BLEPHAMIDE SUS OP	3	
<i>dexamethasone sodium phosphate ophth soln 0.1%</i>	1	
<i>difluprednate ophth emulsion 0.05%</i>	1	
DUREZOL EMU 0.05%	3	
EYSUVIS DRO 0.25%	3	PA
<i>fluorometholone ophth susp 0.1%</i>	1	
<i>loteprednol etabonate ophth gel 0.5%</i>	1	
<i>loteprednol etabonate ophth susp 0.5%</i>	1	
MAXITROL OIN 0.1% OP	3	
MAXITROL SUS 0.1% OP	3	
<i>neomycin-polymyxin-dexamethasone ophth oint 0.1%</i>	1	
<i>neomycin-polymyxin-dexamethasone ophth susp 0.1%</i>	1	
<i>neomycin-polymyxin-hc ophth susp</i>	1	
PRED SOD PHO SOL 1% OP	3	
PRED-G S.O.P OIN OP	3	
PRED-G SUS OP	3	
<i>prednisolone acetate ophth susp 1%</i>	1	

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

215

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PREDNISOLONE SUS 1%	3	
<i>sulfacetamide sodium-prednisolone ophth soln 10-0.23(0.25)%</i>	1	
TOBRADEX OIN 0.3-0.1%	2	
TOBRADEX SUS 0.3-0.1%	3	
<i>tobramycin-dexamethasone ophth susp 0.3-0.1%</i>	1	
<b>OPHTHALMIC SURGICAL AIDS</b>		
GELFILM MIS OP	3	
MEMBRANEBLUE INJ 0.15%	3	
VISIONBLUE INJ 0.06%	3	
<b>OPHTHALMICS - MISC.</b>		
ACULAR LS SOL 0.4%	3	
ACULAR SOL 0.5% OP	3	
ALOCRIAL SOL 2%	3	
ALOMIDE SOL 0.1% OP	3	
<i>azelastine hcl ophth soln 0.05%</i>	1	
AZOPT SUS 1% OP	3	
<i>brinzolamide ophth susp 1%</i>	1	
<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i>	1	
<i>cromolyn sodium ophth soln 4%</i>	1	
CYSTARAN SOL 0.44%	3	PA, QL (4 BOTTLES PER 28 DAYS)
<i>diclofenac sodium ophth soln 0.1%</i>	1	
<i>dorzolamide hcl ophth soln 2%</i>	1	
DORZOLAMIDE SOL 2%	3	
<i>epinastine hcl ophth soln 0.05%</i>	1	
<i>flurbiprofen sodium ophth soln 0.03%</i>	1	
ILEVRO DRO 0.3% OP	2	
<i>ketorolac tromethamine ophth soln 0.4%</i>	1	
<i>ketorolac tromethamine ophth soln 0.5%</i>	1	
PROLENSA SOL 0.07%	2	
TRUSOPT SOL 2% OP	3	

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

216

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>PROSTAGLANDINS - OPHTHALMIC</b>		
<i>bimatoprost ophth soln 0.03%</i>	1	
<i>latanoprost ophth soln 0.005%</i>	1	
<i>tafluprost preservative free (pf) ophth soln 0.0015%</i>	1	
<i>travoprost ophth soln 0.004% (benzalkonium free) (bak free)</i>	1	
XALATAN SOL 0.005%	3	
ZIOPTAN DRO 0.0015%	2	
<b>OTIC AGENTS</b>		
<b>OTIC AGENTS - MISCELLANEOUS</b>		
<i>acetic acid otic soln 2%</i>	1	
<b>OTIC ANTI-INFECTIVES</b>		
CETRAXAL SOL 0.2%	3	
<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i>	1	
<i>ofloxacin otic soln 0.3%</i>	1	
<b>OTIC COMBINATIONS</b>		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i>	1	
CORTISPORIN SUS -TC OTIC	3	
<i>neomycin-polymyxin-hc otic soln 1%</i>	1	
<i>neomycin-polymyxin-hc otic susp 3.5 mg/ml-10000 unit/ml-1%</i>	1	
<b>OTIC STEROIDS</b>		
DERMOTIC OIL 0.01%	3	
<i>fluocinolone acetonide (otic) oil 0.01%</i>	1	
<i>hydrocortisone w/ acetic acid otic soln 1-2%</i>	1	
<b>OXYTOCICS</b>		
<b>ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING</b>		
CERVIDIL VAG MIS 10MG INS	3	
PREPIDIL GEL 0.5MG/3G	3	
PROSTIN E2 SUP 20MG	3	

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

217

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>OXYTOCICS</b>		
<i>methylergonovine maleate tab 0.2 mg</i>	1	PA, QL (120 tabs every 30 days)
<b>PENICILLINS</b>		
<b>AMINOPENICILLINS</b>		
<i>amoxicillin (trihydrate) cap 250 mg</i>	1	
<i>amoxicillin (trihydrate) cap 500 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 125 mg</i>	1	
<i>amoxicillin (trihydrate) chew tab 250 mg</i>	1	
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i>	1	
<i>amoxicillin (trihydrate) tab 500 mg</i>	1	
<i>amoxicillin (trihydrate) tab 875 mg</i>	1	
<i>ampicillin cap 500 mg</i>	1	
<b>NATURAL PENICILLINS</b>		
<i>penicillin v potassium for soln 125 mg/5ml</i>	1	
<i>penicillin v potassium for soln 250 mg/5ml</i>	1	
<i>penicillin v potassium tab 250 mg</i>	1	
<i>penicillin v potassium tab 500 mg</i>	1	
<b>PENICILLIN COMBINATIONS</b>		
<i>amoxicillin &amp; k clavulanate chew tab 200-28.5 mg</i>	1	
<i>amoxicillin &amp; k clavulanate chew tab 400-57 mg</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml</i>	1	
<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i>	1	

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

218

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i>	1	
<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i>	1	
AUGMENTIN SUS 125/5ML	3	
AUGMENTIN SUS 250/5ML	3	
AUGMENTIN SUS ES-600	3	
AUGMENTIN TAB 500MG	3	
<b>PENICILLINASE-RESISTANT PENICILLINS</b>		
<i>dicloxacillin sodium cap 250 mg</i>	1	
<i>dicloxacillin sodium cap 500 mg</i>	1	
<b>PROGESTINS</b>		
<b>PROGESTINS</b>		
AYGESTIN TAB 5MG	3	
<i>medroxyprogesterone acetate tab 2.5 mg</i>	1	
<i>medroxyprogesterone acetate tab 5 mg</i>	1	
<i>medroxyprogesterone acetate tab 10 mg</i>	1	
<i>megestrol acetate susp 625 mg/5ml</i>	1	
<i>norethindrone acetate tab 5 mg</i>	1	
<i>progesterone cap 100 mg</i>	1	
<i>progesterone cap 200 mg</i>	1	
<i>progesterone im in oil 50 mg/ml</i>	1	
PROVERA TAB 2.5MG	3	
PROVERA TAB 5MG	3	
PROVERA TAB 10MG	3	
<b>PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.</b>		
<b>AGENTS FOR CHEMICAL DEPENDENCY</b>		
<i>acamprosate calcium tab delayed release 333 mg</i>	1	
<i>disulfiram tab 250 mg</i>	1	
<i>disulfiram tab 500 mg</i>	1	
<b>ANTI-CATAPLECTIC AGENTS</b>		
LUMRYZ PAK 6GM	3	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PAK 7.5GM	3	PA, QL (30 PACKETS PER 30 DAYS)

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

219

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
LUMRYZ PAK 9GM	3	PA, QL (30 PACKETS PER 30 DAYS)
LUMRYZ PKG 4.5GM	3	PA, QL (30 PACKETS PER 30 DAYS)
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**

ARICEPT TAB 5MG	3	
ARICEPT TAB 10MG	3	
ARICEPT TAB 23MG	3	
<i>donepezil hydrochloride orally disintegrating tab 5 mg</i>	1	
<i>donepezil hydrochloride orally disintegrating tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 5 mg</i>	1	
<i>donepezil hydrochloride tab 10 mg</i>	1	
<i>donepezil hydrochloride tab 23 mg</i>	1	
EXELON DIS 4.6MG/24	3	
EXELON DIS 9.5MG/24	3	
EXELON DIS 13.3/24	3	
<i>galantamine hydrobromide cap er 24hr 8 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 16 mg</i>	1	
<i>galantamine hydrobromide cap er 24hr 24 mg</i>	1	
<i>galantamine hydrobromide oral soln 4 mg/ml</i>	1	
<i>galantamine hydrobromide tab 4 mg</i>	1	
<i>galantamine hydrobromide tab 8 mg</i>	1	
<i>galantamine hydrobromide tab 12 mg</i>	1	
<i>memantine hcl cap er 24hr 7 mg</i>	1	
<i>memantine hcl cap er 24hr 14 mg</i>	1	
<i>memantine hcl cap er 24hr 21 mg</i>	1	
<i>memantine hcl cap er 24hr 28 mg</i>	1	
<i>memantine hcl oral solution 2 mg/ml</i>	1	
<i>memantine hcl tab 5 mg</i>	1	

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

220

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>memantine hcl tab 10 mg</i>	1	
<i>memantine hcl tab 28 x 5 mg &amp; 21 x 10 mg titration pack</i>	1	
NAMENDA TAB 5-10MG	3	
NAMENDA TAB 5MG	3	
NAMENDA TAB 10MG	3	
NAMENDA XR CAP 7MG	3	
NAMENDA XR CAP 14MG	3	
NAMENDA XR CAP 21MG	3	
NAMENDA XR CAP 28MG	3	
NAMENDA XR CAP TITRATIO	3	
NAMZARIC CAP	2	
NAMZARIC CAP 7-10MG	2	
NAMZARIC CAP 14-10MG	2	
NAMZARIC CAP 21-10MG	2	
NAMZARIC CAP 28-10MG	2	
RAZADYNE ER CAP 8MG	3	
RAZADYNE ER CAP 16MG	3	
RAZADYNE ER CAP 24MG	3	
<i>rivastigmine tartrate cap 1.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 3 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 4.5 mg (base equivalent)</i>	1	
<i>rivastigmine tartrate cap 6 mg (base equivalent)</i>	1	
<i>rivastigmine td patch 24hr 4.6 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 9.5 mg/24hr</i>	1	
<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	1	
<b>COMBINATION PSYCHOTHERAPEUTICS</b>		
<i>chlordiazepoxide-amitriptyline tab 5-12.5 mg</i>	1	
<i>chlordiazepoxide-amitriptyline tab 10-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 3-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-25 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 6-50 mg</i>	1	
<i>olanzapine-fluoxetine hcl cap 12-25 mg</i>	1	

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

221

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
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	
<b>FIBROMYALGIA AGENTS</b>		
SAVELLA MIS TITR PAK	3	
SAVELLA TAB 12.5MG	3	
SAVELLA TAB 25MG	3	
SAVELLA TAB 50MG	3	
SAVELLA TAB 100MG	3	
<b>MOVEMENT DISORDER DRUG THERAPY</b>		
AUSTEDO TAB 6MG	2	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO TAB 9MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO TAB 12MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 6MG	2	PA, QL (90 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 12MG	2	PA, QL (120 TABLETS PER 30 DAYS)
AUSTEDO XR TAB 24MG	2	PA, QL (60 TABLETS PER 30 DAYS)
AUSTEDO XR TAB TITR KIT	2	PA, QL (42 TABLETS PER 28 DAYS)
INGREZZA CAP 40-80MG	2	PA
INGREZZA CAP 40MG	2	PA, QL (30 CAPSULES PER 30 DAYS)

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

222

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
INGREZZA CAP 60MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
INGREZZA CAP 80MG	2	PA, QL (30 CAPSULES PER 30 DAYS)
<i>tetrabenazine tab 12.5 mg</i>	1	PA, QL (120 TABLETS PER 30 DAYS)
<i>tetrabenazine tab 25 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)

**MULTIPLE SCLEROSIS AGENTS**

AMPYRA TAB 10MG	3	PA, QL (60 TABLETS PER 30 DAYS)
AVONEX PEN KIT 30MCG	2	PA, QL (4 PENS PER 28 DAYS)
AVONEX PREFL KIT 30MCG	2	PA, QL (4 SYRINGES PER 28 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)
<i>dalfampridine tab er 12hr 10 mg</i>	1	PA, QL (60 TABLETS PER 30 DAYS)
<i>dimethyl fumarate capsule delayed release 120 mg</i>	1	PA, QL (14 CAPSULES PER 28 DAYS)
<i>dimethyl fumarate capsule delayed release 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>dimethyl fumarate capsule dr starter pack 120 mg &amp; 240 mg</i>	1	PA, QL (60 CAPSULES PER 30 DAYS)
<i>fingolimod hcl cap 0.5 mg (base equiv)</i>	1	PA, QL (30 CAPSULES PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 20 mg/ml</i>	1	PA, QL (30 SYRINGES PER 30 DAYS)
<i>glatiramer acetate soln prefilled syringe 40 mg/ml</i>	1	PA, QL (12 SYRINGES PER 28 DAYS)

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

223

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
KESIMPTA INJ 20/.4ML	2	PA, QL (1 PENS PER 28 DAYS); LOADING DOSE: 3 PENS PER 15 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)
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)

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

224

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
PONVORY TAB 20MG	3	PA, QL (30 TABLETS FOR 30 DAYS)
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 SYR PER 28 DAYS)
REBIF REBIDO INJ 44/0.5	2	PA, QL (12 SYR 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)
<i>teriflunomide tab 7 mg</i>	1	PA, QL (30 tabs every 30 days)
<i>teriflunomide tab 14 mg</i>	1	PA, QL (30 tabs every 30 days)
VUMERITY CAP 231MG	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 (1 Starter Kit per 28 days)
ZEPOSIA CAP STR KIT	2	PA, QL (37 TABLETS PER 37 DAYS)
<b>POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS</b>		
GRALISE TAB 300MG	2	QL (150 tabs every 25 days)
GRALISE TAB 450MG	2	QL (90 tablets per 25 days)
GRALISE TAB 600MG	2	QL (90 tabs every 25 days)
GRALISE TAB 750MG	2	QL (60 tablets per 25 days)

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

225

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

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

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

226

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>nicotine polacrilex gum 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 2 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine polacrilex lozenge 4 mg</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 7 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 14 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
<i>nicotine td patch 24hr 21 mg/24hr</i>	0	OTC; \$0 limited to 2 treatment cycles/year
NICOTROL INH	0	
NICOTROL NS SPR 10MG/ML	0	
<b>TRANSTHYRETIN AMYLOIDOSIS AGENTS</b>		
TEGSEDI INJ 284/1.5	2	PA, QL (4 PFS PER 28 DAYS)
<b>VASOMOTOR SYMPTOM AGENTS</b>		
BRISDELLE CAP 7.5MG	3	
<b>RESPIRATORY AGENTS - MISC.</b>		
<b>CYSTIC FIBROSIS AGENTS</b>		
KALYDECO GRA 5.8MG	3	PA, QL (56 packets per 28 days)
KALYDECO GRA 13.4MG	3	PA, QL (56 packets per 28 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	PA, QL (1 CARTON (56 TABS) PER 28 DAYS)
ORKAMBI GRA 75-94MG	3	PA, QL (56 PACKETS PER 28 DAYS)

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

227

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
ORKAMBI GRA 100-125	3	PA, QL (56 PACKETS PER 28 DAYS)
ORKAMBI GRA 150-188	3	PA, QL (56 PACKETS PER 28 DAYS)
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	3	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 PAK 59.5MG	3	PA, QL (56 packets per 28 days)
TRIKAFTA PAK 75MG	3	PA, QL (56 packets per 28 days)
TRIKAFTA TAB	3	PA, QL (84 TABLETS PER 28 DAYS)
<b>PULMONARY FIBROSIS AGENTS</b>		
ESBRIET CAP 267MG	2	PA, QL (270 CAPSULES 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)
<i>pirfenidone tab 267 mg</i>	1	QL (270 TABLETS PER 30 DAYS)
<i>pirfenidone tab 801 mg</i>	1	QL (90 TABLETS PER 30 DAYS)
<b>SULFONAMIDES</b>		
<b>SULFONAMIDES</b>		
<i>sulfadiazine tab 500 mg</i>	3	

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

228

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>TETRACYCLINES</b>		
<b>AMINOMETHYLCYCLINES</b>		
NUZYRA TAB 150MG	3	
<b>TETRACYCLINES</b>		
<i>demeclocycline hcl tab 150 mg</i>	1	
<i>demeclocycline hcl tab 300 mg</i>	1	
<i>doxycycline hyclate cap 50 mg</i>	1	
<i>doxycycline hyclate cap 100 mg</i>	1	
<i>doxycycline hyclate tab 20 mg</i>	1	
<i>doxycycline hyclate tab 100 mg</i>	1	
<i>doxycycline monohydrate cap 50 mg</i>	1	
<i>doxycycline monohydrate cap 100 mg</i>	1	
<i>doxycycline monohydrate for susp 25 mg/5ml</i>	1	
<i>doxycycline monohydrate tab 50 mg</i>	1	
<i>doxycycline monohydrate tab 75 mg</i>	1	
<i>doxycycline monohydrate tab 100 mg</i>	1	
<i>doxycycline monohydrate tab 150 mg</i>	1	
<i>minocycline hcl cap 50 mg</i>	1	
<i>minocycline hcl cap 75 mg</i>	1	
<i>minocycline hcl cap 100 mg</i>	1	
<i>minocycline hcl tab 50 mg</i>	1	
<i>minocycline hcl tab 75 mg</i>	1	
<i>minocycline hcl tab 100 mg</i>	1	
SOLODYN TAB 55MG	3	
SOLODYN TAB 65MG	3	
SOLODYN TAB 80MG	3	
SOLODYN TAB 105MG	3	
SOLODYN TAB 115MG	3	
<i>tetracycline hcl cap 250 mg</i>	1	QL (120 caps every 25 days)
<i>tetracycline hcl cap 500 mg</i>	1	QL (120 caps every 25 days)
VIBRAMYCIN CAP 100MG	3	
VIBRAMYCIN SUS 25MG/5ML	2	
VIBRAMYCIN SYP 50MG/5ML	2	

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

229

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>THYROID AGENTS</b>		
<b>ANTITHYROID AGENTS</b>		
<i>methimazole tab 5 mg</i>	1	
<i>methimazole tab 10 mg</i>	1	
<i>propylthiouracil tab 50 mg</i>	1	
TAPAZOLE TAB 5MG	2	
TAPAZOLE TAB 10MG	2	
<b>THYROID HORMONES</b>		
ARMOUR THYRO TAB 15MG	3	
ARMOUR THYRO TAB 30MG	3	
ARMOUR THYRO TAB 60MG	3	
ARMOUR THYRO TAB 90MG	3	
ARMOUR THYRO TAB 120MG	3	
ARMOUR THYRO TAB 180MG	3	
ARMOUR THYRO TAB 240MG	3	
ARMOUR THYRO TAB 300MG	3	
<i>levothyroxine sodium tab 25 mcg</i>	1	
<i>levothyroxine sodium tab 50 mcg</i>	1	
<i>levothyroxine sodium tab 75 mcg</i>	1	
<i>levothyroxine sodium tab 88 mcg</i>	1	
<i>levothyroxine sodium tab 100 mcg</i>	1	
<i>levothyroxine sodium tab 112 mcg</i>	1	
<i>levothyroxine sodium tab 125 mcg</i>	1	
<i>levothyroxine sodium tab 137 mcg</i>	1	
<i>levothyroxine sodium tab 150 mcg</i>	1	
<i>levothyroxine sodium tab 175 mcg</i>	1	
<i>levothyroxine sodium tab 200 mcg</i>	1	
<i>levothyroxine sodium tab 300 mcg</i>	1	
<i>liothyronine sodium tab 5 mcg</i>	1	
<i>liothyronine sodium tab 25 mcg</i>	1	
<i>liothyronine sodium tab 50 mcg</i>	1	
NP THYROID TAB 15MG	3	
NP THYROID TAB 30MG	3	
NP THYROID TAB 60MG	3	
NP THYROID TAB 90MG	3	

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

230

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



<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
NP THYROID TAB 120MG	3	
SYNTHROID TAB 25MCG	2	
SYNTHROID TAB 50MCG	2	
SYNTHROID TAB 75MCG	2	
SYNTHROID TAB 88MCG	2	
SYNTHROID TAB 100MCG	2	
SYNTHROID TAB 112MCG	2	
SYNTHROID TAB 125MCG	2	
SYNTHROID TAB 137MCG	2	
SYNTHROID TAB 150MCG	2	
SYNTHROID TAB 175MCG	2	
SYNTHROID TAB 200MCG	2	
SYNTHROID TAB 300MCG	2	

**ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS****ANTISPASMODICS**

ANASPAZ TAB 0.125MG	2	
BELLA/OPIUM SUP 16.2-30	3	
BELLA/OPIUM SUP 16.2-60	3	
<i>chlordiazepoxide hcl-clidinium bromide cap 5-2.5 mg</i>	1	
CUVPOSA SOL 1MG/5ML	3	
<i>dicyclomine hcl cap 10 mg</i>	1	
<i>dicyclomine hcl oral soln 10 mg/5ml</i>	1	
<i>dicyclomine hcl tab 20 mg</i>	1	
<i>glycopyrrolate oral soln 1 mg/5ml</i>	1	
<i>glycopyrrolate tab 1 mg</i>	1	
<i>glycopyrrolate tab 2 mg</i>	1	
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	1	
<i>hyoscyamine sulfate sl tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate soln 0.125 mg/ml</i>	1	
<i>hyoscyamine sulfate tab 0.125 mg</i>	1	
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	1	
LEVBID TAB 0.375 ER	3	
LEVSIN TAB 0.125MG	2	
LEVSIN/SL SUB 0.125MG	2	

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

231

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>methscopolamine bromide tab 2.5 mg</i>	1	
<i>methscopolamine bromide tab 5 mg</i>	1	
SYMAX DUOTAB TAB	3	
<b>H-2 ANTAGONISTS</b>		
<i>cimetidine hcl soln 300 mg/5ml</i>	1	
<i>cimetidine tab 300 mg</i>	1	
<i>cimetidine tab 400 mg</i>	1	
<i>cimetidine tab 800 mg</i>	1	
<i>famotidine for susp 40 mg/5ml</i>	1	
<i>famotidine tab 40 mg</i>	1	
<i>nizatidine cap 150 mg</i>	1	
<i>nizatidine cap 300 mg</i>	1	
<i>nizatidine oral soln 15 mg/ml</i>	1	
PEPCID TAB 40MG	3	
<b>MISC. ANTI-ULCER</b>		
<i>sucralfate tab 1 gm</i>	1	
<b>PROTON PUMP INHIBITORS</b>		
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i>	1	QL (90 caps every year)
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i>	1	QL (90 packets every year)
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i>	1	QL (90 packets every year)
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i>	1	QL (90 packets every year)
<i>lansoprazole cap delayed release 15 mg</i>	1	QL (90 caps every year)
<i>lansoprazole cap delayed release 30 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 10 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 20 mg</i>	1	QL (90 caps every year)
<i>omeprazole cap delayed release 40 mg</i>	1	QL (90 caps every year)
<i>pantoprazole sodium ec tab 20 mg (base equiv)</i>	1	QL (90 tabs every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 ea every year)
<i>pantoprazole sodium ec tab 40 mg (base equiv)</i>	1	QL (90 tabs every year)

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

232

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>pantoprazole sodium for iv soln 40 mg (base equiv)</i>	1	QL (90 vials every year)
PROTONIX INJ 40MG	3	QL (90 vials every year)
RABEPRAZOLE CAP 10MG DR	3	QL (90 caps every year)
<i>rabeprazole sodium ec tab 20 mg</i>	1	QL (90 tabs every year)
<b>ULCER DRUGS - PROSTAGLANDINS</b>		
CYTOTEC TAB 100MCG	2	
CYTOTEC TAB 200MCG	2	
<i>misoprostol tab 100 mcg</i>	1	\$0 copay based on your plan/benefit
<i>misoprostol tab 200 mcg</i>	1	\$0 copay based on your plan/benefit
<b>ULCER THERAPY COMBINATIONS</b>		
<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr 500 &amp; 500 &amp; 30mg</i>	1	
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i>	1	
OMECLAMOX- MIS PAK	3	
PYLERA CAP	2	
TALICIA CAP	2	
VOQUEZNA PAK DUAL PAK	3	
VOQUEZNA PAK TRIP PK	3	
<b>URINARY ANTISPASMODICS</b>		
<b>URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)</b>		
<i>darifenacin hydrobromide tab er 24hr 7.5 mg (base equiv)</i>	1	
<i>darifenacin hydrobromide tab er 24hr 15 mg (base equiv)</i>	1	
DETROL TAB 1MG	3	
DETROL TAB 2MG	3	
DITROPAN XL TAB 5MG	3	
DITROPAN XL TAB 10MG	3	
<i>fesoterodine fumarate tab er 24hr 4 mg</i>	1	
<i>fesoterodine fumarate tab er 24hr 8 mg</i>	1	
GELNIQUE GEL 10%	3	

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

233

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>oxybutynin chloride solution 5 mg/5ml</i>	1	
<i>oxybutynin chloride tab 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 5 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 10 mg</i>	1	
<i>oxybutynin chloride tab er 24hr 15 mg</i>	1	
<i>solifenacin succinate tab 5 mg</i>	1	
<i>solifenacin succinate tab 10 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 2 mg</i>	1	
<i>tolterodine tartrate cap er 24hr 4 mg</i>	1	
<i>tolterodine tartrate tab 1 mg</i>	1	
<i>tolterodine tartrate tab 2 mg</i>	1	
<i>tropium chloride cap er 24hr 60 mg</i>	1	
<i>tropium chloride tab 20 mg</i>	1	
VESICARE LS SUS 5MG/5ML	3	
VESICARE TAB 5MG	3	
VESICARE TAB 10MG	3	
<b>URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS</b>		
GEMTESA TAB 75MG	2	
<b>URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS</b>		
<i>bethanechol chloride tab 5 mg</i>	1	
<i>bethanechol chloride tab 10 mg</i>	1	
<i>bethanechol chloride tab 25 mg</i>	1	
<i>bethanechol chloride tab 50 mg</i>	1	
<b>URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS</b>		
<i>flavoxate hcl tab 100 mg</i>	1	
<b>VAGINAL AND RELATED PRODUCTS</b>		
<b>SPERMICIDES</b>		
ENCARE SUP 100MG	0	OTC
GYNOL II GEL 3%	0	OTC
SHUR-SEAL GEL 2%	0	OTC
TODAY SPONGE MIS	0	OTC
VCF VAGINAL AER CONTRACP	0	OTC
VCF VAGINAL GEL CONTRACE	0	
VCF VAGINAL MIS CONTRACP	0	OTC

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

234

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<b>VAGINAL ANTI-INFECTIVES</b>		
CLEOCIN CRE 2% VAG	2	
CLEOCIN SUP 100MG	3	
<i>clindamycin phosphate vaginal cream 2%</i>	1	
CLINDESSE CRE 2%	3	
GYNAZOLE-1 CRE 2%	3	
<i>metronidazole vaginal gel 0.75%</i>	1	
<i>miconazole nitrate vaginal suppos 200 mg</i>	1	
<i>terconazole vaginal cream 0.4%</i>	1	
<i>terconazole vaginal cream 0.8%</i>	1	
<i>terconazole vaginal suppos 80 mg</i>	1	
VANDAZOLE GEL 0.75%	1	
XACIATO GEL 2%	3	
<b>VAGINAL ESTROGENS</b>		
ESTRACE VAG CRE 0.01%	3	
<i>estradiol vaginal cream 0.1 mg/gm</i>	1	
IMVEXXY MAIN SUP 4MCG	2	
IMVEXXY MAIN SUP 10MCG	2	
IMVEXXY STRT SUP 4MCG	2	
IMVEXXY STRT SUP 10MCG	2	
VAGIFEM TAB 10MCG	1	Tier 1 with DAW9
<b>VAGINAL PROGESTINS</b>		
CRINONE GEL 4% VAG	2	
CRINONE GEL 8% VAG	2	
ENDOMETRIN SUP 100MG	2	
<b>VASOPRESSORS</b>		
<b>ANAPHYLAXIS THERAPY AGENTS</b>		
AUVI-Q INJ 0.1MG	2	QL (3 pens every 300 days)
AUVI-Q INJ 0.3MG	2	QL (6 pens every 300 days)
AUVI-Q INJ 0.15MG	2	QL (3 pens every 300 days)
<i>epinephrine inj 30 mg/30ml (1 mg/ml) (1:1000)</i>	1	

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

235

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

<b>Drug Name</b>	<b>Drug Tier</b>	<b>Requirements/Limits</b>
<i>epinephrine solution auto-injector 0.3 mg/0.3ml (1:1000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.3ml (1:2000)</i>	1	QL (6 pens every 300 days)
<i>epinephrine solution auto-injector 0.15 mg/0.15ml (1:1000)</i>	1	QL (3 pens every 300 days)
EPIPEN 2-PAK INJ 0.3MG	2	QL (6 pens every 300 days)
EPIPEN-JR INJ 0.15MG	2	QL (6 pens every 300 days)
<b>NEUROGENIC ORTHOSTATIC HYPOTENSION (NOH) - AGENTS</b>		
<i>droxidopa cap 100 mg</i>	1	PA, QL (90 CAPSULES PER 30 DAYS)
<i>droxidopa cap 200 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
<i>droxidopa cap 300 mg</i>	1	PA, QL (180 CAPSULES PER 30 DAYS)
<b>VASOPRESSORS</b>		
EPINEPHRINE INJ 0.2MG	3	
<i>midodrine hcl tab 2.5 mg</i>	1	
<i>midodrine hcl tab 5 mg</i>	1	
<i>midodrine hcl tab 10 mg</i>	1	
<b>VITAMINS</b>		
<b>OIL SOLUBLE VITAMINS</b>		
DRISDOL CAP 50000UNT	3	
<i>ergocalciferol cap 1.25 mg (50000 unit)</i>	1	
MEPHYTON TAB 5MG	3	
<i>phytonadione tab 5 mg</i>	1	

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

236

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

## Index

<b>A</b>	
<i>abacavir sulfate-lamivudine tab 600-300 mg</i> .....	106
<i>abacavir sulfate-lamivudine-zidovudine tab 300-150-300 mg</i> .....	106
<i>abacavir sulfate soln 20 mg/ml (base equiv)</i> .....	106
<i>abacavir sulfate tab 300 mg (base equiv)</i> .....	106
ABILIFY MAIN INJ 300MG .....	105
ABILIFY MAIN INJ 400MG .....	105
<i>abiraterone acetate tab 250 mg</i> .....	86
<i>abiraterone acetate tab 500 mg</i> .....	86
ABSORICA CAP 10MG .....	133
ABSORICA CAP 20MG.....	133
ABSORICA CAP 25MG.....	133
ABSORICA CAP 30MG.....	133
ABSORICA CAP 35MG.....	133
ABSORICA CAP 40MG .....	133
<i>acamprosate calcium tab delayed release 333 mg</i> .....	219
<i>acarbose tab 100 mg</i> .....	59
<i>acarbose tab 25 mg</i> .....	59
<i>acarbose tab 50 mg</i> .....	59
ACCOLATE TAB 10MG.....	41
ACCOLATE TAB 20MG .....	41
ACCU-CHEK GUIDE .....	149
ACCU-CHEK KIT FASTCLIX.....	180
ACCU-CHEK KIT SOFTCLIX.....	180
ACCU-CHEK LIQ GUIDE .....	180
ACCU-CHEK LIQ SMART .....	180
ACCU-CHEK MIS MLTICLIX .....	180
ACCU-CHEK SOL .....	180
ACCU-CHEK SOL COMPACT .....	180
ACCU-CHEK TES AVIVA PL.....	149
ACCU-CHEK TES COMPACT.....	149
ACCU-CHEK TES SMART.....	149
ACCUPRIL TAB 10MG.....	72
ACCUPRIL TAB 20MG .....	72
ACCUPRIL TAB 40MG.....	72
ACCUPRIL TAB 5MG .....	72
ACCURETIC TAB 10-12.5.....	76
ACCURETIC TAB 20-12.5 .....	76
ACCURETIC TAB 20-25MG .....	76
ACCUTREND SOL GLUCOSE.....	180
<i>acebutolol hcl cap 200 mg</i> .....	116
<i>acebutolol hcl cap 400 mg</i> .....	116
<i>acetaminophen-caffeine-dihydrocodeine cap 320.5-30-16 mg</i> .....	30
<i>acetaminophen-caffeine-dihydrocodeine tab 325-30-16 mg</i> .....	30
<i>acetaminophen w/ codeine soln 120-12 mg/5ml</i> .....	30
<i>acetaminophen w/ codeine tab 300-15 mg</i> .....	30
<i>acetaminophen w/ codeine tab 300-30 mg</i> .....	30
<i>acetaminophen w/ codeine tab 300-60 mg</i> .....	30
<i>acetazolamide cap er 12hr 500 mg</i> .....	156
<i>acetazolamide tab 125 mg</i> .....	156
<i>acetazolamide tab 250 mg</i> .....	156
<i>acetic acid otic soln 2%</i> .....	217
<i>acetylcysteine inhal soln 10%</i> .....	133
<i>acetylcysteine inhal soln 20%</i> .....	133
<i>acitretin cap 10 mg</i> .....	138
<i>acitretin cap 17.5 mg</i> .....	138
<i>acitretin cap 25 mg</i> .....	138
ACTHAR INJ 80UNIT .....	159
ACTI-LANCE MIS 28G .....	180
ACTI-LANCE MIS LITE 28G.....	180
ACTI-LANCE MIS SPEC 17G .....	180
ACTI-LANCE MIS UNIV 23G .....	180
ACTIMMUNE INJ 2MU/0.5.....	95
ACTIQ LOZ 1200MCG.....	23
ACTIQ LOZ 1600MCG.....	23
ACTIQ LOZ 200MCG .....	23
ACTIQ LOZ 400MCG .....	23
ACTIQ LOZ 600MCG .....	23
ACTIQ LOZ 800MCG .....	23
ACTIVELLA TAB 1-0.5MG.....	164
ACTONEL TAB 150MG.....	158
ACTONEL TAB 35MG .....	158
ACTOPLUS MET TAB 15-500MG.....	60

ACTOPLUS MET TAB 15-850MG.....	60	ADVOCATE MIS LANCETS .....	181
ACULAR LS SOL 0.4% .....	216	ADV TRAVEL MIS LANC 28G.....	181
ACULAR SOL 0.5% OP .....	216	AEMCOLO TAB 194MG .....	34
<i>acyclovir cap 200 mg</i> .....	114	AERCHMBR PLS MIS FLOW-VU.....	200
<i>acyclovir oint 5%</i> .....	142	AERCHMBR PLS MIS LRG MASK.....	200
<i>acyclovir susp 200 mg/5ml</i> .....	114	AERCHMBR PLS MIS MED MASK.....	200
<i>acyclovir tab 400 mg</i> .....	114	AERCHMBR PLS MIS SM MASK.....	200
<i>acyclovir tab 800 mg</i> .....	114	AERCHMBR Z- MIS STAT PLS .....	200
ADALIMU-ADAZ INJ 40/0.4ML .....	10	AEROCHAMBER KIT ACTION.....	200
<i>adapalene-benzoyl peroxide gel 0.1-2.5%</i> .....	133	AEROCHAMBER MIS CHAMBER .....	200
<i>adapalene-benzoyl peroxide gel 0.3-2.5%</i> .....	134	AEROCHAMBER MIS FLOSIGNA .....	200
<i>adapalene cream 0.1%</i> .....	133	AEROCHAMBER MIS MV .....	200
<i>adapalene gel 0.1%</i> .....	133	AEROCHAMBER MIS PLUS.....	200
<i>adapalene gel 0.3%</i> .....	133	AEROVENT MIS PLUS.....	200
ADASUVE INH 10MG.....	102	AGAMATRIX MIS 33G.....	181
ADBRY INJ 150MG/ML.....	146	AGAMATRIX SOL HIGH.....	181
<i>adefovir dipivoxil tab 10 mg</i> .....	113	AGAMATRIX SOL LEVEL 2 .....	181
ADEMPAS TAB 0.5MG.....	125	AGAMATRIX SOL LEVEL 4.....	181
ADEMPAS TAB 1.5MG.....	125	AGAMATRIX SOL NORM/HGH .....	181
ADEMPAS TAB 1MG.....	125	AGAMATRIX SOL NORMAL.....	181
ADEMPAS TAB 2.5MG.....	126	AGRYLIN CAP 0.5MG .....	173
ADEMPAS TAB 2MG .....	126	AIMOVIG INJ 140MG/ML.....	201
ADIPEX-P CAP 37.5MG.....	3	AIMOVIG INJ 70MG/ML.....	201
ADIPEX-P TAB 37.5MG .....	3	AIMSCO TWIST MIS 32G .....	181
ADJ LANCING MIS DEVICE .....	181	AIMSCO TWIST MIS 33G .....	181
ADVAIR DISKU AER 100/50 .....	43	AIRSUPRA AER 90-80MCG.....	43
ADVAIR DISKU AER 250/50 .....	43	AJOVY INJ 225/1.5.....	201
ADVAIR DISKU AER 500/50.....	43	AKLIEF CRE 0.005% .....	134
ADVAIR HFA AER 115/21 .....	43	AKTEN GEL 3.5%.....	215
ADVAIR HFA AER 230/21.....	43	AKYNZEO CAP 300-0.5.....	66
ADVAIR HFA AER 45/21.....	43	<i>albendazole tab 200 mg</i> .....	34
ADVANCE LIQ CONTROL .....	181	ALBENZA TAB 200MG.....	34
ADVANCE LIQ INTUITIO.....	181	<i>albuterol sulfate inhal aero 108 mcg/act</i> (90mcg base equiv) .....	43
ADVANCE NORM LIQ CONTROL.....	181	<i>albuterol sulfate soln nebu 0.083% (2.5</i> <i>mg/3ml)</i> .....	43
ADVOCATE SAFE MIS LANC 26G.....	181	<i>albuterol sulfate soln nebu 0.5% (5 mg/ml)</i> .....	43
ADV LANCING MIS DEVICE.....	181	<i>albuterol sulfate soln nebu 0.63 mg/3ml</i> (base equiv).....	43
ADVOCATE+ SOL REDI-COD .....	181	<i>albuterol sulfate soln nebu 1.25 mg/3ml</i> (base equiv).....	43
ADVOCATE LIQ HIGH.....	181	<i>albuterol sulfate syrup 2 mg/5ml</i> .....	43
ADVOCATE LIQ LOW.....	181		
ADVOCATE MIS LANC 30G.....	181		
ADVOCATE MIS LANC DEV.....	181		



<i>albuterol sulfate tab 2 mg</i> .....	44	<i>allopurinol tab 100 mg</i> .....	172
<i>albuterol sulfate tab 4 mg</i> .....	44	<i>allopurinol tab 300 mg</i> .....	172
<i>albuterol sulfate tab er 12hr 4 mg</i> .....	44	<i>almotriptan malate tab 12.5 mg</i> .....	202
<i>albuterol sulfate tab er 12hr 8 mg</i> .....	44	<i>almotriptan malate tab 6.25 mg</i> .....	202
ALCAINE SOL 0.5% OP .....	215	ALOCRILO SOL 2% .....	216
<i>alclometasone dipropionate cream 0.05%</i> .....	143	ALOMIDE SOL 0.1% OP .....	216
<i>alclometasone dipropionate oint 0.05%</i> .	143	ALORA DIS 0.025MG .....	165
ALCOH-GLOVE PAD CONTOURE .....	198	ALORA DIS 0.05MG .....	165
ALCOHOL PAD .....	198	ALORA DIS 0.075MG .....	165
ALCOHOL PAD 70% .....	198	ALORA DIS 0.1MG .....	165
ALCOHOL PAD PREP .....	198	<i>alose tron hcl tab 0.5 mg (base equiv)</i> ....	169
ALCOHOL PAD SWABSTIC.....	199	<i>alose tron hcl tab 1 mg (base equiv)</i> .....	169
ALCOHOL PREP PAD.....	199	ALPHAGAN P SOL 0.1% .....	213
ALCOHOL PREP PAD 70% .....	199	ALPHAGAN P SOL 0.15% .....	213
ALCOHOL PREP PAD MED 70% .....	199	ALPRAZOLAM CON 1 MG/ML.....	38
ALCOHOL PREP PAD PADS 70% .....	199	<i>alprazolam orally disintegrating tab 0.25</i> <i>mg</i> .....	38
ALCOHOL SWAB PAD .....	199	<i>alprazolam orally disintegrating tab 0.5 mg</i> .....	38
ALCOHOL SWAB PAD 70%.....	199	<i>alprazolam orally disintegrating tab 1 mg</i> .	38
ALCOHOL SWAB PAD EX-THICK .....	199	<i>alprazolam orally disintegrating tab 2 mg</i> 38	
ALCOHOL WIPE PAD.....	199	<i>alprazolam tab 0.25 mg</i> .....	38
ALCOH-WIPE MIS 12.....	198	<i>alprazolam tab 0.5 mg</i> .....	38
ALDACTAZIDE TAB 25/25 .....	156	<i>alprazolam tab 1 mg</i> .....	38
ALDACTAZIDE TAB 50/50.....	156	<i>alprazolam tab 2 mg</i> .....	38
ALDACTONE TAB 100MG .....	157	<i>alprazolam tab er 24hr 0.5 mg</i> .....	39
ALDACTONE TAB 25MG .....	157	<i>alprazolam tab er 24hr 1 mg</i> .....	39
ALDACTONE TAB 50MG .....	157	<i>alprazolam tab er 24hr 2 mg</i> .....	39
ALDARA CRE 5%.....	147	<i>alprazolam tab er 24hr 3 mg</i> .....	39
ALECENSA CAP 150MG.....	89	ALTABAX OIN 1% .....	136
<i>alendronate sodium oral soln 70 mg/75ml</i> .....	158	ALTACE CAP 1.25MG.....	72
<i>alendronate sodium tab 10 mg</i> .....	158	ALTACE CAP 10MG.....	72
<i>alendronate sodium tab 35 mg</i> .....	158	ALTACE CAP 2.5MG .....	72
<i>alendronate sodium tab 5 mg</i> .....	158	ALTACE CAP 5MG .....	72
<i>alendronate sodium tab 70 mg</i> .....	158	ALTEMIA EMU .....	212
<i>alfuzosin hcl tab er 24hr 10 mg</i> .....	171	ALUNBRIG PAK .....	89
ALINIA SUS 100/5ML .....	35	ALUNBRIG TAB 180MG.....	89
ALINIA TAB 500MG.....	35	ALUNBRIG TAB 30MG .....	89
<i>aliskiren fumarate tab 150 mg (base</i> <i>equivalent)</i> .....	80	ALUNBRIG TAB 90MG .....	89
<i>aliskiren fumarate tab 300 mg (base</i> <i>equivalent)</i> .....	80	<i>alvimopan cap 12 mg</i> .....	170
ALKERAN TAB 2MG.....	82	<i>amantadine hcl cap 100 mg</i> .....	96
		<i>amantadine hcl soln 50 mg/5ml</i> .....	96
		<i>amantadine hcl tab 100 mg</i> .....	96

AMARYL TAB 1MG.....	64	<i>amlodipine besylate-atorvastatin calcium</i>	
AMARYL TAB 2MG.....	64	<i>tab 2.5-10 mg.....</i>	121
AMARYL TAB 4MG.....	64	<i>amlodipine besylate-atorvastatin calcium</i>	
AMBIEN CR TAB 12.5MG.....	177	<i>tab 2.5-20 mg.....</i>	121
AMBIEN CR TAB 6.25MG.....	177	<i>amlodipine besylate-atorvastatin calcium</i>	
AMBIEN TAB 10MG.....	177	<i>tab 2.5-40 mg.....</i>	121
AMBIEN TAB 5MG.....	177	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>ambrisentan tab 10 mg.....</i>	124	<i>tab 5-10 mg.....</i>	121
<i>ambrisentan tab 5 mg.....</i>	124	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>amcinonide cream 0.1%.....</i>	143	<i>tab 5-20 mg.....</i>	121
<i>amcinonide lotion 0.1%.....</i>	143	<i>amlodipine besylate-atorvastatin calcium</i>	
<i>amcinonide oint 0.1%.....</i>	143	<i>tab 5-40 mg.....</i>	121
AMERGE TAB 1MG.....	202	<i>amlodipine besylate-atorvastatin calcium</i>	
AMERGE TAB 2.5MG.....	202	<i>tab 5-80 mg.....</i>	121
AMICAR TAB 1000MG.....	176	<i>amlodipine besylate-benazepril hcl cap 10-</i>	
AMICAR TAB 500MG.....	176	<i>20 mg.....</i>	76
<i>amiloride &amp; hydrochlorothiazide tab 5-50</i>		<i>amlodipine besylate-benazepril hcl cap 10-</i>	
<i>mg.....</i>	156	<i>40 mg.....</i>	76
<i>amiloride hcl tab 5 mg.....</i>	157	<i>amlodipine besylate-benazepril hcl cap 2.5-</i>	
<i>aminocaproic acid oral soln 0.25 gm/ml.....</i>	176	<i>10 mg.....</i>	76
<i>aminocaproic acid tab 1000 mg.....</i>	176	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>aminocaproic acid tab 500 mg.....</i>	176	<i>10 mg.....</i>	76
<i>amiodarone hcl tab 100 mg.....</i>	40	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>amiodarone hcl tab 200 mg.....</i>	40	<i>20 mg.....</i>	76
<i>amiodarone hcl tab 400 mg.....</i>	40	<i>amlodipine besylate-benazepril hcl cap 5-</i>	
<i>amitriptyline hcl tab 100 mg.....</i>	58	<i>40 mg.....</i>	76
<i>amitriptyline hcl tab 10 mg.....</i>	58	<i>amlodipine besylate-olmesartan</i>	
<i>amitriptyline hcl tab 150 mg.....</i>	58	<i>medoxomil tab 10-20 mg.....</i>	76
<i>amitriptyline hcl tab 25 mg.....</i>	58	<i>amlodipine besylate-olmesartan</i>	
<i>amitriptyline hcl tab 50 mg.....</i>	58	<i>medoxomil tab 10-40 mg.....</i>	76
<i>amitriptyline hcl tab 75 mg.....</i>	58	<i>amlodipine besylate-olmesartan</i>	
AMJEVITA INJ 10/0.2ML.....	10	<i>medoxomil tab 5-20 mg.....</i>	76
AMJEVITA INJ 20/0.4ML.....	10	<i>amlodipine besylate-olmesartan</i>	
AMJEVITA INJ 40/0.8ML.....	10	<i>medoxomil tab 5-40 mg.....</i>	76
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 10 mg (base</i>	
<i>tab 10-10 mg.....</i>	121	<i>equivalent).....</i>	118
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 2.5 mg (base</i>	
<i>tab 10-20 mg.....</i>	121	<i>equivalent).....</i>	117
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate tab 5 mg (base</i>	
<i>tab 10-40 mg.....</i>	121	<i>equivalent).....</i>	117
<i>amlodipine besylate-atorvastatin calcium</i>		<i>amlodipine besylate-valsartan tab 10-160</i>	
<i>tab 10-80 mg.....</i>	121	<i>mg.....</i>	76

