TUFTS iii Health Plan Generic Focused Formulary Prescription Drug List in Alphabetical Order

Last Updated: 12/22/2014

Key Terms

Generic Focused Formulary

Tufts Health Plan Drug List

Formulary

A formulary is a list of prescription medications developed by a committee of practicing physicians and practicing pharmacists who represent a variety of specialty areas and who are knowledgeable in the diagnosis and treatment of disease.

Brand-Name Drugs

Brand-name drugs are typically the first products to gain U.S. Food and Drug Administration (FDA) approval.

Generic Drugs

Generic drugs have the same active ingredients and come in the same strengths and dosage forms as the equivalent brand-name drug. Multiple manufacturers may produce the same generic drug and the product may differ from its brand name counterpart in color, size or shape, but the differences do not alter the effectiveness. Generic versions of brand-name drugs are reviewed and approved by the FDA. The FDA works closely with all pharmaceutical companies to make sure that all drugs sold in the U.S. meet appropriate standards for strength, quality, and purity.

3-Tier Pharmacy Copayment Program (3-Tier Program)

To help maintain affordability in the pharmacy benefit, we encourage the use of cost-effective drugs and preferred brand names through the three-tier program. This program gives you and your doctor the opportunity to work together to find a prescription medication that's affordable and appropriate for you.

All covered drugs are placed into one of three tiers. Your physician may have the option to write you a prescription for a Tier 1, Tier 2, or Tier 3 drug (as defined below); however, there may be instances when only a Tier 3 drug is appropriate, which will require a higher copayment.

- Tier 1: Medications on this tier have the lowest copayment. This tier includes many generic drugs.
- Tier 2: Medications on this tier are subject to the middle copayment. This tier includes some generics and brand-name drugs.
- Tier 3: This is the highest copayment tier and includes some generics and brand-name covered drugs not selected for Tier 2.

 Please note that tier placement is subject to change throughout the year.

Copayment

A copayment is the fee a member pays for certain covered drugs. A member pays the copayment directly to the provider when he/she receives a covered drug, unless the provider arranges otherwise.

Boldface - indicates generic availability.
SP - Designated Specialty Pharmacy

STPA - Step Therapy Prior Authorization SI - Specialty Infusion PA - Prior Authorization
QL - Quantity Limitation Program
MM - Managed Mail

Coinsurance

Coinsurance requires the member to pay a percentage of the total cost for certain covered drugs.

Medical Review Process

Tufts Health Plan has pharmacy programs in place to help manage the pharmacy benefit. Requests for medically necessary review for coverage of drugs included in the New-to-Market Drug Evaluation Process (NTM). Prior Authorization Program (PA). Step Therapy Prior Authorization Program (STPA). Quantity Limitations Program (QL), Non-Covered Drugs (NC) With Suggested Alternatives Program should be completed by the physician and sent to Tufts Health Plan. Drugs excluded under your pharmacy benefit will not be covered through this process. The request must include clinical information that supports why the drug is medically necessary for you. Tufts Health Plan will approve the request if it meets coverage quidelines. If Tufts Health Plan does not approve the request, you have the right to appeal. The appeal process is described in your benefit document.

Note: Drugs approved through the Medical Review Process will be subject to a Tier 3 copayment.

Quantity Limitation (QL) Program

Because of potential safety and utilization concerns. Tufts Health Plan has placed quantity limitations on some prescription drugs. You are covered for up to the amount posted in our list of covered drugs. These quantities are based on recognized standards of care as well as from FDA-approved dosing guidelines. If your provider believes it is necessary for you to take more than the QL amount posted on the list, he or she may submit a request for coverage under the Medical Review Process.

New-To-Market Drug Evaluation Process (NTM)

In an effort to make sure the new-to-market prescription drugs we cover are safe, effective and affordable, we delay coverage of many new drug products until the Plan's Pharmacy and Therapeutics Committee and physician specialists have reviewed them. This review process is usually completed within six months after a drug becomes available.

The review process enables us to learn a great deal about these new drugs, including how a physician can safely prescribe these new drugs and how physicians can choose the most appropriate patients for the new therapy. During the review process, if your physician believes you have a medical need for the New-To-Market drug, your doctor can submit a request for coverage to Tufts Health Plan under the Medical Review Process.

If your plan includes the 3-Tier Copayment Program, then you will pay the Tier-3 (highest) copayment if the medication is approved for coverage.