<i>amlodipine besylate-valsartan tab 10-320 mg</i> .....	77	<i>amoxicillin &amp; k clavulanate for susp 250-62.5 mg/5ml</i> .....	218
<i>amlodipine besylate-valsartan tab 5-160 mg</i> .....	76	<i>amoxicillin &amp; k clavulanate for susp 400-57 mg/5ml</i> .....	218
<i>amlodipine besylate-valsartan tab 5-320 mg</i> .....	76	<i>amoxicillin &amp; k clavulanate for susp 600-42.9 mg/5ml</i> .....	218
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-12.5 mg</i> .....	77	<i>amoxicillin &amp; k clavulanate tab 250-125 mg</i> .....	218
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-160-25 mg</i> .....	77	<i>amoxicillin &amp; k clavulanate tab 500-125 mg</i> .....	218
<i>amlodipine-valsartan-hydrochlorothiazide tab 10-320-25 mg</i> .....	77	<i>amoxicillin &amp; k clavulanate tab 875-125 mg</i> .....	219
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-12.5 mg</i> .....	77	<i>amoxicillin &amp; k clavulanate tab er 12hr 1000-62.5 mg</i> .....	219
<i>amlodipine-valsartan-hydrochlorothiazide tab 5-160-25 mg</i> .....	77	<i>AMPHETAMI ER SUS 1.25/ML</i> .....	1
<i>amoxapine tab 100 mg</i> .....	58	<i>amphetamine-dextroamphetamine cap er 24hr 10 mg</i> .....	1
<i>amoxapine tab 150 mg</i> .....	58	<i>amphetamine-dextroamphetamine cap er 24hr 15 mg</i> .....	1
<i>amoxapine tab 25 mg</i> .....	58	<i>amphetamine-dextroamphetamine cap er 24hr 20 mg</i> .....	1
<i>amoxapine tab 50 mg</i> .....	58	<i>amphetamine-dextroamphetamine cap er 24hr 25 mg</i> .....	1
<i>amoxicil cap &amp; clarithro tab &amp; lansopraz cap dr 500 &amp; 500 &amp; 30mg</i> .....	233	<i>amphetamine-dextroamphetamine cap er 24hr 30 mg</i> .....	1
<i>amoxicillin (trihydrate) cap 250 mg</i> .....	218	<i>amphetamine-dextroamphetamine cap er 24hr 5 mg</i> .....	1
<i>amoxicillin (trihydrate) cap 500 mg</i> .....	218	<i>amphetamine-dextroamphetamine tab 10 mg</i> .....	1
<i>amoxicillin (trihydrate) chew tab 125 mg</i> 218		<i>amphetamine-dextroamphetamine tab 12.5 mg</i> .....	1
<i>amoxicillin (trihydrate) chew tab 250 mg</i> 218		<i>amphetamine-dextroamphetamine tab 15 mg</i> .....	1
<i>amoxicillin (trihydrate) for susp 125 mg/5ml</i> .....	218	<i>amphetamine-dextroamphetamine tab 20 mg</i> .....	1
<i>amoxicillin (trihydrate) for susp 200 mg/5ml</i> .....	218	<i>amphetamine-dextroamphetamine tab 30 mg</i> .....	1
<i>amoxicillin (trihydrate) for susp 250 mg/5ml</i> .....	218	<i>amphetamine-dextroamphetamine tab 5 mg</i> .....	1
<i>amoxicillin (trihydrate) for susp 400 mg/5ml</i> .....	218	<i>amphetamine-dextroamphetamine tab 7.5 mg</i> .....	1
<i>amoxicillin (trihydrate) tab 500 mg</i> .....	218	<i>amphetamine sulfate tab 10 mg</i> .....	1
<i>amoxicillin (trihydrate) tab 875 mg</i> .....	218	<i>amphetamine sulfate tab 5 mg</i> .....	1
<i>amoxicillin &amp; k clavulanate chew tab 200-28.5 mg</i> .....	218		
<i>amoxicillin &amp; k clavulanate chew tab 400-57 mg</i> .....	218		
<i>amoxicillin &amp; k clavulanate for susp 200-28.5 mg/5ml</i> .....	218		

<i>ampicillin cap 500 mg</i> .....	218	ARANESP INJ 10MCG.....	174
AMPYRA TAB 10MG.....	223	ARANESP INJ 150MCG.....	174
ANACAINE OIN.....	147	ARANESP INJ 200MCG.....	174
ANAFRANIL CAP 25MG.....	58	ARANESP INJ 25MCG.....	174
ANAFRANIL CAP 50MG.....	58	ARANESP INJ 300MCG.....	174
ANAFRANIL CAP 75MG.....	58	ARANESP INJ 40MCG.....	174
<i>anagrelide hcl cap 0.5 mg</i> .....	173	ARANESP INJ 500MCG.....	174
<i>anagrelide hcl cap 1 mg</i> .....	173	ARANESP INJ 60MCG.....	174
ANALPRAM-HC CRE 1-1%.....	34	ARAVA TAB 10MG.....	21
ANALPRAM-HC LOT 2.5%.....	34	ARAVA TAB 20MG.....	21
ANASPAZ TAB 0.125MG.....	231	ARAZLO LOT 0.045%.....	134
<i>anastrozole tab 1 mg</i> .....	86	<i>arformoterol tartrate soln nebu 15 mcg/2ml</i> <i>(base equiv)</i> .....	44
ANCOBON CAP 250MG.....	67	ARICEPT TAB 10MG.....	220
ANCOBON CAP 500MG.....	67	ARICEPT TAB 23MG.....	220
ANDRODERM DIS 2MG/24HR.....	33	ARICEPT TAB 5MG.....	220
ANDRODERM DIS 4MG/24HR.....	33	ARIKAYCE SUS.....	9
ANGELIQ TAB 0.25-0.5.....	165	ARIMIDEX TAB 1MG.....	86
ANGELIQ TAB 0.5-1MG.....	165	<i>aripiprazole orally disintegrating tab 10 mg</i> .....	105
ANNOVERA MIS.....	130	<i>aripiprazole orally disintegrating tab 15 mg</i> .....	105
ANORO ELLIPT AER 62.5-25.....	44	<i>aripiprazole oral solution 1 mg/ml</i> .....	105
ANTARA CAP 30MG.....	70	<i>aripiprazole tab 10 mg</i> .....	105
ANTARA CAP 90MG.....	70	<i>aripiprazole tab 15 mg</i> .....	105
ANUSOL-HC CRE 2.5%.....	34	<i>aripiprazole tab 20 mg</i> .....	105
ANZEMET TAB 100MG.....	66	<i>aripiprazole tab 2 mg</i> .....	105
ANZEMET TAB 50MG.....	66	<i>aripiprazole tab 30 mg</i> .....	105
ALENZIN TAB 174MG.....	54	<i>aripiprazole tab 5 mg</i> .....	105
ALENZIN TAB 348MG.....	54	ARISTADA INJ 1064MG.....	105
ALENZIN TAB 522MG.....	54	ARISTADA INJ 441MG/1.....	105
APLICARE ALC PAD SWABSTIC.....	199	ARISTADA INJ 662MG/2.....	105
<i>apraclonidine hcl ophth soln 0.5% (base</i> <i>equivalent)</i> .....	213	ARISTADA INJ 882MG/3.....	105
<i>aprepitant capsule 125 mg</i> .....	66	ARISTADA INJ INITIO.....	105
<i>aprepitant capsule 40 mg</i> .....	66	ARIXTRA INJ 10/0.8ML.....	46
<i>aprepitant capsule 80 mg</i> .....	66	ARIXTRA INJ 2.5/0.5.....	46
<i>aprepitant capsule therapy pack 80 &amp; 125</i> <i>mg</i> .....	67	ARIXTRA INJ 5/0.4ML.....	46
APRISO CAP 0.375GM.....	168	ARIXTRA INJ 7.5/0.6.....	46
APTIOM TAB 200MG.....	48	<i>armodafinil tab 150 mg</i> .....	6
APTIOM TAB 400MG.....	48	<i>armodafinil tab 200 mg</i> .....	6
APTIOM TAB 600MG.....	48	<i>armodafinil tab 250 mg</i> .....	6
APTIOM TAB 800MG.....	48	<i>armodafinil tab 50 mg</i> .....	6
AQUALANCE MIS 30G.....	181	ARMOUR THYRO TAB 120MG.....	230
ARANESP INJ 100MCG.....	174		

ARMOUR THYRO TAB 15MG.....	230	ASTAGRAF XL CAP 0.5MG .....	206
ARMOUR THYRO TAB 180MG .....	230	ASTAGRAF XL CAP 1MG.....	206
ARMOUR THYRO TAB 240MG .....	230	ASTAGRAF XL CAP 5MG.....	206
ARMOUR THYRO TAB 300MG .....	230	<i>atazanavir sulfate cap 150 mg (base equiv)</i>	
ARMOUR THYRO TAB 30MG.....	230	.....	106
ARMOUR THYRO TAB 60MG.....	230	<i>atazanavir sulfate cap 200 mg (base equiv)</i>	
ARMOUR THYRO TAB 90MG.....	230	.....	106
ARNICA TIN FLOWER.....	148	<i>atazanavir sulfate cap 300 mg (base equiv)</i>	
AROMASIN TAB 25MG .....	86	.....	106
ARTISS SOL 10ML.....	176	ATELVIA TAB.....	158
ARTISS SOL 2ML .....	176	<i>atenolol &amp; chlorthalidone tab 100-25 mg..</i>	77
ARTISS SOL 4ML .....	176	<i>atenolol &amp; chlorthalidone tab 50-25 mg ...</i>	77
<i>asenapine maleate sl tab 10 mg (base equiv)</i> .....	102	<i>atenolol tab 100 mg.....</i>	116
<i>asenapine maleate sl tab 2.5 mg (base equiv)</i> .....	102	<i>atenolol tab 25 mg.....</i>	116
<i>asenapine maleate sl tab 5 mg (base equiv)</i>	102	<i>atenolol tab 50 mg .....</i>	116
.....	102	<i>atomoxetine hcl cap 100 mg (base equiv) ..</i>	5
<i>aspirin chew tab 81 mg .....</i>	22	<i>atomoxetine hcl cap 10 mg (base equiv) ...</i>	4
<i>aspirin-dipyridamole cap er 12hr 25-200 mg</i>	173	<i>atomoxetine hcl cap 18 mg (base equiv)....</i>	4
.....	173	<i>atomoxetine hcl cap 25 mg (base equiv) ....</i>	4
<i>aspirin tab delayed release 81 mg.....</i>	22	<i>atomoxetine hcl cap 40 mg (base equiv)....</i>	4
ASSURE 3 LIQ CONTROL .....	181	<i>atomoxetine hcl cap 60 mg (base equiv)....</i>	5
ASSURE 4 LIQ LEVEL1/2.....	181	<i>atomoxetine hcl cap 80 mg (base equiv)....</i>	5
ASSURE CMFRT MIS 28G .....	181	<i>atorvastatin calcium tab 10 mg (base equivalent)</i>	70
ASSURE DOSE SOL NORM/HGH .....	181	<i>atorvastatin calcium tab 20 mg (base equivalent)</i>	71
ASSURE DOSE SOL NORMAL .....	181	<i>atorvastatin calcium tab 40 mg (base equivalent)</i>	71
ASSURE II LIQ LEVEL 1.....	181	<i>atorvastatin calcium tab 80 mg (base equivalent)</i>	71
ASSURE II LIQ LEVEL1/2.....	181	<i>atovaquone-proguanil hcl tab 250-100 mg</i>	
ASSURE LANCE MIS 21G.....	181	.....	81
ASSURE LANCE MIS 28G.....	181	<i>atovaquone-proguanil hcl tab 62.5-25 mg</i>	81
ASSURE LANCE MIS LOW FLOW .....	181	<i>atovaquone susp 750 mg/5ml .....</i>	35
ASSURE LANCE MIS MICRO .....	181	ATRALIN GEL 0.05% .....	134
ASSURE LANCE MIS SAFE 25G.....	181	ATROPINE SUL SOL 1% OP.....	213
ASSURE LANCE MIS SAFE 30G.....	181	ATROVENT HFA AER 17MCG.....	41
ASSURE PLUS MIS HIGH 18G.....	182	AUGMENTIN SUS 125/5ML.....	219
ASSURE PLUS MIS LOW 25G.....	182	AUGMENTIN SUS 250/5ML.....	219
ASSURE PLUS MIS MCRO 28G.....	182	AUGMENTIN SUS ES-600 .....	219
ASSURE PLUS MIS NORM 21G .....	182	AUGMENTIN TAB 500MG.....	219
ASSURE PLUS MIS PEDIATRI.....	182	AURORA LANCE MIS 30G.....	182
ASSURE PRISM SOL LEVEL1/2 .....	182	AURORA LANCE MIS THIN 23G .....	182
ASSURE PRISM TES MULTI.....	149		
ASSURE PRO LIQ LEVEL1/2 .....	182		

AURYXIA TAB 210MG .....	170	<i>azelastine hcl-fluticasone prop nasal spray</i>	
AUSTEDO TAB 12MG .....	222	137-50 mcg/act .....	211
AUSTEDO TAB 6MG .....	222	<i>azelastine hcl nasal spray 0.1% (137</i>	
AUSTEDO TAB 9MG .....	222	mcg/spray) .....	211
AUSTEDO XR TAB 12MG .....	222	<i>azelastine hcl nasal spray 0.15% (205.5</i>	
AUSTEDO XR TAB 24MG .....	222	mcg/spray) .....	211
AUSTEDO XR TAB 6MG .....	222	<i>azelastine hcl ophth soln 0.05%.....</i>	216
AUSTEDO XR TAB TITR KIT .....	222	AZILECT TAB 0.5MG .....	99
AUTO LANCET MIS .....	182	AZILECT TAB 1MG .....	99
AUTO-LANCET MIS.....	182	<i>azithromycin for susp 100 mg/5ml.....</i>	179
AUTO-LANCET MIS MINI .....	182	<i>azithromycin for susp 200 mg/5ml.....</i>	179
AUTOLET II KIT CLINISAF.....	182	<i>azithromycin powd pack for susp 1 gm ...</i>	179
AUTOLET IMPR MIS LANC DEV .....	182	<i>azithromycin tab 250 mg.....</i>	179
AUTOLET LANC MIS DEVICE.....	182	<i>azithromycin tab 500 mg.....</i>	179
AUTOLET LITE KIT .....	182	<i>azithromycin tab 600 mg .....</i>	179
AUTOLET LITE KIT CLINISAF .....	182	AZOPT SUS 1% OP .....	216
AUTOLET LITE KIT STARTER .....	182	AZSTARYS CAP 26.1-5.2 .....	6
AUTOLET MINI MIS .....	182	AZSTARYS CAP 39.2-7.8 .....	6
AUTOLET PLAT MIS 1.8MM .....	182	AZSTARYS CAP 52.3-10.....	6
AUTOLET PLAT MIS 2.4MM.....	182	AZULFIDINE TAB 500MG.....	168
AUTOLET PLAT MIS 3.0MM.....	182	AZULFIDINE TAB 500MG EN .....	168
AUTOLET PLUS MIS .....	182	<b>B</b>	
AUTOLET PLUS MIS LANC DEV .....	182	<i>bacitracin ophth oint 500 unit/gm .....</i>	213
AUVI-Q INJ 0.15MG .....	235	<i>bacitracin-polymyxin b ophth oint.....</i>	213
AUVI-Q INJ 0.1MG .....	235	<i>bacitracin-polymyxin-neomycin-hc ophth</i>	
AUVI-Q INJ 0.3MG.....	235	<i>oint 1% .....</i>	215
AVALIDE TAB 150-12.5 .....	77	<i>baclofen tab 10 mg .....</i>	209
AVALIDE TAB 300-12.5 .....	77	<i>baclofen tab 20 mg.....</i>	209
AVANDIA TAB 2MG .....	63	<i>baclofen tab 5 mg.....</i>	209
AVANDIA TAB 4MG.....	63	BACTRIM DS TAB 800-160 .....	35
AVAPRO TAB 150MG .....	74	BACTRIM TAB 400-80MG.....	35
AVAPRO TAB 300MG.....	74	<i>balsalazide disodium cap 750 mg.....</i>	168
AVAPRO TAB 75MG .....	74	BALVERSA TAB 3MG.....	89
AVODART CAP 0.5MG .....	171	BALVERSA TAB 4MG .....	89
AVONEX PEN KIT 30MCG .....	223	BALVERSA TAB 5MG .....	89
AVONEX PREFL KIT 30MCG .....	223	BAQSIMI ONE POW 3MG/DOSE .....	61
AYGESTIN TAB 5MG.....	219	BAQSIMI TWO POW 3MG/DOSE .....	61
<i>azacitidine for inj 100 mg .....</i>	83	BARACLUDGE SOL .....	113
<i>azathioprine tab 100 mg .....</i>	206	BASAGLAR INJ 100UNIT.....	63
<i>azathioprine tab 50 mg .....</i>	206	BAXDELA TAB 450MG .....	166
<i>azathioprine tab 75 mg .....</i>	206	BD LANCET UF MIS 30G.....	182
<i>azelaic acid gel 15% .....</i>	148	BD LANCET UF MIS 33G.....	182
		BD MICROTAIN MIS LANCETS.....	182

BD SWAB BFLY PAD SNGL USE.....	199	<i>benzoyl peroxide liq 7%</i> .....	134
BD U-500 MIS 31GX6MM.....	199	<i>benzphetamine hcl tab 25 mg</i> .....	3
BD ULTRAFINE INSULIN		<i>benzphetamine hcl tab 50 mg</i> .....	3
SYRINGES/NEEDLES .....	200	<i>benztropine mesylate tab 0.5 mg</i> .....	96
BD ULTRAFINE PEN NEEDLES .....	200	<i>benztropine mesylate tab 1 mg</i> .....	96
BELBUCA MIS 150MCG .....	31	<i>benztropine mesylate tab 2 mg</i> .....	96
BELBUCA MIS 300MCG.....	31	BESIVANCE SUS 0.6%.....	213
BELBUCA MIS 450MCG.....	31	BESREMI SOL 500MCG.....	95
BELBUCA MIS 600MCG .....	31	BETADINE SOL 5% OP.....	213
BELBUCA MIS 750MCG.....	31	<i>betamethasone dipropionate augmented</i>	
BELBUCA MIS 75MCG .....	31	<i>cream 0.05%</i> .....	143
BELBUCA MIS 900MCG .....	31	<i>betamethasone dipropionate augmented</i>	
BELLA/OPIUM SUP 16.2-30 .....	231	<i>gel 0.05%</i> .....	143
BELLA/OPIUM SUP 16.2-60 .....	231	<i>betamethasone dipropionate augmented</i>	
BELSOMRA TAB 10MG .....	177	<i>lotion 0.05%</i> .....	143
BELSOMRA TAB 15MG .....	177	<i>betamethasone dipropionate augmented</i>	
BELSOMRA TAB 20MG.....	178	<i>ointment 0.05%</i> .....	143
BELSOMRA TAB 5MG.....	177	<i>betamethasone dipropionate cream 0.05%</i>	
<i>benazepril &amp; hydrochlorothiazide tab 10-</i>		.....	143
<i>12.5 mg</i> .....	77	<i>betamethasone dipropionate lotion 0.05%</i>	
<i>benazepril &amp; hydrochlorothiazide tab 20-</i>		.....	143
<i>12.5 mg</i> .....	77	<i>betamethasone valerate aerosol foam</i>	
<i>benazepril &amp; hydrochlorothiazide tab 20-25</i>		<i>0.12%</i> .....	143
<i>mg</i> .....	77	<i>betamethasone valerate cream 0.1% (base</i>	
<i>benazepril &amp; hydrochlorothiazide tab 5-</i>		<i>equivalent)</i> .....	143
<i>6.25 mg</i> .....	77	<i>betamethasone valerate lotion 0.1% (base</i>	
<i>benazepril hcl tab 10 mg</i> .....	73	<i>equivalent)</i> .....	143
<i>benazepril hcl tab 20 mg</i> .....	73	<i>betamethasone valerate oint 0.1% (base</i>	
<i>benazepril hcl tab 40 mg</i> .....	73	<i>equivalent)</i> .....	143
<i>benazepril hcl tab 5 mg</i> .....	73	BETASERON INJ 0.3MG .....	223
BENLYSTA INJ 200MG/ML .....	208	<i>betaxolol hcl ophth soln 0.5%</i> .....	212
BENZALKONIUM SOL NF.....	106	<i>betaxolol hcl tab 10 mg</i> .....	116
BENZAMYCIN GEL 5-3%.....	134	<i>betaxolol hcl tab 20 mg</i> .....	116
BENZNIDAZOLE TAB 100MG .....	34	<i>bethanechol chloride tab 10 mg</i> .....	234
BENZNIDAZOLE TAB 12.5MG.....	34	<i>bethanechol chloride tab 25 mg</i> .....	234
<i>benzonatate cap 100 mg</i> .....	132	<i>bethanechol chloride tab 50 mg</i> .....	234
<i>benzonatate cap 150 mg</i> .....	132	<i>bethanechol chloride tab 5 mg</i> .....	234
<i>benzonatate cap 200 mg</i> .....	132	BETOPTIC-S SUS 0.25% OP .....	212
<i>benzoyl peroxide-erythromycin gel 5-3%</i>		<i>bexarotene cap 75 mg</i> .....	95
.....	134	<i>bicalutamide tab 50 mg</i> .....	86
<i>benzoyl peroxide foam 9.8%</i> .....	134	BIDIL TAB .....	121
<i>benzoyl peroxide-hydrocortisone lotion 5-</i>		BIJUVA CAP 1-100MG.....	165
<i>0.5%</i> .....	134	BIKTARVY TAB .....	106

BILTRICIDE TAB 600MG.....	34	BRISDELLE CAP 7.5MG.....	227
<i>bimatoprost ophth soln 0.03%</i> .....	217	BRIVIACT SOL 10MG/ML.....	48
BINOSTO TAB 70MG .....	158	BRIVIACT TAB 100MG.....	49
BIO-STATIN CAP 1000000.....	67	BRIVIACT TAB 10MG .....	48
BIO-STATIN CAP 500000 .....	67	BRIVIACT TAB 25MG .....	49
<i>bisacodyl tab &amp; peg 3350-kcl-sod bicarb- nacl for soln kit</i> .....	178	BRIVIACT TAB 50MG .....	49
<i>bismuth subcit-metronidazole-tetracycline cap 140-125-125 mg</i> .....	233	BRIVIACT TAB 75MG .....	49
<i>bisoprolol &amp; hydrochlorothiazide tab 10- 6.25 mg</i> .....	77	<i>bromfenac sodium ophth soln 0.09% (base equiv) (once-daily)</i> .....	216
<i>bisoprolol &amp; hydrochlorothiazide tab 2.5- 6.25 mg</i> .....	77	<i>bromocriptine mesylate cap 5 mg (base equivalent)</i> .....	96
<i>bisoprolol &amp; hydrochlorothiazide tab 5-6.25 mg</i> .....	77	<i>bromocriptine mesylate tab 2.5 mg (base equivalent)</i> .....	96
<i>bisoprolol fumarate tab 10 mg</i> .....	116	BROVANA NEB 15MCG.....	44
<i>bisoprolol fumarate tab 5 mg</i> .....	116	BRUKINSA CAP 80MG .....	89
BLEPH-10 SOL 10% OP .....	214	BRYHALI LOT 0.01% .....	143
BLEPHAMIDE OIN S.O.P.....	215	<i>budesonide delayed release particles cap 3 mg</i> .....	130
BLEPHAMIDE SUS OP .....	215	<i>budesonide inhalation susp 0.25 mg/2ml</i> 42	
BONIVA TAB 150MG .....	158	<i>budesonide inhalation susp 0.5 mg/2ml</i> ..42	
BONJESTA TAB 20-20MG.....	66	<i>budesonide inhalation susp 1 mg/2ml</i> .....42	
<i>bosentan tab 125 mg</i> .....	124	<i>bumetanide tab 0.5 mg</i> .....	157
<i>bosentan tab 62.5 mg</i> .....	124	<i>bumetanide tab 1 mg</i> .....	157
BOSULIF TAB 100MG .....	89	<i>bumetanide tab 2 mg</i> .....	157
BOSULIF TAB 400MG .....	89	BUMEX TAB 0.5MG.....	157
BOSULIF TAB 500MG .....	89	BUNAVAIL MIS 4.2-0.7.....	32
BRAFTOVI CAP 75MG.....	89	BUNAVAIL MIS 6.3-1MG.....	32
BREATHE EASE MIS LG MASK .....	200	<i>buprenorphine hcl-naloxone hcl sl film 12-3 mg (base equiv)</i> .....	32
BREATHE EASE MIS MED MASK.....	200	<i>buprenorphine hcl-naloxone hcl sl film 2- 0.5 mg (base equiv)</i> .....	32
BREATHE EASE MIS SM MASK .....	200	<i>buprenorphine hcl-naloxone hcl sl film 4-1 mg (base equiv)</i> .....	32
BREO ELLIPTA INH 100-25.....	44	<i>buprenorphine hcl-naloxone hcl sl film 8-2 mg (base equiv)</i> .....	32
BREO ELLIPTA INH 200-25 .....	44	<i>buprenorphine hcl-naloxone hcl sl tab 2-0.5 mg (base equiv)</i> .....	32
BREO ELLIPTA INH 50-25MCG .....	44	<i>buprenorphine hcl-naloxone hcl sl tab 8-2 mg (base equiv)</i> .....	32
BREXAFEMME TAB 150MG .....	67	<i>buprenorphine hcl sl tab 2 mg (base equiv)</i> .....	32
BREZTRI AERO AER SPHERE .....	44	<i>buprenorphine hcl sl tab 8 mg (base equiv)</i> .....	32
BRILINTA TAB 60MG .....	173		
BRILINTA TAB 90MG .....	173		
<i>brimonidine tartrate ophth soln 0.15%</i> ....	213		
<i>brimonidine tartrate ophth soln 0.2%</i> .....	213		
<i>brimonidine tartrate-timolol maleate ophth soln 0.2-0.5%</i> .....	212		
<i>brinzolamide ophth susp 1%</i> .....	216		



<i>buprenorphine td patch weekly 10 mcg/hr</i> .....32	CADUET TAB 10-80MG .....121
<i>buprenorphine td patch weekly 15 mcg/hr</i> .....32	CADUET TAB 5-10MG.....121
<i>buprenorphine td patch weekly 20 mcg/hr</i> .....32	CADUET TAB 5-20MG .....121
<i>buprenorphine td patch weekly 5 mcg/hr</i> 32	CADUET TAB 5-40MG .....121
<i>buprenorphine td patch weekly 7.5 mcg/hr</i> .....32	CADUET TAB 5-80MG .....121
<i>bupropion hcl (smoking deterrent) tab er</i> <i>12hr 150 mg</i> .....226	<i>caffeine citrate oral soln 60 mg/3ml (10</i> <i>mg/ml base equiv)</i> .....3
<i>bupropion hcl tab 100 mg</i> .....54	CALAN SR TAB 120MG.....118
<i>bupropion hcl tab 75 mg</i> .....54	CALAN SR TAB 180MG.....118
<i>bupropion hcl tab er 12hr 100 mg</i> .....54	CALAN SR TAB 240MG .....118
<i>bupropion hcl tab er 12hr 150 mg</i> .....54	<i>calcipotriene oint 0.005%</i> .....138
<i>bupropion hcl tab er 12hr 200 mg</i> .....54	<i>calcipotriene soln 0.005% (50 mcg/ml)</i> .138
<i>bupropion hcl tab er 24hr 150 mg</i> .....54	<i>calcitonin (salmon) nasal soln 200 unit/act</i> .....158
<i>bupropion hcl tab er 24hr 300 mg</i> .....55	<i>calcitriol cap 0.25 mcg</i> .....161
<i>bupirone hcl tab 10 mg</i> .....38	<i>calcitriol cap 0.5 mcg</i> .....161
<i>bupirone hcl tab 15 mg</i> .....38	<i>calcitriol oral soln 1 mcg/ml</i> .....161
<i>bupirone hcl tab 30 mg</i> .....38	<i>calcium acetate (phosphate binder) cap</i> <i>667 mg (169 mg ca)</i> .....170
<i>bupirone hcl tab 5 mg</i> .....38	CALQUENCE CAP 100MG .....89
<i>bupirone hcl tab 7.5 mg</i> .....38	CAMINO PRO LIQ 15PE .....150
<i>butalbital-acetaminophen-caffeine tab 50-</i> <i>325-40 mg</i> .....22	CAMZYOS CAP 10MG.....120
<i>butalbital-acetaminophen-caff w/ cod cap</i> <i>50-300-40-30 mg</i> .....30	CAMZYOS CAP 15MG.....120
<i>butalbital-acetaminophen-caff w/ cod cap</i> <i>50-325-40-30 mg</i> .....30	CAMZYOS CAP 2.5MG .....120
<i>butalbital-acetaminophen tab 50-325 mg</i> 22	CAMZYOS CAP 5MG .....120
<i>butalbital-aspirin-caffeine cap 50-325-40</i> <i>mg</i> .....22	CANASA SUP 1000MG .....168
<i>butalbital-aspirin-caff w/ codeine cap 50-</i> <i>325-40-30 mg</i> .....30	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 16-12.5 mg</i> .....77
<i>butorphanol tartrate nasal soln 10 mg/ml</i> .32	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 32-12.5 mg</i> .....77
<b>C</b>	<i>candesartan cilexetil-hydrochlorothiazide</i> <i>tab 32-25 mg</i> .....77
<i>cabergoline tab 0.5 mg</i> .....164	<i>candesartan cilexetil tab 16 mg</i> .....74
CABOMETRYX TAB 20MG .....89	<i>candesartan cilexetil tab 32 mg</i> .....74
CABOMETRYX TAB 40MG.....89	<i>candesartan cilexetil tab 4 mg</i> .....74
CABOMETRYX TAB 60MG.....89	<i>candesartan cilexetil tab 8 mg</i> .....74
CADUET TAB 10-10MG .....121	<i>capecitabine tab 150 mg</i> .....83
CADUET TAB 10-20MG .....121	<i>capecitabine tab 500 mg</i> .....83
CADUET TAB 10-40MG .....121	CAPEX SHA 0.01% .....143
	CAPLYTA CAP 10.5MG .....99
	CAPLYTA CAP 21MG.....99
	CAPLYTA CAP 42MG.....99
	CAPRELSA TAB 100MG .....90

CAPRELSA TAB 300MG .....	90	<i>carbidopa-levodopa-entacapone tabs</i>	
<i>captopril &amp; hydrochlorothiazide tab 25-15</i>		<i>31.25-125-200 mg .....</i>	97
<i>mg.....</i>	77	<i>carbidopa-levodopa-entacapone tabs 37.5-</i>	
<i>captopril &amp; hydrochlorothiazide tab 25-25</i>		<i>150-200 mg .....</i>	97
<i>mg.....</i>	77	<i>carbidopa-levodopa-entacapone tabs 50-</i>	
<i>captopril &amp; hydrochlorothiazide tab 50-15</i>		<i>200-200 mg .....</i>	97
<i>mg.....</i>	77	<i>carbidopa tab 25 mg .....</i>	95
<i>captopril &amp; hydrochlorothiazide tab 50-25</i>		<i>carbinoxamine maleate soln 4 mg/5ml ....</i>	68
<i>mg.....</i>	77	<i>carbinoxamine maleate tab 4 mg .....</i>	68
<i>captopril tab 100 mg .....</i>	73	CARDIOCOM MIS LANCING.....	182
<i>captopril tab 12.5 mg .....</i>	73	CARDURA TAB 1MG.....	75
<i>captopril tab 25 mg .....</i>	73	CARDURA TAB 2MG.....	75
<i>captopril tab 50 mg.....</i>	73	CARDURA TAB 4MG.....	75
<i>carbamazepine cap er 12hr 100 mg.....</i>	49	CARDURA TAB 8MG.....	75
<i>carbamazepine cap er 12hr 200 mg .....</i>	49	CARDURA XL TAB 4MG .....	171
<i>carbamazepine cap er 12hr 300 mg .....</i>	49	CARDURA XL TAB 8MG .....	171
<i>carbamazepine chew tab 100 mg.....</i>	49	CAREONE ADV MIS LANCING.....	182
<i>carbamazepine susp 100 mg/5ml .....</i>	49	CAREONE LANC MIS 30G.....	182
<i>carbamazepine tab 200 mg .....</i>	49	CAREONE LANC MIS THIN 23G.....	182
<i>carbamazepine tab er 12hr 100 mg .....</i>	49	CARESENS 30G MIS LANCETS .....	182
<i>carbamazepine tab er 12hr 200 mg.....</i>	49	CARESENS SOL CONTROL.....	182
<i>carbamazepine tab er 12hr 400 mg.....</i>	49	CARETOUCH MIS EJECTOR.....	182
CARBATROL CAP 100MG.....	49	CARETOUCH MIS LANC 26G.....	182
CARBATROL CAP 200MG.....	49	CARETOUCH MIS LANC 28G.....	183
CARBATROL CAP 300MG.....	49	CARETOUCH MIS LANC 30G .....	183
<i>carbidopa &amp; levodopa orally disintegrating</i>		CARETOUCH MIS TWIST 28.....	183
<i>tab 10-100 mg .....</i>	96	CARETOUCH MIS TWIST 30.....	183
<i>carbidopa &amp; levodopa orally disintegrating</i>		CARETOUCH MIS TWIST 33.....	183
<i>tab 25-100 mg.....</i>	96	CARETOUCH PAD ALCOHOL.....	199
<i>carbidopa &amp; levodopa orally disintegrating</i>		<i>carglumic acid soluble tab 200 mg .....</i>	161
<i>tab 25-250 mg .....</i>	96	<i>carisoprodol tab 350 mg .....</i>	210
<i>carbidopa &amp; levodopa tab 10-100 mg .....</i>	96	<i>carisoprodol w/ aspirin &amp; codeine tab 200-</i>	
<i>carbidopa &amp; levodopa tab 25-100 mg.....</i>	96	<i>325-16 mg .....</i>	210
<i>carbidopa &amp; levodopa tab 25-250 mg .....</i>	96	<i>carteolol hcl ophth soln 1% .....</i>	212
<i>carbidopa &amp; levodopa tab er 25-100 mg ..</i>	96	<i>carvedilol phosphate cap er 24hr 10 mg ..</i>	115
<i>carbidopa &amp; levodopa tab er 50-200 mg .</i>	96	<i>carvedilol phosphate cap er 24hr 20 mg .</i>	115
<i>carbidopa-levodopa-entacapone tabs 12.5-</i>		<i>carvedilol phosphate cap er 24hr 40 mg .</i>	115
<i>50-200 mg .....</i>	96	<i>carvedilol phosphate cap er 24hr 80 mg .</i>	115
<i>carbidopa-levodopa-entacapone tabs</i>		<i>carvedilol tab 12.5 mg .....</i>	115
<i>18.75-75-200 mg .....</i>	97	<i>carvedilol tab 25 mg.....</i>	115
<i>carbidopa-levodopa-entacapone tabs 25-</i>		<i>carvedilol tab 3.125 mg.....</i>	115
<i>100-200 mg.....</i>	97	<i>carvedilol tab 6.25 mg .....</i>	115
		CASCARA EXT SAGRADA.....	178

CASODEX TAB 50MG .....	86	CELLCEPT CAP 250MG.....	206
CATAPRES-TTS DIS 0.1/24HR .....	75	CELLCEPT IV INJ 500MG.....	206
CATAPRES-TTS DIS 0.2/24HR .....	75	CELLCEPT SUS 200MG/ML.....	206
CATAPRES-TTS DIS 0.3/24HR .....	75	CELLCEPT TAB 500MG.....	206
CAVERJECT IM KIT 10MCG .....	122	CELONTIN CAP 300MG.....	53
CAVERJECT INJ 40MCG.....	122	CENTANY OIN 2%.....	136
CAVERJECT KIT 20MCG .....	122	<i>cephalexin cap 250 mg</i> .....	126
CAYA DPR .....	180	<i>cephalexin cap 500 mg</i> .....	126
<i>cefaclor cap 250 mg</i> .....	126	<i>cephalexin cap 750 mg</i> .....	126
<i>cefaclor cap 500 mg</i> .....	126	<i>cephalexin for susp 125 mg/5ml</i> .....	126
CEFACLOR ER TAB 500MG .....	126	<i>cephalexin for susp 250 mg/5ml</i> .....	126
<i>cefaclor for susp 125 mg/5ml</i> .....	126	<i>cephalexin tab 250 mg</i> .....	126
<i>cefaclor for susp 250 mg/5ml</i> .....	126	<i>cephalexin tab 500 mg</i> .....	126
<i>cefaclor for susp 375 mg/5ml</i> .....	127	CEQUR SIMPL KIT PATCH 2U .....	200
<i>cefadroxil cap 500 mg</i> .....	126	CERDELGA CAP 84MG.....	173
<i>cefadroxil for susp 250 mg/5ml</i> .....	126	CERVIDIL VAG MIS 10MG INS.....	217
<i>cefadroxil for susp 500 mg/5ml</i> .....	126	CETRAXAL SOL 0.2% .....	217
<i>cefadroxil tab 1 gm</i> .....	126	CETROTIDE KIT 0.25MG .....	160
<i>cefdinir cap 300 mg</i> .....	127	<i>cevimeline hcl cap 30 mg</i> .....	209
<i>cefdinir for susp 125 mg/5ml</i> .....	127	CHANTIX PAK 1MG.....	226
<i>cefdinir for susp 250 mg/5ml</i> .....	127	CHANTIX TAB 0.5& 1MG .....	226
<i>cefixime cap 400 mg</i> .....	127	CHANTIX TAB 0.5MG.....	226
<i>cefixime for susp 100 mg/5ml</i> .....	127	CHANTIX TAB 1MG.....	226
<i>cefixime for susp 200 mg/5ml</i> .....	127	CHEMET CAP 100MG.....	65
<i>cefpodoxime proxetil for susp 100 mg/5ml</i> .....	127	CHEMSTRIP K TES .....	150
<i>cefpodoxime proxetil for susp 50 mg/5ml</i> .....	127	CHEMSTRIP TES UGK.....	150
<i>cefpodoxime proxetil tab 100 mg</i> .....	127	CHENODAL TAB 250MG.....	167
<i>cefpodoxime proxetil tab 200 mg</i> .....	127	<i>chlordiazepoxide-amitriptyline tab 10-25</i> <i>mg</i> .....	221
<i>cefprozil for susp 125 mg/5ml</i> .....	127	<i>chlordiazepoxide-amitriptyline tab 5-12.5</i> <i>mg</i> .....	221
<i>cefprozil for susp 250 mg/5ml</i> .....	127	<i>chlordiazepoxide hcl cap 10 mg</i> .....	39
<i>cefprozil tab 250 mg</i> .....	127	<i>chlordiazepoxide hcl cap 25 mg</i> .....	39
<i>cefprozil tab 500 mg</i> .....	127	<i>chlordiazepoxide hcl cap 5 mg</i> .....	39
<i>cefuroxime axetil tab 250 mg</i> .....	127	<i>chlordiazepoxide hcl-clidinium bromide</i> <i>cap 5-2.5 mg</i> .....	231
<i>cefuroxime axetil tab 500 mg</i> .....	127	CHLORHEX GLU SOL 20% .....	106
<i>celecoxib cap 100 mg</i> .....	18	<i>chlorhexidine gluconate soln 0.12%</i> .....	209
<i>celecoxib cap 200 mg</i> .....	18	<i>chloroquine phosphate tab 250 mg</i> .....	81
<i>celecoxib cap 400 mg</i> .....	18	<i>chloroquine phosphate tab 500 mg</i> .....	81
<i>celecoxib cap 50 mg</i> .....	18	<i>chlorpromazine hcl inj 25 mg/ml</i> .....	104
CELEXA TAB 10MG .....	55	<i>chlorpromazine hcl inj 50 mg/2ml</i> .....	104
CELEXA TAB 20MG .....	55	<i>chlorpromazine hcl tab 100 mg</i> .....	104
CELEXA TAB 40MG .....	55		

<i>chlorpromazine hcl tab 10 mg</i> .....	104	<i>ciprofloxacin hcl ophth soln 0.3% (base equivalent)</i> .....	214
<i>chlorpromazine hcl tab 200 mg</i> .....	104	<i>ciprofloxacin hcl otic soln 0.2% (base equivalent)</i> .....	217
<i>chlorpromazine hcl tab 25 mg</i> .....	104	<i>ciprofloxacin hcl tab 100 mg (base equiv)</i> .....	167
<i>chlorpromazine hcl tab 50 mg</i> .....	104	<i>ciprofloxacin hcl tab 250 mg (base equiv)</i> .....	167
<i>chlorthalidone tab 25 mg</i> .....	157	<i>ciprofloxacin hcl tab 500 mg (base equiv)</i> .....	167
<i>chlorthalidone tab 50 mg</i> .....	158	<i>ciprofloxacin hcl tab 750 mg (base equiv)</i> .....	167
<i>chlorzoxazone tab 500 mg</i> .....	210	CIPRO TAB 250MG .....	167
CHOLBAM CAP 250MG .....	167	CIPRO TAB 500MG .....	167
CHOLBAM CAP 50MG.....	167	<i>citalopram hydrobromide oral soln 10 mg/5ml</i> .....	55
<i>cholestyramine light powder 4 gm/dose</i> ..	69	<i>citalopram hydrobromide tab 10 mg (base equiv)</i> .....	55
<i>cholestyramine light powder packets 4 gm</i> .....	69	<i>citalopram hydrobromide tab 20 mg (base equiv)</i> .....	55
<i>cholestyramine powder 4 gm/dose</i> .....	69	<i>citalopram hydrobromide tab 40 mg (base equiv)</i> .....	55
<i>cholestyramine powder packets 4 gm</i> .....	69	CLARINEX-D TAB 2.5-120 .....	132
<i>choline fenofibrate cap dr 135 mg (fenofibric acid equiv)</i> .....	70	CLARINEX TAB 5MG .....	68
<i>choline fenofibrate cap dr 45 mg (fenofibric acid equiv)</i> .....	70	<i>clarithromycin for susp 125 mg/5ml</i> .....	179
CIBINQO TAB 100MG .....	146	<i>clarithromycin for susp 250 mg/5ml</i> .....	179
CIBINQO TAB 200MG.....	146	<i>clarithromycin tab 250 mg</i> .....	179
CIBINQO TAB 50MG .....	146	<i>clarithromycin tab 500 mg</i> .....	179
<i>ciclopirox gel 0.77%</i> .....	136	<i>clarithromycin tab er 24hr 500 mg</i> .....	179
<i>ciclopirox olamine cream 0.77% (base equiv)</i> .....	136	CLEANLET 28G MIS LANCETS.....	183
<i>ciclopirox olamine susp 0.77% (base equiv)</i> .....	136	<i>clemastine fumarate tab 2.68 mg</i> .....	68
<i>ciclopirox shampoo 1%</i> .....	136	CLENPIQ SOL.....	178
<i>ciclopirox solution 8%</i> .....	136	CLEOCIN CAP 150MG .....	36
<i>cilostazol tab 100 mg</i> .....	173	CLEOCIN CAP 300MG .....	36
<i>cilostazol tab 50 mg</i> .....	173	CLEOCIN CAP 75MG.....	36
CIMDUO TAB 300-300.....	106	CLEOCIN CRE 2% VAG .....	235
<i>cimetidine hcl soln 300 mg/5ml</i> .....	232	CLEOCIN PED SOL 75MG/5ML .....	36
<i>cimetidine tab 300 mg</i> .....	232	CLEOCIN SUP 100MG .....	235
<i>cimetidine tab 400 mg</i> .....	232	CLEOCIN-T LOT 1%.....	134
<i>cimetidine tab 800 mg</i> .....	232	CLEVER CHECK MIS .....	183
<i>cinacalcet hcl tab 30 mg (base equiv)</i> .....	161	CLEVER CHECK MIS 30G.....	183
<i>cinacalcet hcl tab 60 mg (base equiv)</i> .....	161	CLEVR CHOICE LIQ HIGH .....	183
<i>cinacalcet hcl tab 90 mg (base equiv)</i> .....	161	CLEVR CHOICE LIQ LOW .....	183
CIPRO (10%) SUS 500MG/5 .....	166		
CIPRO (5%) SUS 250MG/5 .....	166		
<i>ciprofloxacin-dexamethasone otic susp 0.3-0.1%</i> .....	217		