Non-Covered Drugs (NC)

There are thousands of drugs listed on the Tufts Health Plan covered drug list. In fact, most drugs are covered. There is, however, a list of drugs that Tufts Health Plan currently does not cover.

In many cases, these drugs are not covered by Tufts Health Plan because there are safe, comparably effective, and cost effective alternatives available. Our goal is to keep pharmacy benefits as affordable as possible.

If your doctor feels that one of the non-covered drugs is needed, your doctor can submit a request for coverage to Tufts Health Plan under the Medical Review Process.

Prior Authorization (PA) Program

In order to ensure safety and affordability for everyone, some medications require prior authorization. This helps us work with your doctor to ensure that medications are prescribed appropriately.

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STPA - Step Therapy Prior Authorization

- Specialty Infusion

PA - Prior Authorization **OL** - Quantity Limitation Program MM - Managed Mail

If your doctor feels it is medically necessary for you to take one of the drugs listed below, he/she can submit a request for coverage to Tufts Health Plan under the Medical Review Process.

Step Therapy Prior Authorization (STPA)

Step Therapy is an automated form of Prior Authorization. It encourages the use of therapies that should be tried first, before other treatments are covered, based on clinical practice guidelines and costeffectiveness. Some types of Step Therapy include requiring the use of generics before brand name drugs. preferred before non-preferred brand name drugs, and first-line before second-line therapies.

Medications included on step 1- the lowest step-are usually covered without authorization. We have noted the few exceptions, which may require your physician to submit a request to Tufts Health Plan for coverage. Medications on Step 2 or higher are automatically authorized at the point-of-sale if you have taken the required prerequisite drugs. However, if your physician prescribes a medication on a higher step, and you have not yet taken the required medication(s) on a lower step, or if you are a new Tufts Health Plan member and do not have any prescription drug claims history, the prescription will deny at the point-of-sale with a message indicating that a Prior Authorization (PA) is required. Physicians may submit requests for coverage to Tufts Health Plan for members who do not meet the Step Therapy criteria at the point of sale under the Medical Review process.

Designated Specialty Pharmacy Program (SP)

Tufts Health Plan's goal is to offer you the most clinically appropriate and cost-effective services.

As a result, we have designated special pharmacies to supply a select number of medications used in the treatment of complex diseases. These pharmacies are specialized in providing these medications and are staffed with nurses, coordinators and pharmacists to provide support services for members.

Medications include, but are not limited to, those used in the treatment of infertility, multiple sclerosis, hemophilia, hepatitis C and growth hormone deficiency. You can obtain up to a 30-day supply of these medications at a time.

Other special designated pharmacies and medications may be identified and added to this program from time to time.

Benefits vary; some members may not participate in this program. Please see your benefit document for complete information.

Physicians may obtain a select number of specialty medications through a designated SP for administration in the office as an alternative to direct purchase. These medications are covered under the medical benefit, and will be shipped directly to and administered in the office by the member's provider. The designated pharmacy will bill Tufts Health Plan directly for the medication.

For the most current listing of special designated pharmacies or to find out if your plan includes this program, please call us at the number listed on the back of your member identification card.

Designated Specialty Infusion Program for Drugs Covered Under the Medical Benefit (SI)

Tufts Health Plan has designated home infusion providers for a select number of specialized pharmacy products and drug administration services.

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The designated specialty infusion provider offers clinical management of drug therapies, nursing support, and care coordination to members with acute and chronic conditions. Place of service may be in the home or alternate infusion site based on availability of infusion centers and determination of the most clinically appropriate site for treatment. These medications are covered under the medical benefit (not the pharmacy benefit) and generally require support services, medication dose management, and special handling in addition to the drug administration services. Medications include, but are not limited to, medications used in the treatment of hemophilia, pulmonary arterial hypertension, and immune deficiency. Other specialty infusion providers and medications may be identified and added to this program from time to time.

Generic Focused Formulary

The Generic Focused Formulary, which is the formulary used in our Select Network and/or Connector Plans differs from other Tufts Health Plan formularies. Most generic drugs are covered, and only select brand name drugs that have no generic drug equivalent are covered. Brand name drugs with generic equivalents are not covered under this formulary. If the patent of a brand name drug listed expires and a generic version becomes available, the brand will no longer be covered. This change will happen automatically and without notification to members or providers.