CLIMARA PRO DIS WEEKLY .....	165	<i>clonazepam orally disintegrating tab 0.125</i>	
CLINDAGEL GEL 1% .....	134	<i>mg</i> .....	48
<i>clindamycin hcl cap 150 mg</i> .....	36	<i>clonazepam orally disintegrating tab 0.25</i>	
<i>clindamycin hcl cap 300 mg</i> .....	36	<i>mg</i> .....	48
<i>clindamycin hcl cap 75 mg</i> .....	36	<i>clonazepam orally disintegrating tab 0.5 mg</i>	
<i>clindamycin palmitate hcl for soln 75</i>		.....	48
<i>mg/5ml (base equiv)</i> .....	36	<i>clonazepam orally disintegrating tab 1 mg</i>	
<i>clindamycin phosphate-benzoyl peroxide</i>		.....	48
<i>gel 1.2-2.5%</i> .....	134	<i>clonazepam orally disintegrating tab 2 mg</i>	
<i>clindamycin phosphate-benzoyl peroxide</i>		.....	48
<i>gel 1-5%</i> .....	134	<i>clonazepam tab 0.5 mg</i> .....	48
<i>clindamycin phosphate foam 1%</i> .....	134	<i>clonazepam tab 1 mg</i> .....	48
<i>clindamycin phosphate gel 1%</i> .....	134	<i>clonazepam tab 2 mg</i> .....	48
<i>clindamycin phosphate lotion 1%</i> .....	134	<i>clonidine hcl tab 0.1 mg</i> .....	75
<i>clindamycin phosphate soln 1%</i> .....	134	<i>clonidine hcl tab 0.2 mg</i> .....	75
<i>clindamycin phosphate swab 1%</i> .....	134	<i>clonidine hcl tab 0.3 mg</i> .....	75
<i>clindamycin phosphate-tretinoin gel 1.2-</i>		<i>clonidine hcl tab er 12hr 0.1 mg</i> .....	5
<i>0.025%</i> .....	134	<i>clonidine td patch weekly 0.1 mg/24hr</i> .....	75
<i>clindamycin phosphate vaginal cream 2%</i>		<i>clonidine td patch weekly 0.2 mg/24hr</i> ....	75
.....	235	<i>clonidine td patch weekly 0.3 mg/24hr</i> ....	75
<i>clindamycin phosph-benzoyl peroxide</i>		<i>clopidogrel bisulfate tab 300 mg (base</i>	
<i>(refrig) gel 1.2 (1)-5%</i> .....	134	<i>equiv)</i> .....	173
CLINDESSE CRE 2% .....	235	<i>clopidogrel bisulfate tab 75 mg (base equiv)</i>	
<i>clobazam suspension 2.5 mg/ml</i> .....	47	.....	173
<i>clobazam tab 10 mg</i> .....	47	<i>clorazepate dipotassium tab 15 mg</i> .....	39
<i>clobazam tab 20 mg</i> .....	48	<i>clorazepate dipotassium tab 3.75 mg</i> .....	39
<i>clobetasol propionate cream 0.05%</i> .....	143	<i>clorazepate dipotassium tab 7.5 mg</i> .....	39
<i>clobetasol propionate emollient base cream</i>		<i>clotrimazole troche 10 mg</i> .....	208
<i>0.05%</i> .....	143	<i>clotrimazole w/ betamethasone cream 1-</i>	
<i>clobetasol propionate foam 0.05%</i> .....	143	<i>0.05%</i> .....	136
<i>clobetasol propionate gel 0.05%</i> .....	143	<i>clotrimazole w/ betamethasone lotion 1-</i>	
<i>clobetasol propionate lotion 0.05%</i> .....	143	<i>0.05%</i> .....	136
<i>clobetasol propionate oint 0.05%</i> .....	143	<i>clozapine orally disintegrating tab 100 mg</i>	
<i>clobetasol propionate shampoo 0.05%</i> ..	143	.....	102
<i>clobetasol propionate soln 0.05%</i> .....	143	<i>clozapine orally disintegrating tab 12.5 mg</i>	
CLOBEX LOT 0.05% .....	144	.....	102
CLOBEX SHA 0.05% .....	144	<i>clozapine orally disintegrating tab 150 mg</i>	
CLODERM CRE 0.1%.....	144	.....	102
<i>clomiphene citrate tab 50 mg</i> .....	159	<i>clozapine orally disintegrating tab 200 mg</i>	
<i>clomipramine hcl cap 25 mg</i> .....	58	.....	102
<i>clomipramine hcl cap 50 mg</i> .....	58	<i>clozapine orally disintegrating tab 25 mg</i>	
<i>clomipramine hcl cap 75 mg</i> .....	58	.....	102
		<i>clozapine tab 100 mg</i> .....	102

<i>clozapine tab 200 mg</i> .....	102	COMPACT SPAC MIS MD MASK .....	200
<i>clozapine tab 25 mg</i> .....	102	COMPACT SPAC MIS SM MASK.....	200
<i>clozapine tab 50 mg</i> .....	102	COMPLEAT LIQ CLS SYS .....	150
CLOZARIL TAB 100MG .....	102	COMPLEAT PED LIQ ORG BLND .....	150
CLOZARIL TAB 200MG .....	102	COMTAN TAB 200MG .....	96
CLOZARIL TAB 25MG.....	102	CONDYLOX GEL 0.5%.....	147
CLOZARIL TAB 50MG.....	102	CONTOUR HIGH LIQ CONTROL.....	183
COAGUCHEK MIS LANCETS .....	183	CONTOUR LOW LIQ CONTROL .....	183
<i>coal tar soln 20%</i> .....	149	CONTOUR NEXT SOL LEVEL 1.....	183
COARTEM TAB 20-120MG .....	81	CONTOUR NEXT SOL LEVEL 2 .....	183
<i>codeine sulfate tab 30 mg</i> .....	23	CONTOUR NORM LIQ CONTROL .....	183
CODEINE SULF TAB 15MG.....	23	CONTROL HIGH SOL UNISTRIP .....	183
CODEINE SULF TAB 60MG.....	23	CONTROL LOW SOL UNISTRIP .....	183
<i>colchicine tab 0.6 mg</i> .....	172	CONTROL NORM SOL EASY STP .....	183
<i>colchicine w/ probenecid tab 0.5-500 mg</i> .....	171	CONTROL SOL LIQ HI/MID/L.....	183
<i>colesevelam hcl packet for susp 3.75 gm</i> 69		CONTROL SOL LIQ HIGH/LOW.....	183
<i>colesevelam hcl tab 625 mg</i> .....	69	CONTROL SOL LIQ LEVEL 2 .....	183
COLESTID FLA GRA 5/7.5GM.....	69	CONTROL SOL LIQ MID .....	183
COLESTID FLA GRA 5GM .....	69	CONTROL SOL NORMAL .....	183
COLESTID GRA 5GM .....	69	CONZIP CAP 100MG .....	23
COLESTID POW 5GM.....	69	CONZIP CAP 200MG.....	23
COLESTID TAB 1GM .....	69	CONZIP CAP 300MG.....	23
<i>colestipol hcl granule packets 5 gm</i> .....	69	COOL CONTROL SOL A.....	183
<i>colestipol hcl granules 5 gm</i> .....	69	COOL CONTROL SOL B.....	183
<i>colestipol hcl tab 1 gm</i> .....	70	COPAXONE INJ 20MG/ML .....	223
COMBIPATCH DIS.....	165	COPAXONE INJ 40MG/ML .....	223
COMBIVENT AER 20-100 .....	44	COPIKTRA CAP 15MG.....	90
COMBIVIR TAB 150-300 .....	106	COPIKTRA CAP 25MG .....	90
COMETRIQ KIT 100MG .....	90	COREG TAB 12.5MG .....	115
COMETRIQ KIT 140MG .....	90	COREG TAB 25MG .....	115
COMETRIQ KIT 60MG.....	90	COREG TAB 3.125MG .....	115
COMFORT ASSU MIS LANC 28G .....	183	COREG TAB 6.25MG.....	115
COMFORT ASSU MIS LANC 33G .....	183	CORGARD TAB 20MG .....	116
COMFORT EZ MIS 21G .....	183	CORGARD TAB 40MG .....	116
COMFORT EZ MIS 23G .....	183	CORGARD TAB 80MG .....	117
COMFORT EZ MIS 28G .....	183	CORLANOR SOL 5MG/5ML.....	126
COMFORT MIS LANCETS .....	183	CORLANOR TAB 5MG .....	126
COMFORTOUCH MIS LANCET.....	183	CORLANOR TAB 7.5MG .....	126
COMFORT TCH MIS LANC 28G .....	183	CORTEF TAB 10MG .....	130
COMFORT TCH MIS LANC 31G .....	183	CORTEF TAB 20MG .....	130
COMPACT SPAC MIS CHAMBER .....	200	CORTEF TAB 5MG.....	130
COMPACT SPAC MIS LG MASK .....	200	CORTENEMA ENE 100MG .....	33
		CORTIFOAM AER 90MG .....	33

CORTISPORIN SUS -TC OTIC .....	217	CYCLOMYDRIL SOL OP .....	213
CORTROPHIN GEL 80UNIT .....	159	<i>cyclopentolate hcl ophth soln 0.5%</i> .....	213
COSENTYX INJ 150MG/ML .....	138	<i>cyclopentolate hcl ophth soln 1%</i> .....	213
COSENTYX INJ 300DOSE .....	139	<i>cyclopentolate hcl ophth soln 2%</i> .....	213
COSENTYX INJ 75MG/0.5 .....	138	<i>cyclophosphamide cap 25 mg</i> .....	82
COSENTYX PEN INJ 150MG/ML.....	139	<i>cyclophosphamide cap 50 mg</i> .....	82
COSENTYX PEN INJ 300DOSE .....	139	CYCLOPHOSPH TAB 25MG .....	82
COSENTYX UNO INJ 300/2ML.....	140	CYCLOPHOSPH TAB 50MG.....	82
COSOFT PF SOL 2%-0.5%.....	212	<i>cycloserine cap 250 mg</i> .....	82
COSOFT SOL 2-0.5%OP .....	212	CYCLOSET TAB 0.8MG.....	62
COTELLIC TAB 20MG .....	90	<i>cyclosporine cap 100 mg</i> .....	206
CREON CAP 12000UNT.....	155	<i>cyclosporine cap 25 mg</i> .....	206
CREON CAP 24000UNT .....	155	<i>cyclosporine modified cap 100 mg</i> .....	206
CREON CAP 3000UNIT .....	155	<i>cyclosporine modified cap 25 mg</i> .....	206
CREON CAP 36000UNT .....	155	<i>cyclosporine modified cap 50 mg</i> .....	206
CREON CAP 6000UNIT .....	155	<i>cyclosporine modified oral soln 100 mg/ml</i> .....	206
CRINONE GEL 4% VAG.....	235	<i>cyproheptadine hcl syrup 2 mg/5ml</i> .....	69
CRINONE GEL 8% VAG.....	235	<i>cyproheptadine hcl tab 4 mg</i> .....	69
CRIXIVAN CAP 400MG .....	106	CYSTAGON CAP 150MG .....	171
<i>cromolyn sodium ophth soln 4%</i> .....	216	CYSTAGON CAP 50MG.....	171
<i>cromolyn sodium oral conc 100 mg/5ml</i> .....	167	CYSTARAN SOL 0.44% .....	216
<i>cromolyn sodium soln nebu 20 mg/2ml</i> .....	40	CYTOTEC TAB 100MCG .....	233
<i>crotamiton lotion 10%</i> .....	149	CYTOTEC TAB 200MCG.....	233
CRUCIAL LIQ UNFLAVOR .....	150	<b>D</b>	
CURITY PREP PAD ALCOHOL .....	199	<i>dalfampridine tab er 12hr 10 mg</i> .....	223
CURITY SWABS PAD ALCOHOL .....	199	<i>danazol cap 100 mg</i> .....	33
CUTIVATE LOT 0.05% .....	144	<i>danazol cap 200 mg</i> .....	33
CUVPOSA SOL 1MG/5ML.....	231	<i>danazol cap 50 mg</i> .....	33
CVS KETONE TES CARE.....	150	DANTRIUM CAP 25MG.....	210
CVS LANCETS MIS 21G .....	184	DANTRIUM CAP 50MG .....	210
CVS LANCETS MIS 30G .....	184	<i>dantrolene sodium cap 100 mg</i> .....	210
CVS LANCETS MIS 33G.....	184	<i>dantrolene sodium cap 25 mg</i> .....	210
CVS LANCETS MIS ORIGINAL.....	184	<i>dantrolene sodium cap 50 mg</i> .....	210
CVS LANCETS MIS THIN 26G.....	184	<i>dapsone gel 5%</i> .....	134
CVS LANCETS MIS THIN 30G .....	184	<i>dapsone gel 7.5%</i> .....	134
CVS LANCETS MIS THIN 33G.....	184	<i>dapsone tab 100 mg</i> .....	36
CVS LANCING MIS DEVICE .....	184	<i>dapsone tab 25 mg</i> .....	36
<i>cyanocobalamin inj 1000 mcg/ml</i> .....	174	<i>darifenacin hydrobromide tab er 24hr 15</i> <i>mg (base equiv)</i> .....	233
<i>cyclobenzaprine hcl tab 10 mg</i> .....	210	<i>darifenacin hydrobromide tab er 24hr 7.5</i> <i>mg (base equiv)</i> .....	233
<i>cyclobenzaprine hcl tab 5 mg</i> .....	210	DAYPRO TAB 600MG .....	18
CYCLOGYL SOL 0.5% OP .....	213		
CYCLOGYL SOL 1% OP.....	213		
CYCLOGYL SOL 2% OP .....	213		

DAYVIGO TAB 10MG.....	178	<i>desmopressin acetate nasal spray soln</i>	
DAYVIGO TAB 5MG.....	178	0.01%.....	163
DDAVP SOL 0.01% .....	163	<i>desmopressin acetate nasal spray soln</i>	
DDAVP TAB 0.1MG.....	163	0.01% (refrigerated) .....	163
DDAVP TAB 0.2MG .....	163	<i>desmopressin acetate tab 0.1 mg</i> .....	163
<i>deferasirox granules packet 180 mg</i> .....	65	<i>desmopressin acetate tab 0.2 mg</i> .....	163
<i>deferasirox granules packet 360 mg</i> .....	65	<i>desogest-eth estrad &amp; eth estrad tab 0.15-</i>	
<i>deferasirox granules packet 90 mg</i> .....	65	0.02/0.01 mg(21/5) .....	127
<i>deferasirox tab 180 mg</i> .....	65	<i>desogest-ethin est tab 0.1-0.025/0.125-</i>	
<i>deferasirox tab 360 mg</i> .....	65	0.025/0.15-0.025mg-mg .....	127
<i>deferasirox tab 90 mg</i> .....	65	<i>desogestrel &amp; ethinyl estradiol tab 0.15 mg-</i>	
<i>deferasirox tab for oral susp 125 mg</i> .....	65	30 mcg .....	127
<i>deferasirox tab for oral susp 250 mg</i> .....	65	DESONATE GEL 0.05% .....	144
<i>deferasirox tab for oral susp 500 mg</i> .....	65	<i>desonide cream 0.05%</i> .....	144
<i>deferiprone tab 500 mg</i> .....	65	<i>desonide lotion 0.05%</i> .....	144
<i>deferoxamine mesylate for inj 2 gm</i> .....	65	<i>desonide oint 0.05%</i> .....	144
DELESTROGEN INJ 10MG/ML .....	165	DESOWEN CRE 0.05% .....	144
DELESTROGEN INJ 20MG/ML.....	165	<i>desoximetasone cream 0.05%</i> .....	144
DELESTROGEN INJ 40MG/ML.....	165	<i>desoximetasone cream 0.25%</i> .....	144
<i>demeclocycline hcl tab 150 mg</i> .....	229	<i>desoximetasone gel 0.05%</i> .....	144
<i>demeclocycline hcl tab 300 mg</i> .....	229	<i>desoximetasone oint 0.25%</i> .....	144
DEMSER CAP 250MG.....	74	<i>desoximetasone spray 0.25%</i> .....	144
DENAVIR CRE 1% .....	142	DESOXYN TAB 5MG .....	1
DEPEN TITRA TAB 250MG.....	205	<i>desvenlafaxine succinate tab er 24hr 100</i>	
DEPO-ESTRADI INJ 5MG/ML.....	165	mg (base equiv) .....	57
DEPO-PROVERA INJ 150MG/ML.....	130	<i>desvenlafaxine succinate tab er 24hr 25 mg</i>	
DEPO-SQ PROV INJ 104.....	130	(base equiv).....	57
DERMA-SMOOTH OIL /FS BODY.....	144	<i>desvenlafaxine succinate tab er 24hr 50 mg</i>	
DERMA-SMOOTH OIL /FS SCLP .....	144	(base equiv).....	57
DERMOTIC OIL 0.01%.....	217	DESVENLAFAX TAB 100MG ER .....	57
DESCOVY TAB 120-15MG .....	107	DESVENLAFAX TAB 50MG ER.....	57
DESCOVY TAB 200/25MG.....	107	DETROL TAB 1MG .....	233
<i>desipramine hcl tab 100 mg</i> .....	58	DETROL TAB 2MG .....	233
<i>desipramine hcl tab 10 mg</i> .....	58	DEXAMETHASON CON 1MG/ML.....	130
<i>desipramine hcl tab 150 mg</i> .....	58	<i>dexamethasone elixir 0.5 mg/5ml</i> .....	130
<i>desipramine hcl tab 25 mg</i> .....	58	<i>dexamethasone sodium phosphate ophth</i>	
<i>desipramine hcl tab 50 mg</i> .....	58	soln 0.1% .....	215
<i>desipramine hcl tab 75 mg</i> .....	58	<i>dexamethasone soln 0.5 mg/5ml</i> .....	130
<i>desloratadine tab 5 mg</i> .....	68	<i>dexamethasone tab 0.5 mg</i> .....	130
<i>desloratadine tab orally disintegrating 2.5</i>		<i>dexamethasone tab 0.75 mg</i> .....	130
mg .....	68	<i>dexamethasone tab 1.5 mg</i> .....	130
<i>desloratadine tab orally disintegrating 5 mg</i>		<i>dexamethasone tab 1 mg</i> .....	130
.....	68	<i>dexamethasone tab 2 mg</i> .....	130



<i>dexamethasone tab 4 mg</i> .....	130	<i>dextroamphetamine sulfate oral solution 5</i>	
<i>dexamethasone tab 6 mg</i> .....	130	<i>mg/5ml</i> .....	2
<i>dexamethasone tab therapy pack 1.5 mg</i>		<i>dextroamphetamine sulfate tab 10 mg</i> .....	2
<i>(21)</i> .....	131	<i>dextroamphetamine sulfate tab 15 mg</i> .....	2
<i>dexamethasone tab therapy pack 1.5 mg</i>		<i>dextroamphetamine sulfate tab 2.5 mg</i> .....	2
<i>(35)</i> .....	131	<i>dextroamphetamine sulfate tab 20 mg</i> .....	2
<i>dexamethasone tab therapy pack 1.5 mg</i>		<i>dextroamphetamine sulfate tab 30 mg</i> .....	2
<i>(51)</i> .....	131	<i>dextroamphetamine sulfate tab 5 mg</i> .....	2
DEXCOM G5 MIS RECEIVER.....	184	<i>dextroamphetamine sulfate tab 7.5 mg</i> .....	2
DEXCOM G5 MIS TRANSMIT .....	184	DIABETIC TF LIQ.....	150
DEXCOM G6 MIS RECEIVER.....	184	DIABETISOURC LIQ .....	151
DEXCOM G6 MIS SENSOR.....	184	DIASTAT ACDL GEL 12.5-20 .....	48
DEXCOM G6 MIS TRANSMIT .....	184	DIASTAT ACDL GEL 5-10MG .....	48
DEXCOM G7 MIS RECEIVER.....	184	DIASTAT PED GEL 2.5M GEL .....	48
DEXCOM G7 MIS SENSOR.....	184	DIASTIX TES STRIPS.....	150
DEXEDRINE CAP 10MG CR.....	1	DIATHRIVE LIQ CONTROL .....	184
DEXEDRINE CAP 15MG CR .....	2	DIATHRIVE MIS LANCETS .....	184
DEXEDRINE CAP 5MG CR .....	1	DIATHRIVE MIS LANCING.....	184
<i>dexmethylphenidate hcl cap er 24 hr 10 mg</i>		DIATHRIVE MIS UT 30G .....	184
.....	6	DIATRUE CONT SOL LEVEL 1 .....	184
<i>dexmethylphenidate hcl cap er 24 hr 15 mg</i>		DIATRUE CONT SOL LEVEL 2.....	184
.....	6	DIATRUE CONT SOL LEVEL 3.....	184
<i>dexmethylphenidate hcl cap er 24 hr 20 mg</i>		<i>diazepam conc 5 mg/ml</i> .....	39
.....	6	<i>diazepam oral soln 1 mg/ml</i> .....	39
<i>dexmethylphenidate hcl cap er 24 hr 25 mg</i>		<i>diazepam rectal gel delivery system 10 mg</i>	
.....	6	.....	48
<i>dexmethylphenidate hcl cap er 24 hr 30 mg</i>		<i>diazepam rectal gel delivery system 2.5 mg</i>	
.....	6	.....	48
<i>dexmethylphenidate hcl cap er 24 hr 35 mg</i>		<i>diazepam rectal gel delivery system 20 mg</i>	
.....	6	.....	48
<i>dexmethylphenidate hcl cap er 24 hr 40 mg</i>		<i>diazepam tab 10 mg</i> .....	39
.....	6	<i>diazepam tab 2 mg</i> .....	39
<i>dexmethylphenidate hcl cap er 24 hr 5 mg</i>	6	<i>diazepam tab 5 mg</i> .....	39
<i>dexmethylphenidate hcl tab 10 mg</i> .....	6	<i>diazoxide susp 50 mg/ml</i> .....	61
<i>dexmethylphenidate hcl tab 2.5 mg</i> .....	6	DIBENZYLINE CAP 10MG.....	74
<i>dexmethylphenidate hcl tab 5 mg</i> .....	6	<i>dichlorphenamide tab 50 mg</i> .....	156
<i>dextroamphetamine sulfate cap er 24hr 10</i>		DICLEGIS TAB 10-10MG.....	66
<i>mg</i> .....	2	<i>diclofenac epolamine patch 1.3%</i> .....	136
<i>dextroamphetamine sulfate cap er 24hr 15</i>		<i>diclofenac potassium tab 50 mg</i> .....	18
<i>mg</i> .....	2	<i>diclofenac sodium (actinic keratoses) gel</i>	
<i>dextroamphetamine sulfate cap er 24hr 5</i>		<i>3%</i> .....	137
<i>mg</i> .....	2	<i>diclofenac sodium ophth soln 0.1%</i> .....	216
		<i>diclofenac sodium soln 1.5%</i> .....	136

<i>diclofenac sodium tab delayed release 25 mg</i> .....	18	<i>diltiazem hcl cap er 24hr 180 mg</i> .....	118
<i>diclofenac sodium tab delayed release 50 mg</i> .....	18	<i>diltiazem hcl cap er 24hr 240 mg</i> .....	118
<i>diclofenac sodium tab delayed release 75 mg</i> .....	18	<i>diltiazem hcl coated beads cap er 24hr 120 mg</i> .....	118
<i>diclofenac sodium tab er 24hr 100 mg</i> .....	18	<i>diltiazem hcl coated beads cap er 24hr 180 mg</i> .....	118
<i>diclofenac w/ misoprostol tab delayed release 50-0.2 mg</i> .....	19	<i>diltiazem hcl coated beads cap er 24hr 240 mg</i> .....	118
<i>diclofenac w/ misoprostol tab delayed release 75-0.2 mg</i> .....	19	<i>diltiazem hcl coated beads cap er 24hr 300 mg</i> .....	118
<i>dicloxacillin sodium cap 250 mg</i> .....	219	<i>diltiazem hcl coated beads cap er 24hr 360 mg</i> .....	118
<i>dicloxacillin sodium cap 500 mg</i> .....	219	<i>diltiazem hcl extended release beads cap er 24hr 120 mg</i> .....	118
<i>dicyclomine hcl cap 10 mg</i> .....	231	<i>diltiazem hcl extended release beads cap er 24hr 180 mg</i> .....	118
<i>dicyclomine hcl oral soln 10 mg/5ml</i> .....	231	<i>diltiazem hcl extended release beads cap er 24hr 240 mg</i> .....	118
<i>dicyclomine hcl tab 20 mg</i> .....	231	<i>diltiazem hcl extended release beads cap er 24hr 300 mg</i> .....	118
<i>diethylpropion hcl tab 25 mg</i> .....	4	<i>diltiazem hcl extended release beads cap er 24hr 360 mg</i> .....	118
<i>diethylpropion hcl tab er 24hr 75 mg</i> .....	4	<i>diltiazem hcl extended release beads cap er 24hr 420 mg</i> .....	118
DIFFERIN CRE 0.1%.....	134	<i>diltiazem hcl tab 120 mg</i> .....	118
DIFFERIN GEL 0.1% .....	134	<i>diltiazem hcl tab 30 mg</i> .....	118
DIFFERIN GEL 0.3% .....	134	<i>diltiazem hcl tab 60 mg</i> .....	118
DIFICID SUS.....	180	<i>diltiazem hcl tab 90 mg</i> .....	118
DIFICID TAB 200MG .....	180	<i>dimethyl fumarate capsule delayed release 120 mg</i> .....	223
DIFLUCAN SUS 10MG/ML .....	67	<i>dimethyl fumarate capsule delayed release 240 mg</i> .....	223
DIFLUCAN SUS 40MG/ML .....	67	<i>dimethyl fumarate capsule dr starter pack 120 mg &amp; 240 mg</i> .....	223
DIFLUCAN TAB 100MG .....	67	DIPENTUM CAP 250MG.....	168
DIFLUCAN TAB 150MG .....	67	<i>diphenoxylate w/ atropine liq 2.5-0.025 mg/5ml</i> .....	65
DIFLUCAN TAB 200MG .....	67	<i>diphenoxylate w/ atropine tab 2.5-0.025 mg</i> .....	65
DIFLUCAN TAB 50MG.....	67	DIPROLENE AF CRE 0.05% .....	144
<i>diflunisal tab 500 mg</i> .....	22	DIPROLENE OIN 0.05%.....	144
<i>difluprednate ophth emulsion 0.05%</i> .....	215	<i>dipyridamole tab 25 mg</i> .....	173
<i>digoxin oral soln 0.05 mg/ml</i> .....	120	<i>dipyridamole tab 50 mg</i> .....	173
<i>digoxin tab 125 mcg (0.125 mg)</i> .....	120		
<i>digoxin tab 250 mcg (0.25 mg)</i> .....	120		
DILATRATE SR CAP 40MG .....	37		
DILAUDID LIQ 1MG/ML .....	23		
DILAUDID TAB 2MG.....	23		
DILAUDID TAB 4MG .....	23		
DILAUDID TAB 8MG .....	23		
<i>diltiazem hcl cap er 12hr 120 mg</i> .....	118		
<i>diltiazem hcl cap er 12hr 60 mg</i> .....	118		
<i>diltiazem hcl cap er 12hr 90 mg</i> .....	118		
<i>diltiazem hcl cap er 24hr 120 mg</i> .....	118		

<i>dipyridamole tab 75 mg</i> .....	173	<i>doxazosin mesylate tab 1 mg</i> .....	75
<i>disopyramide phosphate cap 100 mg</i> .....	39	<i>doxazosin mesylate tab 2 mg</i> .....	75
<i>disopyramide phosphate cap 150 mg</i> .....	39	<i>doxazosin mesylate tab 4 mg</i> .....	75
<i>disulfiram tab 250 mg</i> .....	219	<i>doxazosin mesylate tab 8 mg</i> .....	75
<i>disulfiram tab 500 mg</i> .....	219	<i>doxepin hcl (sleep) tab 3 mg (base equiv)</i> .....	176
DITROPAN XL TAB 10MG.....	233	<i>doxepin hcl (sleep) tab 6 mg (base equiv)</i> .....	177
DITROPAN XL TAB 5MG.....	233	<i>doxepin hcl cap 100 mg</i> .....	59
DIURIL SUS 250/5ML.....	158	<i>doxepin hcl cap 10 mg</i> .....	58
<i>divalproex sodium cap delayed release</i> <i>sprinkle 125 mg</i> .....	54	<i>doxepin hcl cap 150 mg</i> .....	59
<i>divalproex sodium tab delayed release 125</i> <i>mg</i> .....	54	<i>doxepin hcl cap 25 mg</i> .....	58
<i>divalproex sodium tab delayed release 250</i> <i>mg</i> .....	54	<i>doxepin hcl cap 50 mg</i> .....	58
<i>divalproex sodium tab delayed release 500</i> <i>mg</i> .....	54	<i>doxepin hcl cap 75 mg</i> .....	59
<i>divalproex sodium tab er 24 hr 250 mg</i> ....	54	<i>doxepin hcl conc 10 mg/ml</i> .....	59
<i>divalproex sodium tab er 24 hr 500 mg</i> ....	54	<i>doxercalciferol cap 0.5 mcg</i> .....	161
DIVIGEL GEL 0.25MG.....	165	<i>doxercalciferol cap 1 mcg</i> .....	161
DIVIGEL GEL 0.5MG.....	165	<i>doxercalciferol cap 2.5 mcg</i> .....	161
DIVIGEL GEL 0.75MG.....	165	<i>doxycycline hyclate cap 100 mg</i> .....	229
DIVIGEL GEL 1.25MG.....	165	<i>doxycycline hyclate cap 50 mg</i> .....	229
DIVIGEL GEL 1MG/GM.....	165	<i>doxycycline hyclate tab 100 mg</i> .....	229
<i>dofetilide cap 125 mcg (0.125 mg)</i> .....	40	<i>doxycycline hyclate tab 20 mg</i> .....	229
<i>dofetilide cap 250 mcg (0.25 mg)</i> .....	40	<i>doxycycline monohydrate cap 100 mg</i> ....	229
<i>dofetilide cap 500 mcg (0.5 mg)</i> .....	40	<i>doxycycline monohydrate cap 50 mg</i> ....	229
<i>donepezil hydrochloride orally</i> <i>disintegrating tab 10 mg</i> .....	220	<i>doxycycline monohydrate for susp 25</i> <i>mg/5ml</i> .....	229
<i>donepezil hydrochloride orally</i> <i>disintegrating tab 5 mg</i> .....	220	<i>doxycycline monohydrate tab 100 mg</i> ....	229
<i>donepezil hydrochloride tab 10 mg</i> .....	220	<i>doxycycline monohydrate tab 150 mg</i> ....	229
<i>donepezil hydrochloride tab 23 mg</i> .....	220	<i>doxycycline monohydrate tab 50 mg</i> .....	229
<i>donepezil hydrochloride tab 5 mg</i> .....	220	<i>doxycycline monohydrate tab 75 mg</i> .....	229
DOPTELET TAB 20MG.....	174	<i>doxylamine-pyridoxine tab delayed release</i> <i>10-10 mg</i> .....	66
DORAL TAB 15MG.....	177	DRISDOL CAP 50000UNT.....	236
<i>dorzolamide hcl ophth soln 2%</i> .....	216	<i>dronabinol cap 10 mg</i> .....	66
<i>dorzolamide hcl-timolol maleate ophth soln</i> <i>2-0.5%</i> .....	212	<i>dronabinol cap 2.5 mg</i> .....	66
<i>dorzolamide hcl-timolol maleate pf ophth</i> <i>soln 2-0.5%</i> .....	212	<i>dronabinol cap 5 mg</i> .....	66
DORZOLAMIDE SOL 2%.....	216	DROPLET LANC MIS 30G.....	184
DOVATO TAB 50-300MG.....	107	DROPLET LANC MIS DEVICE.....	184
DOVONEX CRE 0.005%.....	140	DROPLET PERS MIS LANC 30G.....	184
		<i>drospirenone-ethinyl estradiol tab 3-0.02</i> <i>mg</i> .....	128
		<i>drospirenone-ethinyl estradiol tab 3-0.03</i> <i>mg</i> .....	128

<i>drospirenone-ethinyl estrad-levomefolate</i>	EASY COMFORT MIS 30G.....	184
<i>tab 3-0.02-0.451 mg</i> .....	EASY COMFORT MIS LANC/30G .....	184
<i>drospirenone-ethinyl estrad-levomefolate</i>	EASY COMFORT MIS TWIST .....	185
<i>tab 3-0.03-0.451 mg</i> .....	EASY COMFORT PAD ALCOHOL.....	199
DROXIA CAP 200MG .....	EASYGLUCO SOL PLUS.....	185
DROXIA CAP 300MG .....	EASYMAX 15 LIQ LEVEL2-3 .....	185
DROXIA CAP 400MG .....	EASYMAX 15 SOL LEVEL 2.....	185
<i>droxidopa cap 100 mg</i> .....	EASYMAX LIQ NORM/HIG.....	185
<i>droxidopa cap 200 mg</i> .....	EASYMAX SOL NORMAL .....	185
<i>droxidopa cap 300 mg</i> .....	EASY MINI MIS.....	185
DRYSOL SOL 20%.....	EASY MINI MIS EJECT .....	185
DUAVEE TAB 0.45-20.....	EASY PLUS II SOL HIGH .....	185
DUETACT TAB 30-2MG .....	EASY PLUS II SOL LOW .....	185
DUETACT TAB 30-4MG .....	EASYPHASE HGH SOL CONTROL .....	185
DUEXIS TAB 800-26.6 .....	EASYPHASE LOW SOL CONTROL.....	185
<i>duloxetine hcl enteric coated pellets cap 20</i>	EASY TALK SOL HIGH .....	185
<i>mg (base eq)</i> .....	EASY TALK SOL LOW .....	185
<i>duloxetine hcl enteric coated pellets cap 30</i>	EASY TALK SOL NORMAL .....	185
<i>mg (base eq)</i> .....	EASY TOUCH MIS.....	185
<i>duloxetine hcl enteric coated pellets cap 40</i>	EASY TOUCH MIS LANC/21G.....	185
<i>mg (base eq)</i> .....	EASY TOUCH MIS LANC/23G .....	185
<i>duloxetine hcl enteric coated pellets cap 60</i>	EASY TOUCH MIS LANC/26G .....	185
<i>mg (base eq)</i> .....	EASY TOUCH MIS LANC/28G .....	185
DUO-CARE LIQ LEVEL1/2.....	EASY TOUCH MIS LANC/30G .....	185
DUPIXENT INJ 100/0.67 .....	EASY TOUCH MIS LANC/32G .....	185
DUPIXENT INJ 200/1.14.....	EASY TOUCH MIS LANC/33G .....	185
DUPIXENT INJ 200MG .....	EASY TOUCH SOL CONTROL.....	185
DUPIXENT INJ 300/2ML.....	EASY TOUCH SOL HIGH/LOW .....	185
DURAGESIC DIS 100MCG/H .....	EASY TRAK II LIQ NORMAL .....	185
DURAGESIC DIS 12MCG/HR.....	EASY TRAK SOL HIGH .....	185
DURAGESIC DIS 25MCG/HR.....	EASY TRAK SOL LOW .....	185
DURAGESIC DIS 50MCG/HR .....	EASY TRAK SOL NORMAL.....	185
DURAGESIC DIS 75MCG/HR.....	EC-NAPROSYN TAB 375MG.....	19
DUREZOL EMU 0.05% .....	EC-NAPROSYN TAB 500MG .....	19
<i>dutasteride cap 0.5 mg</i> .....	<i>econazole nitrate cream 1%</i> .....	136
<i>dutasteride-tamsulosin hcl cap 0.5-0.4 mg</i>	ECOZA AER 1% .....	136
.....	EDECRIN TAB 25MG .....	157
<b>E</b>	EDEX KIT 10MCG .....	122
EAA SUPPLEME POW TROPICAL.....	EDEX KIT 20MCG.....	122
EASIVENT MIS .....	EDEX KIT 40MCG .....	122
EASIVENT MIS MASK LG.....	EDURANT TAB 25MG .....	107
EASIVENT MIS MASK MED .....	<i>efavirenz cap 200 mg</i> .....	107
EASIVENT MIS MASK SM.....	<i>efavirenz cap 50 mg</i> .....	107

<i>efavirenz-emtricitabine-tenofovir df tab</i>	<i>emtricitabine caps 200 mg</i> .....	107
600-200-300 mg.....	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz-lamivudine-tenofovir df tab 400-</i>	<i>tab 100-150 mg</i> .....	107
300-300 mg .....	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz-lamivudine-tenofovir df tab 600-</i>	<i>tab 133-200 mg</i> .....	107
300-300 mg .....	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
<i>efavirenz tab 600 mg</i> .....	<i>tab 167-250 mg</i> .....	107
EFFIENT TAB 10MG .....	<i>emtricitabine-tenofovir disoproxil fumarate</i>	
EFFIENT TAB 5MG.....	<i>tab 200-300 mg</i> .....	108
EFUDEX CRE 5%.....	EMTRIVA CAP 200MG .....	108
EGRIFTA SV INJ 2MG .....	EMTRIVA SOL 10MG/ML.....	108
ELEMENT CONT LIQ NORMAL.....	EMVERM CHW 100MG.....	34
ELEMENT LIQ HIGH .....	<i>enalapril maleate &amp; hydrochlorothiazide tab</i>	
ELEMENT LIQ LOW .....	<i>10-25 mg</i> .....	78
ELEMNT COMPA SOL LEVEL 2 .....	<i>enalapril maleate &amp; hydrochlorothiazide tab</i>	
ELEMNT COMPA SOL LEVEL 3 .....	<i>5-12.5 mg</i> .....	78
ELESTRIN GEL 0.06%.....	<i>enalapril maleate oral soln 1 mg/ml</i> .....	73
<i>eletriptan hydrobromide tab 20 mg (base</i>	<i>enalapril maleate tab 10 mg</i> .....	73
<i>equivalent)</i> .....	<i>enalapril maleate tab 2.5 mg</i> .....	73
202	<i>enalapril maleate tab 20 mg</i> .....	73
<i>eletriptan hydrobromide tab 40 mg (base</i>	<i>enalapril maleate tab 5 mg</i> .....	73
<i>equivalent)</i> .....	ENBREL INJ 25/0.5ML.....	21
202	ENBREL INJ 50MG/ML.....	21
ELIMITE CRE 5%.....	ENBREL MINI INJ 50MG/ML.....	22
ELIQUIS ST P TAB 5MG.....	ENBREL SRCLK INJ 50MG/ML .....	22
ELIQUIS TAB 2.5MG .....	ENCARE SUP 100MG.....	234
ELIQUIS TAB 5MG.....	ENDARI POW 5GM.....	174
ELLA TAB 30MG .....	ENDOMETRIN SUP 100MG.....	235
EMBRACE CNTR LIQ HIGH .....	<i>enoxaparin sodium inj 300 mg/3ml</i> .....	46
EMBRACE EVO LIQ LEVEL 1.....	<i>enoxaparin sodium inj soln pref syr 100</i>	
EMBRACE LANC MIS /EJECTOR .....	<i>mg/ml</i> .....	46
EMBRACE LANC MIS THIN 30G .....	<i>enoxaparin sodium inj soln pref syr 120</i>	
EMBRACE PRO LIQ GLUCOSE .....	<i>mg/0.8ml</i> .....	46
EMBRACE SOL LOW .....	<i>enoxaparin sodium inj soln pref syr 150</i>	
EMBRACE TALK SOL HIGH/L2 .....	<i>mg/ml</i> .....	46
EMBRACE TALK SOL LOW/L1.....	<i>enoxaparin sodium inj soln pref syr 30</i>	
EMCYT CAP 140MG .....	<i>mg/0.3ml</i> .....	46
EMEND CAP 80MG.....	<i>enoxaparin sodium inj soln pref syr 40</i>	
EMEND SUS 125MG .....	<i>mg/0.4ml</i> .....	46
EMEND TRIPAC PAK 80 & 125 .....	<i>enoxaparin sodium inj soln pref syr 60</i>	
EMGALITY INJ 100MG/ML .....	<i>mg/0.6ml</i> .....	46
EMGALITY INJ 120MG/ML .....	<i>enoxaparin sodium inj soln pref syr 80</i>	
EMSAM DIS 12MG/24H.....	<i>mg/0.8ml</i> .....	46
EMSAM DIS 6MG/24HR.....		
EMSAM DIS 9MG/24HR.....		

ENSPRYNG INJ .....	207	EQL LANCETS MIS THIN 26G.....	186
ENSTILAR AER.....	144	EQL LANCETS MIS THIN 30G.....	186
ENSURE PLANT LIQ CHOCOLAT .....	151	EQUETRO CAP 100MG.....	99
<i>entacapone tab 200 mg</i> .....	96	EQUETRO CAP 200MG .....	99
<i>entecavir tab 0.5 mg</i> .....	113	EQUETRO CAP 300MG .....	99
<i>entecavir tab 1 mg</i> .....	113	<i>ergocalciferol cap 1.25 mg (50000 unit)</i> .....	236
ENTEREG CAP 12MG .....	170	<i>ergoloid mesylates tab 1 mg</i> .....	226
ENTOCORT EC CAP 3MG DR .....	131	ERGOMAR SUB 2MG.....	202
ENTRESTO TAB 24-26MG .....	121	ERIVEDGE CAP 150MG .....	86
ENTRESTO TAB 49-51MG .....	121	ERLEADA TAB 240MG .....	86
ENTRESTO TAB 97-103MG.....	121	ERLEADA TAB 60MG .....	86
ENVARUSUS XR TAB 0.75MG .....	207	<i>erlotinib hcl tab 100 mg (base equivalent)</i> .....	85
ENVARUSUS XR TAB 1MG.....	207	<i>erlotinib hcl tab 150 mg (base equivalent)</i> .....	85
ENVARUSUS XR TAB 4MG.....	207	<i>erlotinib hcl tab 25 mg (base equivalent)</i> .....	85
EO28 SPLASH LIQ ORANGE .....	151	ERTACZO CRE 2%.....	136
EPCLUSA PAK 150-37.5 .....	113	ERYGEL GEL 2% .....	134
EPCLUSA PAK 200-50MG .....	113	<i>erythromycin ethylsuccinate for susp 200</i>	
EPCLUSA TAB 200-50MG .....	113	<i>mg/5ml</i> .....	179
EPCLUSA TAB 400-100.....	113	<i>erythromycin ethylsuccinate for susp 400</i>	
EPIDIOLEX SOL 100MG/ML .....	49	<i>mg/5ml</i> .....	179
EPIDUO FORTE GEL 0.3-2.5% .....	134	<i>erythromycin ethylsuccinate tab 400 mg</i>	
EPIDUO GEL 0.1-2.5%.....	134	.....	179
EPIFOAM AER 1% .....	144	<i>erythromycin gel 2%</i> .....	134
<i>epinastine hcl ophth soln 0.05%</i> .....	216	<i>erythromycin ophth oint 5 mg/gm</i> .....	214
EPINEPHRINE INJ 0.2MG .....	236	<i>erythromycin pads 2%</i> .....	134
<i>epinephrine inj 30 mg/30ml (1 mg/ml)</i>		<i>erythromycin soln 2%</i> .....	134
<i>(1:1000)</i> .....	235	<i>erythromycin stearate tab 250 mg</i> .....	179
<i>epinephrine solution auto-injector 0.15</i>		<i>erythromycin tab 250 mg</i> .....	179
<i>mg/0.15ml (1:1000)</i> .....	236	<i>erythromycin tab 500 mg</i> .....	179
<i>epinephrine solution auto-injector 0.15</i>		<i>erythromycin tab delayed release 250 mg</i>	
<i>mg/0.3ml (1:2000)</i> .....	236	.....	179
<i>epinephrine solution auto-injector 0.3</i>		<i>erythromycin tab delayed release 333 mg</i>	
<i>mg/0.3ml (1:1000)</i> .....	236	.....	179
EPIPEN 2-PAK INJ 0.3MG .....	236	<i>erythromycin tab delayed release 500 mg</i>	
EPIPEN-JR INJ 0.15MG.....	236	.....	179
EPIVIR SOL 10MG/ML .....	108	<i>erythromycin w/ delayed release particles</i>	
EPIVIR TAB 150MG.....	108	<i>cap 250 mg</i> .....	179
EPIVIR TAB 300MG.....	108	ESBRIET CAP 267MG.....	228
<i>eplerenone tab 25 mg</i> .....	80	<i>escitalopram oxalate soln 5 mg/5ml (base</i>	
<i>eplerenone tab 50 mg</i> .....	80	<i>equiv)</i> .....	55
EPZICOM TAB 600-300 .....	108	<i>escitalopram oxalate tab 10 mg (base</i>	
EQL LANCETS MIS 21G COLR .....	186	<i>equiv)</i> .....	56
EQL LANCETS MIS 33G COLR.....	186		

<i>escitalopram oxalate tab 20 mg (base equiv)</i> .....	56	<i>estradiol td patch weekly 0.025 mg/24hr</i> .....	166
<i>escitalopram oxalate tab 5 mg (base equiv)</i> .....	56	<i>estradiol td patch weekly 0.0375 mg/24hr (37.5 mcg/24hr)</i> .....	166
ESGIC TAB.....	22	<i>estradiol td patch weekly 0.05 mg/24hr</i> .	166
<i>esomeprazole magnesium cap delayed release 20 mg (base eq)</i> .....	232	<i>estradiol td patch weekly 0.06 mg/24hr</i> .	166
<i>esomeprazole magnesium cap delayed release 40 mg (base eq)</i> .....	232	<i>estradiol td patch weekly 0.075 mg/24hr</i> .....	166
<i>esomeprazole magnesium for delayed release susp packet 10 mg</i> .....	232	<i>estradiol td patch weekly 0.1 mg/24hr</i> ....	166
<i>esomeprazole magnesium for delayed release susp packet 20 mg</i> .....	232	<i>estradiol vaginal cream 0.1 mg/gm</i> .....	235
<i>esomeprazole magnesium for delayed release susp packet 40 mg</i> .....	232	<i>estradiol valerate im in oil 20 mg/ml</i> .....	166
<i>estazolam tab 1 mg</i> .....	177	<i>estradiol valerate im in oil 40 mg/ml</i> .....	166
<i>estazolam tab 2 mg</i> .....	177	ESTROGEL GEL.....	166
ESTRACE TAB 0.5MG.....	166	ESTROSTEP FE TAB .....	128
ESTRACE TAB 1MG .....	166	<i>eszopiclone tab 1 mg</i> .....	177
ESTRACE TAB 2MG.....	166	<i>eszopiclone tab 2 mg</i> .....	177
ESTRACE VAG CRE 0.01%.....	235	<i>eszopiclone tab 3 mg</i> .....	177
<i>estradiol &amp; norethindrone acetate tab 0.5-0.1 mg</i> .....	165	<i>ethacrynic acid tab 25 mg</i> .....	157
<i>estradiol &amp; norethindrone acetate tab 1-0.5 mg</i> .....	165	<i>ethambutol hcl tab 100 mg</i> .....	82
<i>estradiol tab 0.5 mg</i> .....	166	<i>ethambutol hcl tab 400 mg</i> .....	82
<i>estradiol tab 1 mg</i> .....	166	<i>ethosuximide cap 250 mg</i> .....	53
<i>estradiol tab 2 mg</i> .....	166	<i>ethosuximide soln 250 mg/5ml</i> .....	53
<i>estradiol td gel 0.25 mg/0.25gm (0.1%)</i> .	166	ETHYL CHLOR AER FINE PIN .....	147
<i>estradiol td gel 0.5 mg/0.5gm (0.1%)</i> .....	166	ETHYL CHLOR AER FN STRM .....	148
<i>estradiol td gel 0.75 mg/0.75gm (0.1%)</i> .	166	ETHYL CHLOR AER MED JET .....	148
<i>estradiol td gel 1.25 mg/1.25gm (0.1%)</i> ...	166	ETHYL CHLOR AER MED STRM.....	148
<i>estradiol td gel 1 mg/gm (0.1%)</i> .....	166	ETHYL CHLOR AER MIST .....	148
<i>estradiol td patch twice weekly 0.025 mg/24hr</i> .....	166	<i>ethyl chloride aerosol spray</i> .....	148
<i>estradiol td patch twice weekly 0.0375 mg/24hr</i> .....	166	<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-35 mcg</i> .....	128
<i>estradiol td patch twice weekly 0.05 mg/24hr</i> .....	166	<i>ethynodiol diacetate &amp; ethinyl estradiol tab 1 mg-50 mcg</i> .....	128
<i>estradiol td patch twice weekly 0.075 mg/24hr</i> .....	166	<i>etodolac cap 200 mg</i> .....	19
<i>estradiol td patch twice weekly 0.1 mg/24hr</i> .....	166	<i>etodolac cap 300 mg</i> .....	19
		<i>etodolac tab 400 mg</i> .....	19
		<i>etodolac tab 500 mg</i> .....	19
		<i>etodolac tab er 24hr 400 mg</i> .....	19
		<i>etodolac tab er 24hr 500 mg</i> .....	19
		<i>etodolac tab er 24hr 600 mg</i> .....	19
		<i>etoposide cap 50 mg</i> .....	95
		<i>etravirine tab 100 mg</i> .....	108
		<i>etravirine tab 200 mg</i> .....	108
		EUCRISA OIN 2%.....	148

EVAMIST SPR 1.53MG .....	166
EVENCARE G2 SOL LOW/HIGH .....	186
EVENCARE G3 SOL LOW/HIGH .....	186
EVENCARE SOL LIQ LOW/HIGH .....	186
EVENCAR MINI SOL NORMAL .....	186
<i>everolimus tab 0.25 mg</i> .....	207
<i>everolimus tab 0.5 mg</i> .....	207
<i>everolimus tab 0.75 mg</i> .....	207
<i>everolimus tab 2.5 mg</i> .....	90
<i>everolimus tab 5 mg</i> .....	90
<i>everolimus tab 7.5 mg</i> .....	90
EVISTA TAB 60MG .....	161
EVOCLIN AER 1% .....	135
EVOLUTION SOL NORMAL .....	186
EVOTAZ TAB 300-150 .....	108
EVOXAC CAP 30MG .....	209
EVRYSDI SOL .....	212
EXELDERM CRE 1% .....	136
EXELDERM SOL 1% .....	136
EXELON DIS 13.3/24 .....	220
EXELON DIS 4.6MG/24 .....	220
EXELON DIS 9.5MG/24 .....	220
<i>exemestane tab 25 mg</i> .....	86
EXODERM LOT 25-1% .....	136
EXTINA AER 2% .....	136
EYSUVIS DRO 0.25% .....	215
<i>ezetimibe-simvastatin tab 10-10 mg</i> .....	69
<i>ezetimibe-simvastatin tab 10-20 mg</i> .....	69
<i>ezetimibe-simvastatin tab 10-40 mg</i> .....	69
<i>ezetimibe-simvastatin tab 10-80 mg</i> .....	69
<i>ezetimibe tab 10 mg</i> .....	72
E-ZJECT LANC MIS 33G .....	184
E-Z JECT MIS 21G .....	184
E-Z JECT MIS 21G COLR .....	184
E-Z JECT MIS 30G .....	184
E-Z JECT MIS 32G COLR .....	184
E-Z JECT MIS LANC 21G .....	184
E-Z JECT MIS THIN 26G .....	184
EZ-LETS 21G MIS LANCETS .....	186
EZ-LETS 26G MIS LANCETS .....	186
EZ-LETS 28G MIS LANCETS .....	186
EZ-LETS 30G MIS LANCETS .....	186

<b>F</b>	
F.A.A. LIQ .....	151
<i>famciclovir tab 125 mg</i> .....	114
<i>famciclovir tab 250 mg</i> .....	114
<i>famciclovir tab 500 mg</i> .....	114
<i>famotidine for susp 40 mg/5ml</i> .....	232
<i>famotidine tab 40 mg</i> .....	232
FARESTON TAB 60MG .....	86
FARXIGA TAB 10MG .....	64
FARXIGA TAB 5MG .....	64
FASENRA PEN INJ 30MG/ML .....	41
FASTCLIX MIS LANCETS .....	186
FAVIPIRAVIR TAB 200MG .....	115
FC2 FEMALE MIS CONDOM .....	180
FC FEMALE MIS CONDOM .....	180
<i>febuxostat tab 40 mg</i> .....	172
<i>febuxostat tab 80 mg</i> .....	172
<i>felbamate susp 600 mg/5ml</i> .....	52
<i>felbamate tab 400 mg</i> .....	52
<i>felbamate tab 600 mg</i> .....	52
FELBATOL SUS 600/5ML .....	52
FELBATOL TAB 400MG .....	52
FELBATOL TAB 600MG .....	52
FELDENE CAP 10MG .....	19
FELDENE CAP 20MG .....	19
<i>felodipine tab er 24hr 10 mg</i> .....	118
<i>felodipine tab er 24hr 2.5 mg</i> .....	118
<i>felodipine tab er 24hr 5 mg</i> .....	118
FEMARA TAB 2.5MG .....	86
FEMCAP MIS 22MM .....	180
FEMCAP MIS 26MM .....	180
FEMCAP MIS 30MM .....	180
FEMHRT TAB 0.5-2.5 .....	165
<i>fenofibrate cap 150 mg</i> .....	70
<i>fenofibrate micronized cap 134 mg</i> .....	70
<i>fenofibrate micronized cap 200 mg</i> .....	70
<i>fenofibrate micronized cap 43 mg</i> .....	70
<i>fenofibrate micronized cap 67 mg</i> .....	70
<i>fenofibrate tab 145 mg</i> .....	70
<i>fenofibrate tab 160 mg</i> .....	70
<i>fenofibrate tab 48 mg</i> .....	70
<i>fenofibrate tab 54 mg</i> .....	70
<i>fenofibric acid tab 105 mg</i> .....	70



<i>fenofibric acid tab 35 mg</i> .....	70	FETZIMA CAP TITRATIO .....	57
FENOGLIDE TAB 40MG .....	70	FIASP FLEX INJ TOUCH .....	63
<i>fantanyl citrate buccal tab 100 mcg (base equiv)</i> .....	23	FIASP INJ 100/ML .....	63
<i>fantanyl citrate buccal tab 200 mcg (base equiv)</i> .....	24	FIASP PENFIL INJ U-100 .....	63
<i>fantanyl citrate buccal tab 400 mcg (base equiv)</i> .....	24	FIBERSOURCE LIQ CLS SYS .....	151
<i>fantanyl citrate buccal tab 600 mcg (base equiv)</i> .....	24	FIBERSOUR HN LIQ CLS SYS .....	151
<i>fantanyl citrate buccal tab 800 mcg (base equiv)</i> .....	24	FIBRICOR TAB 105MG.....	70
<i>fantanyl citrate lozenge on a handle 1200 mcg</i> .....	24	FIBRICOR TAB 35MG .....	70
<i>fantanyl citrate lozenge on a handle 1600 mcg</i> .....	24	FIFTY50 PREP PAD PADS .....	199
<i>fantanyl citrate lozenge on a handle 200 mcg</i> .....	24	FIFTY50 SAFE MIS LANCETS .....	186
<i>fantanyl citrate lozenge on a handle 400 mcg</i> .....	24	FINACEA AER 15% .....	148
<i>fantanyl citrate lozenge on a handle 600 mcg</i> .....	24	<i>finasteride tab 5 mg</i> .....	171
<i>fantanyl citrate lozenge on a handle 800 mcg</i> .....	24	FINE 30 MIS.....	186
<i>fantanyl td patch 72hr 100 mcg/hr</i> .....	24	FINGERSTIX MIS LANCETS.....	186
<i>fantanyl td patch 72hr 12 mcg/hr</i> .....	24	<i>ingolimod hcl cap 0.5 mg (base equiv)</i> ..	223
<i>fantanyl td patch 72hr 25 mcg/hr</i> .....	24	FIORICET CAP CODEINE .....	30
<i>fantanyl td patch 72hr 37.5 mcg/hr</i> .....	24	FIRDAPSE TAB 10MG .....	81
<i>fantanyl td patch 72hr 50 mcg/hr</i> .....	24	FLAGYL CAP 375MG .....	34
<i>fantanyl td patch 72hr 62.5 mcg/hr</i> .....	24	FLAGYL TAB 500MG.....	34
<i>fantanyl td patch 72hr 75 mcg/hr</i> .....	24	<i>flavoxate hcl tab 100 mg</i> .....	234
<i>fantanyl td patch 72hr 87.5 mcg/hr</i> .....	24	<i>flecainide acetate tab 100 mg</i> .....	40
FENTORA TAB 100MCG.....	24	<i>flecainide acetate tab 150 mg</i> .....	40
FENTORA TAB 200MCG .....	24	<i>flecainide acetate tab 50 mg</i> .....	40
FENTORA TAB 400MCG.....	24	FLECTOR DIS 1.3% .....	136
FENTORA TAB 600MCG.....	24	FLEXICHAMBER MIS.....	200
FENTORA TAB 800MCG.....	24	FLEXICHAMBER MIS MASK LRG .....	200
<i>fesoterodine fumarate tab er 24hr 4 mg</i> .....	233	FLEXICHAMBER MIS MASK SM.....	200
<i>fesoterodine fumarate tab er 24hr 8 mg</i> .....	233	FLOMAX CAP 0.4MG.....	171
FETZIMA CAP 120MG .....	57	FLOVENT HFA AER 110MCG.....	42
FETZIMA CAP 20MG .....	57	FLOVENT HFA AER 220MCG .....	42
FETZIMA CAP 40MG .....	57	FLOVENT HFA AER 44MCG .....	42
FETZIMA CAP 80MG .....	57	<i>fluconazole for susp 10 mg/ml</i> .....	67
		<i>fluconazole for susp 40 mg/ml</i> .....	67
		<i>fluconazole tab 100 mg</i> .....	67
		<i>fluconazole tab 150 mg</i> .....	67
		<i>fluconazole tab 200 mg</i> .....	67
		<i>fluconazole tab 50 mg</i> .....	67
		<i>flucytosine cap 250 mg</i> .....	67
		<i>fludrocortisone acetate tab 0.1 mg</i> .....	132
		<i>flunisolide nasal soln 25 mcg/act (0.025%)</i> .....	211
		<i>fluocinolone acetonide (otic) oil 0.01%</i> ...	217
		<i>fluocinolone acetonide cream 0.01%</i> .....	144

<i>fluocinolone acetonide cream 0.025% ...</i>	144	<i>fluticasone propionate hfa inhal aer 220</i>	
<i>fluocinolone acetonide oil 0.01% (body oil)</i>		<i>mcg/act (250/valve).....</i>	42
<i>.....</i>	144	<i>fluticasone propionate hfa inhal aero 44</i>	
<i>fluocinolone acetonide oil 0.01% (scalp oil)</i>		<i>mcg/act (50/valve).....</i>	42
<i>.....</i>	144	<i>fluticasone propionate lotion 0.05% .....</i>	144
<i>fluocinolone acetonide oint 0.025%.....</i>	144	<i>fluticasone propionate nasal susp 50</i>	
<i>fluocinolone acetonide soln 0.01% .....</i>	144	<i>mcg/act .....</i>	211
<i>fluocinonide cream 0.05%.....</i>	144	<i>fluticasone propionate oint 0.005% .....</i>	144
<i>fluocinonide emulsified base cream 0.05%</i>		<i>fluvastatin sodium cap 20 mg (base</i>	
<i>.....</i>	144	<i>equivalent) .....</i>	71
<i>fluocinonide gel 0.05% .....</i>	144	<i>fluvastatin sodium cap 40 mg (base</i>	
<i>fluocinonide oint 0.05% .....</i>	144	<i>equivalent) .....</i>	71
<i>fluocinonide soln 0.05%.....</i>	144	<i>fluvastatin sodium tab er 24 hr 80 mg (base</i>	
<i>fluorometholone ophth susp 0.1% .....</i>	215	<i>equivalent) .....</i>	71
<b>FLUOROPLEX CRE 1% .....</b>	137	<i>fluvoxamine maleate cap er 24hr 100 mg</i>	56
<i>fluorouracil cream 5% .....</i>	137	<i>fluvoxamine maleate cap er 24hr 150 mg.</i>	56
<i>fluorouracil soln 2%.....</i>	137	<i>fluvoxamine maleate tab 100 mg.....</i>	56
<i>fluorouracil soln 5% .....</i>	137	<i>fluvoxamine maleate tab 25 mg.....</i>	56
<i>fluoxetine hcl cap 10 mg .....</i>	56	<i>fluvoxamine maleate tab 50 mg .....</i>	56
<i>fluoxetine hcl cap 20 mg.....</i>	56	<b>FOCALIN TAB 10MG .....</b>	7
<i>fluoxetine hcl cap 40 mg.....</i>	56	<b>FOCALIN TAB 2.5MG.....</b>	6
<i>fluoxetine hcl cap delayed release 90 mg</i>	56	<b>FOCALIN TAB 5MG.....</b>	7
<i>fluoxetine hcl solution 20 mg/5ml .....</i>	56	<i>folic acid cap 0.8 mg .....</i>	174
<i>fluoxetine hcl tab 10 mg .....</i>	56	<i>folic acid tab 1 mg .....</i>	174
<i>fluoxetine hcl tab 20 mg.....</i>	56	<i>folic acid tab 400 mcg .....</i>	174
<b>FLUOXETINE TAB 60MG.....</b>	56	<i>folic acid tab 800 mcg .....</i>	174
<i>fluphenazine decanoate inj 25 mg/ml .....</i>	104	<i>fondaparinux sodium subcutaneous inj 10</i>	
<i>fluphenazine hcl elixir 2.5 mg/5ml.....</i>	104	<i>mg/0.8ml.....</i>	47
<i>fluphenazine hcl inj 2.5 mg/ml.....</i>	104	<i>fondaparinux sodium subcutaneous inj 2.5</i>	
<i>fluphenazine hcl oral conc 5 mg/ml .....</i>	104	<i>mg/0.5ml.....</i>	46
<i>fluphenazine hcl tab 10 mg .....</i>	104	<i>fondaparinux sodium subcutaneous inj 5</i>	
<i>fluphenazine hcl tab 1 mg.....</i>	104	<i>mg/0.4ml .....</i>	46
<i>fluphenazine hcl tab 2.5 mg.....</i>	104	<i>fondaparinux sodium subcutaneous inj 7.5</i>	
<i>fluphenazine hcl tab 5 mg.....</i>	104	<i>mg/0.6ml .....</i>	46
<i>flurazepam hcl cap 15 mg .....</i>	177	<b>FORACARE GDH SOL HIGH.....</b>	186
<i>flurazepam hcl cap 30 mg .....</i>	177	<b>FORACARE GDH SOL LOW.....</b>	186
<i>flurbiprofen sodium ophth soln 0.03% ....</i>	216	<b>FORACARE GDH SOL NORMAL.....</b>	186
<i>flurbiprofen tab 100 mg.....</i>	19	<b>FORA CONTROL SOL HIGH .....</b>	186
<i>flurbiprofen tab 50 mg .....</i>	19	<b>FORA CONTROL SOL LOW.....</b>	186
<i>flutamide cap 125 mg .....</i>	86	<b>FORA CONTROL SOL NORMAL.....</b>	186
<i>fluticasone propionate cream 0.05% .....</i>	144	<b>FORA GTEL TES KETONE.....</b>	150
<i>fluticasone propionate hfa inhal aer 110</i>		<b>FORA LANCETS MIS 30G.....</b>	186
<i>mcg/act (125/valve).....</i>	42	<b>FORA MIS LANCETS .....</b>	186

FORA MIS LANCING .....	186	FYCOMPA SUS 0.5MG/ML.....	47
FORFIVO XL TAB 450MG.....	55	FYCOMPA TAB 10MG.....	47
<i>formaldehyde solution 10%</i> .....	106	FYCOMPA TAB 12MG.....	47
<i>formoterol fumarate soln nebu 20 mcg/2ml</i> .....	44	FYCOMPA TAB 2MG .....	47
FORTEO INJ 600/2.4 .....	158	FYCOMPA TAB 4MG .....	47
FORTISCARE SOL CNTL HI.....	186	FYCOMPA TAB 6MG .....	47
FORTISCARE SOL CNTL LOW .....	186	FYCOMPA TAB 8MG .....	47
FORTISCARE SOL CNTL NML .....	187	FYLNETRA INJ 6MG/0.6 .....	175
FOSAMAX + D TAB 70-2800 .....	158	<b>G</b>	
FOSAMAX + D TAB 70-5600 .....	158	G4 PLATINUM MIS PEDIATRC .....	187
FOSAMAX TAB 70MG.....	158	G4 PLATINUM MIS RCV/SHAR .....	187
<i>fosamprenavir calcium tab 700 mg (base</i> <i>equiv)</i> .....	108	G4 PLATINUM MIS RECEIVER .....	187
<i>fosfomycin tromethamine powd pack 3 gm</i> <i>(base equivalent)</i> .....	36	G4 PLATINUM MIS TRANSMIT.....	187
<i>fosinopril sodium &amp; hydrochlorothiazide tab</i> <i>10-12.5 mg</i> .....	78	G4 PLAT PED MIS RVC/SHAR.....	187
<i>fosinopril sodium &amp; hydrochlorothiazide tab</i> <i>20-12.5 mg</i> .....	78	G4 SENSOR MIS .....	187
<i>fosinopril sodium tab 10 mg</i> .....	73	G5/G4 MIS SENSOR.....	187
<i>fosinopril sodium tab 20 mg</i> .....	73	<i>gabapentin cap 100 mg</i> .....	49
<i>fosinopril sodium tab 40 mg</i> .....	73	<i>gabapentin cap 300 mg</i> .....	49
FRAGMIN INJ 10000/ML .....	47	<i>gabapentin cap 400 mg</i> .....	49
FRAGMIN INJ 12500UNT .....	47	<i>gabapentin oral soln 250 mg/5ml</i> .....	49
FRAGMIN INJ 15000UNT.....	47	<i>gabapentin tab 600 mg</i> .....	49
FRAGMIN INJ 18000UNT.....	47	<i>gabapentin tab 800 mg</i> .....	49
FRAGMIN INJ 2500/0.2.....	47	GABITRIL TAB 12MG.....	53
FRAGMIN INJ 5000/0.2.....	47	GABITRIL TAB 16MG.....	53
FRAGMIN INJ 7500/0.3.....	47	GABITRIL TAB 2MG .....	53
FRAGMIN INJ 95000UNT .....	47	GABITRIL TAB 4MG .....	53
FREESTYLE LIQ CONTROL .....	187	GALAFOLD CAP 123MG .....	162
FREESTYLE MIS LANCETS.....	187	<i>galantamine hydrobromide cap er 24hr 16</i> <i>mg</i> .....	220
FREESTYLE MIS UNISTICK.....	187	<i>galantamine hydrobromide cap er 24hr 24</i> <i>mg</i> .....	220
FROVA TAB 2.5MG.....	202	<i>galantamine hydrobromide cap er 24hr 8</i> <i>mg</i> .....	220
<i>frovatriptan succinate tab 2.5 mg (base</i> <i>equivalent)</i> .....	202	<i>galantamine hydrobromide oral soln 4</i> <i>mg/ml</i> .....	220
<i>furosemide oral soln 10 mg/ml</i> .....	157	<i>galantamine hydrobromide tab 12 mg</i> ....	220
<i>furosemide oral soln 8 mg/ml</i> .....	157	<i>galantamine hydrobromide tab 4 mg</i> ....	220
<i>furosemide tab 20 mg</i> .....	157	<i>galantamine hydrobromide tab 8 mg</i> ....	220
<i>furosemide tab 40 mg</i> .....	157	<i>ganirelix acetate soln prefilled syringe 250</i> <i>mcg/0.5ml</i> .....	160
<i>furosemide tab 80 mg</i> .....	157	GANIRELIX AC INJ 250/0.5.....	160
FUZEON INJ 90MG .....	108	GASTROCROM CON 100/5ML.....	167
		<i>gatifloxacin ophth soln 0.5%</i> .....	214

GATTEX KIT 5MG .....	170	GENULTIMATE TES.....	150
GAVRETO CAP 100MG .....	90	GENVOYA TAB .....	108
GE100 CONTRL SOL NORMAL.....	187	GEODON CAP 20MG.....	99
GELFILM MIS OP .....	216	GEODON CAP 40MG.....	99
GELNIQUE GEL 10% .....	233	GEODON CAP 60MG.....	99
<i>gemfibrozil tab 600 mg</i> .....	70	GEODON CAP 80MG.....	99
GEMTESA TAB 75MG.....	234	GEODON INJ 20MG.....	100
GENERESS FE CHW .....	128	GILOTRIF TAB 20MG.....	85
GENOTROPIN INJ 0.2MG .....	160	GILOTRIF TAB 30MG.....	85
GENOTROPIN INJ 0.4MG .....	160	GILOTRIF TAB 40MG.....	85
GENOTROPIN INJ 0.6MG .....	160	<i>glatiramer acetate soln prefilled syringe 20</i>	
GENOTROPIN INJ 0.8MG .....	160	<i>mg/ml</i> .....	223
GENOTROPIN INJ 1.2MG .....	160	<i>glatiramer acetate soln prefilled syringe 40</i>	
GENOTROPIN INJ 1.4MG .....	160	<i>mg/ml</i> .....	223
GENOTROPIN INJ 1.6MG .....	160	GLEOSTINE CAP 100MG.....	83
GENOTROPIN INJ 1.8MG .....	160	GLEOSTINE CAP 10MG .....	82
GENOTROPIN INJ 12MG .....	160	GLEOSTINE CAP 40MG .....	82
GENOTROPIN INJ 1MG.....	160	<i>glimepiride tab 1 mg</i> .....	64
GENOTROPIN INJ 2MG.....	160	<i>glimepiride tab 2 mg</i> .....	64
GENOTROPIN INJ 5MG.....	160	<i>glimepiride tab 4 mg</i> .....	64
<i>gentamicin sulfate cream 0.1%</i> .....	136	<i>glipizide-metformin hcl tab 2.5-250 mg</i> ...	60
<i>gentamicin sulfate oint 0.1%</i> .....	136	<i>glipizide-metformin hcl tab 2.5-500 mg</i> ...	60
<i>gentamicin sulfate ophth oint 0.3%</i> .....	214	<i>glipizide-metformin hcl tab 5-500 mg</i> .....	60
<i>gentamicin sulfate ophth soln 0.3%</i> .....	214	<i>glipizide tab 10 mg</i> .....	64
GENTEEL LANC KIT BLUE .....	187	<i>glipizide tab 5 mg</i> .....	64
GENTEEL MIS LANCETS.....	187	<i>glipizide tab er 24hr 10 mg</i> .....	64
GENTEEL MIS NOZZLES .....	187	<i>glipizide tab er 24hr 2.5 mg</i> .....	64
GENTEEL PLUS MIS BLACK.....	187	<i>glipizide tab er 24hr 5 mg</i> .....	64
GENTEEL PLUS MIS BLUE .....	187	GLOBAL 28G MIS LANCETS .....	187
GENTEEL PLUS MIS PINK .....	187	GLOBAL 30G MIS LANCETS.....	187
GENTEEL PLUS MIS PURPLE.....	187	GLOBAL LANC MIS DEVICE.....	187
GENTEEL PLUS MIS WHITE .....	187	GLOBAL PREP PAD PADS.....	199
GENTEEL TIPS MIS BLUE .....	187	<i>glucagon (rdna) for inj kit 1 mg</i> .....	61
GENTEEL TIPS MIS CLEAR.....	187	GLUC CONTROL LIQ NORMAL .....	187
GENTEEL TIPS MIS GREEN .....	187	GLUC CONTROL SOL .....	188
GENTEEL TIPS MIS ORANGE.....	187	GLUC CONTROL SOL MID .....	188
GENTEEL TIPS MIS RAINBOW .....	187	GLUC CONTROL SOL NORMAL.....	188
GENTEEL TIPS MIS VIOLET.....	187	GLUCERNA 1.0 LIQ CARB VAN .....	151
GENTEEL TIPS MIS YELLOW .....	187	GLUCERNA LIQ 1.2 CAL.....	151
GENTLE-LET MIS 26G.....	187	GLUCERNA SEL LIQ VANILLA.....	151
GENTLE-LET MIS 28G.....	187	GLUCOCARD 01 LIQ NORM/HGH.....	188
GENTLE-LET MIS LANCETS.....	187	GLUCOCARD 01 SOL NORMAL.....	188
GENTLE-LET MIS PLATFORM .....	187	GLUCOCARD LIQ LEVEL 1.....	188

GLUCOCARD SOL NORMAL.....	188	GOJJI CNTRL SOL NORMAL .....	188
GLUCOCARD SOL SHINE .....	188	GOJJI LANCET MIS 30G .....	188
GLUCOCARD TES SHINE .....	150	GOJJI MIS LANC DEV .....	188
GLUCOCOM MIS 28G .....	188	GONAL-F INJ 1050UNIT .....	159
GLUCOCOM MIS 30G.....	188	GONAL-F INJ 450UNIT.....	159
GLUCOCOM MIS 33G.....	188	GONAL-F RFF INJ 300/0.5 .....	159
GLUCOCOM TES HIGH CON .....	188	GONAL-F RFF INJ 450/0.75.....	160
GLUCOCOM TES NORM CON .....	188	GONAL-F RFF INJ 75UNIT .....	159
GLUCOSE CONT LIQ HIGH/LOW.....	188	GONAL-F RFF INJ 900/1.5.....	160
GLUCOSE CONT SOL HIGH .....	188	GOODSENSE MIS LANC 26G.....	188
GLUCOSE CONT SOL NORMAL.....	188	GOODSENSE MIS LANC 30G .....	188
GLUCOSE CONT SOL PRECISIO .....	188	GOODSENSE MIS LANC 33G.....	188
GLUCOTROL TAB 10MG .....	64	GOODSENSE MIS LANC DVC.....	188
GLUCOTROL XL TAB 10MG.....	64	GORDOFILM SOL .....	147
GLUCOTROL XL TAB 2.5MG .....	64	GRALISE TAB 300MG .....	225
GLUCOTROL XL TAB 5MG .....	64	GRALISE TAB 450MG .....	225
GLUTARALDEHY SOL 25%.....	106	GRALISE TAB 600MG .....	225
<i>glyburide-metformin tab 1.25-250 mg</i> .....	60	GRALISE TAB 750MG.....	225
<i>glyburide-metformin tab 2.5-500 mg</i> .....	60	GRALISE TAB 900MG .....	226
<i>glyburide-metformin tab 5-500 mg</i> .....	60	<i>granisetron hcl tab 1 mg</i> .....	66
<i>glyburide micronized tab 1.5 mg</i> .....	64	GRASTEK SUB 2800BAU .....	9
<i>glyburide micronized tab 3 mg</i> .....	64	<i>griseofulvin microsize susp 125 mg/5ml</i> ...67	
<i>glyburide micronized tab 6 mg</i> .....	64	<i>griseofulvin microsize tab 500 mg</i> .....	67
<i>glyburide tab 1.25 mg</i> .....	64	<i>griseofulvin ultramicrosize tab 125 mg</i> .....67	
<i>glyburide tab 2.5 mg</i> .....	64	<i>griseofulvin ultramicrosize tab 250 mg</i> .....67	
<i>glyburide tab 5 mg</i> .....	64	<i>guaifenesin-codeine liquid 225-7.5 mg/5ml</i> .....	132
<i>glycopyrrolate oral soln 1 mg/5ml</i> .....	231	<i>guaifenesin-codeine soln 100-10 mg/5ml</i> .....	132
<i>glycopyrrolate tab 1 mg</i> .....	231	<i>guanfacine hcl tab 1 mg</i> .....	75
<i>glycopyrrolate tab 2 mg</i> .....	231	<i>guanfacine hcl tab 2 mg</i> .....	75
GLYNASE TAB 1.5MG .....	64	<i>guanfacine hcl tab er 24hr 1 mg (base</i> <i>equiv)</i> .....	5
GLYNASE TAB 3MG.....	64	<i>guanfacine hcl tab er 24hr 2 mg (base</i> <i>equiv)</i> .....	5
GLYNASE TAB 6MG .....	64	<i>guanfacine hcl tab er 24hr 3 mg (base</i> <i>equiv)</i> .....	5
GLYTACTIN PAK BTMK/DLT .....	151	<i>guanfacine hcl tab er 24hr 4 mg (base</i> <i>equiv)</i> .....	5
GLYTACTIN POW BETMLK15.....	151	GUANIDINE TAB 125MG .....	81
GLYTACTIN POW RST LT10 .....	151	GVOKE HYPO 1 INJ .5/.1ML.....	61
GLYTROL LIQ PREBIO1.....	151	GVOKE HYPO 1 INJ 1MG/.2ML .....	61
GLYXAMBI TAB 10-5 MG.....	60	GVOKE HYPO 2 INJ .5/.1ML.....	61
GLYXAMBI TAB 25-5 MG .....	60		
GNP ALCOHOL PAD SWABS.....	199		
GNP LANCETS MIS 21G.....	188		
GNP LANCETS MIS THIN .....	188		
GNP LANCETS MIS THIN 26G .....	188		
GOJJI BLOOD TES KETONE .....	150		

GVOKE HYPO 2 INJ 1MG/.2ML.....	61	HEMLIBRA INJ 30MG/ML.....	172
GVOKE KIT SOL 1MG/0.2M.....	61	HEMLIBRA INJ 60/0.4.....	172
GVOKE PFS INJ.....	61	<i>heparin sodium (porcine) inj 10000 unit/ml</i>	
GYNAZOLE-1 CRE 2%.....	235	.....	47
GYNOL II GEL 3%.....	234	<i>heparin sodium (porcine) inj 1000 unit/ml</i>	47
<b>H</b>		<i>heparin sodium (porcine) inj 20000 unit/ml</i>	
HAEGARDA INJ 2000UNIT.....	172	.....	47
HAEGARDA INJ 3000UNIT.....	172	<i>heparin sodium (porcine) inj 5000 unit/ml</i>	
HAEMOLANCE MIS HIGH FLO.....	188	.....	47
HAEMOLANCE MIS LOW FLOW.....	188	<i>heparin sodium (porcine) pf inj 5000</i>	
HAEMOLANCE MIS PLUS.....	188	<i>unit/0.5ml.....</i>	47
HAEMOLANCE MIS PLUS LOW.....	188	HETLIOZ CAP 20MG.....	178
HAEMOLANCE MIS PLUS MAX.....	188	HETLIOZ LQ SUS 4MG/ML.....	178
HAEMOLANCE MIS PLUS PED.....	188	HIPREX TAB 1GM.....	36
HAEMOLANCE MIS RETRACT.....	188	HLTHY ACCNTS MIS LANC 30G.....	189
HALCION TAB 0.25MG.....	177	HM STERILE PAD ALCHOL.....	199
HALDOL DECAN INJ 100MG/ML.....	101	HOLD CHAMBER MIS ADLT LG.....	200
HALDOL DECAN INJ 50MG/ML.....	101	HOLD CHAMBER MIS MEDIUM.....	200
HALDOL INJ 5MG/ML.....	101	HOLD CHAMBER MIS SMALL.....	200
<i>halobetasol propionate cream 0.05%.....</i>	144	HOMACTIN AA LIQ PLUS.....	151
<i>halobetasol propionate oint 0.05%.....</i>	145	HUMIRA INJ 10/0.1ML.....	10
<i>haloperidol decanoate im soln 100 mg/ml</i>		HUMIRA INJ 20/0.2ML.....	11
.....	101	HUMIRA INJ 40/0.4ML.....	11
<i>haloperidol decanoate im soln 50 mg/ml</i>	101	HUMIRA KIT 40MG/0.8.....	11
<i>haloperidol lactate inj 5 mg/ml.....</i>	101	HUMIRA PEDIA INJ CROHNS.....	11, 12
<i>haloperidol lactate oral conc 2 mg/ml.....</i>	101	HUMIRA PEN INJ 40/0.4ML.....	12
<i>haloperidol tab 0.5 mg.....</i>	101	HUMIRA PEN INJ 40MG/0.8.....	12
<i>haloperidol tab 10 mg.....</i>	102	HUMIRA PEN INJ 80/0.8ML.....	12
<i>haloperidol tab 1 mg.....</i>	101	HUMIRA PEN INJ CD/UC/HS.....	13
<i>haloperidol tab 20 mg.....</i>	102	HUMIRA PEN INJ PS/UV.....	13
<i>haloperidol tab 2 mg.....</i>	102	HUMIRA PEN KIT CD/UC/HS.....	13
<i>haloperidol tab 5 mg.....</i>	102	HUMIRA PEN KIT PED UC.....	13
HARVONI PAK.....	113	HUMIRA PEN KIT PS/UV.....	14
HARVONI PAK 45-200MG.....	113	HUMULIN R INJ U-500.....	63
HARVONI TAB 45-200MG.....	113	HYCAMTIN CAP 0.25MG.....	95
HARVONI TAB 90-400MG.....	113	HYCAMTIN CAP 1MG.....	95
HC/PRAMOXINE CRE 1-2.35%.....	145	<i>hydralazine hcl tab 100 mg.....</i>	81
HC LANCING MIS DEVICE.....	188	<i>hydralazine hcl tab 10 mg.....</i>	81
HCU EXP20 PAK UNFLAVOR.....	151	<i>hydralazine hcl tab 25 mg.....</i>	81
HCU EXPRESS PAK.....	151	<i>hydralazine hcl tab 50 mg.....</i>	81
HEMANGEOL SOL 4.28/ML.....	117	HYDREA CAP 500MG.....	95
HEMLIBRA INJ 105/0.7.....	172	<i>hydrochlorothiazide cap 12.5 mg.....</i>	158
HEMLIBRA INJ 150/ML.....	172	<i>hydrochlorothiazide tab 12.5 mg.....</i>	158

hydrochlorothiazide tab 25 mg.....	158	hydrocodone bitartrate tab er 24hr deter 60 mg.....	25
hydrochlorothiazide tab 50 mg .....	158	hydrocodone bitartrate tab er 24hr deter 80 mg.....	25
hydrocodone-acetaminophen soln 10-325 mg/15ml .....	30	hydrocodone-ibuprofen tab 10-200 mg ....	31
hydrocodone-acetaminophen soln 7.5-325 mg/15ml .....	30	hydrocodone-ibuprofen tab 5-200 mg.....	31
hydrocodone-acetaminophen tab 10-300 mg .....	30	hydrocodone-ibuprofen tab 7.5-200 mg...	31
hydrocodone-acetaminophen tab 10-325 mg .....	31	hydrocod polst-chlorphen polst er susp 10-8 mg/5ml.....	132
hydrocodone-acetaminophen tab 5-300 mg .....	30	hydrocortisone acetate suppos 25 mg .....	34
hydrocodone-acetaminophen tab 5-325 mg .....	30	hydrocortisone acetate w/ pramoxine perianal cream 1-1%.....	34
hydrocodone-acetaminophen tab 7.5-300 mg .....	30	hydrocortisone butyrate cream 0.1% .....	145
hydrocodone-acetaminophen tab 7.5-325 mg .....	30	hydrocortisone butyrate oint 0.1%.....	145
hydrocodone bitart-homatropine methylbromide tab 5-1.5 mg .....	132	hydrocortisone butyrate soln 0.1% .....	145
hydrocodone bitart-homatropine methylbrom soln 5-1.5 mg/5ml.....	132	hydrocortisone cream 2.5% .....	145
hydrocodone bitartrate cap er 12hr 10 mg	25	hydrocortisone enema 100 mg/60ml.....	33
hydrocodone bitartrate cap er 12hr 15 mg	25	hydrocortisone lotion 2.5% .....	145
hydrocodone bitartrate cap er 12hr 20 mg .....	25	hydrocortisone oint 2.5% .....	145
hydrocodone bitartrate cap er 12hr 30 mg .....	25	hydrocortisone perianal cream 1%.....	34
hydrocodone bitartrate cap er 12hr 40 mg .....	25	hydrocortisone perianal cream 2.5% .....	34
hydrocodone bitartrate cap er 12hr 50 mg .....	25	hydrocortisone tab 10 mg.....	131
hydrocodone bitartrate tab er 24hr deter 100 mg .....	25	hydrocortisone tab 20 mg .....	131
hydrocodone bitartrate tab er 24hr deter 120 mg.....	25	hydrocortisone tab 5 mg .....	131
hydrocodone bitartrate tab er 24hr deter 20 mg.....	25	hydrocortisone valerate cream 0.2% .....	145
hydrocodone bitartrate tab er 24hr deter 30 mg.....	25	hydrocortisone valerate oint 0.2%.....	145
hydrocodone bitartrate tab er 24hr deter 40 mg.....	25	hydrocortisone w/ acetic acid otic soln 1-2% .....	217
hydrocodone bitartrate tab er 24hr deter 40 mg.....	25	hydrogen peroxide soln 30% .....	106
		hydromorphone hcl liqd 1 mg/ml.....	25
		hydromorphone hcl tab 2 mg .....	25
		hydromorphone hcl tab 4 mg .....	25
		hydromorphone hcl tab 8 mg .....	25
		hydromorphone hcl tab er 24hr 12 mg .....	26
		hydromorphone hcl tab er 24hr 16 mg .....	26
		hydromorphone hcl tab er 24hr 32 mg .....	26
		hydromorphone hcl tab er 24hr 8 mg .....	25
		HYDROMORPHON SUP 3MG.....	25
		hydroxychloroquine sulfate tab 200 mg....	81
		hydroxyurea cap 500 mg.....	95
		hydroxyzine hcl syrup 10 mg/5ml.....	38
		hydroxyzine hcl tab 10 mg .....	38
		hydroxyzine hcl tab 25 mg.....	38

<i>hydroxyzine hcl tab 50 mg</i> .....	38	IMBRUVICA CAP 70MG.....	91
<i>hydroxyzine pamoate cap 100 mg</i> .....	38	IMBRUVICA SUS 70MG/ML.....	91
<i>hydroxyzine pamoate cap 25 mg</i> .....	38	IMBRUVICA TAB 140MG.....	91
<i>hydroxyzine pamoate cap 50 mg</i> .....	38	IMBRUVICA TAB 280MG.....	91
<i>hyoscyamine sulfate elixir 0.125 mg/5ml</i>	231	IMBRUVICA TAB 420MG.....	91
<i>hyoscyamine sulfate sl tab 0.125 mg</i> .....	231	IMBRUVICA TAB 560MG.....	91
<i>hyoscyamine sulfate soln 0.125 mg/ml</i> ...	231	<i>imipramine hcl tab 10 mg</i> .....	59
<i>hyoscyamine sulfate tab 0.125 mg</i> .....	231	<i>imipramine hcl tab 25 mg</i> .....	59
<i>hyoscyamine sulfate tab disint 0.125 mg</i>	231	<i>imipramine hcl tab 50 mg</i> .....	59
HYPERSAL NEB 3.5%.....	133	<i>imipramine pamoate cap 100 mg</i> .....	59
HYPERSAL NEB 7%.....	133	<i>imipramine pamoate cap 125 mg</i> .....	59
HYPOLANCE KIT LANCING.....	189	<i>imipramine pamoate cap 150 mg</i> .....	59
HYRIMOZ.....	14	<i>imipramine pamoate cap 75 mg</i> .....	59
HYRIMOZ INJ 10/0.1ML.....	14	<i>imiquimod cream 3.75%</i> .....	147
HYRIMOZ INJ 20/0.2ML.....	14	<i>imiquimod cream 5%</i> .....	147
HYRIMOZ INJ 40/0.4ML.....	14	IMITREX INJ 4MG/0.5.....	202
HYRIMOZ INJ 40/0.8ML.....	14	IMITREX INJ 6MG/0.5.....	203
HYRIMOZ INJ 80/0.8ML.....	14	IMITREX SPR 20MG/ACT.....	203
HYRIMOZ-PED INJ CROHNS.....	14	IMITREX SPR 5MG/ACT.....	203
HYRIMOZ-PLAQ INJ PSORIASI.....	15	IMITREX TAB 100MG.....	203
<b>I</b>		IMITREX TAB 25MG.....	203
<i>ibandronate sodium tab 150 mg (base</i>		IMITREX TAB 50MG.....	203
<i>equivalent)</i> .....	158	IMPAVIDO CAP 50MG.....	34
IBRANCE CAP 100MG.....	90	IMURAN TAB 50MG.....	207
IBRANCE CAP 125MG.....	90	IMVEXXY MAIN SUP 10MCG.....	235
IBRANCE CAP 75MG.....	90	IMVEXXY MAIN SUP 4MCG.....	235
IBRANCE TAB 100MG.....	90	IMVEXXY STRT SUP 10MCG.....	235
IBRANCE TAB 125MG.....	90	IMVEXXY STRT SUP 4MCG.....	235
IBRANCE TAB 75MG.....	90	INBRIJA CAP 42MG.....	97
<i>ibuprofen tab 400 mg</i> .....	19	INCONTROL MIS LANC 28G.....	189
<i>ibuprofen tab 600 mg</i> .....	19	INCONTROL MIS LANC 30G.....	189
<i>ibuprofen tab 800 mg</i> .....	19	INCONTROL MIS LANC 33G.....	189
<i>icatibant acetate subcutaneous soln pref</i>		INCONTROL MIS LANC DEV.....	189
<i>syr 30 mg/3ml</i> .....	172	INCONTROL PAD ALCOHOL.....	199
ICLUSIG TAB 30MG.....	91	INCRELEX INJ 40MG/4ML.....	161
IDHIFA TAB 100MG.....	91	<i>indapamide tab 1.25 mg</i> .....	158
IDHIFA TAB 50MG.....	91	<i>indapamide tab 2.5 mg</i> .....	158
ILEVRO DRO 0.3% OP.....	216	<i>indomethacin cap 25 mg</i> .....	19
<i>imatinib mesylate tab 100 mg (base</i>		<i>indomethacin cap 50 mg</i> .....	19
<i>equivalent)</i> .....	91	<i>indomethacin cap er 75 mg</i> .....	19
<i>imatinib mesylate tab 400 mg (base</i>		INFINITY SOL NORM CON.....	189
<i>equivalent)</i> .....	91	INFNTY VOICE LIQ LEVEL 2.....	189
IMBRUVICA CAP 140MG.....	91	INGREZZA CAP 40-80MG.....	222



INGREZZA CAP 40MG.....	222	<i>ipratropium bromide nasal soln 0.06% (42</i>	
INGREZZA CAP 60MG.....	223	<i>mcg/spray) .....</i>	211
INGREZZA CAP 80MG.....	223	<i>irbesartan-hydrochlorothiazide tab 150-12.5</i>	
INLYTA TAB 1MG .....	84	<i>mg .....</i>	78
INLYTA TAB 5MG.....	84	<i>irbesartan-hydrochlorothiazide tab 300-</i>	
INPEN 100EL MIS BLUE-HUM .....	200	<i>12.5 mg.....</i>	78
INQOVI TAB 35-100MG.....	88	<i>irbesartan tab 150 mg.....</i>	74
INSPIRACHAMB MIS LARGE .....	200	<i>irbesartan tab 300 mg.....</i>	74
INSPIRACHAMB MIS MEDIUM.....	201	<i>irbesartan tab 75 mg.....</i>	74
INSPIRACHAMB MIS MOUTHPC.....	201	IRESSA TAB 250MG .....	85
INSPIRACHAMB MIS SMALL.....	201	ISENTRESS CHW 100MG .....	108
INSPIREASE MIS DD SYST .....	201	ISENTRESS CHW 25MG .....	108
INSPIREASE MIS RES BAG.....	201	ISENTRESS HD TAB 600MG.....	109
INSPIREASE MIS RES BAG.....	201	ISENTRESS POW 100MG .....	109
INSPIREASE MIS RES BAG.....	201	ISENTRESS TAB 400MG .....	109
INSPIREASE MIS RES BAG.....	201	<i>isoniazid syrup 50 mg/5ml .....</i>	82
INSPIREASE MIS RES BAG.....	201	<i>isoniazid tab 100 mg .....</i>	82
INSPIREASE MIS RES BAG.....	201	<i>isoniazid tab 300 mg .....</i>	82
INSPIREASE MIS RES BAG.....	201	ISOPTO ATROP SOL 1% OP .....	213
INSPIREASE MIS RES BAG.....	201	ISOPTO CARP SOL 1% OP .....	213
INSPIREASE MIS RES BAG.....	201	ISOPTO CARP SOL 2% OP .....	213
INSPIREASE MIS RES BAG.....	201	ISOPTO CARP SOL 4% OP .....	213
INSPIREASE MIS RES BAG.....	201	ISORDIL TAB 40MG .....	37
INSPIREASE MIS RES BAG.....	201	ISORDIL TAB 5MG .....	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide dinitrate tab 10 mg .....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide dinitrate tab 20 mg .....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide dinitrate tab 30 mg .....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide dinitrate tab 5 mg.....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide mononitrate tab 10 mg .....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide mononitrate tab 20 mg.....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide mononitrate tab er 24hr 120 mg</i>	
INSPIREASE MIS RES BAG.....	201	<i>.....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide mononitrate tab er 24hr 30 mg</i>	
INSPIREASE MIS RES BAG.....	201	<i>.....</i>	37
INSPIREASE MIS RES BAG.....	201	<i>isosorbide mononitrate tab er 24hr 60 mg</i>	
INSPIREASE MIS RES BAG.....	201	<i>.....</i>	37
INSPIREASE MIS RES BAG.....	201	ISOSOURCE HN LIQ .....	151
INSPIREASE MIS RES BAG.....	201	ISOSOURCE LIQ.....	152
INSPIREASE MIS RES BAG.....	201	<i>isotretinoin cap 10 mg .....</i>	135
INSPIREASE MIS RES BAG.....	201	<i>isotretinoin cap 20 mg .....</i>	135
INSPIREASE MIS RES BAG.....	201	<i>isotretinoin cap 30 mg .....</i>	135
INSPIREASE MIS RES BAG.....	201	<i>isotretinoin cap 40 mg .....</i>	135
INSPIREASE MIS RES BAG.....	201	ISOVACTIN AA LIQ PLUS .....	152

<i>isradipine cap 2.5 mg</i> .....	119	KERENDIA TAB 10MG .....	163
<i>isradipine cap 5 mg</i> .....	119	KERENDIA TAB 20MG .....	163
ISTALOL SOL 0.5% OP .....	212	KERYDIN SOL 5%.....	136
<i>itraconazole cap 100 mg</i> .....	68	KESIMPTA INJ 20/.4ML .....	224
<i>itraconazole oral soln 10 mg/ml</i> .....	68	<i>ketoconazole cream 2%</i> .....	137
<i>ivermectin lotion 0.5%</i> .....	149	<i>ketoconazole shampoo 2%</i> .....	137
<i>ivermectin tab 3 mg</i> .....	34	<i>ketoconazole tab 200 mg</i> .....	68
<b>J</b>		KETO-DIASTIX TES .....	150
JAKAFI TAB 10MG .....	91	KETONE TES .....	150
JAKAFI TAB 15MG .....	91	KETONE TEST TES .....	150
JAKAFI TAB 20MG .....	91	<i>ketoprofen cap 50 mg</i> .....	19
JAKAFI TAB 25MG.....	91	<i>ketoprofen cap 75 mg</i> .....	19
JAKAFI TAB 5MG.....	91	<i>ketorolac tromethamine ophth soln 0.4%</i> .....	216
JANUMET TAB 50-1000 .....	60	<i>ketorolac tromethamine ophth soln 0.5%</i> .....	216
JANUMET TAB 50-500MG .....	60	<i>ketorolac tromethamine tab 10 mg</i> .....	19
JANUMET XR TAB 100-1000 .....	60	KETOSTIX TES STRIP.....	150
JANUMET XR TAB 50-1000 .....	60	KEVEYIS TAB 50MG.....	156
JANUMET XR TAB 50-500MG .....	60	KEVZARA INJ 150/1.14 .....	18
JANUVIA TAB 100MG .....	61	KEVZARA INJ 200/1.14 .....	18
JANUVIA TAB 25MG .....	61	KINNEY MIS LANCETS .....	189
JANUVIA TAB 50MG.....	61	KINNEY THIN MIS LANCETS .....	189
JARDIANCE TAB 10MG.....	64	KISQALI 200 PAK FEMARA .....	88
JARDIANCE TAB 25MG .....	64	KISQALI 400 PAK FEMARA .....	88
JEVITY 1.2 LIQ CAL.....	152	KISQALI 600 PAK FEMARA .....	88
JEVITY 1.5 LIQ CAL.....	152	KISQALI TAB 200DOSE .....	91
JEVITY 1 CAL LIQ.....	152	KISQALI TAB 400DOSE.....	92
JUBLIA SOL 10%.....	136	KISQALI TAB 600DOSE.....	92
JULUCA TAB 50-25MG .....	109	KLARON LOT 10% .....	135
<b>K</b>		KLONOPIN TAB 0.5MG.....	48
KALBITOR INJ 10MG/ML .....	173	KLONOPIN TAB 1MG .....	48
KALETRA SOL.....	109	KLONOPIN TAB 2MG .....	48
KALETRA TAB 100-25MG .....	109	KLOXXADO SPR 8MG .....	65
KALETRA TAB 200-50MG .....	109	KOSELUGO CAP 10MG.....	92
KALYDECO GRA 13.4MG .....	227	KOSELUGO CAP 25MG.....	92
KALYDECO GRA 5.8MG.....	227	K-PHOS TAB NO 2.....	170
KALYDECO PAK 25MG .....	227	KRAZATI TAB 200MG .....	92
KALYDECO PAK 50MG .....	227	KRISTALOSE PAK 10GM.....	178
KALYDECO PAK 75MG .....	227	KRISTALOSE PAK 20GM .....	178
KALYDECO TAB 150MG.....	227	KROGER LANCE MIS .....	189
KAPVAY TAB 0.1 MG.....	5	KROGER LANCE MIS 26G .....	189
KARBINAL ER SUS 4MG/5ML.....	68	KROGER LANCE MIS THIN .....	189
KEFLEX CAP 750MG.....	126		
KENALOG AER SPRAY.....	145		

KROGER LANCE MIS THIN 30G .....	189	<i>lamotrigine tab chewable dispersible 5 mg</i>	50
K-TAB TAB 10MEQ CR .....	204	<i>lamotrigine tab disint 25 (14) &amp; 50 mg (14) &amp; 100 mg (7) kit</i> .....	50
K-TAB TAB 20MEQ .....	204	<i>lamotrigine tab er 24hr 100 mg</i> .....	50
K-TAB TAB 8MEQ CR.....	204	<i>lamotrigine tab er 24hr 200 mg</i> .....	50
<b>L</b>		<i>lamotrigine tab er 24hr 250 mg</i> .....	50
<i>labetalol hcl tab 100 mg</i> .....	115	<i>lamotrigine tab er 24hr 25 mg</i> .....	50
<i>labetalol hcl tab 200 mg</i> .....	115	<i>lamotrigine tab er 24hr 300 mg</i> .....	50
<i>labetalol hcl tab 300 mg</i> .....	115	<i>lamotrigine tab er 24hr 50 mg</i> .....	50
<i>lacosamide oral solution 10 mg/ml</i> .....	49	LAMPIT TAB 120MG .....	35
<i>lacosamide tab 100 mg</i> .....	49	LAMPIT TAB 30MG.....	35
<i>lacosamide tab 150 mg</i> .....	49	LANAFLEX PAK.....	152
<i>lacosamide tab 200 mg</i> .....	49	LANCET AUTO MIS INJECTOR.....	189
<i>lacosamide tab 50 mg</i> .....	49	LANCET CARRY MIS CASE .....	189
LACTIC ACID LOT 10% .....	147	LANCET DEVIC MIS 30G .....	189
<i>lactulose (encephalopathy) solution 10 gm/15ml</i> .....	169	LANCET DEVIC MIS ADJUST .....	189
<i>lactulose solution 10 gm/15ml</i> .....	178	LANCET MICRO MIS THIN 33G.....	189
LAGEVRIO CAP 200MG .....	115	LANCETS MICR MIS THIN 33G .....	189
<i>lamivudine oral soln 10 mg/ml</i> .....	109	LANCETS MIS .....	189
<i>lamivudine tab 100 mg (hbv)</i> .....	113	LANCETS MIS 21G.....	189
<i>lamivudine tab 150 mg</i> .....	109	LANCETS MIS 21G COLR.....	189
<i>lamivudine tab 300 mg</i> .....	109	LANCETS MIS 28G .....	189
<i>lamivudine-zidovudine tab 150-300 mg</i> .	109	LANCETS MIS 30G.....	189
<i>lamotrigine orally disintegrating tab 100 mg</i> .....	50	LANCETS MIS 33G .....	189
<i>lamotrigine orally disintegrating tab 200 mg</i> .....	50	LANCETS MIS ORANGE .....	189
<i>lamotrigine orally disintegrating tab 25 mg</i> .....	50	LANCETS MIS ORIGINAL .....	190
<i>lamotrigine orally disintegrating tab 50 mg</i> .....	50	LANCETS MIS THIN .....	190
<i>lamotrigine tab 100 mg</i> .....	50	LANCETS MIS THIN 26G .....	190
<i>lamotrigine tab 150 mg</i> .....	50	LANCETS MIS THIN 30G.....	190
<i>lamotrigine tab 200 mg</i> .....	50	LANCETS SUPR MIS THIN 28G .....	190
<i>lamotrigine tab 25 mg</i> .....	50	LANCET STAND MIS 21G .....	189
<i>lamotrigine tab 25 mg (42) &amp; 100 mg (7) starter kit</i> .....	50	LANCETS THIN MIS .....	190
<i>lamotrigine tab 35 x 25 mg starter kit</i> .....	50	LANCETS THIN MIS 26G .....	190
<i>lamotrigine tab 84 x 25 mg &amp; 14 x 100 mg starter kit</i> .....	50	LANCETS ULTR MIS THIN.....	190
<i>lamotrigine tab chewable dispersible 25 mg</i> .....	50	LANCET SUPER MIS THIN 30G .....	189
		LANCET ULTRA MIS 28G .....	189
		LANCET ULTRA MIS THIN 30G .....	189
		LANCET WITH MIS EJECTOR.....	189
		LANCING DEVI MIS.....	190
		LANCING DEVI MIS 25G.....	190
		LANCING DEVI MIS 30G .....	190
		LANCING MIS DEVICE.....	190

LANOXIN TAB 0.0625MG .....	120	<i>levalbuterol tartrate inhal aerosol 45</i>	
<i>lansoprazole cap delayed release 15 mg</i>	232	<i>mcg/act (base equiv) .....</i>	44
<i>lansoprazole cap delayed release 30 mg</i>		LEVIBID TAB 0.375 ER .....	231
.....	232	LEVEMIR INJ .....	63
LANZO MIS LANCING.....	190	LEVEMIR INJ FLEXPEN .....	63
<i>lapatinib ditosylate tab 250 mg (base equiv)</i>		LEVEMIR INJ FLEXTOUC .....	63
.....	92	<i>levetiracetam oral soln 100 mg/ml .....</i>	50
LASIX TAB 20MG.....	157	<i>levetiracetam tab 1000 mg.....</i>	50
LASIX TAB 40MG.....	157	<i>levetiracetam tab 250 mg.....</i>	50
LASIX TAB 80MG.....	157	<i>levetiracetam tab 500 mg .....</i>	50
<i>latanoprost ophth soln 0.005% .....</i>	217	<i>levetiracetam tab 750 mg.....</i>	50
LB LANCET MIS 28G.....	190	<i>levetiracetam tab er 24hr 500 mg .....</i>	50
LB LANCING MIS DEVICE .....	190	<i>levetiracetam tab er 24hr 750 mg .....</i>	50
<i>leflunomide tab 10 mg .....</i>	21	LEVITRA TAB 10MG.....	122
<i>leflunomide tab 20 mg .....</i>	21	LEVITRA TAB 20MG .....	122
<i>lenalidomide cap 10 mg .....</i>	205	<i>levobunolol hcl ophth soln 0.5% .....</i>	212
<i>lenalidomide cap 15 mg .....</i>	205	<i>levocarnitine oral soln 1 gm/10ml (10%)..</i>	162
<i>lenalidomide cap 25 mg .....</i>	205	<i>levocarnitine tab 330 mg.....</i>	162
<i>lenalidomide cap 5 mg.....</i>	205	<i>levocetirizine dihydrochloride soln 2.5</i>	
LENVIMA CAP 10 MG .....	84	<i>mg/5ml (0.5 mg/ml) .....</i>	68
LENVIMA CAP 12MG .....	84	<i>levofloxacin ophth soln 0.5%.....</i>	214
LENVIMA CAP 14 MG .....	84	<i>levofloxacin oral soln 25 mg/ml.....</i>	167
LENVIMA CAP 18 MG .....	84	<i>levofloxacin tab 250 mg .....</i>	167
LENVIMA CAP 20 MG .....	84	<i>levofloxacin tab 500 mg .....</i>	167
LENVIMA CAP 24 MG.....	84	<i>levofloxacin tab 750 mg .....</i>	167
LENVIMA CAP 4MG.....	84	<i>levonor-eth est tab 0.15-0.02/0.025/0.03</i>	
LENVIMA CAP 8 MG.....	84	<i>mg &amp;eth est 0.01 mg .....</i>	128
<i>letrozole tab 2.5 mg .....</i>	86	<i>levonorgestrel &amp; ethinyl estradiol (91-day)</i>	
<i>leucovorin calcium tab 10 mg.....</i>	95	<i>tab 0.15-0.03 mg.....</i>	128
<i>leucovorin calcium tab 15 mg.....</i>	95	<i>levonorgestrel &amp; ethinyl estradiol tab 0.15</i>	
<i>leucovorin calcium tab 25 mg .....</i>	95	<i>mg-30 mcg .....</i>	128
<i>leucovorin calcium tab 5 mg .....</i>	95	<i>levonorgestrel &amp; ethinyl estradiol tab 0.1</i>	
LEUKERAN TAB 2MG .....	83	<i>mg-20 mcg .....</i>	128
<i>leuprolide acetate inj kit 1 mg/0.2ml (5</i>		<i>levonorgestrel-eth estra tab 0.05-</i>	
<i>mg/ml) .....</i>	86	<i>30/0.075-40/0.125-30mg-mcg.....</i>	128
<i>levalbuterol hcl soln nebu 0.31 mg/3ml</i>		<i>levonorgestrel-ethinyl estradiol</i>	
<i>(base equiv) .....</i>	44	<i>(continuous) tab 90-20 mcg .....</i>	128
<i>levalbuterol hcl soln nebu 0.63 mg/3ml</i>		<i>levonorgestrel tab 1.5 mg .....</i>	130
<i>(base equiv) .....</i>	44	<i>levonorg-eth est tab 0.1-0.02mg(84) &amp; eth</i>	
<i>levalbuterol hcl soln nebu 1.25 mg/3ml</i>		<i>est tab 0.01mg(7) .....</i>	128
<i>(base equiv) .....</i>	44	<i>levonorg-eth est tab 0.15-0.03mg(84) &amp; eth</i>	
<i>levalbuterol hcl soln nebu conc 1.25</i>		<i>est tab 0.01mg(7) .....</i>	128
<i>mg/0.5ml (base equiv) .....</i>	44	<i>levothyroxine sodium tab 100 mcg .....</i>	230

<i>levothyroxine sodium tab 112 mcg</i> .....	230	<i>lisinopril tab 10 mg</i> .....	73
<i>levothyroxine sodium tab 125 mcg</i> .....	230	<i>lisinopril tab 2.5 mg</i> .....	73
<i>levothyroxine sodium tab 137 mcg</i> .....	230	<i>lisinopril tab 20 mg</i> .....	73
<i>levothyroxine sodium tab 150 mcg</i> .....	230	<i>lisinopril tab 30 mg</i> .....	73
<i>levothyroxine sodium tab 175 mcg</i> .....	230	<i>lisinopril tab 40 mg</i> .....	73
<i>levothyroxine sodium tab 200 mcg</i> .....	230	<i>lisinopril tab 5 mg</i> .....	73
<i>levothyroxine sodium tab 25 mcg</i> .....	230	LITETOUCH MIS LANCETS .....	190
<i>levothyroxine sodium tab 300 mcg</i> .....	230	LITE TOUCH MIS LANCETS .....	190
<i>levothyroxine sodium tab 50 mcg</i> .....	230	LITE TOUCH MIS LANC PEN.....	190
<i>levothyroxine sodium tab 75 mcg</i> .....	230	LITFULO CAP 50MG .....	147
<i>levothyroxine sodium tab 88 mcg</i> .....	230	<i>lithium carbonate cap 150 mg</i> .....	99
LEVSIN/SL SUB 0.125MG .....	231	<i>lithium carbonate cap 300 mg</i> .....	99
LEVSIN TAB 0.125MG .....	231	<i>lithium carbonate cap 600 mg</i> .....	99
LEVULAN KERA SOL 20% .....	137	<i>lithium carbonate tab 300 mg</i> .....	99
<i>lidocaine hcl laryngotracheal soln 4%</i> ....	208	<i>lithium carbonate tab er 300 mg</i> .....	99
<i>lidocaine hcl soln 4%</i> .....	148	<i>lithium carbonate tab er 450 mg</i> .....	99
<i>lidocaine hcl urethral/mucosal gel 2%</i> ....	148	LITHIUM SOL 8MEQ/5ML .....	99
<i>lidocaine hcl urethral/mucosal gel prefilled</i> <i>syringe 2%</i> .....	148	LITHOBID TAB 300MG CR .....	99
<i>lidocaine hcl viscous soln 2%</i> .....	208	LIVTENCITY TAB 200MG .....	112
<i>lidocaine oint 5%</i> .....	148	LOCOID LIPO CRE 0.1% .....	145
<i>lidocaine patch 5%</i> .....	148	LOCOID LOT 0.1% .....	145
<i>lidocaine-prilocaine cream 2.5-2.5%</i> .....	148	LODOSYN TAB 25MG .....	96
LIDODERM DIS 5%.....	148	LO LOESTRIN TAB 1-10-10 .....	128
LIFESCAN MIS UNISTIK2 .....	190	LOMOTIL TAB 2.5MG.....	65
<i>lindane shampoo 1%</i> .....	149	LONGS LANCET MIS STANDARD.....	190
<i>linezolid for susp 100 mg/5ml</i> .....	36	LONGS LANCET MIS THIN .....	190
<i>linezolid tab 600 mg</i> .....	36	LONGS LANCET MIS ULTRA TH .....	190
LINZESS CAP 145MCG .....	169	LONSURF TAB 15-6.14.....	88
LINZESS CAP 290MCG.....	169	LONSURF TAB 20-8.19.....	88
LINZESS CAP 72MCG .....	169	LOPHLEX POW .....	152
<i>liothyronine sodium tab 25 mcg</i> .....	230	LOPID TAB 600MG.....	70
<i>liothyronine sodium tab 50 mcg</i> .....	230	<i>lopinavir-ritonavir soln 400-100 mg/5ml</i> <i>(80-20 mg/ml)</i> .....	109
<i>liothyronine sodium tab 5 mcg</i> .....	230	<i>lopinavir-ritonavir tab 100-25 mg</i> .....	109
LIPOFEN CAP 150MG .....	70	<i>lopinavir-ritonavir tab 200-50 mg</i> .....	109
LIPOFEN CAP 50MG .....	70	LOPRESSOR TAB 100MG.....	116
LIQUID HOPE LIQ.....	152	LOPRESSOR TAB 50MG .....	116
<i>lisinopril &amp; hydrochlorothiazide tab 10-12.5</i> <i>mg</i> .....	78	LOPROX SHA 1% .....	137
<i>lisinopril &amp; hydrochlorothiazide tab 20-12.5</i> <i>mg</i> .....	78	<i>lorazepam conc 2 mg/ml</i> .....	39
<i>lisinopril &amp; hydrochlorothiazide tab 20-25</i> <i>mg</i> .....	78	<i>lorazepam tab 0.5 mg</i> .....	39
		<i>lorazepam tab 1 mg</i> .....	39
		<i>lorazepam tab 2 mg</i> .....	39
		LORBRENA TAB 100MG.....	92

LORBRENA TAB 25MG.....	92	LUMAKRAS TAB 320MG.....	92
LORTAB ELX 10-300MG .....	31	LUMRYZ PAK 6GM .....	219
<i>losartan potassium &amp; hydrochlorothiazide</i>		LUMRYZ PAK 7.5GM .....	219
<i>tab 100-12.5 mg .....</i>	78	LUMRYZ PAK 9GM .....	220
<i>losartan potassium &amp; hydrochlorothiazide</i>		LUMRYZ PKG 4.5GM.....	220
<i>tab 100-25 mg.....</i>	78	LUPRON DEPOT INJ 11.25MG .....	86
<i>losartan potassium &amp; hydrochlorothiazide</i>		LUPRON DEPOT INJ 3.75MG.....	86
<i>tab 50-12.5 mg .....</i>	78	<i>lurasidone hcl tab 120 mg .....</i>	100
<i>losartan potassium tab 100 mg .....</i>	75	<i>lurasidone hcl tab 20 mg.....</i>	100
<i>losartan potassium tab 25 mg .....</i>	74	<i>lurasidone hcl tab 40 mg.....</i>	100
<i>losartan potassium tab 50 mg.....</i>	75	<i>lurasidone hcl tab 60 mg.....</i>	100
LOTENSIN HCT TAB 10-12.5.....	78	<i>lurasidone hcl tab 80 mg.....</i>	100
LOTENSIN HCT TAB 20-12.5.....	78	LUXIQ AER 0.12% .....	145
LOTENSIN HCT TAB 20-25MG .....	78	LUZU CRE 1%.....	137
LOTENSIN TAB 10MG.....	73	LYNPARZA TAB 100MG .....	92
LOTENSIN TAB 20MG .....	73	LYNPARZA TAB 150MG .....	92
LOTENSIN TAB 40MG.....	73	LYSODREN TAB 500MG.....	86
<i>loteprednol etabonate ophth gel 0.5%....</i>	215	LYSTEDA TAB 650MG .....	176
<i>loteprednol etabonate ophth susp 0.5%.</i>	215	LYVISPAH GRA 10MG.....	210
LOTREL CAP 10-20MG.....	78	LYVISPAH GRA 20MG .....	210
LOTREL CAP 10-40MG .....	78	LYVISPAH GRA 5MG.....	210
LOTREL CAP 5-10MG.....	78	<b>M</b>	
LOTREL CAP 5-20MG .....	78	MACROBID CAP 100MG .....	36
LOTRONEX TAB 0.5MG.....	169	<i>mafenide acetate packet for topical soln</i>	
LOTRONEX TAB 1MG.....	169	<i>5% (50 gm).....</i>	142
<i>lovastatin tab 10 mg.....</i>	71	MALARONE TAB 250-100 .....	81
<i>lovastatin tab 20 mg .....</i>	71	MALARONE TAB 62.5-25 .....	81
<i>lovastatin tab 40 mg .....</i>	71	<i>malathion lotion 0.5%.....</i>	149
LOVENOX INJ 100MG/ML.....	47	<i>maprotiline hcl tab 25 mg .....</i>	55
LOVENOX INJ 120/0.8 .....	47	<i>maprotiline hcl tab 50 mg.....</i>	55
LOVENOX INJ 150MG/ML.....	47	<i>maprotiline hcl tab 75 mg .....</i>	55
LOVENOX INJ 30/0.3ML .....	47	MAR-COF CG LIQ 225-7.5.....	132
LOVENOX INJ 300/3ML .....	47	MARINOL CAP 10MG .....	66
LOVENOX INJ 40/0.4ML .....	47	MARINOL CAP 2.5MG.....	66
LOVENOX INJ 60/0.6ML.....	47	MARINOL CAP 5MG.....	66
LOVENOX INJ 80/0.8ML.....	47	MARPLAN TAB 10MG.....	55
<i>loxapine succinate cap 10 mg.....</i>	102	MATULANE CAP 50MG .....	95
<i>loxapine succinate cap 25 mg .....</i>	102	MAVENCLAD PAK 10MG(10) .....	224
<i>loxapine succinate cap 50 mg .....</i>	102	MAVENCLAD PAK 10MG(4) .....	224
<i>loxapine succinate cap 5 mg .....</i>	102	MAVENCLAD PAK 10MG(5) .....	224
<i>lubiprostone cap 24 mcg.....</i>	168	MAVENCLAD PAK 10MG(6) .....	224
<i>lubiprostone cap 8 mcg.....</i>	168	MAVENCLAD PAK 10MG(7) .....	224
LUMAKRAS TAB 120MG .....	92	MAVENCLAD PAK 10MG(8) .....	224

MAVENCLAD PAK 10MG(9) .....	224	<i>megestrol acetate tab 20 mg</i> .....	86
MAXITROL OIN 0.1% OP .....	215	<i>megestrol acetate tab 40 mg</i> .....	87
MAXITROL SUS 0.1% OP .....	215	MEIJER LANCE MIS COLOR .....	191
MAXZIDE-25 TAB .....	156	MEIJER LANCE MIS UNIV 21G.....	191
MAXZIDE TAB 75-50.....	156	MEIJER LANCE MIS UNIV 30G.....	191
MAYZENT PAK STARTER .....	224	MEIJER LANCE MIS UNIVERSA .....	191
MAYZENT TAB 0.25MG .....	224	MEIJER MIS LANCETS .....	191
MAYZENT TAB 1MG.....	224	MEKTOVI TAB 15MG.....	92
MAYZENT TAB 2MG.....	224	<i>meloxicam tab 15 mg</i> .....	19
MCT PRO-CAL PAK .....	152	<i>meloxicam tab 7.5 mg</i> .....	19
<i>meclofenamate sodium cap 100 mg</i> .....	19	<i>melfhalan tab 2 mg</i> .....	83
<i>meclofenamate sodium cap 50 mg</i> .....	19	<i>memantine hcl cap er 24hr 14 mg</i> .....	220
MEDICHOICE MIS LANCET .....	190	<i>memantine hcl cap er 24hr 21 mg</i> .....	220
MEDISENSE LIQ GLUC/KET .....	190	<i>memantine hcl cap er 24hr 28 mg</i> .....	220
MEDISENSE LIQ GLUC-KET.....	190	<i>memantine hcl cap er 24hr 7 mg</i> .....	220
MEDLANCE MIS 30G PLUS .....	190	<i>memantine hcl oral solution 2 mg/ml</i> .....	220
MEDLANCE MIS EXTR 21G .....	190	<i>memantine hcl tab 10 mg</i> .....	221
MEDLANCE MIS LITE 25G .....	190	<i>memantine hcl tab 28 x 5 mg &amp; 21 x 10 mg</i>	
MEDLANCE MIS PLUS.....	190	<i>titration pack</i> .....	221
MEDLANCE MIS PLUS 30G .....	190	<i>memantine hcl tab 5 mg</i> .....	220
MEDLANCE MIS UNV 21G .....	190	MEMBRANEBLUE INJ 0.15% .....	216
MEDLANCE PLS MIS 0.8MM.....	190	MENOPUR INJ 75UNIT .....	160
MEDLANCE PLS MIS EXTR 21G.....	190	MENOSTAR DIS 14MCG .....	166
MEDLANCE PLS MIS LITE 25G.....	190	<i>mepерidine hcl oral soln 50 mg/5ml</i> .....	26
MEDLANCE PLS MIS UNIV 21G .....	190	<i>mepерidine hcl tab 50 mg</i> .....	26
MEDROL TAB 16MG.....	131	MEPHYTON TAB 5MG .....	236
MEDROL TAB 2MG .....	131	<i>meprobamate tab 200 mg</i> .....	38
MEDROL TAB 32MG .....	131	<i>meprobamate tab 400 mg</i> .....	38
MEDROL TAB 4MG .....	131	MEPRON SUS .....	35
MEDROL TAB 8MG .....	131	<i>mercaptopurine tab 50 mg</i> .....	83
<i>medroxyprogesterone acetate im susp 150</i>		<i>mesalamine cap dr 400 mg</i> .....	168
<i>mg/ml</i> .....	130	<i>mesalamine cap er 24hr 0.375 gm</i> .....	168
<i>medroxyprogesterone acetate im susp</i>		<i>mesalamine cap er 500 mg</i> .....	168
<i>prefilled syr 150 mg/ml</i> .....	130	<i>mesalamine enema 4 gm</i> .....	168
<i>medroxyprogesterone acetate tab 10 mg</i>		<i>mesalamine rectal enema 4 gm &amp; cleanser</i>	
.....	219	<i>wipe kit</i> .....	168
<i>medroxyprogesterone acetate tab 2.5 mg</i>		<i>mesalamine suppos 1000 mg</i> .....	168
.....	219	<i>mesalamine tab delayed release 1.2 gm</i> .	168
<i>medroxyprogesterone acetate tab 5 mg</i>	219	<i>mesalamine tab delayed release 800 mg</i>	
<i>mefenamic acid cap 250 mg</i> .....	19	.....	168
<i>mefloquine hcl tab 250 mg</i> .....	81	MESNEX TAB 400MG .....	95
<i>megestrol acetate susp 40 mg/ml</i> .....	86	MESTINON SOL 60MG/5ML.....	81
<i>megestrol acetate susp 625 mg/5ml</i> .....	219	MESTINON TAB 60MG .....	81

MESTINON TAB TIMESPAN .....	82	<i>methscopolamine bromide tab 2.5 mg</i> ...	232
<i>metaxalone tab 800 mg</i> .....	210	<i>methscopolamine bromide tab 5 mg</i> .....	232
<i>metformin hcl oral soln 500 mg/5ml</i> .....	61	<i>methyldopa &amp; hydrochlorothiazide tab 250-</i>	
<i>metformin hcl tab 1000 mg</i> .....	61	<i>15 mg</i> .....	78
<i>metformin hcl tab 500 mg</i> .....	61	<i>methyldopa &amp; hydrochlorothiazide tab 250-</i>	
<i>metformin hcl tab 850 mg</i> .....	61	<i>25 mg</i> .....	78
<i>metformin hcl tab er 24hr 500 mg</i> .....	61	<i>methyldopa tab 250 mg</i> .....	75
<i>metformin hcl tab er 24hr 750 mg</i> .....	61	<i>methyldopa tab 500 mg</i> .....	75
<i>methadone hcl conc 10 mg/ml</i> .....	26	<i>methylergonovine maleate tab 0.2 mg</i> ....	218
<i>methadone hcl soln 10 mg/5ml</i> .....	26	METHYLIN SOL 10MG/5ML.....	7
<i>methadone hcl soln 5 mg/5ml</i> .....	26	METHYLIN SOL 5MG/5ML .....	7
<i>methadone hcl tab 10 mg</i> .....	26	<i>methylphenidate hcl cap er 10 mg (cd)</i> .....	7
<i>methadone hcl tab 5 mg</i> .....	26	<i>methylphenidate hcl cap er 20 mg (cd)</i> .....	7
<i>methadone hcl tab for oral susp 40 mg</i> ....	26	<i>methylphenidate hcl cap er 24hr 10 mg (la)</i>	
METHADOSE CON 10MG/ML .....	26	.....	7
METHADOSE SF CON 10MG/ML.....	26	<i>methylphenidate hcl cap er 24hr 10 mg (xr)</i>	
<i>methamphetamine hcl tab 5 mg</i> .....	2	.....	7
<i>methazolamide tab 25 mg</i> .....	156	<i>methylphenidate hcl cap er 24hr 15 mg (xr)</i>	
<i>methazolamide tab 50 mg</i> .....	156	.....	7
<i>methenamine hippurate tab 1 gm</i> .....	36	<i>methylphenidate hcl cap er 24hr 20 mg (la)</i>	
<i>methenamine-hyos-meth blue-sod phos-</i>		.....	7
<i>phen sal tab 81.6 mg</i> .....	35	<i>methylphenidate hcl cap er 24hr 20 mg (xr)</i>	
<i>methenamine mandelate tab 0.5 gm</i> .....	36	.....	7
<i>methenamine mandelate tab 1 gm</i> .....	36	<i>methylphenidate hcl cap er 24hr 30 mg (la)</i>	
<i>methimazole tab 10 mg</i> .....	230	.....	7
<i>methimazole tab 5 mg</i> .....	230	<i>methylphenidate hcl cap er 24hr 30 mg (xr)</i>	
METHITEST TAB 10MG .....	33	.....	7
<i>methocarbamol tab 500 mg</i> .....	210	<i>methylphenidate hcl cap er 24hr 40 mg (la)</i>	
<i>methocarbamol tab 750 mg</i> .....	210	.....	7
<i>methotrexate sodium for inj 1 gm</i> .....	83	<i>methylphenidate hcl cap er 24hr 40 mg (xr)</i>	
<i>methotrexate sodium inj 250 mg/10ml (25</i>		.....	7
<i>mg/ml)</i> .....	83	<i>methylphenidate hcl cap er 24hr 50 mg (xr)</i>	
<i>methotrexate sodium inj 50 mg/2ml (25</i>		.....	7
<i>mg/ml)</i> .....	83	<i>methylphenidate hcl cap er 24hr 60 mg (la)</i>	
<i>methotrexate sodium inj pf 1000 mg/40ml</i>		.....	7
<i>(25 mg/ml)</i> .....	83	<i>methylphenidate hcl cap er 24hr 60 mg (xr)</i>	
<i>methotrexate sodium inj pf 250 mg/10ml</i>		.....	7
<i>(25 mg/ml)</i> .....	83	<i>methylphenidate hcl cap er 30 mg (cd)</i> .....	8
<i>methotrexate sodium inj pf 50 mg/2ml (25</i>		<i>methylphenidate hcl cap er 40 mg (cd)</i> .....	8
<i>mg/ml)</i> .....	83	<i>methylphenidate hcl cap er 50 mg (cd)</i> .....	8
<i>methotrexate sodium tab 2.5 mg (base</i>		<i>methylphenidate hcl cap er 60 mg (cd)</i> .....	8
<i>equiv)</i> .....	83	<i>methylphenidate hcl chew tab 10 mg</i> .....	8
<i>methoxsalen rapid cap 10 mg</i> .....	140	<i>methylphenidate hcl chew tab 2.5 mg</i> .....	8



<i>methylphenidate hcl chew tab 5 mg</i> .....	8	<i>metoprolol &amp; hydrochlorothiazide tab 100-</i>	
<i>methylphenidate hcl soln 10 mg/5ml</i> .....	8	<i>50 mg</i> .....	78
<i>methylphenidate hcl soln 5 mg/5ml</i> .....	8	<i>metoprolol &amp; hydrochlorothiazide tab 50-25</i>	
<i>methylphenidate hcl tab 10 mg</i> .....	8	<i>mg</i> .....	78
<i>methylphenidate hcl tab 20 mg</i> .....	8	<i>metoprolol succinate tab er 24hr 100 mg</i>	
<i>methylphenidate hcl tab 5 mg</i> .....	8	<i>(tartrate equiv)</i> .....	116
<i>methylphenidate hcl tab er 10 mg</i> .....	8	<i>metoprolol succinate tab er 24hr 200 mg</i>	
<i>methylphenidate hcl tab er 20 mg</i> .....	8	<i>(tartrate equiv)</i> .....	116
<i>methylphenidate hcl tab er 24hr 18 mg</i> .....	8	<i>metoprolol succinate tab er 24hr 25 mg</i>	
<i>methylphenidate hcl tab er 24hr 27 mg</i> .....	8	<i>(tartrate equiv)</i> .....	116
<i>methylphenidate hcl tab er 24hr 36 mg</i> .....	8	<i>metoprolol succinate tab er 24hr 50 mg</i>	
<i>methylphenidate hcl tab er 24hr 54 mg</i> .....	8	<i>(tartrate equiv)</i> .....	116
<i>methylphenidate hcl tab er osmotic release</i>		<i>metoprolol tartrate tab 100 mg</i> .....	116
<i>(osm) 18 mg</i> .....	8	<i>metoprolol tartrate tab 25 mg</i> .....	116
<i>methylphenidate hcl tab er osmotic release</i>		<i>metoprolol tartrate tab 37.5 mg</i> .....	116
<i>(osm) 27 mg</i> .....	9	<i>metoprolol tartrate tab 50 mg</i> .....	116
<i>methylphenidate hcl tab er osmotic release</i>		<i>metoprolol tartrate tab 75 mg</i> .....	116
<i>(osm) 36 mg</i> .....	9	METROCREAM CRE 0.75% .....	148
<i>methylphenidate hcl tab er osmotic release</i>		METROGEL GEL 1% .....	148
<i>(osm) 54 mg</i> .....	9	METROLOTION LOT 0.75% .....	149
METHYLPHENID TAB 72MG ER .....	7	<i>metronidazole cap 375 mg</i> .....	35
<i>methylprednisolone tab 16 mg</i> .....	131	<i>metronidazole cream 0.75%</i> .....	149
<i>methylprednisolone tab 32 mg</i> .....	131	<i>metronidazole gel 0.75%</i> .....	149
<i>methylprednisolone tab 4 mg</i> .....	131	<i>metronidazole gel 1%</i> .....	149
<i>methylprednisolone tab 8 mg</i> .....	131	<i>metronidazole lotion 0.75%</i> .....	149
<i>methylprednisolone tab therapy pack 4 mg</i>		<i>metronidazole tab 250 mg</i> .....	35
<i>(21)</i> .....	131	<i>metronidazole tab 500 mg</i> .....	35
<i>methyltestosterone cap 10 mg</i> .....	33	<i>metronidazole vaginal gel 0.75%</i> .....	235
<i>metoclopramide hcl orally disintegrating</i>		<i>metyrosine cap 250 mg</i> .....	74
<i>tab 5 mg (base eq)</i> .....	168	<i>mexiletine hcl cap 150 mg</i> .....	40
<i>metoclopramide hcl soln 5 mg/5ml (10</i>		<i>mexiletine hcl cap 200 mg</i> .....	40
<i>mg/10ml) (base equiv)</i> .....	168	<i>mexiletine hcl cap 250 mg</i> .....	40
<i>metoclopramide hcl tab 10 mg (base</i>		<i>miconazole nitrate vaginal suppos 200 mg</i>	
<i>equivalent)</i> .....	168	.....	235
<i>metoclopramide hcl tab 5 mg (base</i>		<i>miconazole-zinc oxide-white petrolatum</i>	
<i>equivalent)</i> .....	168	<i>oint 0.25-15-81.35%</i> .....	137
METOCLOPRAMI TAB 10MG ODT .....	168	MICROCHAMBER MIS .....	201
<i>metolazone tab 10 mg</i> .....	158	MICRODOT CON SOL HIGH/LOW .....	191
<i>metolazone tab 2.5 mg</i> .....	158	MICROLET MIS LANCETS .....	191
<i>metolazone tab 5 mg</i> .....	158	MICROLET MIS NEXT .....	191
<i>metoprolol &amp; hydrochlorothiazide tab 100-</i>		MICRO THIN MIS LANC 33G .....	191
<i>25 mg</i> .....	78	<i>midodrine hcl tab 10 mg</i> .....	236
		<i>midodrine hcl tab 2.5 mg</i> .....	236

<i>midodrine hcl tab 5 mg</i> .....	236	<i>misoprostol tab 200 mcg</i> .....	233
MIFEPREX TAB 200MG .....	163	MITIGARE CAP 0.6MG.....	172
<i>mifepristone tab 200 mg</i> .....	163	MITOSOL KIT 0.2MG.....	214
<i>miglitol tab 100 mg</i> .....	59	MM LANCING MIS DEVICE.....	191
<i>miglitol tab 25 mg</i> .....	59	MM TWIST MIS LANCETS .....	191
<i>miglitol tab 50 mg</i> .....	59	MOBIC TAB 15MG.....	19
<i>miglustat cap 100 mg</i> .....	173	MOBIC TAB 7.5MG.....	19
MIGRANAL SPR 4MG/ML .....	202	MOBILE LANCE MIS 30G .....	191
MINI LANCING MIS DEVICE .....	191	<i>modafinil tab 100 mg</i> .....	9
MINIPRESS CAP 1MG .....	75	<i>modafinil tab 200 mg</i> .....	9
MINIPRESS CAP 2MG .....	76	<i>moexipril hcl tab 15 mg</i> .....	73
MINIPRESS CAP 5MG .....	76	<i>moexipril hcl tab 7.5 mg</i> .....	73
<i>minocycline hcl cap 100 mg</i> .....	229	<i>molindone hcl tab 10 mg</i> .....	104
<i>minocycline hcl cap 50 mg</i> .....	229	<i>molindone hcl tab 25 mg</i> .....	104
<i>minocycline hcl cap 75 mg</i> .....	229	<i>molindone hcl tab 5 mg</i> .....	104
<i>minocycline hcl tab 100 mg</i> .....	229	<i>mometasone furoate cream 0.1%</i> .....	145
<i>minocycline hcl tab 50 mg</i> .....	229	<i>mometasone furoate nasal susp 50</i>	
<i>minocycline hcl tab 75 mg</i> .....	229	<i>mcg/act</i> .....	211
<i>minoxidil tab 10 mg</i> .....	81	<i>mometasone furoate oint 0.1%</i> .....	145
<i>minoxidil tab 2.5 mg</i> .....	81	<i>mometasone furoate solution 0.1% (lotion)</i>	
MIRAPEX ER TAB 0.375MG.....	97	.....	145
MIRAPEX ER TAB 0.75MG.....	97	MONOLET MIS LANCETS .....	191
MIRAPEX ER TAB 1.5MG .....	97	MONOLET OPD MIS LANCETS .....	191
MIRAPEX ER TAB 2.25MG .....	97	MONOLETTOR MIS LANCETS .....	191
MIRAPEX ER TAB 3.75MG .....	97	<i>montelukast sodium chew tab 4 mg (base</i>	
MIRAPEX ER TAB 3MG.....	97	<i>equiv)</i> .....	41
MIRAPEX ER TAB 4.5MG .....	97	<i>montelukast sodium chew tab 5 mg (base</i>	
MIRAPEX TAB 0.125MG .....	97	<i>equiv)</i> .....	41
MIRAPEX TAB 0.5MG.....	97	<i>montelukast sodium oral granules packet 4</i>	
MIRAPEX TAB 0.75MG.....	97	<i>mg (base equiv)</i> .....	41
MIRAPEX TAB 1MG .....	97	<i>montelukast sodium tab 10 mg (base equiv)</i>	
MIRCETTE TAB 28 DAY .....	128	.....	41
<i>mirtazapine orally disintegrating tab 15 mg</i>		MONUROL PAK GRANULES.....	36
.....	54	<i>morphine sulfat e beads cap er 24hr 120 mg</i>	
<i>mirtazapine orally disintegrating tab 30 mg</i>		.....	26
.....	54	<i>morphine sulfat e beads cap er 24hr 30 mg</i>	
<i>mirtazapine orally disintegrating tab 45 mg</i>		.....	26
.....	54	<i>morphine sulfat e beads cap er 24hr 45 mg</i>	
<i>mirtazapine tab 15 mg</i> .....	54	.....	26
<i>mirtazapine tab 30 mg</i> .....	54	<i>morphine sulfat e beads cap er 24hr 60 mg</i>	
<i>mirtazapine tab 45 mg</i> .....	54	.....	26
<i>mirtazapine tab 7.5 mg</i> .....	54	<i>morphine sulfat e beads cap er 24hr 75 mg</i>	
<i>misoprostol tab 100 mcg</i> .....	233	.....	26

<i>morphine sulfate beads cap er 24hr 90 mg</i> .....	26	MS CONTIN TAB 200MG ER .....	28
<i>morphine sulfate cap er 24hr 100 mg</i> .....	27	MS CONTIN TAB 30MG ER.....	28
<i>morphine sulfate cap er 24hr 10 mg</i> .....	26	MS CONTIN TAB 60MG ER.....	28
<i>morphine sulfate cap er 24hr 20 mg</i> .....	26	MULPLETA TAB 3MG.....	175
<i>morphine sulfate cap er 24hr 30 mg</i> .....	27	MULTI-LANCET KIT DEVICE.....	191
<i>morphine sulfate cap er 24hr 40 mg</i> .....	27	MULTI-LANCET MIS DEVICE.....	191
<i>morphine sulfate cap er 24hr 50 mg</i> .....	27	<i>mupirocin oint 2%</i> .....	136
<i>morphine sulfate cap er 24hr 60 mg</i> .....	27	MUSE SUP 1000MCG.....	123
<i>morphine sulfate cap er 24hr 80 mg</i> .....	27	MUSE SUP 125MCG.....	122
<i>morphine sulfate oral soln 100 mg/5ml (20</i> <i>mg/ml)</i> .....	27	MUSE SUP 250MCG.....	122
<i>morphine sulfate oral soln 10 mg/5ml</i> .....	27	MUSE SUP 500MCG.....	122
<i>morphine sulfate oral soln 20 mg/5ml</i> .....	27	MYALEPT INJ 11.3MG .....	162
<i>morphine sulfate suppos 10 mg</i> .....	27	MYAMBUTOL TAB 400MG.....	82
<i>morphine sulfate suppos 20 mg</i> .....	27	MYCOBUTIN CAP 150MG.....	82
<i>morphine sulfate suppos 30 mg</i> .....	27	<i>mycophenolate mofetil cap 250 mg</i> .....	207
<i>morphine sulfate suppos 5 mg</i> .....	27	<i>mycophenolate mofetil for oral susp 200</i> <i>mg/ml</i> .....	207
<i>morphine sulfate tab 15 mg</i> .....	27	<i>mycophenolate mofetil tab 500 mg</i> .....	207
<i>morphine sulfate tab 30 mg</i> .....	27	<i>mycophenolate sodium tab dr 180 mg</i> <i>(mycophenolic acid equiv)</i> .....	207
<i>morphine sulfate tab er 100 mg</i> .....	27	<i>mycophenolate sodium tab dr 360 mg</i> <i>(mycophenolic acid equiv)</i> .....	207
<i>morphine sulfate tab er 15 mg</i> .....	27	MYFORTIC TAB 180MG .....	207
<i>morphine sulfate tab er 200 mg</i> .....	27	MYFORTIC TAB 360MG.....	207
<i>morphine sulfate tab er 30 mg</i> .....	27	MYGLUCOHEALT MIS LANC 30G .....	191
<i>morphine sulfate tab er 60 mg</i> .....	27	MYGLUCOHEALT SOL LO/NL/HI .....	191
MOUNJARO INJ 12.5/0.5.....	62	MYLERAN TAB 2MG.....	83
MOUNJARO INJ 15MG/0.5 .....	62	MYSOLINE TAB 250MG.....	50
MOUNJARO INJ 2.5/0.5 .....	62	MYSOLINE TAB 50MG.....	50
MOUNJARO INJ 5MG/0.5.....	62	<b>N</b>	
MOUNJARO INJ 7.5/0.5 .....	62	<i>nabumetone tab 500 mg</i> .....	19
MOXEZA SOL 0.5%.....	214	<i>nabumetone tab 750 mg</i> .....	20
<i>moxifloxacin hcl ophth soln 0.5% (base eq)</i> <i>(2 times daily)</i> .....	214	<i>nadolol tab 20 mg</i> .....	117
<i>moxifloxacin hcl ophth soln 0.5% (base</i> <i>equiv)</i> .....	214	<i>nadolol tab 40 mg</i> .....	117
<i>moxifloxacin hcl tab 400 mg (base equiv)</i> .....	167	<i>nadolol tab 80 mg</i> .....	117
MPD SFTY LAN MIS 21G.....	191	NAFRINSE DLY SOL /NEUTRAL .....	209
MPD SFTY LAN MIS 23G.....	191	NAFRINSE SOL DAILY.....	209
MPD SFTY LAN MIS 28G.....	191	NAFRINSE WK SOL 0.2% .....	209
MPD SFTY LAN MIS 30G.....	191	<i>naftifine hcl cream 1%</i> .....	137
MS CONTIN TAB 100MG ER.....	28	<i>naftifine hcl cream 2%</i> .....	137
MS CONTIN TAB 15MG ER .....	28	<i>naftifine hcl gel 1%</i> .....	137
		NAFTIN GEL 1%.....	137
		NAFTIN GEL 2%.....	137

NALFON CAP 400MG .....	20	NATPARA INJ 25MCG .....	158
NALFON TAB 600MG.....	20	NATPARA INJ 50MCG.....	158
<i>naloxone hcl inj 0.4 mg/ml</i> .....	65	NATPARA INJ 75MCG .....	159
<i>naloxone hcl inj 4 mg/10ml</i> .....	65	NATROBA SUS 0.9% .....	149
<i>naloxone hcl nasal spray 4 mg/0.1ml</i> .....	65	NAYZILAM SPR 5MG.....	48
<i>naloxone hcl soln cartridge 0.4 mg/ml</i> .....	65	<i>nebivolol hcl tab 10 mg (base equivalent)</i>	116
<i>naloxone hcl soln prefilled syringe 2</i>		<i>nebivolol hcl tab 2.5 mg (base equivalent)</i>	116
<i>mg/2ml</i> .....	65	.....	116
<i>naltrexone hcl tab 50 mg</i> .....	65	<i>nebivolol hcl tab 20 mg (base equivalent)</i>	116
NAMENDA TAB 10MG.....	221	.....	116
NAMENDA TAB 5-10MG.....	221	<i>nebivolol hcl tab 5 mg (base equivalent)</i> .	116
NAMENDA TAB 5MG .....	221	<i>nefazodone hcl tab 100 mg</i> .....	56
NAMENDA XR CAP 14MG .....	221	<i>nefazodone hcl tab 150 mg</i> .....	56
NAMENDA XR CAP 21MG.....	221	<i>nefazodone hcl tab 200 mg</i> .....	56
NAMENDA XR CAP 28MG.....	221	<i>nefazodone hcl tab 250 mg</i> .....	56
NAMENDA XR CAP 7MG .....	221	<i>nefazodone hcl tab 50 mg</i> .....	56
NAMENDA XR CAP TITRATIO .....	221	NEOCATE LIQ SPLASH.....	152
NAMZARIC CAP.....	221	NEOKE MCT70 POW.....	152
NAMZARIC CAP 14-10MG .....	221	<i>neomycin-bacitrac zn-polymyx 5(3.5)mg-</i>	
NAMZARIC CAP 21-10MG .....	221	<i>400unt-10000unt op oin</i> .....	214
NAMZARIC CAP 28-10MG.....	221	<i>neomycin-polymy-gramicid op sol 1.75-</i>	
NAMZARIC CAP 7-10MG.....	221	<i>10000-0.025mg-unt-mg/ml</i> .....	214
NAPROSYN SUS 125/5ML .....	20	<i>neomycin-polymyxin-dexamethasone</i>	
NAPROSYN TAB 500MG .....	20	<i>ophth oint 0.1%</i> .....	215
<i>naproxen sodium tab 275 mg</i> .....	20	<i>neomycin-polymyxin-dexamethasone</i>	
<i>naproxen sodium tab 550 mg</i> .....	20	<i>ophth susp 0.1%</i> .....	215
<i>naproxen tab 250 mg</i> .....	20	<i>neomycin-polymyxin-hc ophth susp</i> .....	215
<i>naproxen tab 375 mg</i> .....	20	<i>neomycin-polymyxin-hc otic soln 1%</i> .....	217
<i>naproxen tab 500 mg</i> .....	20	<i>neomycin-polymyxin-hc otic susp 3.5</i>	
<i>naproxen tab ec 375 mg</i> .....	20	<i>mg/ml-10000 unit/ml-1%</i> .....	217
<i>naproxen tab ec 500 mg</i> .....	20	<i>neomycin sulfate tab 500 mg</i> .....	9
<i>naratriptan hcl tab 1 mg (base equiv)</i> .....	203	NEORAL CAP 100MG .....	207
<i>naratriptan hcl tab 2.5 mg (base equiv)</i> ..	203	NEORAL CAP 25MG .....	207
NARCAN SPR 4MG.....	66	NEORAL SOL 100MG/ML .....	207
NARDIL TAB 15MG.....	55	NEOTUSS PLUS LIQ .....	133
NASCOBAL SPR 500MCG .....	174	NEPRO LIQ VANILLA.....	152
NASONEX SPR 50MCG/AC.....	211	NERLYNX TAB 40MG.....	92
NATACYN SUS 5% OP.....	214	NEUPRO DIS 1MG/24HR.....	97
NATAZIA TAB.....	128	NEUPRO DIS 2MG/24HR .....	97
<i>nateglinide tab 120 mg</i> .....	64	NEUPRO DIS 3MG/24HR .....	97
<i>nateglinide tab 60 mg</i> .....	63	NEUPRO DIS 4MG/24HR .....	97
NATESTO GEL 5.5MG.....	33	NEUPRO DIS 6MG/24HR .....	97
NATPARA INJ 100MCG .....	159	NEUPRO DIS 8MG/24HR .....	97

NEURONTIN CAP 100MG .....	50	<i>nicotine polacrilex lozenge 2 mg .....</i>	227
NEURONTIN CAP 300MG .....	51	<i>nicotine polacrilex lozenge 4 mg .....</i>	227
NEURONTIN CAP 400MG .....	51	<i>nicotine td patch 24hr 14 mg/24hr .....</i>	227
NEURONTIN SOL 250/5ML.....	51	<i>nicotine td patch 24hr 21 mg/24hr .....</i>	227
NEURONTIN TAB 600MG.....	51	<i>nicotine td patch 24hr 7 mg/24hr .....</i>	227
NEURONTIN TAB 800MG.....	51	NICOTROL INH.....	227
NEUTEK 2TEK SOL CONTROL .....	191	NICOTROL NS SPR 10MG/ML .....	227
<i>nevirapine susp 50 mg/5ml .....</i>	109	<i>nifedipine cap 10 mg .....</i>	119
<i>nevirapine tab 200 mg.....</i>	109	<i>nifedipine cap 20 mg .....</i>	119
<i>nevirapine tab er 24hr 100 mg .....</i>	109	<i>nifedipine tab er 24hr 30 mg.....</i>	119
<i>nevirapine tab er 24hr 400 mg .....</i>	109	<i>nifedipine tab er 24hr 60 mg .....</i>	119
NEXAVAR TAB 200MG .....	92	<i>nifedipine tab er 24hr 90 mg .....</i>	119
NEXLETOL TAB 180MG.....	69	<i>nifedipine tab er 24hr osmotic release 30</i>	
NEXLIZET TAB 180/10MG.....	69	<i>mg.....</i>	119
<i>niacin tab er 1000 mg (antihyperlipidemic)</i>		<i>nifedipine tab er 24hr osmotic release 60</i>	
.....	72	<i>mg.....</i>	119
<i>niacin tab er 500 mg (antihyperlipidemic)</i>	72	<i>nifedipine tab er 24hr osmotic release 90</i>	
<i>niacin tab er 750 mg (antihyperlipidemic)</i>	72	<i>mg.....</i>	119
NIASPAN TAB 1000 ER .....	72	<i>nilutamide tab 150 mg .....</i>	87
NIASPAN TAB 500MG ER.....	72	<i>nimodipine cap 30 mg.....</i>	119
NIASPAN TAB 750MG ER .....	72	NINLARO CAP 2.3MG.....	92
<i>nicardipine hcl cap 20 mg.....</i>	119	NINLARO CAP 3MG.....	92
<i>nicardipine hcl cap 30 mg.....</i>	119	NINLARO CAP 4MG.....	92
NICODERM CQ DIS 14MG/24H .....	226	<i>nisoldipine tab er 24hr 17 mg .....</i>	119
NICODERM CQ DIS 21MG/24H.....	226	<i>nisoldipine tab er 24hr 20 mg .....</i>	119
NICODERM CQ DIS 7MG/24HR.....	226	<i>nisoldipine tab er 24hr 25.5 mg.....</i>	119
NICORETTE GUM 2MG .....	226	<i>nisoldipine tab er 24hr 30 mg .....</i>	119
NICORETTE GUM 2MG CINN.....	226	<i>nisoldipine tab er 24hr 34 mg .....</i>	119
NICORETTE GUM 2MGFRUIT.....	226	<i>nisoldipine tab er 24hr 40 mg.....</i>	119
NICORETTE GUM 2MG MINT.....	226	<i>nisoldipine tab er 24hr 8.5 mg .....</i>	119
NICORETTE GUM 2MG ORIG.....	226	<i>nitazoxanide tab 500 mg .....</i>	35
NICORETTE GUM 4MG .....	226	<i>nitisinone cap 10 mg.....</i>	162
NICORETTE GUM 4MG CINN.....	226	<i>nitisinone cap 2 mg .....</i>	162
NICORETTE GUM 4MGFRUIT.....	226	<i>nitisinone cap 5 mg .....</i>	162
NICORETTE GUM 4MG MINT.....	226	NITRO-BID OIN 2% .....	37
NICORETTE GUM 4MG ORIG.....	226	NITRO-DUR DIS 0.1MG/HR.....	37
NICORETTE LOZ 2MG MINT .....	226	NITRO-DUR DIS 0.2MG/HR.....	37
NICORETTE LOZ 4MG MINT .....	226	NITRO-DUR DIS 0.3MG/HR.....	37
NICORETTE ST GUM 2MG MINT .....	226	NITRO-DUR DIS 0.4MG/HR.....	37
NICORETTE ST GUM 2MG ORIG.....	226	NITRO-DUR DIS 0.6MG/HR.....	37
NICORETTE ST GUM 4MG ORIG .....	226	NITRO-DUR DIS 0.8MG/HR.....	37
<i>nicotine polacrilex gum 2 mg .....</i>	226	<i>nitrofurantoin macrocrystalline cap 100 mg</i>	
<i>nicotine polacrilex gum 4 mg .....</i>	227	.....	36

<i>nitrofurantoin macrocrystalline cap 25 mg</i>	<i>norethindrone &amp; ethinyl estradiol tab 0.5</i>
.....36	<i>mg-35 mcg</i> .....128
<i>nitrofurantoin macrocrystalline cap 50 mg</i>	<i>norethindrone &amp; ethinyl estradiol tab 1 mg-</i>
.....36	<i>35 mcg</i> .....128
<i>nitrofurantoin monohydrate</i>	<i>norethindrone ace &amp; ethinyl estradiol-fe tab</i>
<i>macrocrystalline cap 100 mg</i> .....36	<i>1.5 mg-30 mcg</i> .....129
<i>nitrofurantoin susp 25 mg/5ml</i> .....37	<i>norethindrone ace &amp; ethinyl estradiol-fe tab</i>
<i>nitroglycerin sl tab 0.3 mg</i> .....37	<i>1 mg-20 mcg</i> .....129
<i>nitroglycerin sl tab 0.4 mg</i> .....37	<i>norethindrone ace &amp; ethinyl estradiol tab 1.5</i>
<i>nitroglycerin sl tab 0.6 mg</i> .....37	<i>mg-30 mcg</i> .....129
<i>nitroglycerin td patch 24hr 0.1 mg/hr</i> .....37	<i>norethindrone ace &amp; ethinyl estradiol tab 1</i>
<i>nitroglycerin td patch 24hr 0.2 mg/hr</i> .....37	<i>mg-20 mcg</i> .....129
<i>nitroglycerin td patch 24hr 0.4 mg/hr</i> .....37	<i>norethindrone ace-eth estradiol-fe chew</i>
<i>nitroglycerin td patch 24hr 0.6 mg/hr</i> .....37	<i>tab 1 mg-20 mcg (24)</i> .....129
<i>nitroglycerin tl soln 0.4 mg/spray (400</i>	<i>norethindrone ace-ethinyl estradiol-fe cap 1</i>
<i>mcg/spray)</i> .....38	<i>mg-20 mcg (24)</i> .....129
NITROLINGUAL SPR PUMPSRA.....38	<i>norethindrone ace-ethinyl estradiol-fe tab 1</i>
NITROMIST AER 400MCG.....38	<i>mg-20 mcg (24)</i> .....129
NITROSTAT SUB 0.3MG .....38	<i>norethindrone acetate-ethinyl estradiol tab</i>
NITROSTAT SUB 0.4MG .....38	<i>0.5 mg-2.5 mcg</i> .....165
NITROSTAT SUB 0.6MG .....38	<i>norethindrone acetate-ethinyl estradiol tab</i>
NIVESTYM INJ 300/0.5.....175	<i>1 mg-5 mcg</i> .....165
NIVESTYM INJ 300MCG .....175	<i>norethindrone acetate tab 5 mg</i> .....219
NIVESTYM INJ 480/0.8.....175	<i>norethindrone ac-ethinyl estrad-fe tab 1-</i>
NIVESTYM INJ 480MCG .....175	<i>20/1-30/1-35 mg-mcg</i> .....129
<i>nizatidine cap 150 mg</i> .....232	<i>norethindrone-eth estradiol tab 0.5-</i>
<i>nizatidine cap 300 mg</i> .....232	<i>35/0.75-35/1-35 mg-mcg</i> .....129
<i>nizatidine oral soln 15 mg/ml</i> .....232	<i>norethindrone-eth estradiol tab 0.5-35/1-</i>
NOCDURNA SUB 27.7MCG.....163	<i>35/0.5-35 mg-mcg</i> .....129
NOCDURNA SUB 55.3MCG .....163	<i>norethindrone tab 0.35 mg</i> .....130
NORDITROPIN INJ 10/1.5ML.....161	<i>norgestimate &amp; ethinyl estradiol tab 0.25</i>
NORDITROPIN INJ 15/1.5ML .....161	<i>mg-35 mcg</i> .....129
NORDITROPIN INJ 30/3ML.....161	<i>norgestimate-eth estrad tab 0.18-25/0.215-</i>
NORDITROPIN INJ 5/1.5ML.....161	<i>25/0.25-25 mg-mcg</i> .....129
<i>norelgestromin-ethinyl estradiol td ptwk</i>	<i>norgestimate-eth estrad tab 0.18-35/0.215-</i>
<i>150-35 mcg/24hr</i> .....129	<i>35/0.25-35 mg-mcg</i> .....129
<i>norethindrone &amp; ethinyl estradiol-fe chew</i>	<i>norgestrel &amp; ethinyl estradiol tab 0.3 mg-30</i>
<i>tab 0.4 mg-35 mcg</i> .....129	<i>mcg</i> .....129
<i>norethindrone &amp; ethinyl estradiol-fe chew</i>	NORPACE CAP 100MG CR .....39
<i>tab 0.8 mg-25 mcg</i> .....129	NORPACE CAP 150MG CR .....39
<i>norethindrone &amp; ethinyl estradiol tab 0.4</i>	NORPRAMIN TAB 10MG .....59
<i>mg-35 mcg</i> .....128	NORPRAMIN TAB 25MG .....59
	<i>nortriptyline hcl cap 10 mg</i> .....59

<i>nortriptyline hcl cap 25 mg</i> .....	59	NUTREN LIQ JUNIOR .....	153
<i>nortriptyline hcl cap 50 mg</i> .....	59	NUTREN RENAL LIQ.....	153
<i>nortriptyline hcl cap 75 mg</i> .....	59	NUTRIRENAL LIQ.....	153
<i>nortriptyline hcl soln 10 mg/5ml</i> .....	59	NUVARING MIS.....	130
NORVIR POW 100MG .....	109	NUZYRA TAB 150MG.....	229
NORVIR SOL 80MG/ML.....	110	NYMALIZE SOL.....	119
NORVIR TAB 100MG.....	110	<i>nystatin cream 100000 unit/gm</i> .....	137
NOVA MAX GLU LIQ /KET CON .....	191	<i>nystatin oint 100000 unit/gm</i> .....	137
NOVA MAX PLS TES KETONE .....	150	<i>nystatin oral powder</i> .....	67
NOVA SAFETY MIS LANC 23G .....	191	<i>nystatin susp 100000 unit/ml</i> .....	208
NOVA SAFETY MIS LANC 28G .....	191	<i>nystatin tab 500000 unit</i> .....	67
NOVASOURCE LIQ RENAL.....	152	<i>nystatin topical powder 100000 unit/gm</i> .....	137
NOVA SUREFLX MIS LANC DEV .....	191	<i>nystatin-triamcinolone cream 100000-0.1</i> <i>unit/gm-%</i> .....	137
NOVA SURE MIS LANCETS.....	191	<i>nystatin-triamcinolone oint 100000-0.1</i> <i>unit/gm-%</i> .....	137
NOVOLIN INJ 70/30.....	63	NYVEPRIA INJ 6/0.6ML .....	175
NOVOLIN INJ 70/30 FP .....	63	●	
NOVOLIN N INJ 100 UNIT .....	63	OCALIVA TAB 10MG .....	167
NOVOLIN N INJ U-100 .....	63	OCALIVA TAB 5MG.....	167
NOVOLIN R INJ 100 UNIT .....	63	<i>octreotide acetate inj 1000 mcg/ml (1</i> <i>mg/ml)</i> .....	164
NOVOLIN R INJ U-100.....	63	<i>octreotide acetate inj 100 mcg/ml (0.1</i> <i>mg/ml)</i> .....	164
NOVOLOG INJ 100/ML .....	63	<i>octreotide acetate inj 200 mcg/ml (0.2</i> <i>mg/ml)</i> .....	164
NOVOLOG INJ FLEXPEN .....	63	<i>octreotide acetate inj 500 mcg/ml (0.5</i> <i>mg/ml)</i> .....	164
NOVOLOG INJ PENFILL.....	63	<i>octreotide acetate inj 50 mcg/ml (0.05</i> <i>mg/ml)</i> .....	164
NOVOLOG MIX INJ 70/30.....	63	OCUFLOX DRO 0.3% OP .....	214
NOVOLOG MIX INJ FLEXPEN .....	63	ODEFSEY TAB.....	110
NOZIN NASAL MIS SANITIZE .....	211	ODOMZO CAP 200MG.....	86
NP THYROID TAB 120MG.....	231	OFEV CAP 100MG.....	228
NP THYROID TAB 15MG .....	230	OFEV CAP 150MG.....	228
NP THYROID TAB 30MG .....	230	<i>ofloxacin ophth soln 0.3%</i> .....	214
NP THYROID TAB 60MG .....	230	<i>ofloxacin otic soln 0.3%</i> .....	217
NP THYROID TAB 90MG .....	230	<i>ofloxacin tab 300 mg</i> .....	167
NUBEQA TAB 300MG.....	87	<i>ofloxacin tab 400 mg</i> .....	167
NUCALA INJ 100MG/ML .....	41	<i>olanzapine-fluoxetine hcl cap 12-25 mg</i> ..	221
NUCALA INJ 40MG/0.4 .....	41	<i>olanzapine-fluoxetine hcl cap 12-50 mg</i> ..	222
NULYTELY SOL LMN/LIME.....	178	<i>olanzapine-fluoxetine hcl cap 3-25 mg</i> ...	221
NUPLAZID CAP 34MG.....	100	<i>olanzapine-fluoxetine hcl cap 6-25 mg</i> ...	221
NUPLAZID TAB 10MG.....	100		
NURTEC TAB 75MG ODT .....	202		
NUTRAMINE PAK .....	152		
NUTREN 1.0 LIQ UNFLAVOR.....	152		
NUTREN 1.5 LIQ FIBER .....	152		
NUTREN 2.0 LIQ VANILLA.....	152		
NUTREN JR LIQ .....	152		

<i>olanzapine-fluoxetine hcl cap 6-50 mg</i> ...221	OMNIPOD 5 G6 KIT INTRO .....191
<i>olanzapine for im inj 10 mg</i> .....102	OMNIPOD 5 G6 MIS PODS .....191
<i>olanzapine orally disintegrating tab 10 mg</i> .....102	OMNIPOD MIS CLASSIC .....191
<i>olanzapine orally disintegrating tab 15 mg</i> .....102	OMNIPOD PDM KIT CLASSIC.....192
<i>olanzapine orally disintegrating tab 20 mg</i> .....102	<i>ondansetron hcl oral soln 4 mg/5ml</i> .....66
<i>olanzapine orally disintegrating tab 5 mg</i> .....102	<i>ondansetron hcl tab 24 mg</i> .....66
<i>olanzapine tab 10 mg</i> .....102	<i>ondansetron hcl tab 4 mg</i> .....66
<i>olanzapine tab 15 mg</i> .....103	<i>ondansetron hcl tab 8 mg</i> .....66
<i>olanzapine tab 2.5 mg</i> .....102	<i>ondansetron orally disintegrating tab 4 mg</i> .....66
<i>olanzapine tab 20 mg</i> .....103	<i>ondansetron orally disintegrating tab 8 mg</i> .....66
<i>olanzapine tab 5 mg</i> .....102	ONETOUCH DEL MIS LANC DEV .....192
<i>olanzapine tab 7.5 mg</i> .....102	ONETOUCH DEL MIS PLUS 30G .....192
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 20-5-12.5 mg</i> ..79	ONETOUCH DEL MIS PLUS 33G.....192
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-12.5 mg</i> 79	ONETOUCH FP MIS LANCETS .....192
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-10-25 mg</i> ...79	ONETOUCH KIT ULTRA 2 .....192
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-5-12.5 mg</i> ..79	ONETOUCH KIT VERIO FL.....192
<i>olmesartan-amlodipine-</i> <i>hydrochlorothiazide tab 40-5-25 mg</i> ....79	ONETOUCH KIT VERIO RE .....192
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 20-12.5 mg</i> .....79	ONETOUCH LIQ ULT CONT .....192
<i>olmesartan medoxomil-</i> <i>hydrochlorothiazide tab 40-12.5 mg</i> .....79	ONETOUCH LIQ VERIO .....192
<i>olmesartan medoxomil tab 20 mg</i> .....75	ONETOUCH LIQ VERIO 4.....192
<i>olmesartan medoxomil tab 40 mg</i> .....75	ONETOUCH MIS 30G .....192
<i>olmesartan medoxomil tab 5 mg</i> .....75	ONETOUCH MIS LANC DEV .....192
<i>olopatadine hcl nasal soln 0.6%</i> .....211	ONETOUCH MIS LANCETS .....192
OLUX AER 0.05% .....145	ONETOUCH SOL KIT COMPLETE .....192
OMECLAMOX- MIS PAK.....233	ONETOUCH SOL KIT FIT .....192
<i>omega-3-acid ethyl esters cap 1 gm</i> .....69	ONETOUCH SOL KIT REFILL.....192
<i>omeprazole cap delayed release 10 mg</i> .232	ONETOUCH TES ULTRA.....150
<i>omeprazole cap delayed release 20 mg</i> .232	ONETOUCH TES VERIO.....150
<i>omeprazole cap delayed release 40 mg</i> .232	ONETOUCH US MIS LANCETS .....192
OMNIFLEX DPR .....180	ONEXTON GEL 1.2-3.75 .....135
	ON-THE-GO MIS LANC 30G .....192
	ONUREG TAB 200MG .....83
	ONUREG TAB 300MG .....84
	ONZETRA XSAI MIS 11MG .....203
	OPSUMIT TAB 10MG.....124
	OPTICHAMBER MIS DIA MD .....201
	OPTICHAMBER MIS DIAMOND .....201
	OPTICHAMBER MIS DIA SM.....201
	OPTIMENTAL LIQ .....153
	OPZELURA CRE 1.5%.....146
	ORACEA CAP 40MG.....149



ORACIT SOL.....	170	OSMOLITE 1 LIQ CAL .....	153
ORAFATE PST 10%.....	209	OSMOLITE HN LIQ .....	153
ORAPRED ODT TAB 10MG.....	131	OSMOLITE LIQ .....	153
ORAPRED ODT TAB 15MG.....	131	OTEZLA TAB 10/20/30 .....	20
ORAPRED ODT TAB 30MG .....	131	OTEZLA TAB 30MG .....	21
ORAVIG TAB 50MG.....	208	OVIDE LOT 0.5% .....	149
ORENITRAM TAB 0.125MG.....	124	OVIDREL INJ .....	160
ORENITRAM TAB 0.25MG .....	124	<i>oxandrolone tab 10 mg</i> .....	33
ORENITRAM TAB 1MG.....	124	<i>oxandrolone tab 2.5 mg</i> .....	33
ORENITRAM TAB 2.5MG.....	124	<i>oxaprozin tab 600 mg</i> .....	20
ORENITRAM TAB 5MG .....	124	<i>oxazepam cap 10 mg</i> .....	39
ORENITRAM TAB MONTH 1.....	124	<i>oxazepam cap 15 mg</i> .....	39
ORENITRAM TAB MONTH 2 .....	124	<i>oxazepam cap 30 mg</i> .....	39
ORENITRAM TAB MONTH 3 .....	124	<i>oxcarbazepine susp 300 mg/5ml (60</i> <i>mg/ml)</i> .....	51
ORFADIN CAP 10MG.....	162	<i>oxcarbazepine tab 150 mg</i> .....	51
ORFADIN CAP 20MG .....	162	<i>oxcarbazepine tab 300 mg</i> .....	51
ORFADIN CAP 2MG .....	162	<i>oxcarbazepine tab 600 mg</i> .....	51
ORFADIN CAP 5MG .....	162	OXEPA 1.5 LIQ .....	153
ORFADIN SUS 4MG/ML .....	162	OXEPA LIQ.....	153
ORGOVYX TAB 120MG.....	87	OXERVATE SOL 20MCG/ML .....	215
ORIAHNN CAP.....	165	<i>oxiconazole nitrate cream 1%</i> .....	137
ORLISSA TAB 150MG .....	160	OXISTAT CRE 1% .....	137
ORLISSA TAB 200MG.....	160	OXISTAT LOT 1% .....	137
ORKAMBI GRA 100-125 .....	228	OXSORALEN-UL CAP 10MG.....	140
ORKAMBI GRA 150-188.....	228	OXTELLAR XR TAB 150MG.....	51
ORKAMBI GRA 75-94MG.....	227	OXTELLAR XR TAB 300MG.....	51
ORKAMBI TAB 100-125 .....	228	OXTELLAR XR TAB 600MG.....	51
ORKAMBI TAB 200-125 .....	228	<i>oxybutynin chloride solution 5 mg/5ml</i> ..	234
ORLADEYO CAP 110MG.....	173	<i>oxybutynin chloride tab 5 mg</i> .....	234
ORLADEYO CAP 150MG.....	173	<i>oxybutynin chloride tab er 24hr 10 mg</i> ..	234
<i>orlistat cap 120 mg</i> .....	4	<i>oxybutynin chloride tab er 24hr 15 mg</i> ....	234
<i>orphenadrine citrate tab er 12hr 100 mg</i> .	210	<i>oxybutynin chloride tab er 24hr 5 mg</i> .....	234
ORTHO MICRON TAB 0.35MG.....	130	<i>oxycodone-aspirin tab 4.8355-325 mg</i> ....	31
<i>oseltamivir phosphate cap 30 mg (base</i> <i>equiv)</i> .....	114	<i>oxycodone hcl cap 5 mg</i> .....	28
<i>oseltamivir phosphate cap 45 mg (base</i> <i>equiv)</i> .....	114	<i>oxycodone hcl conc 100 mg/5ml (20</i> <i>mg/ml)</i> .....	28
<i>oseltamivir phosphate cap 75 mg (base</i> <i>equiv)</i> .....	114	<i>oxycodone hcl soln 5 mg/5ml</i> .....	28
<i>oseltamivir phosphate for susp 6 mg/ml</i> <i>(base equiv)</i> .....	115	<i>oxycodone hcl tab 10 mg</i> .....	28
OSMOLITE 1.2 LIQ CAL .....	153	<i>oxycodone hcl tab 15 mg</i> .....	28
OSMOLITE 1.5 LIQ CAL.....	153	<i>oxycodone hcl tab 20 mg</i> .....	28
		<i>oxycodone hcl tab 30 mg</i> .....	28
		<i>oxycodone hcl tab 5 mg</i> .....	28

<i>oxycodone hcl tab er 12hr deter 10 mg</i> .....28	<i>pantoprazole sodium for iv soln 40 mg</i>
<i>oxycodone hcl tab er 12hr deter 15 mg</i> .....28	(base equiv) .....233
<i>oxycodone hcl tab er 12hr deter 20 mg</i> .....28	<i>paricalcitol cap 1 mcg</i> .....162
<i>oxycodone hcl tab er 12hr deter 30 mg</i> .....28	<i>paricalcitol cap 2 mcg</i> .....162
<i>oxycodone hcl tab er 12hr deter 40 mg</i> .....28	<i>paricalcitol cap 4 mcg</i> .....162
<i>oxycodone hcl tab er 12hr deter 60 mg</i> .....28	PARLODEL CAP 5MG.....97
<i>oxycodone hcl tab er 12hr deter 80 mg</i> .....29	PARLODEL TAB 2.5MG .....97
<i>oxycodone w/ acetaminophen tab 10-325</i>	PARNATE TAB 10MG.....55
<i>mg</i> .....31	<i>paromomycin sulfate cap 250 mg</i> .....9
<i>oxycodone w/ acetaminophen tab 2.5-325</i>	<i>paroxetine hcl tab 10 mg</i> .....56
<i>mg</i> .....31	<i>paroxetine hcl tab 20 mg</i> .....56
<i>oxycodone w/ acetaminophen tab 5-325</i>	<i>paroxetine hcl tab 30 mg</i> .....56
<i>mg</i> .....31	<i>paroxetine hcl tab 40 mg</i> .....56
<i>oxycodone w/ acetaminophen tab 7.5-325</i>	<i>paroxetine hcl tab er 24hr 12.5 mg</i> .....56
<i>mg</i> .....31	<i>paroxetine hcl tab er 24hr 25 mg</i> .....56
<i>oxymorphone hcl tab 10 mg</i> .....29	<i>paroxetine hcl tab er 24hr 37.5 mg</i> .....56
<i>oxymorphone hcl tab 5 mg</i> .....29	PASER GRA 4GM .....82
OZEMPIC INJ 2/1.5ML.....62	PATANASE SPR 0.6%.....211
OZEMPIC INJ 2MG/3ML.....62	PAXLOVID TAB 150-100 .....112
OZEMPIC INJ 4MG/3ML.....62	PAXLOVID TAB 300-100 .....112
OZEMPIC INJ 8MG/3ML.....62	PC LANCETS MIS 30G .....192
<b>P</b>	PEDIAPRED SOL 5MG/5ML.....131
<i>paliperidone tab er 24hr 1.5 mg</i> .....100	PEDIASURE EN LIQ /FIBER .....153
<i>paliperidone tab er 24hr 3 mg</i> .....100	PEDIASURE LIQ PEPTIDE .....153
<i>paliperidone tab er 24hr 6 mg</i> .....100	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>
<i>paliperidone tab er 24hr 9 mg</i> .....100	<i>soln 236 gm</i> .....178
PAMELOR CAP 10MG.....59	<i>peg 3350-kcl-na bicarb-nacl-na sulfate for</i>
PAMELOR CAP 25MG .....59	<i>soln 240 gm</i> .....178
PAMELOR CAP 50MG.....59	<i>peg 3350-kcl-sod bicarb-nacl for soln 420</i>
PAMELOR CAP 75MG .....59	<i>gm</i> .....178
PANCREAZE CAP 10500UNT .....155	PEGINTRON KIT 50MCG.....113
PANCREAZE CAP 16800UNT .....155	PEG-PREP KIT .....178
PANCREAZE CAP 21000UNT .....155	<i>penciclovir cream 1%</i> .....142
PANCREAZE CAP 2600UNIT .....155	<i>penicillamine cap 250 mg</i> .....205
PANCREAZE CAP 37000 .....155	<i>penicillamine tab 250 mg</i> .....205
PANCREAZE CAP 4200UNIT .....155	<i>penicillin v potassium for soln 125 mg/5ml</i>
PANDEL CRE 0.1% .....145	.....218
PANRETIN GEL 0.1% .....137	<i>penicillin v potassium for soln 250 mg/5ml</i>
<i>pantoprazole sodium ec tab 20 mg (base</i>	.....218
<i>equiv)</i> .....232	<i>penicillin v potassium tab 250 mg</i> .....218
<i>pantoprazole sodium ec tab 40 mg (base</i>	<i>penicillin v potassium tab 500 mg</i> .....218
<i>equiv)</i> .....232	PENLET II KIT BLOOD .....192
	PENLET II MIS REPL CAP .....192

<i>pentazocine w/ naloxone hcl tab 50-0.5 mg</i>	<i>phenobarbital tab 30 mg</i> .....	176
.....32	<i>phenobarbital tab 32.4 mg</i> .....	176
<i>pentoxifylline tab er 400 mg</i> .....	<i>phenobarbital tab 60 mg</i> .....	176
172	<i>phenobarbital tab 64.8 mg</i> .....	176
PEPCID TAB 40MG .....	<i>phenobarbital tab 97.2 mg</i> .....	176
232	<i>phenoxybenzamine hcl cap 10 mg</i> .....	74
PEPTAMEN LIQ PREBIO1.....	<i>phentermine hcl cap 15 mg</i> .....	4
153	<i>phentermine hcl cap 30 mg</i> .....	4
PEPTAMEN LIQ UNFLAVOR .....	<i>phentermine hcl cap 37.5 mg</i> .....	4
153	<i>phentermine hcl tab 37.5 mg</i> .....	4
PEPTINEX DT LIQ .....	<i>phenylephrine hcl ophth soln 10%</i> .....	213
153	<i>phenylephrine hcl ophth soln 2.5%</i> .....	213
PEPTINEX DT LIQ VANILLA .....	<i>phenytoin chew tab 50 mg</i> .....	53
153	<i>phenytoin sodium extended cap 100 mg</i> .53	
PERATIVE LIQ .....	<i>phenytoin sodium extended cap 200 mg</i> .53	
153	<i>phenytoin sodium extended cap 300 mg</i> .53	
PERFECT 28G MIS LANCETS.....	<i>phenytoin susp 125 mg/5ml</i> .....	53
192	PHLEXY-10 POW .....	154
PERFECT 30G MIS LANCETS .....	PHOSLYRA SOL.....	170
192	PHOSPHOLINE SOL 0.125%OP .....	213
PERFOROMIST NEB 20MCG.....	<i>phytonadione tab 5 mg</i> .....	236
44	PICATO GEL 0.015% .....	137
PERIDEX SOL 0.12%.....	PICATO GEL 0.05%.....	137
209	<i>pilocarpine hcl ophth soln 1%</i> .....	213
<i>perindopril erbumine tab 2 mg</i> .....	<i>pilocarpine hcl ophth soln 2%</i> .....	213
73	<i>pilocarpine hcl ophth soln 4%</i> .....	213
<i>perindopril erbumine tab 4 mg</i> .....	<i>pilocarpine hcl tab 5 mg</i> .....	209
73	<i>pilocarpine hcl tab 7.5 mg</i> .....	209
<i>perindopril erbumine tab 8 mg</i> .....	<i>pimecrolimus cream 1%</i> .....	147
73	<i>pimozide tab 1 mg</i> .....	226
<i>permethrin cream 5%</i> .....	<i>pimozide tab 2 mg</i> .....	226
149	<i>pindolol tab 10 mg</i> .....	117
<i>perphenazine-amitriptyline tab 2-10 mg</i> .222	<i>pindolol tab 5 mg</i> .....	117
<i>perphenazine-amitriptyline tab 2-25 mg</i> 222	<i>pioglitazone hcl-glimepiride tab 30-2 mg</i> 60	
<i>perphenazine-amitriptyline tab 4-10 mg</i> .222	<i>pioglitazone hcl-glimepiride tab 30-4 mg</i> 60	
<i>perphenazine-amitriptyline tab 4-25 mg</i> 222	<i>pioglitazone hcl-metformin hcl tab 15-500</i>	
<i>perphenazine-amitriptyline tab 4-50 mg</i> 222	<i>mg</i> .....	60
<i>perphenazine tab 16 mg</i> .....	<i>pioglitazone hcl-metformin hcl tab 15-850</i>	
104	<i>mg</i> .....	60
<i>perphenazine tab 2 mg</i> .....	<i>pioglitazone hcl tab 15 mg (base equiv)</i> ...63	
104	<i>pioglitazone hcl tab 30 mg (base equiv)</i> ...63	
<i>perphenazine tab 4 mg</i> .....	<i>pioglitazone hcl tab 45 mg (base equiv)</i> ...63	
104	PIP LANCETS MIS 28G .....	192
<i>perphenazine tab 8 mg</i> .....		
104		
PERSERIS INJ 120MG .....		
101		
PERSERIS INJ 90MG .....		
101		
PERTZYE CAP 16000U.....		
156		
PERTZYE CAP 24000U.....		
156		
PERTZYE CAP 4000UNIT.....		
155		
PERTZYE CAP 8000UNIT .....		
155		
PHARMACY COU MIS LANCETS .....		
192		
PHEBURANE MIS 483/GM .....		
162		
PHENACTIN AA LIQ PLUS.....		
154		
<i>phenazopyridine hcl tab 200 mg</i> .....		
171		
PHENDIMETRAZ CAP 105MG ER.....		
4		
<i>phendimetrazine tartrate tab 35 mg</i> .....		
4		
<i>phenelzine sulfate tab 15 mg</i> .....		
55		
<i>phenobarbital elixir 20 mg/5ml</i> .....		
176		
<i>phenobarbital tab 100 mg</i> .....		
176		
<i>phenobarbital tab 15 mg</i> .....		
176		
<i>phenobarbital tab 16.2 mg</i> .....		
176		

PIP LANCETS MIS 30G .....	192	<i>potassium chloride powder packet 20 meq</i>	
PIQRAY 200MG TAB DOSE .....	93	.....	205
PIQRAY 250MG TAB DOSE .....	93	<i>potassium chloride tab er 10 meq</i> .....	205
PIQRAY 300MG TAB DOSE .....	93	<i>potassium chloride tab er 20 meq (1500</i>	
<i>pirfenidone tab 267 mg</i> .....	228	<i>mg)</i> .....	205
<i>pirfenidone tab 801 mg</i> .....	228	<i>potassium chloride tab er 8 meq (600 mg)</i>	
<i>piroxicam cap 10 mg</i> .....	20	.....	205
<i>piroxicam cap 20 mg</i> .....	20	<i>potassium citrate &amp; citric acid powder pack</i>	
PIVOT LIQ 1.5 CAL.....	154	<i>3300-1002 mg</i> .....	170
PKU EXPLORE5 POW UNFLAVOR.....	154	<i>potassium citrate &amp; citric acid soln 1100-</i>	
PLAQUENIL TAB 200MG .....	81	<i>334 mg/5ml</i> .....	171
PLEGRIDY INJ .....	224	<i>potassium citrate tab er 10 meq (1080 mg)</i>	
PLEGRIDY INJ PEN.....	224	.....	171
PLEGRIDY INJ STARTER.....	224	<i>potassium citrate tab er 15 meq (1620 mg)</i>	
PLEGRIDY PEN INJ STARTER.....	224	.....	171
POCKET CHAMB MIS .....	201	<i>potassium citrate tab er 5 meq (540 mg)</i>	171
POCKETCHEM SOL EZ .....	192	POTASSIUM POW CHLORIDE .....	205
POCKET SPACE MIS.....	201	POVIDONE IOD SOL 5% .....	214
<i>podofilox soln 0.5%</i> .....	147	PPA/MMA POW EXPRESS.....	154
<i>polymyxin b-trimethoprim ophth soln</i>		<i>pramipexole dihydrochloride tab 0.125 mg</i>	
<i>10000 unit/ml-0.1%</i> .....	214	.....	97
POLYTRIM SOL OP.....	214	<i>pramipexole dihydrochloride tab 0.25 mg</i>	
POMALYST CAP 1MG.....	87	.....	97
POMALYST CAP 2MG .....	87	<i>pramipexole dihydrochloride tab 0.5 mg</i> .	97
POMALYST CAP 3MG .....	87	<i>pramipexole dihydrochloride tab 0.75 mg</i>	
POMALYST CAP 4MG.....	87	.....	97
PONVORY TAB 20MG .....	225	<i>pramipexole dihydrochloride tab 1.5 mg</i> ..	98
PONVORY TAB STARTER.....	225	<i>pramipexole dihydrochloride tab 1 mg</i> ....	98
<i>posaconazole susp 40 mg/ml</i> .....	68	<i>pramipexole dihydrochloride tab er 24hr</i>	
<i>pot &amp; sod citrates w/ cit ac soln 550-500-</i>		<i>0.375 mg</i> .....	98
<i>334 mg/5ml</i> .....	170	<i>pramipexole dihydrochloride tab er 24hr</i>	
<i>potassium chloride cap er 10 meq</i> .....	205	<i>0.75 mg</i> .....	98
<i>potassium chloride cap er 8 meq</i> .....	204	<i>pramipexole dihydrochloride tab er 24hr 1.5</i>	
<i>potassium chloride microencapsulated crys</i>		<i>mg</i> .....	98
<i>er tab 10 meq</i> .....	205	<i>pramipexole dihydrochloride tab er 24hr</i>	
<i>potassium chloride microencapsulated crys</i>		<i>2.25 mg</i> .....	98
<i>er tab 15 meq</i> .....	205	<i>pramipexole dihydrochloride tab er 24hr</i>	
<i>potassium chloride microencapsulated crys</i>		<i>3.75 mg</i> .....	98
<i>er tab 20 meq</i> .....	205	<i>pramipexole dihydrochloride tab er 24hr 3</i>	
<i>potassium chloride oral soln 10% (20</i>		<i>mg</i> .....	98
<i>meq/15ml)</i> .....	205	<i>pramipexole dihydrochloride tab er 24hr</i>	
<i>potassium chloride oral soln 20% (40</i>		<i>4.5 mg</i> .....	98
<i>meq/15ml)</i> .....	205	PRAMOSONE CRE 1-1% .....	145

PRAMOSONE LOT 1%.....	145	<i>prednisone tab 2.5 mg</i> .....	132
PRAMOSONE LOT 2.5%.....	145	<i>prednisone tab 20 mg</i> .....	132
<i>prasugrel hcl tab 10 mg (base equiv)</i> .....	173	<i>prednisone tab 50 mg</i> .....	132
<i>prasugrel hcl tab 5 mg (base equiv)</i> .....	173	<i>prednisone tab 5 mg</i> .....	132
<i>pravastatin sodium tab 10 mg</i> .....	71	<i>prednisone tab therapy pack 10 mg (21)</i> ..	132
<i>pravastatin sodium tab 20 mg</i> .....	71	<i>prednisone tab therapy pack 10 mg (48)</i> ..	132
<i>pravastatin sodium tab 40 mg</i> .....	71	<i>prednisone tab therapy pack 5 mg (21)</i> ...	132
<i>pravastatin sodium tab 80 mg</i> .....	71	<i>prednisone tab therapy pack 5 mg (48)</i> ..	132
<i>praziquantel tab 600 mg</i> .....	34	PRED SOD PHO SOL 1% OP .....	215
<i>prazosin hcl cap 1 mg</i> .....	76	PREFEST TAB.....	165
<i>prazosin hcl cap 2 mg</i> .....	76	<i>pregabalin cap 100 mg</i> .....	51
<i>prazosin hcl cap 5 mg</i> .....	76	<i>pregabalin cap 150 mg</i> .....	51
PR BENZOYL LIQ 7% WASH .....	135	<i>pregabalin cap 200 mg</i> .....	51
PRECISION LIQ CONTROL.....	192	<i>pregabalin cap 225 mg</i> .....	51
PRECISION LIQ GLUC/KET .....	192	<i>pregabalin cap 25 mg</i> .....	51
PRECISION LIQ NRML/MID .....	192	<i>pregabalin cap 300 mg</i> .....	51
PRECISN XTRA TES KETONE .....	150	<i>pregabalin cap 50 mg</i> .....	51
PRECOSE TAB 100MG .....	60	<i>pregabalin cap 75 mg</i> .....	51
PRECOSE TAB 25MG .....	60	<i>pregabalin soln 20 mg/ml</i> .....	51
PRECOSE TAB 50MG .....	60	<i>pregabalin tab er 24hr 165 mg</i> .....	226
PRED-G S.O.P OIN OP .....	215	<i>pregabalin tab er 24hr 330 mg</i> .....	226
PRED-G SUS OP.....	215	<i>pregabalin tab er 24hr 82.5 mg</i> .....	226
<i>prednicarbate cream 0.1%</i> .....	145	PREMARIN INJ 25MG .....	166
<i>prednicarbate oint 0.1%</i> .....	145	PREMPHASE TAB.....	165
<i>prednisolone acetate ophth susp 1%</i> .....	215	PREMPRO TAB .....	165
<i>prednisolone sodium phosphate oral soln</i> <i>25 mg/5ml (base eq)</i> .....	131	PREMPRO TAB 0.3-1.5.....	165
<i>prednisolone sod phos orally disintegr tab</i> <i>10 mg (base eq)</i> .....	131	PREMPRO TAB 0.45-1.5 .....	165
<i>prednisolone sod phos orally disintegr tab</i> <i>15 mg (base eq)</i> .....	131	PREMPRO TAB 0.625-5 .....	165
<i>prednisolone sod phos orally disintegr tab</i> <i>30 mg (base eq)</i> .....	131	<i>prenatal vit w/ dss-iron carbonyl-fa tab 90-1</i> <i>mg</i> .....	209
<i>prednisolone sod phosphate oral soln 15</i> <i>mg/5ml (base equiv)</i> .....	131	<i>prenatal vit w/ fe fumarate-fa chew tab 29-1</i> <i>mg</i> .....	209
<i>prednisolone sod phosph oral soln 6.7</i> <i>mg/5ml (5 mg/5ml base)</i> .....	131	<i>prenatal vit w/ fe fumarate-fa tab 28-1 mg</i> .....	209
<i>prednisolone soln 15 mg/5ml</i> .....	131	<i>prenatal vit w/ fe fum-methylfolate-fa tab</i> <i>27-0.6-0.4 mg</i> .....	209
PREDNISOLONE SUS 1%.....	216	<i>prenatal vit w/ iron carbonyl-fa tab 29-1 mg</i> .....	209
PREDNISON CON 5MG/ML.....	131	<i>prenat w/o a w/fefum-methfol-fa-dha cap</i> <i>27-0.6-0.4-300 mg</i> .....	209
<i>prednisone oral soln 5 mg/5ml</i> .....	132	PREPIDIL GEL 0.5MG/3G .....	217
<i>prednisone tab 10 mg</i> .....	132	PREP PADS PAD.....	199
<i>prednisone tab 1 mg</i> .....	132	PRESSURE ACT MIS LANCET .....	192

PRESSURE ACT MIS LANCETS.....	192	PROCTOCORT SUP 30MG .....	34
PRETOMANID TAB 200MG .....	82	PROCTOFOAM AER HC 1% .....	34
PREVYMIS TAB 240MG.....	112	PRODIGY MIS 26G.....	193
PREVYMIS TAB 480MG.....	112	PRODIGY MIS 28G.....	193
PREZCOBIX TAB 800-150.....	110	PRODIGY MIS LANC DEV .....	193
PREZISTA SUS 100MG/ML .....	110	PRODIGY SOL HIGH.....	193
PREZISTA TAB 150MG .....	110	PRODIGY SOL LOW .....	193
PREZISTA TAB 600MG .....	110	<i>progesterone cap 100 mg .....</i>	219
PREZISTA TAB 75MG .....	110	<i>progesterone cap 200 mg.....</i>	219
PREZISTA TAB 800MG.....	110	<i>progesterone im in oil 50 mg/ml .....</i>	219
PRIFTIN TAB 150MG.....	82	PROGLYCEM SUS 50MG/ML .....	61
<i>primaquine phosphate tab 26.3 mg (15 mg</i>		PROGRAF CAP 0.5MG.....	207
<i>base) .....</i>	81	PROGRAF CAP 1MG .....	207
PRIMAQUINE TAB 26.3MG.....	81	PROGRAF CAP 5MG .....	207
<i>primidone tab 250 mg .....</i>	51	PROGRAF GRA 0.2MG.....	207
<i>primidone tab 50 mg .....</i>	51	PROGRAF GRA 1MG .....	207
PRIMSOL SOL 50MG/5ML .....	35	PROLENSA SOL 0.07% .....	216
PRINIVIL TAB 20MG .....	73	PROMACTA PAK 25MG.....	175
<i>probenecid tab 500 mg .....</i>	172	PROMACTA POW 12.5MG.....	175
PROCARDIA CAP 10MG.....	119	PROMACTA TAB 12.5MG .....	175
PROCARDIA XL TAB 30MG CR.....	119	PROMACTA TAB 25MG.....	175
PROCARDIA XL TAB 60MG CR.....	119	PROMACTA TAB 50MG.....	175
PROCARDIA XL TAB 90MG CR.....	119	PROMACTA TAB 75MG.....	175
<i>prochlorperazine edisylate inj 10 mg/2ml</i>		PROMACTIN AA SUS PLUS .....	154
<i>.....</i>	104	<i>promethazine &amp; phenylephrine syrup 6.25-</i>	
<i>prochlorperazine edisylate inj 50 mg/10ml</i>		<i>5 mg/5ml.....</i>	133
<i>.....</i>	104	<i>promethazine-dm syrup 6.25-15 mg/5ml</i>	
<i>prochlorperazine maleate tab 10 mg (base</i>		<i>.....</i>	133
<i>equivalent) .....</i>	104	<i>promethazine hcl suppos 12.5 mg .....</i>	68
<i>prochlorperazine maleate tab 5 mg (base</i>		<i>promethazine hcl suppos 25 mg.....</i>	68
<i>equivalent) .....</i>	104	<i>promethazine hcl suppos 50 mg .....</i>	68
<i>prochlorperazine suppos 25 mg .....</i>	104	<i>promethazine hcl syrup 6.25 mg/5ml.....</i>	68
PRO COMFORT MIS 31G .....	192	<i>promethazine hcl tab 12.5 mg .....</i>	68
PRO COMFORT MIS LANCETS.....	192	<i>promethazine hcl tab 25 mg.....</i>	68
PRO COMFORT PAD ALCOHOL .....	199	<i>promethazine hcl tab 50 mg.....</i>	68
PROCORT CRE .....	34	<i>promethazine-phenylephrine-codeine</i>	
PROCRIT INJ 10000/ML .....	175	<i>syrup 6.25-5-10 mg/5ml .....</i>	133
PROCRIT INJ 2000/ML .....	175	<i>promethazine w/ codeine syrup 6.25-10</i>	
PROCRIT INJ 20000/ML.....	175	<i>mg/5ml.....</i>	133
PROCRIT INJ 3000/ML .....	175	PROMOTE/ LIQ FIBER .....	154
PROCRIT INJ 4000/ML .....	175	PROMOTE 1.0 LIQ W/ FIBER.....	154
PROCRIT INJ 40000/ML.....	175	PROMOTE LIQ VANILLA.....	154
PROCTOCORT CRE 1% .....	34	PROMOTE W/FB LIQ VANILLA .....	154

PROMOTE W/ LIQ FIBER.....	154	PTS PANELS TES KETONE.....	150
<i>propafenone hcl cap er 12hr 225 mg</i> .....	40	PULMICORT INH 180MCG.....	42
<i>propafenone hcl cap er 12hr 325 mg</i> .....	40	PULMICORT INH 90MCG .....	42
<i>propafenone hcl cap er 12hr 425 mg</i> .....	40	PULMICORT SUS 0.25MG/2 .....	43
<i>propafenone hcl tab 150 mg</i> .....	40	PULMICORT SUS 0.5MG/2.....	42
<i>propafenone hcl tab 225 mg</i> .....	40	PULMICORT SUS 1MG/2ML .....	43
<i>propafenone hcl tab 300 mg</i> .....	40	PULMOZYME SOL 1MG/ML .....	228
<i>proparacaine hcl ophth soln 0.5%</i> .....	215	PURE COMFORT PAD .....	199
PRO-PHREE POW .....	154	PURIXAN SUS 20MG/ML.....	84
<i>propranolol &amp; hydrochlorothiazide tab 40-</i> <i>25 mg</i> .....	79	PX LANCETS MIS 28G .....	193
<i>propranolol &amp; hydrochlorothiazide tab 80-</i> <i>25 mg</i> .....	79	PX LANCETS MIS ULT THIN .....	193
<i>propranolol hcl cap er 24hr 120 mg</i> .....	117	PYLERA CAP.....	233
<i>propranolol hcl cap er 24hr 160 mg</i> .....	117	<i>pyrazinamide tab 500 mg</i> .....	82
<i>propranolol hcl cap er 24hr 60 mg</i> .....	117	<i>pyridostigmine bromide oral soln 60</i> <i>mg/5ml</i> .....	82
<i>propranolol hcl cap er 24hr 80 mg</i> .....	117	<i>pyridostigmine bromide tab 60 mg</i> .....	82
<i>propranolol hcl oral soln 20 mg/5ml</i> .....	117	<i>pyridostigmine bromide tab er 180 mg</i> .....	82
<i>propranolol hcl oral soln 40 mg/5ml</i> .....	117	<i>pyrimethamine tab 25 mg</i> .....	81
<i>propranolol hcl tab 10 mg</i> .....	117	PYROGALL ACD OIN.....	147
<i>propranolol hcl tab 20 mg</i> .....	117	<b>Q</b>	
<i>propranolol hcl tab 40 mg</i> .....	117	QBRELIS SOL 1MG/ML.....	73
<i>propranolol hcl tab 60 mg</i> .....	117	QBREXZA PAD 2.4%.....	148
<i>propranolol hcl tab 80 mg</i> .....	117	QC ALCOHOL PAD SWABS .....	199
<i>propylthiouracil tab 50 mg</i> .....	230	QC LANCETS MIS 28G.....	193
PROSCAR TAB 5MG .....	171	QC LANCETS MIS 30G .....	193
PROSOURCE LIQ TF.....	154	QC LANCING MIS DEVICE .....	193
PROSTIN E2 SUP 20MG.....	217	QELBREE CAP 200MG ER.....	5
PROTHELIAL PST 10%.....	209	QSYMIA CAP 11.25-69 .....	4
PROTONIX INJ 40MG .....	233	QSYMIA CAP 15-92MG.....	4
PROTOPIC OIN 0.03%.....	147	QSYMIA CAP 3.75-23 .....	4
PROTOPIC OIN 0.1%.....	147	QSYMIA CAP 7.5-46MG.....	4
<i>protriptyline hcl tab 10 mg</i> .....	59	QUALAQUIN CAP 324MG.....	81
<i>protriptyline hcl tab 5 mg</i> .....	59	QUDEXY XR CAP 100/24HR .....	52
PROVERA TAB 10MG .....	219	QUDEXY XR CAP 150/24HR .....	52
PROVERA TAB 2.5MG.....	219	QUDEXY XR CAP 200/24HR .....	52
PROVERA TAB 5MG.....	219	QUDEXY XR CAP 25/24HR.....	52
PRUDOXIN CRE 5%.....	138	QUDEXY XR CAP 50/24HR.....	52
<i>pseudoephed-bromphen-dm syrup 30-2-10</i> <i>mg/5ml</i> .....	133	QUESTRAN POW 4GM.....	70
PSS SAFE LAN MIS.....	193	QUESTRAN POW 4GM LITE .....	70
PSS SEL LANC MIS.....	193	<i>quetiapine fumarate tab 100 mg</i> .....	103
PSS SEL PLAT MIS .....	193	<i>quetiapine fumarate tab 200 mg</i> .....	103
		<i>quetiapine fumarate tab 25 mg</i> .....	103
		<i>quetiapine fumarate tab 300 mg</i> .....	103

<i>quetiapine fumarate tab 400 mg</i> .....	103	<i>ramipril cap 1.25 mg</i> .....	74
<i>quetiapine fumarate tab 50 mg</i> .....	103	<i>ramipril cap 10 mg</i> .....	74
<i>quetiapine fumarate tab er 24hr 150 mg</i> .	103	<i>ramipril cap 2.5 mg</i> .....	74
<i>quetiapine fumarate tab er 24hr 200 mg</i>	103	<i>ramipril cap 5 mg</i> .....	74
<i>quetiapine fumarate tab er 24hr 300 mg</i>	103	RANEXA TAB 1000MG .....	37
<i>quetiapine fumarate tab er 24hr 400 mg</i>	103	RANEXA TAB 500MG.....	37
<i>quetiapine fumarate tab er 24hr 50 mg</i> ..	103	<i>ranolazine tab er 12hr 1000 mg</i> .....	37
QUICKTEK LIQ SOLUTION .....	193	<i>ranolazine tab er 12hr 500 mg</i> .....	37
<i>quinapril hcl tab 10 mg</i> .....	73	RAPAMUNE SOL 1MG/ML.....	207
<i>quinapril hcl tab 20 mg</i> .....	73	RAPAMUNE TAB 0.5MG.....	207
<i>quinapril hcl tab 40 mg</i> .....	74	RAPAMUNE TAB 1MG .....	207
<i>quinapril hcl tab 5 mg</i> .....	73	RAPAMUNE TAB 2MG .....	207
<i>quinapril-hydrochlorothiazide tab 10-12.5</i> <i>mg</i> .....	79	RAPID-SAFE MIS LANCING .....	193
<i>quinapril-hydrochlorothiazide tab 20-12.5</i> <i>mg</i> .....	79	<i>rasagiline mesylate tab 0.5 mg (base equiv)</i> .....	99
<i>quinapril-hydrochlorothiazide tab 20-25 mg</i> .....	79	<i>rasagiline mesylate tab 1 mg (base equiv)</i>	99
<i>quinidine gluconate tab er 324 mg</i> .....	39	RASUVO INJ 10MG .....	17
<i>quinidine sulfate tab 200 mg</i> .....	39	RASUVO INJ 12.5MG .....	17
<i>quinidine sulfate tab 300 mg</i> .....	39	RASUVO INJ 15MG .....	17
<i>quinine sulfate cap 324 mg</i> .....	81	RASUVO INJ 17.5MG .....	17
QUINTET CONT SOL HGH/NORM .....	193	RASUVO INJ 20MG .....	17
QULIPTA TAB 10MG .....	202	RASUVO INJ 22.5MG .....	17
QULIPTA TAB 30MG .....	202	RASUVO INJ 25MG.....	18
QULIPTA TAB 60MG .....	202	RASUVO INJ 30MG .....	18
QUVIVIQ TAB 25MG.....	178	RASUVO INJ 7.5MG.....	17
QUVIVIQ TAB 50MG.....	178	RAZADYNE ER CAP 16MG.....	221
QVAR REDIIHA AER 80MCG .....	43	RAZADYNE ER CAP 24MG .....	221
QVAR REDIIHAL AER 40MCG .....	43	RAZADYNE ER CAP 8MG .....	221
<b>R</b>		READYLANCE MIS 21G .....	193
RABEPRAZOLE CAP 10MG DR.....	233	READYLANCE MIS 23G .....	193
<i>rabeprazole sodium ec tab 20 mg</i> .....	233	READYLANCE MIS 26G .....	193
RADICAVA ORS SUS 105/5ML .....	211	READYLANCE MIS 28G .....	193
RADICAVA ORS SUS STARTER .....	212	READYLANCE MIS 30G .....	193
RADIOGARDASE CAP 0.5GM .....	65	REALITY MIS LANCETS .....	193
RA E-ZJECT MIS 28G.....	193	REALITY SWAB PAD .....	199
RA E-ZJECT MIS THIN 26G .....	193	REALITY TRIG MIS LANCETS .....	193
RA E-ZJECT MIS THIN 28G .....	193	REBIF INJ 22/0.5.....	225
RA E-ZJECT MIS ULT THIN .....	193	REBIF INJ 44/0.5 .....	225
RAGWITEK SUB .....	9	REBIF REBIDO INJ 22/0.5.....	225
<i>raloxifene hcl tab 60 mg</i> .....	161	REBIF REBIDO INJ 44/0.5 .....	225
<i>ramelteon tab 8 mg</i> .....	178	REBIF REBIDO INJ TITRATN.....	225
		REBIF TITRTN INJ PACK.....	225
		RECTIV OIN 0.4% .....	34



REFUAH PLUS SOL CONTROL .....	193	RETACRIT INJ 3000UNIT .....	175
REGLAN TAB 10MG.....	168	RETACRIT INJ 40000UNT .....	175
REGLAN TAB 5MG .....	168	RETACRIT INJ 4000UNIT .....	175
REGRANEX GEL 0.01%.....	149	RETEVMO CAP 40MG .....	93
RELENZA MIS DISKHALE .....	115	RETEVMO CAP 80MG .....	93
RELION KIT LANCING.....	193	RETIN-A CRE 0.025% .....	135
RELION LANCE MIS THIN 26G .....	193	RETIN-A CRE 0.05% .....	135
RELION LANCE MIS THIN 30G .....	193	RETIN-A CRE 0.1% .....	135
RELION LANCI MIS DEVICE .....	193	RETIN-A GEL 0.01% .....	135
RELION MICRO MIS THIN 33G .....	193	RETIN-A GEL 0.025% .....	135
RELION TES KETONE.....	150	RETIN-A MICR GEL 0.04%.....	135
RELION ULTRA MIS THIN 30G .....	193	RETIN-A MICR GEL 0.04%PMP .....	135
RELION ULTRA MIS THIN PLS.....	193	RETIN-A MICR GEL 0.06%.....	135
RELISTOR INJ 12/0.6ML.....	170	RETIN-A MICR GEL 0.08%.....	135
RELISTOR INJ 8/0.4ML .....	170	RETIN-A MICR GEL 0.1% .....	135
RELISTOR TAB 150MG.....	170	RETIN-A MICR GEL 0.1%PUMP .....	135
RELPAK TAB 20MG .....	203	RETROVIR CAP 100MG .....	110
RELPAK TAB 40MG.....	203	RETROVIR SYP 50MG/5ML.....	110
REMERON SLTB TAB 15MG .....	54	REVCovi INJ 1.6MG/ML.....	162
REMERON SLTB TAB 30MG.....	54	REVLIMID CAP 10MG .....	206
REMERON SLTB TAB 45MG.....	54	REVLIMID CAP 15MG .....	206
REMERON TAB 15MG.....	54	REVLIMID CAP 2.5MG .....	205
REMERON TAB 30MG.....	54	REVLIMID CAP 20MG .....	206
RENAGEL TAB 800MG .....	170	REVLIMID CAP 25MG .....	206
<i>repaglinide tab 0.5 mg</i> .....	64	REVLIMID CAP 5MG.....	205
<i>repaglinide tab 1 mg</i> .....	64	REXULTI TAB 0.25MG .....	105
<i>repaglinide tab 2 mg</i> .....	64	REXULTI TAB 0.5MG.....	105
REPATHA INJ 140MG/ML.....	72	REXULTI TAB 1MG.....	105
REPATHA PUSH INJ 420/3.5 .....	72	REXULTI TAB 2MG .....	105
REPATHA SURE INJ 140MG/ML .....	72	REXULTI TAB 3MG .....	105
REPLETE FIBE LIQ 1 CAL .....	154	REXULTI TAB 4MG.....	105
REPLETE LIQ ULTRAPAK .....	154	REYATAZ CAP 150MG.....	110
RESOURCE DIA LIQ TF .....	154	REYATAZ CAP 200MG .....	110
RESTASIS EMU 0.05% OP .....	214	REYATAZ CAP 300MG .....	110
RESTASIS MUL EMU 0.05% OP .....	214	REYATAZ POW 50MG .....	110
RESTORA RX CAP 60-1.25.....	65	REYVOW TAB 100MG .....	203
RESTORIL CAP 15MG.....	177	REYVOW TAB 50MG .....	203
RESTORIL CAP 22.5MG .....	177	RHOFADE CRE 1%.....	149
RESTORIL CAP 30MG .....	177	RIAX AER 5.5% .....	135
RESTORIL CAP 7.5MG .....	177	RIAX AER 9.5% .....	135
RETACRIT INJ 10000UNT .....	175	<i>ribavirin cap 200 mg</i> .....	113
RETACRIT INJ 20000UNI.....	175	<i>ribavirin tab 200 mg</i> .....	113
RETACRIT INJ 2000UNIT .....	175	RIDAURA CAP 3MG.....	18

<i>rifabutin cap 150 mg</i> .....	82	<i>risperidone tab 0.5 mg</i> .....	101
<i>rifampin cap 150 mg</i> .....	82	<i>risperidone tab 1 mg</i> .....	101
<i>rifampin cap 300 mg</i> .....	82	<i>risperidone tab 2 mg</i> .....	101
RIGHTEST ALT MIS ADAPTOR .....	194	<i>risperidone tab 3 mg</i> .....	101
RIGHTEST LIQ HIGH CON .....	194	<i>risperidone tab 4 mg</i> .....	101
RIGHTEST LIQ NORM CON .....	194	RITALIN LA CAP 10MG .....	9
RIGHTEST MIS GD500 .....	194	RITALIN LA CAP 20MG .....	9
RIGHTEST MIS GL300 .....	194	RITALIN LA CAP 30MG .....	9
RILUTEK TAB 50MG .....	212	RITALIN LA CAP 40MG .....	9
<i>riluzole tab 50 mg</i> .....	212	RITALIN TAB 10MG .....	9
<i>rimantadine hydrochloride tab 100 mg</i> ...	115	RITALIN TAB 20MG .....	9
RINVOQ TAB 15MG ER .....	15	RITALIN TAB 5MG .....	9
RINVOQ TAB 30MG ER .....	15	RITEFLO MIS .....	201
RINVOQ TAB 45MG ER .....	15	<i>ritonavir tab 100 mg</i> .....	110
<i>risedronate sodium tab 150 mg</i> .....	159	<i>rivastigmine tartrate cap 1.5 mg (base</i> <i>equivalent)</i> .....	221
<i>risedronate sodium tab 30 mg</i> .....	159	<i>rivastigmine tartrate cap 3 mg (base</i> <i>equivalent)</i> .....	221
<i>risedronate sodium tab 35 mg</i> .....	159	<i>rivastigmine tartrate cap 4.5 mg (base</i> <i>equivalent)</i> .....	221
<i>risedronate sodium tab 5 mg</i> .....	159	<i>rivastigmine tartrate cap 6 mg (base</i> <i>equivalent)</i> .....	221
<i>risedronate sodium tab delayed release 35</i> <i>mg</i> .....	159	<i>rivastigmine td patch 24hr 13.3 mg/24hr</i>	221
RISPERDAL INJ 12.5MG .....	101	<i>rivastigmine td patch 24hr 4.6 mg/24hr</i> ..	221
RISPERDAL INJ 25MG .....	101	<i>rivastigmine td patch 24hr 9.5 mg/24hr</i> ..	221
RISPERDAL INJ 37.5MG .....	101	<i>rizatriptan benzoate oral disintegrating tab</i> <i>10 mg (base eq)</i> .....	203
RISPERDAL INJ 50MG .....	101	<i>rizatriptan benzoate oral disintegrating tab</i> <i>5 mg (base eq)</i> .....	203
RISPERDAL SOL 1MG/ML .....	101	<i>rizatriptan benzoate tab 10 mg (base</i> <i>equivalent)</i> .....	203
RISPERDAL TAB 0.5MG .....	101	<i>rizatriptan benzoate tab 5 mg (base</i> <i>equivalent)</i> .....	203
RISPERDAL TAB 1MG .....	101	ROCALTROL CAP 0.25MCG .....	162
RISPERDAL TAB 2MG .....	101	ROCALTROL CAP 0.5MCG .....	162
RISPERDAL TAB 3MG .....	101	ROCALTROL SOL 1MCG/ML .....	162
RISPERDAL TAB 4MG .....	101	<i>ropinirole hydrochloride tab 0.25 mg</i> .....	98
<i>risperidone orally disintegrating tab 0.25</i> <i>mg</i> .....	101	<i>ropinirole hydrochloride tab 0.5 mg</i> .....	98
<i>risperidone orally disintegrating tab 0.5 mg</i> .....	101	<i>ropinirole hydrochloride tab 1 mg</i> .....	98
<i>risperidone orally disintegrating tab 1 mg</i>	101	<i>ropinirole hydrochloride tab 2 mg</i> .....	98
<i>risperidone orally disintegrating tab 2 mg</i> .....	101	<i>ropinirole hydrochloride tab 3 mg</i> .....	98
<i>risperidone orally disintegrating tab 3 mg</i> .....	101	<i>ropinirole hydrochloride tab 4 mg</i> .....	98
<i>risperidone orally disintegrating tab 4 mg</i> .....	101	<i>ropinirole hydrochloride tab 5 mg</i> .....	98
<i>risperidone soln 1 mg/ml</i> .....	101		
<i>risperidone tab 0.25 mg</i> .....	101		

<i>ropinirole hydrochloride tab er 24hr 12 mg (base equivalent)</i> .....	98	SAFE-T-PRO MIS LANCETS.....	194
<i>ropinirole hydrochloride tab er 24hr 2 mg (base equivalent)</i> .....	98	SAFE-T-PRO MIS PLUS .....	194
<i>ropinirole hydrochloride tab er 24hr 4 mg (base equivalent)</i> .....	98	SAFETY 21G MIS LANCETS.....	194
<i>ropinirole hydrochloride tab er 24hr 6 mg (base equivalent)</i> .....	98	SAFETY 23G MIS LANCETS .....	194
<i>ropinirole hydrochloride tab er 24hr 8 mg (base equivalent)</i> .....	98	SAFETY 28G MIS LANCETS .....	194
<i>rosuvastatin calcium tab 10 mg</i> .....	71	SAFETY 30G MIS LANCETS.....	194
<i>rosuvastatin calcium tab 20 mg</i> .....	71	SAFETY MIS LANCETS .....	194
<i>rosuvastatin calcium tab 40 mg</i> .....	71	SAFYRAL TAB .....	129
<i>rosuvastatin calcium tab 5 mg</i> .....	71	SALAGEN TAB 5MG .....	209
ROWASA KIT 4GM .....	168	SALAGEN TAB 7.5MG.....	209
ROXICODONE TAB 15MG .....	29	SALIMEZ FORT CRE 10%.....	147
ROXICODONE TAB 30MG .....	29	<i>salsalate tab 500 mg</i> .....	22
ROXICODONE TAB 5MG.....	29	<i>salsalate tab 750 mg</i> .....	22
ROZLYTREK CAP 100MG.....	93	SAMSCA TAB 15MG.....	164
ROZLYTREK CAP 200MG .....	93	SAMSCA TAB 30MG.....	164
RUCONEST INJ 2100UNIT.....	172	SANCUSO DIS 3.1MG .....	66
<i>rufinamide susp 40 mg/ml</i> .....	52	SANDIMMUNE CAP 100MG.....	207
RUKOBIA TAB 600MG ER.....	110	SANDIMMUNE CAP 25MG.....	207
RUZURGI TAB 10MG .....	82	SANDIMMUNE SOL 100MG/ML.....	207
RYBELSUS TAB 14MG .....	62	SANDOSTATIN INJ 100MCG .....	164
RYBELSUS TAB 3MG .....	62	SANDOSTATIN INJ 500MCG .....	164
RYBELSUS TAB 7MG .....	62	SANDOSTATIN INJ 50MCG/ML .....	164
RYDAPT CAP 25MG .....	93	SANTYL OIN 250/GM .....	147
RYTARY CAP 145MG.....	98	SAPHRIS SUB 10MG.....	103
RYTARY CAP 195MG.....	98	SAPHRIS SUB 2.5MG .....	103
RYTARY CAP 245MG .....	98	SAPHRIS SUB 5MG .....	103
RYTARY CAP 95MG .....	98	<i>sapropterin dihydrochloride powder packet 100 mg</i> .....	162
RYTHMOL SR CAP 225MG.....	40	<i>sapropterin dihydrochloride powder packet 500 mg</i> .....	162
RYTHMOL SR CAP 325MG.....	40	<i>sapropterin dihydrochloride tab 100 mg</i> .....	162
RYTHMOL SR CAP 425MG .....	40	SAPSCARE MIS TWIST .....	194
<b>S</b>		SAPS CARE PAD ALCOHOL .....	199
S.O.S. 20 POW .....	154	SAPS HEALTH MIS TWIST .....	194
S.O.S. 25 POW .....	154	SAPS HEALTH PAD ALCOHOL.....	199
SAFE-T-LANCE MIS 21G.....	194	SAPS TWIST MIS 30G.....	194
SAFE-T-LANCE MIS 25G.....	194	SAVELLA MIS TITR PAK.....	222
SAFE-T-LANCE MIS HI FLOW .....	194	SAVELLA TAB 100MG .....	222
SAFE-T-LANCE MIS LOW FLOW .....	194	SAVELLA TAB 12.5MG.....	222
SAFE-T-LANCE MIS NOR FLOW .....	194	SAVELLA TAB 25MG .....	222
		SAVELLA TAB 50MG .....	222
		SAXENDA INJ 18MG/3ML.....	3
		SB ALCOHOL PAD PREP .....	199

SB LANCETS MIS THIN.....	194	<i>sildenafil citrate for suspension 10 mg/ml</i>	
SB LANCETS MIS ULTR THN .....	194	.....	125
<i>scopolamine td patch 72hr 1 mg/3days</i> ....	66	<i>sildenafil citrate tab 100 mg</i> .....	123
SELECT-LITE KIT DEV/LANC .....	194	<i>sildenafil citrate tab 20 mg</i> .....	125
SELECT-LITE MIS LANC DEV .....	194	<i>sildenafil citrate tab 25 mg</i> .....	123
<i>selegiline hcl cap 5 mg</i> .....	99	<i>sildenafil citrate tab 50 mg</i> .....	123
<i>selegiline hcl tab 5 mg</i> .....	99	<i>silodosin cap 4 mg</i> .....	171
<i>selenium sulfide lotion 2.5%</i> .....	142	<i>silodosin cap 8 mg</i> .....	171
SENSIPAR TAB 30MG.....	162	SILVADENE CRE 1% .....	142
SENSIPAR TAB 60MG.....	162	<i>silver sulfadiazine cream 1%</i> .....	142
SENSIPAR TAB 90MG.....	162	SIMBRINZA SUS 1-0.2% .....	213
SEREVENT DIS AER 50MCG .....	44	SIMPLE DIAG MIS LANCING.....	194
SERNIVO SPR.....	145	<i>simvastatin tab 10 mg</i> .....	71
SERNIVO SPR 0.05%.....	145	<i>simvastatin tab 20 mg</i> .....	72
SEROQUEL TAB 100MG .....	103	<i>simvastatin tab 40 mg</i> .....	72
SEROQUEL TAB 200MG.....	103	<i>simvastatin tab 5 mg</i> .....	71
SEROQUEL TAB 25MG .....	103	<i>simvastatin tab 80 mg</i> .....	72
SEROQUEL TAB 300MG.....	103	SINEMET TAB 10-100MG.....	98
SEROQUEL TAB 400MG.....	103	SINEMET TAB 25-100MG .....	98
SEROQUEL TAB 50MG .....	103	SINGLE-LET MIS 23G.....	194
SEROSTIM INJ 4MG .....	161	<i>sirolimus oral soln 1 mg/ml</i> .....	207
SEROSTIM INJ 5MG.....	161	<i>sirolimus tab 0.5 mg</i> .....	208
SEROSTIM INJ 6MG.....	161	<i>sirolimus tab 1 mg</i> .....	208
<i>sertraline hcl oral concentrate for solution</i>		<i>sirolimus tab 2 mg</i> .....	208
<i>20 mg/ml</i> .....	56	SIRTURO TAB 100MG.....	82
<i>sertraline hcl tab 100 mg</i> .....	56	SIRTURO TAB 20MG.....	82
<i>sertraline hcl tab 25 mg</i> .....	56	SITAVIG TAB 50MG .....	114
<i>sertraline hcl tab 50 mg</i> .....	56	SIVEXTRO TAB 200MG .....	36
<i>sevelamer carbonate packet 0.8 gm</i> .....	170	SKELAXIN TAB 800MG .....	210
<i>sevelamer carbonate packet 2.4 gm</i> .....	170	SKYRIZI INJ 150DOSE.....	140
<i>sevelamer carbonate tab 800 mg</i> .....	170	SKYRIZI INJ 150MG/ML .....	140
<i>sevelamer hcl tab 400 mg</i> .....	170	SKYRIZI INJ 180/1.2.....	169
<i>sevelamer hcl tab 800 mg</i> .....	170	SKYRIZI INJ 360/2.4 .....	169
SFROWASA ENE 4GM .....	168	SKYRIZI PEN INJ 150MG/ML.....	140
SHOPKO LANC MIS DEVICE.....	194	SM ALCOHOL PAD PREP .....	199
SHUR-SEAL GEL 2%.....	234	SMARTEST MIS LANCETS .....	194
SIDE BUTTON MIS SAFETY .....	194	SMARTEST SOL CONTROL.....	195
SIGNIFOR INJ 0.3MG/ML .....	164	SMART SENSE MIS LANC 21G.....	194
SIGNIFOR INJ 0.6MG/ML .....	164	SMART SENSE MIS LANC 26G.....	194
SIGNIFOR INJ 0.9MG/ML .....	164	SMART SENSE MIS LANC 30G.....	194
SIKLOS TAB 1000MG.....	174	SMART SENSE MIS LANC 33G.....	194
SIKLOS TAB 100MG .....	174	SM LANCETS MIS 33G .....	194
		SM TRUEDRAW MIS LANC DEV.....	194

<i>sodium chloride soln nebu 0.9%</i> .....	133	SORIATANE CAP 10MG.....	141
<i>sodium chloride soln nebu 10%</i> .....	133	SORIATANE CAP 25MG.....	141
<i>sodium chloride soln nebu 3%</i> .....	133	<i>sotalol hcl (afib/afl) tab 120 mg</i> .....	117
<i>sodium chloride soln nebu 7%</i> .....	133	<i>sotalol hcl (afib/afl) tab 160 mg</i> .....	117
<i>sodium citrate &amp; citric acid soln 500-334</i> <i>mg/5ml</i> .....	171	<i>sotalol hcl (afib/afl) tab 80 mg</i> .....	117
<i>sodium fluoride gel 1.1% (0.5% f)</i> .....	209	<i>sotalol hcl tab 120 mg</i> .....	117
<i>sodium phenylbutyrate oral powder 3</i> <i>gm/teaspoonful</i> .....	162	<i>sotalol hcl tab 160 mg</i> .....	117
<i>sodium phenylbutyrate tab 500 mg</i> .....	163	<i>sotalol hcl tab 240 mg</i> .....	117
<i>sodium polystyrene sulfonate oral susp 15</i> <i>gm/60ml</i> .....	208	<i>sotalol hcl tab 80 mg</i> .....	117
<i>sodium polystyrene sulfonate powder</i> ...	208	SOTYKTU TAB 6MG.....	141
SODIUM SULFA LIQ 10% WASH.....	142	SOTYLIZE SOL 5MG/ML.....	117
<i>sod sulfate-pot sulf-mg sulf oral sol 17.5-</i> <i>3.13-1.6 gm/177ml</i> .....	178	SOVALDI PAK 150MG.....	114
SOFTCLIX MIS LANCETS.....	195	SOVALDI PAK 200MG.....	114
SOGROYA INJ 10MG/1.5.....	161	SOVALDI TAB 200MG.....	114
SOGROYA INJ 15MG/1.5.....	161	SOVALDI TAB 400MG.....	114
SOGROYA INJ 5MG/1.5.....	161	<i>spinosad susp 0.9%</i> .....	149
<i>solifenacin succinate tab 10 mg</i> .....	234	SPIRIVA AER 1.25MCG.....	41
<i>solifenacin succinate tab 5 mg</i> .....	234	SPIRIVA CAP HANDIHLR.....	41
SOLIQUA INJ 100/33.....	60	SPIRIVA SPR 2.5MCG.....	41
SOLODYN TAB 105MG.....	229	<i>spironolactone &amp; hydrochlorothiazide tab</i> <i>25-25 mg</i> .....	156
SOLODYN TAB 115MG.....	229	<i>spironolactone tab 100 mg</i> .....	157
SOLODYN TAB 55MG.....	229	<i>spironolactone tab 25 mg</i> .....	157
SOLODYN TAB 65MG.....	229	<i>spironolactone tab 50 mg</i> .....	157
SOLODYN TAB 80MG.....	229	SPORANOX CAP 100MG.....	68
SOLTAMOX SOL 10MG/5ML.....	87	SPORANOX CAP PULSEPAK.....	68
SOLU-CORTEF INJ 1000MG.....	132	SPORANOX SOL 10MG/ML.....	68
SOLU-CORTEF INJ 100MG.....	132	SPRAVATO SOL 56MG DOS.....	55
SOLU-CORTEF INJ 250MG.....	132	SPRAVATO SOL 84MG DOS.....	55
SOLU-CORTEF INJ 500MG.....	132	SPRYCEL TAB 100MG.....	93
SOLUS V2 MIS LANC 28G.....	195	SPRYCEL TAB 140MG.....	93
SOLUS V2 MIS LANC 30G.....	195	SPRYCEL TAB 20MG.....	93
SOLUS V2 MIS LANC DEV.....	195	SPRYCEL TAB 50MG.....	93
SOLUS V2 SOL HIGH.....	195	SPRYCEL TAB 70MG.....	93
SOLUS V2 SOL LOW.....	195	SPRYCEL TAB 80MG.....	93
SOMA TAB 250MG.....	210	STALEVO 100 TAB.....	99
SOMA TAB 350MG.....	210	STALEVO 125 TAB.....	99
SOOLANTRA CRE 1%.....	149	STALEVO 150 TAB.....	99
<i>sorafenib tosylate tab 200 mg (base</i> <i>equivalent)</i> .....	93	STALEVO 200 TAB.....	99
		STALEVO 50 TAB.....	99
		STALEVO 75 TAB.....	99
		STARLIX TAB 120MG.....	64
		<i>stavudine cap 15 mg</i> .....	110

<i>stavudine cap 20 mg</i> .....	110	<i>sulfamethoxazole-trimethoprim susp 200-</i>	
<i>stavudine cap 30 mg</i> .....	111	<i>40 mg/5ml</i> .....	35
<i>stavudine cap 40 mg</i> .....	111	<i>sulfamethoxazole-trimethoprim tab 400-80</i>	
STAXYN TAB 10MG .....	123	<i>mg</i> .....	35
STELARA INJ 45MG/0.5 .....	141	<i>sulfamethoxazole-trimethoprim tab 800-</i>	
STELARA INJ 90MG/ML .....	141	<i>160 mg</i> .....	35
STERILANCE MIS 1.8MM .....	195	SULFAMYLON CRE 85MG/GM .....	142
STERILANCE MIS TL 28G .....	195	SULFAMYLON PAK 5% .....	143
STERILANCE MIS TL 30G .....	195	<i>sulfasalazine tab 500 mg</i> .....	169
STERILANCE MIS TL 32G .....	195	<i>sulfasalazine tab delayed release 500 mg</i>	
STIMATE SOL 1.5MG/ML .....	163	.....	169
STIOLTO AER 2.5-2.5 .....	45	SULF LIME SOL .....	149
STIVARGA TAB 40MG .....	93	<i>sulindac tab 150 mg</i> .....	20
STRATTERA CAP 100MG .....	5	<i>sulindac tab 200 mg</i> .....	20
STRATTERA CAP 10MG .....	5	<i>sumatriptan nasal spray 20 mg/act</i> .....	203
STRATTERA CAP 18MG .....	5	<i>sumatriptan nasal spray 5 mg/act</i> .....	203
STRATTERA CAP 25MG .....	5	<i>sumatriptan succinate inj 6 mg/0.5ml</i> ....	203
STRATTERA CAP 40MG .....	5	<i>sumatriptan succinate solution auto-</i>	
STRATTERA CAP 60MG .....	5	<i>injector 4 mg/0.5ml</i> .....	203
STRATTERA CAP 80MG .....	5	<i>sumatriptan succinate solution auto-</i>	
STRENSIQ INJ 18/0.45 .....	163	<i>injector 6 mg/0.5ml</i> .....	204
STRENSIQ INJ 28/0.7ML .....	163	<i>sumatriptan succinate solution cartridge 4</i>	
STRENSIQ INJ 40MG/ML .....	163	<i>mg/0.5ml</i> .....	204
STRENSIQ INJ 80/0.8ML .....	163	<i>sumatriptan succinate solution cartridge 6</i>	
STRIVERDI AER 2.5MCG .....	45	<i>mg/0.5ml</i> .....	204
STROMECTOL TAB 3MG .....	34	<i>sumatriptan succinate solution prefilled</i>	
SUCRAID SOL 8500/ML .....	156	<i>syringe 6 mg/0.5ml</i> .....	204
<i>sucrafate tab 1 gm</i> .....	232	<i>sumatriptan succinate tab 100 mg</i> .....	204
SULAR TAB 17MG .....	119	<i>sumatriptan succinate tab 25 mg</i> .....	204
SULAR TAB 34MG .....	119	<i>sumatriptan succinate tab 50 mg</i> .....	204
SULAR TAB 8.5MG .....	119	<i>sunitinib malate cap 12.5 mg (base</i>	
<i>sulconazole nitrate cream 1%</i> .....	137	<i>equivalent)</i> .....	93
<i>sulconazole nitrate solution 1%</i> .....	137	<i>sunitinib malate cap 25 mg (base</i>	
<i>sulfacetamide sodium lotion 10% (acne)</i> 135		<i>equivalent)</i> .....	93
<i>sulfacetamide sodium ophth oint 10%</i> ....	214	<i>sunitinib malate cap 37.5 mg (base</i>	
<i>sulfacetamide sodium ophth soln 10%</i> ....	214	<i>equivalent)</i> .....	94
<i>sulfacetamide sodium-prednisolone ophth</i>		<i>sunitinib malate cap 50 mg (base</i>	
<i>soln 10-0.23(0.25)%</i> .....	216	<i>equivalent)</i> .....	94
<i>sulfacetamide sodium w/ sulfur cleansing</i>		SUNOSI TAB 150MG .....	5
<i>pad 10-4%</i> .....	135	SUNOSI TAB 75MG .....	5
<i>sulfacetamide sodium w/ sulfur emulsion</i>		SUPER THIN MIS LANC 28G .....	195
<i>10-1%</i> .....	135	SUPER THIN MIS LANCETS .....	195
<i>sulfadiazine tab 500 mg</i> .....	228	SUPLANA LIQ VANILLA .....	155

SUPRAX CAP 400MG .....	127	SYNALAR CRE 0.025% .....	145
SUPRAX CHW 100MG.....	127	SYNALAR OIN 0.025% .....	145
SUPRAX CHW 200MG .....	127	SYNALAR SOL 0.01%.....	145
SUPRAX SUS 100/5ML .....	127	SYNAREL SOL 2MG/ML.....	161
SUPRAX SUS 200/5ML.....	127	SYNERA DIS 70-70MG .....	148
SUPRAX SUS 500/5ML.....	127	SYNJARDY TAB .....	60
SUPREME II LIQ HIGH/LOW .....	195	SYNJARDY TAB 12.5-500.....	60
SURE COMFORT MIS LANC 18G .....	195	SYNJARDY TAB 5-1000MG .....	60
SURE COMFORT MIS LANC 21G .....	195	SYNJARDY TAB 5-500MG .....	60
SURE COMFORT MIS LANC 23G.....	195	SYNJARDY XR TAB .....	60
SURE COMFORT MIS LANC 30G .....	195	SYNJARDY XR TAB 10-1000 .....	61
SURE COMFORT MIS LANCETS.....	195	SYNJARDY XR TAB 25-1000 .....	61
SURE COMFORT MIS LANC PEN .....	195	SYNJARDY XR TAB 5-1000MG .....	61
SUREFLEX MIS LANCETS.....	195	SYNTHROID TAB 100MCG.....	231
SURE-LANCE MIS 26G .....	195	SYNTHROID TAB 112MCG.....	231
SURE-LANCE MIS LANCETS .....	195	SYNTHROID TAB 125MCG .....	231
SURELITE MIS LANCETS .....	195	SYNTHROID TAB 137MCG .....	231
SURE-PEN MIS.....	195	SYNTHROID TAB 150MCG .....	231
SURESTEP GLU SOL.....	195	SYNTHROID TAB 175MCG .....	231
SURESTEP GLU SOL HIGH/LOW .....	195	SYNTHROID TAB 200MCG .....	231
SURESTEP PRO TES HIGH CON.....	195	SYNTHROID TAB 25MCG.....	231
SURESTEP PRO TES LOW CON .....	195	SYNTHROID TAB 300MCG.....	231
SURESTEP PRO TES NORM CON .....	195	SYNTHROID TAB 50MCG .....	231
SURESTEP SOL CONTROL.....	195	SYNTHROID TAB 75MCG.....	231
SURE-TOUCH MIS UNV LANC.....	195	SYNTHROID TAB 88MCG.....	231
SUSTIVA CAP 200MG .....	111	<b>T</b>	
SUSTIVA CAP 50MG.....	111	TABLOID TAB 40MG .....	84
SUSTIVA TAB 600MG .....	111	TACHOSIL PAD 4.8X4.8 .....	176
SYMAX DUOTAB TAB .....	232	TACHOSIL PAD 9.5X4.8 .....	176
SYMBICORT AER 160-4.5.....	45	TACLONEX OIN .....	145
SYMBICORT AER 80-4.5 .....	45	TACLONEX SUS.....	145
SYMBYAX CAP 12-50MG.....	222	<i>tacrolimus cap 0.5 mg</i> .....	208
SYMBYAX CAP 3-25MG .....	222	<i>tacrolimus cap 1 mg</i> .....	208
SYMBYAX CAP 6-25MG .....	222	<i>tacrolimus cap 5 mg</i> .....	208
SYMBYAX CAP 6-50MG .....	222	<i>tacrolimus oint 0.03%</i> .....	147
SYMDEKO TAB 100-150.....	228	<i>tacrolimus oint 0.1%</i> .....	147
SYMDEKO TAB 50-75MG.....	228	<i>tadalafil tab 10 mg</i> .....	123
SYMFI LO TAB .....	111	<i>tadalafil tab 2.5 mg</i> .....	123
SYMFI TAB .....	111	<i>tadalafil tab 20 mg</i> .....	123
SYMLINPEN 60 INJ 1000MCG .....	60	<i>tadalafil tab 20 mg (pah)</i> .....	125
SYMLNPEN 120 INJ 1000MCG .....	60	<i>tadalafil tab 5 mg</i> .....	123
SYMPROIC TAB 0.2MG .....	170	TADLIQ SUS 20MG/5ML.....	125
SYMTUZA TAB.....	111		

<i>tafluprost preservative free (pf) ophth soln</i>	<i>telmisartan-amlodipine tab 80-5 mg</i> .....	79
0.0015% .....	<i>telmisartan-hydrochlorothiazide tab 40-</i>	
TAGRISSO TAB 40MG.....	12.5 mg.....	79
TAGRISSO TAB 80MG.....	<i>telmisartan-hydrochlorothiazide tab 80-12.5</i>	
TAI DOC SOL NORM CON.....	mg .....	79
TAKHZYRO INJ 150MG/ML .....	<i>telmisartan-hydrochlorothiazide tab 80-25</i>	
TAKHZYRO INJ 300/2ML.....	mg .....	80
TALICIA CAP .....	<i>telmisartan tab 20 mg</i> .....	75
TAMIFLU CAP 30MG .....	<i>telmisartan tab 40 mg</i> .....	75
TAMIFLU CAP 45MG .....	<i>telmisartan tab 80 mg</i> .....	75
TAMIFLU CAP 75MG .....	<i>temazepam cap 15 mg</i> .....	177
TAMIFLU SUS 6MG/ML.....	<i>temazepam cap 22.5 mg</i> .....	177
<i>tamoxifen citrate tab 10 mg (base</i>	<i>temazepam cap 30 mg</i> .....	177
<i>equivalent)</i> .....	<i>temazepam cap 7.5 mg</i> .....	177
<i>tamoxifen citrate tab 20 mg (base</i>	TEMBEXA SUS 10MG/ML.....	115
<i>equivalent)</i> .....	TEMBEXA TAB 100MG .....	115
<i>tamsulosin hcl cap 0.4 mg</i> .....	TEMIXYS TAB 300-300.....	111
TAPAZOLE TAB 10MG.....	TEMODAR CAP 100MG.....	83
TAPAZOLE TAB 5MG .....	TEMODAR CAP 140MG.....	83
TARCEVA TAB 100MG .....	TEMODAR CAP 180MG.....	83
TARCEVA TAB 150MG .....	TEMODAR CAP 250MG .....	83
TARCEVA TAB 25MG .....	TEMOVATE CRE 0.05%.....	145
TARKA TAB 2-180 CR.....	TEMOVATE OIN 0.05% .....	145
TARKA TAB 2-240 CR .....	<i>temozolomide cap 100 mg</i> .....	83
TARKA TAB 4-240 CR.....	<i>temozolomide cap 140 mg</i> .....	83
<i>tasimelteon capsule 20 mg</i> .....	<i>temozolomide cap 180 mg</i> .....	83
TASMAR TAB 100MG .....	<i>temozolomide cap 20 mg</i> .....	83
TAVALISSE TAB 100MG .....	<i>temozolomide cap 250 mg</i> .....	83
TAVALISSE TAB 150MG.....	<i>temozolomide cap 5 mg</i> .....	83
<i>tazarotene cream 0.1%</i> .....	<i>tenofovir disoproxil fumarate tab 300 mg</i>	111
TECHLITE AST MIS LANCETS .....	TENORETIC TAB 100 .....	80
TECHLITE MIS LANC 30G .....	TENORETIC TAB 50.....	80
TECHLITE MIS LANCETS .....	TENORMIN TAB 100MG.....	116
TEGSEDI INJ 284/1.5 .....	TENORMIN TAB 25MG.....	116
TEKURNA HCT TAB 150-12.5 .....	TENORMIN TAB 50MG.....	116
TEKURNA HCT TAB 150-25MG .....	<i>terazosin hcl cap 10 mg (base equivalent)</i>	76
TEKURNA HCT TAB 300-12.5 .....	<i>terazosin hcl cap 1 mg (base equivalent)</i> ..	76
TEKURNA HCT TAB 300-25MG .....	<i>terazosin hcl cap 2 mg (base equivalent)</i> .	76
TEKURNA TAB 150MG.....	<i>terazosin hcl cap 5 mg (base equivalent)</i> .	76
TEKURNA TAB 300MG.....	<i>terbinafine hcl tab 250 mg</i> .....	67
<i>telmisartan-amlodipine tab 40-10 mg</i> .....	<i>terbutaline sulfate tab 2.5 mg</i> .....	45
<i>telmisartan-amlodipine tab 40-5 mg</i> .....	<i>terbutaline sulfate tab 5 mg</i> .....	45
<i>telmisartan-amlodipine tab 80-10 mg</i> .....	<i>terconazole vaginal cream 0.4%</i> .....	235



<i>terconazole vaginal cream 0.8%</i> .....	235	THIN LANCETS MIS 30G .....	196
<i>terconazole vaginal suppos 80 mg</i> .....	235	THINLETS GP MIS 26G .....	196
<i>teriflunomide tab 14 mg</i> .....	225	<i>thioridazine hcl tab 100 mg</i> .....	105
<i>teriflunomide tab 7 mg</i> .....	225	<i>thioridazine hcl tab 10 mg</i> .....	104
TESSALON PER CAP 100MG .....	132	<i>thioridazine hcl tab 25 mg</i> .....	104
<i>testosterone cypionate im inj in oil 100</i> <i>mg/ml</i> .....	33	<i>thioridazine hcl tab 50 mg</i> .....	105
<i>testosterone cypionate im inj in oil 200</i> <i>mg/ml</i> .....	33	<i>thiothixene cap 10 mg</i> .....	105
<i>testosterone enanthate im inj in oil 200</i> <i>mg/ml</i> .....	33	<i>thiothixene cap 1 mg</i> .....	105
<i>testosterone td gel 10mg/act (2%)</i> .....	33	<i>thiothixene cap 2 mg</i> .....	105
<i>testosterone td gel 12.5 mg/act (1%)</i> .....	33	<i>thiothixene cap 5 mg</i> .....	105
<i>testosterone td gel 20.25 mg/1.25gm</i> <i>(1.62%)</i> .....	33	<i>tiagabine hcl tab 12 mg</i> .....	53
<i>testosterone td gel 20.25 mg/act (1.62%)</i>	33	<i>tiagabine hcl tab 16 mg</i> .....	53
<i>testosterone td gel 25 mg/2.5gm (1%)</i> .....	33	<i>tiagabine hcl tab 2 mg</i> .....	53
<i>testosterone td gel 40.5 mg/2.5gm (1.62%)</i> .....	33	<i>tiagabine hcl tab 4 mg</i> .....	53
<i>testosterone td gel 50 mg/5gm (1%)</i> .....	33	TIAZAC CAP 120MG/24 .....	119
<i>testosterone td soln 30 mg/act</i> .....	33	TIAZAC CAP 180MG/24 .....	119
<i>tetrabenazine tab 12.5 mg</i> .....	223	TIAZAC CAP 240MG/24 .....	119
<i>tetrabenazine tab 25 mg</i> .....	223	TIAZAC CAP 300MG/24 .....	119
<i>tetracaine hcl ophth soln 0.5%</i> .....	215	TIAZAC CAP 360MG/24 .....	119
<i>tetracycline hcl cap 250 mg</i> .....	229	TIAZAC CAP 420MG/24 .....	119
<i>tetracycline hcl cap 500 mg</i> .....	229	TIBSOVO TAB 250MG.....	94
TEXACORT SOL 2.5%.....	145	TIGAN CAP 300MG .....	66
TEZSPIRE INJ 210MG .....	41	TIKOSYN CAP 125MCG.....	40
TGT LANCET MIS 26G .....	196	TIKOSYN CAP 250MCG.....	40
TGT LANCET MIS 30G.....	196	TIKOSYN CAP 500MCG .....	40
TGT LANCET MIS 33G .....	196	<i>timolol maleate ophth gel forming soln</i> <i>0.25%</i> .....	212
TGT LANCING MIS DEVICE.....	196	<i>timolol maleate ophth gel forming soln</i> <i>0.5%</i> .....	212
THALOMID CAP 100MG .....	206	<i>timolol maleate ophth soln 0.25%</i> .....	212
THALOMID CAP 150MG .....	206	<i>timolol maleate ophth soln 0.5%</i> .....	212
THALOMID CAP 200MG .....	206	<i>timolol maleate ophth soln 0.5% (once-</i> <i>daily)</i> .....	212
THALOMID CAP 50MG.....	206	<i>timolol maleate preservative free ophth soln</i> <i>0.5%</i> .....	212
<i>theophylline elixir 80 mg/15ml</i> .....	45	<i>timolol maleate tab 10 mg</i> .....	117
<i>theophylline tab er 12hr 300 mg</i> .....	45	<i>timolol maleate tab 20 mg</i> .....	117
<i>theophylline tab er 12hr 450 mg</i> .....	45	<i>timolol maleate tab 5 mg</i> .....	117
<i>theophylline tab er 24hr 400 mg</i> .....	45	TIMOPTIC SOL 0.25% OP .....	212
<i>theophylline tab er 24hr 600 mg</i> .....	45	TIMOPTIC SOL 0.5% OP .....	212
THIN LANCETS MIS .....	196	TIMOPTIC-XE SOL 0.25% OP.....	213
THIN LANCETS MIS 26G .....	196	TIMOPTIC-XE SOL 0.5% OP .....	212
		<i>tinidazole tab 250 mg</i> .....	35

<i>tinidazole tab 500 mg</i> .....	35	TOPAMAX TAB 200MG .....	52
<i>tiopronin tab 100 mg</i> .....	171	TOPAMAX TAB 25MG .....	52
TISSEEL KIT 10ML.....	176	TOPAMAX TAB 50MG.....	52
TISSEEL KIT 2ML .....	176	TOPCARE MIS LANC 33G .....	196
TISSEEL KIT 4ML .....	176	TOPICORT CRE 0.05% .....	145
TISSEEL SOL 10ML .....	176	TOPICORT CRE 0.25% .....	146
TISSEEL SOL 2ML.....	176	TOPICORT GEL 0.05% .....	146
TISSEEL SOL 4ML.....	176	TOPICORT OIN 0.05%.....	146
TIVICAY PD TAB 5MG .....	111	TOPICORT OIN 0.25% .....	146
TIVICAY TAB 10MG.....	111	TOPICORT SPR 0.25% .....	146
TIVICAY TAB 25MG .....	111	<i>topiramate cap er 24hr 200 mg</i> .....	52
TIVICAY TAB 50MG.....	111	<i>topiramate sprinkle cap 15 mg</i> .....	52
<i>tizanidine hcl cap 2 mg (base equivalent)</i> .....	210	<i>topiramate sprinkle cap 25 mg</i> .....	52
<i>tizanidine hcl cap 4 mg (base equivalent)</i> .....	210	<i>topiramate tab 100 mg</i> .....	52
<i>tizanidine hcl cap 6 mg (base equivalent)</i> .....	210	<i>topiramate tab 200 mg</i> .....	52
<i>tizanidine hcl tab 2 mg (base equivalent)</i>	210	<i>topiramate tab 25 mg</i> .....	52
<i>tizanidine hcl tab 4 mg (base equivalent)</i>	210	<i>topiramate tab 50 mg</i> .....	52
TOBRADEX OIN 0.3-0.1%.....	216	<i>toremifene citrate tab 60 mg (base equivalent)</i> .....	87
TOBRADEX SUS 0.3-0.1% .....	216	<i>toremide tab 100 mg</i> .....	157
<i>tobramycin-dexamethasone ophth susp</i> <i>0.3-0.1%</i> .....	216	<i>toremide tab 10 mg</i> .....	157
<i>tobramycin nebu soln 300 mg/4ml</i> .....	9	<i>toremide tab 20 mg</i> .....	157
<i>tobramycin nebu soln 300 mg/5ml</i> .....	10	<i>toremide tab 5 mg</i> .....	157
<i>tobramycin ophth soln 0.3%</i> .....	214	TOUJEO MAX INJ 300IU/ML .....	63
TOBEX OIN 0.3% OP .....	214	TOUJEO SOLO INJ 300IU/ML.....	63
TOBEX SOL 0.3% OP.....	214	TPOXX CAP 200MG .....	115
TODAY SPONGE MIS .....	234	TPOXX INJ.....	115
<i>tolbutamide tab 500 mg</i> .....	65	<i>tramadol-acetaminophen tab 37.5-325 mg</i> .....	31
<i>tolcapone tab 100 mg</i> .....	96	<i>tramadol hcl tab 50 mg</i> .....	29
TOLEREX POW .....	155	<i>tramadol hcl tab er 24hr 100 mg</i> .....	29
<i>tolmetin sodium cap 400 mg</i> .....	20	<i>tramadol hcl tab er 24hr 200 mg</i> .....	29
<i>tolmetin sodium tab 600 mg</i> .....	20	<i>tramadol hcl tab er 24hr 300 mg</i> .....	29
<i>tolterodine tartrate cap er 24hr 2 mg</i> .....	234	<i>tramadol hcl tab er 24hr biphasic release 100 mg</i> .....	29
<i>tolterodine tartrate cap er 24hr 4 mg</i> .....	234	<i>tramadol hcl tab er 24hr biphasic release 200 mg</i> .....	29
<i>tolterodine tartrate tab 1 mg</i> .....	234	<i>tramadol hcl tab er 24hr biphasic release 300 mg</i> .....	29
<i>tolterodine tartrate tab 2 mg</i> .....	234	<i>trandolapril tab 1 mg</i> .....	74
<i>tolvaptan tab 30 mg</i> .....	164	<i>trandolapril tab 2 mg</i> .....	74
TOPAMAX SPR CAP 15MG .....	52	<i>trandolapril tab 4 mg</i> .....	74
TOPAMAX SPR CAP 25MG .....	52		
TOPAMAX TAB 100MG .....	52		

<i>trandolapril-verapamil hcl tab er 1-240 mg</i> .....80	<i>triamcinolone acetonide dental paste 0.1%</i> .....209
<i>trandolapril-verapamil hcl tab er 2-180 mg</i> .....80	<i>triamcinolone acetonide lotion 0.025%</i> ..146
<i>trandolapril-verapamil hcl tab er 2-240 mg</i> .....80	<i>triamcinolone acetonide lotion 0.1%</i> .....146
<i>trandolapril-verapamil hcl tab er 4-240 mg</i> .....80	<i>triamcinolone acetonide oint 0.025%</i> .....146
<i>tranexamic acid tab 650 mg</i> .....176	<i>triamcinolone acetonide oint 0.1%</i> .....146
TRANXENE T TAB 7.5MG .....39	<i>triamcinolone acetonide oint 0.5%</i> .....146
<i>tranylcypromine sulfate tab 10 mg</i> .....55	<i>triamterene &amp; hydrochlorothiazide cap</i> 37.5-25 mg .....156
TRAVEL LANCE MIS 30G .....196	<i>triamterene &amp; hydrochlorothiazide tab 37.5-</i> 25 mg .....157
TRAVEL LANCE MIS ADV 28G.....196	<i>triamterene &amp; hydrochlorothiazide tab 75-</i> 50 mg .....157
<i>travoprost ophth soln 0.004%</i> (benzalkonium free) (bak free).....217	<i>triamterene cap 100 mg</i> .....157
<i>trazodone hcl tab 100 mg</i> .....57	<i>triamterene cap 50 mg</i> .....157
<i>trazodone hcl tab 150 mg</i> .....57	<i>triazolam tab 0.125 mg</i> .....177
<i>trazodone hcl tab 300 mg</i> .....57	<i>triazolam tab 0.25 mg</i> .....177
<i>trazodone hcl tab 50 mg</i> .....56	TRIBENZOR20- TAB 5-12.5MG .....80
TRECTOR TAB 250MG .....82	TRIBENZOR40- TAB 10-12.5 .....80
TRELEGY AER 100MCG .....45	TRIBENZOR40- TAB 10-25MG.....80
TRELEGY AER 200MCG.....45	TRIBENZOR40- TAB 5-12.5MG.....80
TREMFYA INJ 100MG/ML.....142	TRIBENZOR40- TAB 5-25MG .....80
TRESIBA FLEX INJ 100UNIT .....63	TRIDESILON CRE 0.05% .....146
TRESIBA FLEX INJ 200UNIT.....63	<i>trientine hcl cap 250 mg</i> .....205
TRESIBA INJ 100UNIT .....63	<i>trifluoperazine hcl tab 10 mg (base</i> equivalent) .....105
<i>tretinoin cap 10 mg</i> .....95	<i>trifluoperazine hcl tab 1 mg (base</i> equivalent) .....105
<i>tretinoin cream 0.025%</i> .....135	<i>trifluoperazine hcl tab 2 mg (base</i> equivalent) .....105
<i>tretinoin cream 0.05%</i> .....135	<i>trifluoperazine hcl tab 5 mg (base</i> equivalent) .....105
<i>tretinoin cream 0.1%</i> .....135	<i>trifluridine ophth soln 1%</i> .....214
<i>tretinoin gel 0.01%</i> .....135	<i>trihexyphenidyl hcl oral soln 0.4 mg/ml</i> ...96
<i>tretinoin gel 0.025%</i> .....135	<i>trihexyphenidyl hcl tab 2 mg</i> .....96
<i>tretinoin gel 0.05%</i> .....135	<i>trihexyphenidyl hcl tab 5 mg</i> .....96
<i>tretinoin microsphere gel 0.04%</i> .....135	TRIJARDY XR TAB .....61
<i>tretinoin microsphere gel 0.1%</i> .....135	TRIKAFTA PAK 59.5MG .....228
TREXALL TAB 10MG .....84	TRIKAFTA PAK 75MG .....228
TREXALL TAB 15MG .....84	TRIKAFTA TAB .....228
TREXALL TAB 5MG .....84	TRILIPIX CAP 135MG.....70
TREXALL TAB 7.5MG .....84	TRILIPIX CAP 45MG .....70
<i>triamcinolone acetonide cream 0.025%</i> 146	<i>trimethobenzamide hcl cap 300 mg</i> .....66
<i>triamcinolone acetonide cream 0.1%</i> .....146	
<i>triamcinolone acetonide cream 0.5%</i> .....146	

<i>trimethoprim tab 100 mg</i> .....	35	TWYNSTA TAB 40-5MG .....	80
<i>trimipramine maleate cap 100 mg</i> .....	59	TWYNSTA TAB 80-10MG .....	80
<i>trimipramine maleate cap 25 mg</i> .....	59	TWYNSTA TAB 80-5MG .....	80
<i>trimipramine maleate cap 50 mg</i> .....	59	TYBOST TAB 150MG .....	111
TRINTELLIX TAB 10MG .....	57	TYKERB TAB 250MG .....	94
TRINTELLIX TAB 20MG .....	57	TYLACTIN POW BLD 20PE .....	155
TRINTELLIX TAB 5MG .....	57	TYMLOS INJ .....	159
TRIUMEQ PD TAB .....	111	TYVASO REFIL SOL 0.6MG/ML .....	124
TRIUMEQ TAB .....	111	TYVASO SOL 0.6MG/ML .....	124
TRIZIVIR TAB .....	111	TYVASO START SOL 0.6MG/ML .....	124
TROKENDI XR CAP 100MG .....	52	<b>U</b>	
TROKENDI XR CAP 200MG .....	52	UBRELVY TAB 100MG .....	202
TROKENDI XR CAP 25MG .....	52	UBRELVY TAB 50MG .....	202
TROKENDI XR CAP 50MG .....	52	UCERIS AER 2MG/ACT .....	33
<i>trospium chloride cap er 24hr 60 mg</i> .....	234	UCERIS TAB 9MG .....	132
<i>trospium chloride tab 20 mg</i> .....	234	ULTICARE PAD ALCOHOL .....	199
TRUDHESA AER 0.725MG .....	202	ULTI-LANCE MIS CLR TIP .....	196
TRUECONTROL LIQ LEVEL 0 .....	196	ULTILET MIS 26G .....	196
TRUECONTROL LIQ LEVEL 1 .....	196	ULTILET MIS 28G .....	196
TRUEDRAW MIS LANC DEV .....	196	ULTILET MIS 30G .....	196
TRUE METRIX SOL LEVEL 1 .....	196	ULTILET MIS 33G .....	196
TRUE METRIX SOL LEVEL 2 .....	196	ULTILET MIS LANCETS .....	196
TRUE METRIX SOL LEVEL 3 .....	196	ULTILET MIS SAFETY .....	196
TRULANCE TAB 3MG .....	167	ULTILET PAD ALCOHOL .....	199
TRULICITY INJ 0.75/0.5 .....	62	ULTILET SAFE MIS 21G .....	196
TRULICITY INJ 1.5/0.5 .....	62	ULTRACAL HN LIQ PLUS .....	155
TRULICITY INJ 3/0.5 .....	62	ULTRACAL LIQ .....	155
TRULICITY INJ 4.5/0.5 .....	62	ULTRACET TAB 37.5-325 .....	31
TRUPLUS LANC MIS 26G .....	196	ULTRAM TAB 50MG .....	29
TRUPLUS LANC MIS 28G .....	196	ULTRA THIN MIS 28G .....	196
TRUPLUS LANC MIS 30G .....	196	ULTRA THIN MIS 30G .....	196
TRUPLUS LANC MIS 33G .....	196	ULTRA THIN MIS 31G .....	196
TRUSOPT SOL 2% OP .....	216	ULTRA THIN MIS 33G .....	196
TRUZONE PEAK MIS FLOW MTR .....	201	ULTRA THIN MIS LAN 31G .....	197
TUKYSA TAB 150MG .....	85	ULTRA THIN MIS LANC 28G .....	197
TUKYSA TAB 50MG .....	85	ULTRA THIN MIS LANC 30G .....	197
TURPENTINE SOL SPIRITS .....	147	ULTRA THIN MIS LANCETS .....	197
TUSSICAPS CAP 10-8MG .....	133	ULTRIENT 1.5 LIQ SAFE-T .....	155
TUZISTRA XR SUS .....	133	UNILET CMFR MIS TCH 28G .....	197
TWIST LANCET MIS 30G MULT .....	196	UNILET CMFR MIS TCH 30G .....	197
TWOCAL HN LIQ .....	155	UNILET EXCEL MIS 23G .....	197
TWYNEO CRE 0.1-3% .....	135	UNILET EX II MIS 28G .....	197
TWYNSTA TAB 40-10MG .....	80	UNILET G.P. MIS 21G .....	197

UNILET G.P MIS SUPR 23G .....	197	UNIVERSAL 1 MIS LANC 26G.....	198
UNILET GP 28 MIS ULT THIN .....	197	UNIVERSAL 1 MIS LANC 30G.....	198
UNILET LANCE MIS 21G.....	197	UPTRAVI PACK TAB 200/800.....	125
UNILET LANCE MIS 28G.....	197	UPTRAVI TAB 1000MCG .....	125
UNILET LANCE MIS 33G.....	197	UPTRAVI TAB 1200MCG.....	125
UNILET LANC MIS 33G .....	197	UPTRAVI TAB 1400MCG .....	125
UNILET LANCT MIS 28G.....	197	UPTRAVI TAB 1600MCG .....	125
UNILET LANCT MIS 30G .....	197	UPTRAVI TAB 200MCG .....	125
UNILET LANCT MIS 33G.....	197	UPTRAVI TAB 400MCG.....	125
UNILET MICRO MIS 33G.....	197	UPTRAVI TAB 600MCG.....	125
UNILET MIS 21G .....	197	UPTRAVI TAB 800MCG.....	125
UNILET SUPER MIS 23G .....	197	<i>urea cream 39%</i> .....	147
UNILET SUPER MIS G.P. 23G .....	197	<i>urea lotion 40%</i> .....	147
UNISTIK 1 MIS 2.4MM .....	197	UROCIT-K 10 TAB.....	171
UNISTIK 1 MIS 3.0MM .....	197	UROCIT-K 15 TAB .....	171
UNISTIK 2 MIS.....	197	UROCIT-K 5 TAB.....	171
UNISTIK 2 MIS 1.8MM .....	197	URSO 250 TAB 250MG.....	167
UNISTIK 2 MIS 2.4MM .....	197	<i>ursodiol cap 300 mg</i> .....	167
UNISTIK 2 MIS COMFORT .....	197	<i>ursodiol tab 250 mg</i> .....	167
UNISTIK 2 MIS EXTRA.....	197	<i>ursodiol tab 500 mg</i> .....	167
UNISTIK 2 MIS NEONATAL .....	197	URSO FORTE TAB 500MG .....	167
UNISTIK 2 MIS NORMAL .....	197	<b>V</b>	
UNISTIK 2 MIS SUPER.....	197	VAGIFEM TAB 10MCG.....	235
UNISTIK 3 MIS 1.8MM .....	197	<i>valacyclovir hcl tab 1 gm</i> .....	114
UNISTIK 3 MIS COMFORT .....	197	<i>valacyclovir hcl tab 500 mg</i> .....	114
UNISTIK 3 MIS EXTRA.....	197	VALCHLOR GEL 0.016%.....	138
UNISTIK 3 MIS GENT 30G .....	198	<i>valganciclovir hcl for soln 50 mg/ml (base</i> <i>equiv)</i> .....	112
UNISTIK 3 MIS NEONATAL .....	198	<i>valganciclovir hcl tab 450 mg (base</i> <i>equivalent)</i> .....	112
UNISTIK 3 MIS NORMAL .....	198	VALIUM TAB 10MG.....	39
UNISTIK 3 MIS XTR 21G.....	198	VALIUM TAB 2MG.....	39
UNISTIK CZT MIS COMFORT.....	198	VALIUM TAB 5MG.....	39
UNISTIK CZT MIS NORMAL .....	198	<i>valproate sodium oral soln 250 mg/5ml</i> <i>(base equiv)</i> .....	54
UNISTIK II MIS LANCETS.....	198	<i>valproic acid cap 250 mg</i> .....	54
UNISTIK PRO MIS LANC 21G .....	198	<i>valsartan-hydrochlorothiazide tab 160-12.5</i> <i>mg</i> .....	80
UNISTIK PRO MIS LANC 28G .....	198	<i>valsartan-hydrochlorothiazide tab 160-25</i> <i>mg</i> .....	80
UNISTIK SAFE MIS LANC 28G .....	198	<i>valsartan-hydrochlorothiazide tab 320-12.5</i> <i>mg</i> .....	80
UNISTIK SAFE MIS LANC 30G.....	198		
UNISTIK TOUC MIS LANC 21G.....	198		
UNISTIK TOUC MIS LANC 23G.....	198		
UNISTIK TOUC MIS LANC 28G.....	198		
UNISTIK TOUC MIS LANC 30G.....	198		
UNITSTIK PRO MIS LANC 25G .....	198		
UNIVERSAL 1 MIS 33G .....	198		

<i>valsartan-hydrochlorothiazide tab 320-25 mg</i> .....	80	VELTASSA POW 25.2GM .....	208
<i>valsartan-hydrochlorothiazide tab 80-12.5 mg</i> .....	80	VELTASSA POW 8.4GM .....	208
<i>valsartan tab 160 mg</i> .....	75	VEMLIDY TAB 25MG .....	114
<i>valsartan tab 320 mg</i> .....	75	VENCLEXTA TAB 100MG.....	85
<i>valsartan tab 40 mg</i> .....	75	VENCLEXTA TAB 10MG .....	85
<i>valsartan tab 80 mg</i> .....	75	VENCLEXTA TAB 50MG .....	85
VALTOCO SPR 10MG .....	48	VENCLEXTA TAB START PK .....	85
VALTOCO SPR 15MG .....	48	<i>venlafaxine hcl cap er 24hr 150 mg (base equivalent)</i> .....	58
VALTOCO SPR 20MG.....	48	<i>venlafaxine hcl cap er 24hr 37.5 mg (base equivalent)</i> .....	57
VALTOCO SPR 5MG .....	48	<i>venlafaxine hcl cap er 24hr 75 mg (base equivalent)</i> .....	57
VANCOGIN CAP 125MG.....	35	<i>venlafaxine hcl tab 100 mg (base equivalent)</i> .....	58
VANCOGIN CAP 250MG.....	35	<i>venlafaxine hcl tab 25 mg (base equivalent)</i> .....	58
<i>vancomycin hcl cap 125 mg (base equivalent)</i> .....	35	<i>venlafaxine hcl tab 37.5 mg (base equivalent)</i> .....	58
<i>vancomycin hcl cap 250 mg (base equivalent)</i> .....	35	<i>venlafaxine hcl tab 50 mg (base equivalent)</i> .....	58
<i>vancomycin hcl for oral soln 50 mg/ml (base equivalent)</i> .....	35	<i>venlafaxine hcl tab 75 mg (base equivalent)</i> .....	58
VANDAZOLE GEL 0.75% .....	235	<i>venlafaxine hcl tab er 24hr 225 mg (base equivalent)</i> .....	58
VANOS CRE 0.1% .....	146	VENTAVIS SOL 10MCG/ML .....	124
VANTAGE LANC MIS DEVICE.....	198	VENTAVIS SOL 20MCG/ML.....	124
<i>ardenafil hcl orally disintegrating tab 10 mg</i> .....	123	<i>verapamil hcl cap er 24hr 100 mg</i> .....	119
<i>ardenafil hcl tab 10 mg</i> .....	124	<i>verapamil hcl cap er 24hr 120 mg</i> .....	120
<i>ardenafil hcl tab 2.5 mg</i> .....	123	<i>verapamil hcl cap er 24hr 180 mg</i> .....	120
<i>ardenafil hcl tab 20 mg</i> .....	124	<i>verapamil hcl cap er 24hr 200 mg</i> .....	120
<i>ardenafil hcl tab 5 mg</i> .....	123	<i>verapamil hcl cap er 24hr 240 mg</i> .....	120
VARUBI TAB 90MG.....	67	<i>verapamil hcl cap er 24hr 300 mg</i> .....	120
VASCEPA CAP 0.5GM.....	69	<i>verapamil hcl cap er 24hr 360 mg</i> .....	120
VASCEPA CAP 1GM .....	69	<i>verapamil hcl tab 120 mg</i> .....	120
VASERETIC TAB 10-25MG.....	80	<i>verapamil hcl tab 40 mg</i> .....	120
VASOTEC TAB 10MG.....	74	<i>verapamil hcl tab 80 mg</i> .....	120
VASOTEC TAB 2.5MG .....	74	<i>verapamil hcl tab er 120 mg</i> .....	120
VASOTEC TAB 20MG .....	74	<i>verapamil hcl tab er 180 mg</i> .....	120
VASOTEC TAB 5MG .....	74	<i>verapamil hcl tab er 240 mg</i> .....	120
VCF VAGINAL AER CONTRACP .....	234	VERASENS LIQ LEVEL 1 .....	198
VCF VAGINAL GEL CONTRACE.....	234	VERDESO AER 0.05%.....	146
VCF VAGINAL MIS CONTRACP .....	234	VERELAN CAP 120MG SR .....	120
VECAMYL TAB 2.5MG .....	80		
VELPHORO CHW 500MG .....	170		
VELTASSA POW 16.8GM .....	208		

VERELAN CAP 180MG SR .....	120	VIREAD POW 40MG/GM .....	112
VERELAN CAP 240MG SR .....	120	VIREAD TAB 150MG.....	112
VERELAN CAP 360MG SR .....	120	VIREAD TAB 200MG.....	112
VERELAN PM CAP 100MG ER .....	120	VIREAD TAB 250MG .....	112
VERELAN PM CAP 200MG ER.....	120	VIREAD TAB 300MG.....	112
VERELAN PM CAP 300MG ER.....	120	VISIONBLUE INJ 0.06%.....	216
VERQUVO TAB 10MG.....	126	VISTARIL CAP 25MG.....	38
VERQUVO TAB 2.5MG .....	126	VISTARIL CAP 50MG.....	38
VERQUVO TAB 5MG .....	126	VISTOGARD PAK 10GM .....	65
VERSACLOZ SUS 50MG/ML .....	103	VITAL HN POW .....	155
VERZENIO TAB 100MG .....	94	VITRAKVI CAP 100MG .....	94
VERZENIO TAB 150MG .....	94	VITRAKVI CAP 25MG .....	94
VERZENIO TAB 200MG.....	94	VITRAKVI SOL 20MG/ML.....	94
VERZENIO TAB 50MG.....	94	VIVAGUARD LIQ CONTROL.....	198
VESICARE LS SUS 5MG/5ML.....	234	VIVAGUARD MIS 28G .....	198
VESICARE TAB 10MG .....	234	VIVAGUARD MIS 30G .....	198
VESICARE TAB 5MG.....	234	VIVAGUARD MIS LANCING .....	198
VFEND SUS 40MG/ML.....	68	VIVJOA CAP 150MG.....	68
VFEND TAB 200MG.....	68	VIVONEX RTF LIQ.....	155
VFEND TAB 50MG .....	68	VONJO CAP 100MG .....	94
V-GO 20 KIT .....	198	VOQUEZNA PAK DUAL PAK.....	233
V-GO 30 KIT .....	198	VOQUEZNA PAK TRIP PK .....	233
V-GO 40 KIT .....	198	<i>voriconazole for susp 40 mg/ml</i> .....	68
VIBERZI TAB 100MG .....	169	<i>voriconazole tab 200 mg</i> .....	68
VIBERZI TAB 75MG .....	169	<i>voriconazole tab 50 mg</i> .....	68
VIBRAMYCIN CAP 100MG.....	229	VOSEVI TAB .....	114
VIBRAMYCIN SUS 25MG/5ML .....	229	VOWST CAP .....	169
VIBRAMYCIN SYP 50MG/5ML .....	229	VOXZOGO INJ 0.4MG.....	163
VICTOZA INJ 18MG/3ML .....	63	VOXZOGO INJ 0.56MG .....	163
VIDAZA INJ 100MG .....	84	VOXZOGO INJ 1.2MG.....	163
<i>vigabatrin powd pack 500 mg</i> .....	53	VRAYLAR CAP 1.5-3MG .....	100
<i>vigabatrin tab 500 mg</i> .....	53	VRAYLAR CAP 1.5MG.....	100
VIGAMOX DRO 0.5% .....	214	VRAYLAR CAP 3MG .....	100
VILACTIN AA LIQ PLUS .....	155	VRAYLAR CAP 4.5MG .....	100
<i>vilazodone hcl tab 10 mg</i> .....	57	VRAYLAR CAP 6MG .....	100
<i>vilazodone hcl tab 20 mg</i> .....	57	VTAMA CRE 1% .....	142
<i>vilazodone hcl tab 40 mg</i> .....	57	VUMERITY CAP 231MG.....	225
VIMOVO TAB 375-20MG .....	20	VUSION OIN.....	137
VIMOVO TAB 500-20MG.....	20	VYNDAMAX CAP 61MG.....	126
VIOKACE TAB 10440 .....	156	VYTORIN TAB 10-10MG .....	69
VIOKACE TAB 20880.....	156	VYTORIN TAB 10-20MG.....	69
VIRAMUNE SUS 50MG/5ML.....	112	VYTORIN TAB 10-40MG .....	69
VIRAMUNE XR TAB 400MG.....	112	VYTORIN TAB 10-80MG .....	69

VYVANSE CAP 10MG.....	2	WIDE-SEAL DPR KIT 80 .....	180
VYVANSE CAP 20MG .....	2	WIDE-SEAL DPR KIT 85 .....	180
VYVANSE CAP 30MG .....	2	WIDE-SEAL DPR KIT 90 .....	180
VYVANSE CAP 40MG .....	2	WIDE-SEAL DPR KIT 95 .....	180
VYVANSE CAP 50MG .....	2	WINLEVI CRE 1% .....	135
VYVANSE CAP 60MG .....	2	<b>X</b>	
VYVANSE CAP 70MG .....	3	XACIATO GEL 2% .....	235
VYVANSE CHW 10MG .....	3	XALATAN SOL 0.005% .....	217
VYVANSE CHW 20MG.....	3	XARELTO STAR TAB 15/20MG .....	46
VYVANSE CHW 30MG .....	3	XARELTO TAB 10MG .....	46
VYVANSE CHW 40MG .....	3	XARELTO TAB 15MG .....	46
VYVANSE CHW 50MG .....	3	XARELTO TAB 2.5MG.....	46
VYVANSE CHW 60MG .....	3	XARELTO TAB 20MG .....	46
<b>W</b>		XATMEP SOL 2.5MG/ML.....	84
WAKIX TAB 17.8MG .....	5	XCOPRI PAK 100-150 .....	53
WAKIX TAB 4.45MG .....	5	XCOPRI PAK 12.5-25 .....	52
<i>warfarin sodium tab 10 mg</i> .....	46	XCOPRI PAK 150-200 .....	53
<i>warfarin sodium tab 1 mg</i> .....	45	XCOPRI PAK 50-100MG .....	52
<i>warfarin sodium tab 2.5 mg</i> .....	45	XCOPRI PAK 50-200MG.....	53
<i>warfarin sodium tab 2 mg</i> .....	45	XCOPRI TAB 100MG.....	53
<i>warfarin sodium tab 3 mg</i> .....	45	XCOPRI TAB 150MG.....	53
<i>warfarin sodium tab 4 mg</i> .....	45	XCOPRI TAB 200MG .....	53
<i>warfarin sodium tab 5 mg</i> .....	45	XCOPRI TAB 50MG.....	53
<i>warfarin sodium tab 6 mg</i> .....	45	XELJANZ SOL 1MG/ML .....	16
<i>warfarin sodium tab 7.5 mg</i> .....	45	XELJANZ TAB 10MG .....	16
WEBCOL PREP PAD LARGE .....	199	XELJANZ TAB 5MG .....	16
WEBCOL PREP PAD MEDIUM .....	199	XELJANZ XR TAB 11MG.....	17
WEGOVY INJ 0.25MG .....	3	XELJANZ XR TAB 22MG .....	17
WEGOVY INJ 0.5MG.....	3	XELODA TAB 150MG.....	84
WEGOVY INJ 1.7MG.....	3	XELODA TAB 500MG.....	84
WEGOVY INJ 1MG.....	3	XENLETA TAB 600MG .....	36
WEGOVY INJ 2.4MG.....	3	XEPI CRE 1%.....	136
WELCHOL PAK 3.75GM.....	70	XERAC-AC SOL 6.25% .....	148
WELCHOL TAB 625MG.....	70	XERESE CRE 5-1% .....	142
WELLBUTRIN TAB 100MG SR.....	55	XERMELO TAB 250MG.....	170
WELLBUTRIN TAB 150MG SR .....	55	XHANCE MIS 93MCG .....	211
WELLBUTRIN TAB 200MG SR .....	55	XIFAXAN TAB 200MG .....	35
WELLBUTRIN TAB XL 150MG .....	55	XIFAXAN TAB 550MG .....	35
WELLBUTRIN TAB XL 300MG .....	55	XIGDUO XR TAB 10-1000 .....	61
WIDE-SEAL DPR KIT 60 .....	180	XIGDUO XR TAB 10-500MG.....	61
WIDE-SEAL DPR KIT 65 .....	180	XIGDUO XR TAB 2.5-1000 .....	61
WIDE-SEAL DPR KIT 70 .....	180	XIGDUO XR TAB 5-1000MG.....	61
WIDE-SEAL DPR KIT 75.....	180	XIGDUO XR TAB 5-500MG .....	61



XIIDRA DRO 5% .....	215	ZEJULA CAP 100MG.....	94
XOPENEX CONC NEB 1.25/0.5 .....	45	ZEJULA TAB 100MG .....	94
XOPENEX NEB 0.31MG .....	45	ZEJULA TAB 200MG .....	94
XOPENEX NEB 0.63MG .....	45	ZEJULA TAB 300MG .....	94
XOPENEX NEB 1.25/3ML .....	45	ZELAPAR TAB 1.25MG .....	99
XOSPATA TAB 40MG.....	94	ZELBORAF TAB 240MG.....	94
XPOVIO PAK 100MG .....	88	ZEMBRACE SYM INJ 3/0.5ML .....	204
XPOVIO PAK 40MG .....	88	ZEMPLAR CAP 1MCG.....	163
XPOVIO PAK 50MG .....	88	ZEMPLAR CAP 2MCG.....	163
XPOVIO PAK 60MG .....	88	ZENPEP CAP 10000UNT .....	156
XPOVIO PAK 80MG .....	88	ZENPEP CAP 15000UNT .....	156
XTAMPZA ER CAP 13.5MG .....	29	ZENPEP CAP 20000UNT .....	156
XTAMPZA ER CAP 18MG .....	29	ZENPEP CAP 25000UNT .....	156
XTAMPZA ER CAP 27MG.....	29	ZENPEP CAP 3000UNIT .....	156
XTAMPZA ER CAP 36MG .....	30	ZENPEP CAP 40000UNT .....	156
XTAMPZA ER CAP 9MG.....	29	ZENPEP CAP 5000UNIT .....	156
XTANDI CAP 40MG .....	87	ZEPOSIA 7DAY CAP STR PACK.....	225
XTANDI TAB 40MG.....	87	ZEPOSIA CAP .92MG.....	225
XTANDI TAB 80MG.....	87	ZEPOSIA CAP STR KIT .....	225
XULTOPHY INJ 100/3.6 .....	61	ZESTRIL TAB 10MG.....	74
XURIDEN POW 2GM .....	163	ZESTRIL TAB 2.5MG .....	74
XYOSTED INJ 100/0.5.....	33	ZESTRIL TAB 20MG .....	74
XYOSTED INJ 50/0.5 .....	33	ZESTRIL TAB 30MG .....	74
XYOSTED INJ 75/0.5.....	33	ZESTRIL TAB 40MG.....	74
XYREM SOL 500MG/ML .....	220	ZESTRIL TAB 5MG .....	74
XYWAV SOL 0.5GM/ML .....	220	ZIAC TAB 10/6.25 .....	80
<b>Y</b>		ZIAC TAB 2.5/6.25 .....	80
YONSA TAB 125MG .....	87	ZIAC TAB 5-6.25MG .....	80
YUPELRI SOL.....	41	ZIAGEN SOL 20MG/ML.....	112
<b>Z</b>		ZIAGEN TAB 300MG.....	112
ZACLIR LOT 8% .....	136	<i>zidovudine cap 100 mg</i> .....	112
<i>zafirlukast tab 10 mg</i> .....	42	<i>zidovudine syrup 10 mg/ml</i> .....	112
<i>zafirlukast tab 20 mg</i> .....	42	<i>zidovudine tab 300 mg</i> .....	112
<i>zaleplon cap 10 mg</i> .....	177	ZIOPTAN DRO 0.0015% .....	217
<i>zaleplon cap 5 mg</i> .....	177	<i>ziprasidone hcl cap 20 mg</i> .....	100
ZANAFLEX CAP 2MG.....	210	<i>ziprasidone hcl cap 40 mg</i> .....	100
ZANAFLEX CAP 4MG.....	210	<i>ziprasidone hcl cap 60 mg</i> .....	100
ZANAFLEX CAP 6MG.....	210	<i>ziprasidone hcl cap 80 mg</i> .....	100
ZANAFLEX TAB 4MG .....	210	<i>ziprasidone mesylate for inj 20 mg (base equivalent)</i> .....	100
ZARONTIN CAP 250MG.....	53	ZIPSOR CAP 25MG .....	20
ZARONTIN SOL 250/5ML.....	53	ZITHROMAX POW 1GM PAK.....	179
ZAVESCA CAP 100MG.....	174	ZITHROMAX SUS 100/5ML.....	179
ZEGALOGUE INJ 0.6/0.6 .....	61		

ZITHROMAX SUS 200/5ML .....	179	ZORTRESS TAB 0.75MG.....	208
ZITHROMAX TAB 250MG.....	179	ZORTRESS TAB 1MG .....	208
ZITHROMAX TAB 500MG .....	179	ZORYVE CRE 0.3% .....	142
ZITHROMAX TAB TRI-PAK.....	179	ZOVIRAX CRE 5%.....	142
ZITHROMAX TAB Z-PAK .....	179	ZOVIRAX OIN 5%.....	142
ZOCOR TAB 10MG .....	72	ZOVIRAX SUS 200/5ML .....	114
ZOCOR TAB 20MG.....	72	ZTLIDO PAD 1.8%.....	148
ZOCOR TAB 40MG .....	72	ZUBSOLV SUB 0.7-0.18 .....	32
ZOCOR TAB 80MG.....	72	ZUBSOLV SUB 1.4-0.36 .....	32
ZOFRAN TAB 4MG.....	66	ZUBSOLV SUB 11.4-2.9 .....	32
ZOKINVY CAP 50MG .....	208	ZUBSOLV SUB 2.9-0.71 .....	32
ZOKINVY CAP 75MG.....	208	ZUBSOLV SUB 5.7-1.4.....	32
ZOLINZA CAP 100MG .....	95	ZUBSOLV SUB 8.6-2.1.....	32
<i>zolmitriptan nasal spray 2.5 mg/spray unit</i>		ZYCLARA CRE 3.75% .....	147
.....	204	ZYCLARA PUMP CRE 2.5%.....	147
<i>zolmitriptan nasal spray 5 mg/spray unit</i>		ZYCLARA PUMP CRE 3.75%.....	147
.....	204	ZYDELIG TAB 100MG .....	95
<i>zolmitriptan orally disintegrating tab 2.5 mg</i>		ZYDELIG TAB 150MG .....	95
.....	204	ZYFLO TAB 600MG .....	42
<i>zolmitriptan orally disintegrating tab 5 mg</i>		ZYKADIA TAB 150MG.....	95
.....	204	ZYLOPRIM TAB 100MG .....	172
<i>zolmitriptan tab 2.5 mg</i> .....	204	ZYLOPRIM TAB 300MG.....	172
<i>zolmitriptan tab 5 mg</i> .....	204	ZYMAXID SOL 0.5%.....	214
<i>zolpidem tartrate tab 10 mg</i> .....	177	ZYPREXA INJ 10MG .....	103
<i>zolpidem tartrate tab 5 mg</i> .....	177	ZYPREXA RELP INJ 210MG.....	103
<i>zolpidem tartrate tab er 12.5 mg</i> .....	177	ZYPREXA RELP INJ 300MG.....	103
<i>zolpidem tartrate tab er 6.25 mg</i> .....	177	ZYPREXA RELP INJ 405MG.....	103
ZOMIG SPR 2.5MG .....	204	ZYPREXA TAB 10MG.....	103
ZOMIG SPR 5MG .....	204	ZYPREXA TAB 15MG.....	103
ZOMIG TAB 2.5MG .....	204	ZYPREXA TAB 2.5MG .....	103
ZOMIG TAB 5MG .....	204	ZYPREXA TAB 20MG .....	103
ZOMIG ZMT TAB 2.5 MG .....	204	ZYPREXA TAB 5MG .....	103
ZOMIG ZMT TAB 5MG ODT .....	204	ZYPREXA TAB 7.5MG .....	103
ZONALON CRE 5%.....	138	ZYPREXA ZYDI TAB 10MG .....	103
<i>zonisamide cap 100 mg</i> .....	52	ZYPREXA ZYDI TAB 15MG .....	104
<i>zonisamide cap 25 mg</i> .....	52	ZYPREXA ZYDI TAB 20MG.....	104
<i>zonisamide cap 50 mg</i> .....	52	ZYPREXA ZYDI TAB 5MG .....	103
ZORBTIVE INJ 8.8MG .....	161	ZYVOX SUS 100MG/5M .....	36
ZORTRESS TAB 0.25MG.....	208	ZYVOX TAB 600MG.....	36
ZORTRESS TAB 0.5MG.....	208		

For more recent information or other questions, please contact CareFirst Pharmacy Services at **800-241-3371** or visit **[carefirst.com/rxgroup](https://www.carefirst.com/rxgroup)**.



10455 Mill Run Circle  
Owings Mills, MD 21117

**[carefirst.com/rxgroup](https://www.carefirst.com/rxgroup)**

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc. CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., The Dental Network and First Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.). The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

SUM5467-1S (12/23) ■ 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](mailto:civilrightscoordinator@carefirst.com)

Telephone Number        410-528-7820

Fax Number                410-505-2011

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

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

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

## Foreign Language Assistance

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

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

*Èdè Yorùbá (Yoruba) Ìtètíléko: Àkíyèsí yìí ní iwífún nípa isẹ adójútòfò rẹ. Ó le ní àwọn déèti pàtó o sì le ní láti gbé ìgbésé ní àwọn ojò gbèdèké kan. O ni ètò láti gba iwífún yìí àti irànlówó ní èdè rẹ lófèè. Àwọn omọ-egbé gbòdò pe nómà fòdùn tò wà lèyìn kààdi idánimò wọn. Àwọn mírán le pe 855-258-6518 kí o sì dúró nípasè ìjíròrò tí tí a ó fí sọ fún ọ láti tẹ 0. Nígbatí aṣojú kan bá dáhùn, sọ èdè tí o fẹ a ó sì sọ ọ pò mó ògbufò kan.*

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

*Tagalog (Tagalog) Atensyon: Ang abisong ito ay naglalaman ng impormasyon tungkol sa 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।

Bàsòò-wùdù (Bassa) Tò Dùù Cáò! Bǎ nìà kè bá nyò bě kè m̄ gbo kpá bó nì fùà-fúá-tiǐn nyεε jè dyí. Bǎ nìà kè bédé wé jéé bě b́é m̄ ḱé dε wa ḿò m̄ ḱé nyuεε nyu hwè b́é wé b́èa ḱé zi. Ǿ m̀ò nì kpé b́é m̄ ḱé bǎ nìà kè kè gbo-kpá-kpá m̄ ḿóεε dyé dé nì bídí-wùdù mú b́é m̄ ḱé se wídí d̀ò péè. Kpooò nyò b́é m̄ dá fúùn-nòbà nìà dé waa I.D. káàò d́éin nyε. Nyò t̀òò séin m̄ dá nòbà nìà kè: 855-258-6518, ḱé m̄ m̄ f̀ò tee b́é wa ḱéε m̄ gbo ćé b́é m̄ ḱé nòbà m̀òà 0 ḱéε dyi pàd̀àn hwè. Ǿ j̀ú ḱé nyò d̀ò dyi m̄ g̀ǎ j̀úǐn, po wuqu m̄ ḿó poε dyie, ḱé nyò d̀ò mu bó nìin b́é Ǿ ḱé nì wuquò mú zà.

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

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

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

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

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

*Igbo (Igbo)* Nrubama: Okwa a nwere ozi gbasara mkpuchi nchekwa onwe gi. O nwere ike inwe ubochi ndi di mkpa, i nwere ike ime ihe tupu ufodu ubochi njedebe. I nwere ikike inweta ozi na enyemaka a n'asusu gi na akwughi ugwo o bula. Ndi otu kwesiri ikpo akara ekwentu di n'azu nke kaadi njirimara ha. Ndi ozo niile nwere ike ikpo 855-258-6518 wee chere ububo ahu ruo mgbe amanyere ipi 0. Mgbe onye nnochite anya zara, kwuo asusu i choro, a ga-ejiko gi na onye okowa okwu.

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

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

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

*Diné Bizaad (Navajo)* Ge': Díí bee íł hane'ígíí bii' dahóló bee éédahózin béeso ách'ááh naanil ník'ist'í'ígíí bá. Bii' dahólóq doo íyisíí yoolkáálígíí dóo t'áadoo le'é ádadoolyíí'ígíí da yókeedgo t'áa doo bee e'e'ahí ájiil'ííh. Bee ná ahóót'í' díí bee íł hane' dóo níká'ádoowoł t'áa nínizaad bee t'áa jiik'é. Atah danilínígíí béesh bee hane'é bee wólta'ígíí nitł'izgo bee nee hódolzinígíí bikéédéé' bikáá' bich'í' hodoonihjí'. Aadóo náánałta' éi kójjí' dahóoolnih 855-258-6518 dóo yii diiłts'ííł yałtí'ígíí t'áa níléjį́ áádóo éi bikéé'dóo naasbaąs bił adidiilchil. Áká'ánidaalwó'ígíí neidiitáągo, saad bee yániłt'í'ígíí yii diikił dóo ata' halne'é lá níká'ádoowoł.