GFF Formulary

Managed Mail (MM) Program

Our Managed Mail (MM) Program applies to certain plans. It requires that in order to be covered, prescriptions for most maintenance medications must be filled by our mail order pharmacy. Maintenance medications are those you refill monthly for chronic conditions like asthma, high blood pressure, or diabetes. Under this program, you are allowed an initial fill at a retail pharmacy and a limited number of refills. After that, in order to be covered, you must fill your maintenance prescription through the mail order program offered by CVS Caremark, our pharmacy benefits manager. You may obtain up to a 90-day supply for these maintenance medications at mail order. Please note that some medications may not be appropriate for mail order. These include medications with quantity limitations (QL) of less than 84 or 90 days.

If you have questions about this program, please contact us at the number listed on the back of your member identification card.

Over-The-Counter Drugs (OTC)

When a medication with the same active ingredient or a modified version of an active ingredient that is therapeutically equivalent, becomes available over-the-counter, Tufts Health Plan may exclude coverage of the specific medication or all of the prescription drugs in the class. For more information, please call our Member Services Department at the number listed on the back of your member identification card.

SI - Specialty Infusion

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Pharmacy Program

| Drug Name | Tier | Pharmacy Program |
|-----------------------------------|--------------------|---|
| abacavir | Tier 1 | MM |
| abacavir/lamivudine/zidovudine | Tier 1 | MM |
| Abilify (tablets only) | Tier 3 | QL STPA 30 tablets/30 days |
| Abstral | Tiel 3 | QL Drug is not covered, but if covered through |
| Austral | | medical review process, QL of 32 tablets/30 days will apply. |
| acamprosate | Tier 1 | · · · · · · · · · · · · · · · · · · · |
| acarbose | Tier 1 | MM |
| Accu-Chek | Tier 2 | MM |
| Accuneb | | QL Drug is not covered, but if covered through medical review process, QL of 360 unit-dose vials/90 days will apply. |
| acebutolol | Tier 1 | MM |
| acetazolamide | Tier 1 | MM |
| acetazolamide ext-rel | Tier 1 | MM |
| acetic acid otic | Tier 1 | |
| acetic acid/aluminum acetate otic | Tier 1 | |
| acetic acid/hydrocortisone otic | Tier 1 | |
| acitretin | Tier 1 | |
| Actemra prefilled syringe | Tier 2 | SP PA QL 4 syringes/28 days, Call Accredo at 1-877-238-8387 |
| Actemra vial | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| Actimmune | Tier 3 | |
| Actonel | Tier 3 | STPA MM |
| acyclovir | Tier 1 | |
| adapalene cream, gel 0.1% | Tier 1 | PA Prior Authorization required for members 26 years of age or older. |
| Adeirea | Tier 3 | SP PA Call Accredo at 1-866-344-4874 |
| adefovir dipivoxil | Tier 1 | MM |
| Adempas | Tier 2 | SP PA Call Accredo at 1-866-344-4874 |
| Advair Diskus | Tier 3 | QL MM 3 diskus/90 days |
| Advair HFA | Tier 3 | QL MM 6 inhalers/90 days |
| Aerospan | Tier 3 | QL 6 inhalers/90 days |
| Afinitor | Tier 2 | SP PA QL 30 tablets/30 days, Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Pleas contact your plan sponsor/employer about |
| Afinitor Disperz | Tier 2 | applicability and effective date for your group. SP PA QL Oral cancer medications may be |
| | | covered without copayment under the Massachusetts oral cancer therapy mandate. Pleas contact your plan sponsor/employer about applicability and effective date for your group., Call Accredo at 1-877-238-8387, 60 tablets/30 |
| | | davs |
| Aggrenox | Tier 3 | days MM |
| Aggrenox albuterol solution | Tier 3 | |

Tier

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NC - Non Covered Drugs NTM - New-to-Market

Drug Name

| albuterol sulfate ext-rel | Tier 1 | MM |
|--------------------------------------|--------------------|--|
| albuterol sulfate nebulizer solution | | QL 360 unit-dose vials/90 days or 9 dropper |
| | | bottles (180 mL)/90 days |
| albuterol sulfate nebulizer solution | Tier 1 | QL MM 360 unit-dose vials/90 days or 9 dropper bottles (180 mL)/90 days |
| alclometasone cream, ointment 0.05% | Tier 1 | · · · · · · · · · · · · · · · · · · · |
| Aldara | | QL Drug is not covered, but if covered through medical review process, QL of 1 box (12 treatments)/28 days will apply. |
| Aldurazyme | Medical Benefit | SI Covered under the medical benefit. For home infusion services call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767. |
| alendronate tablets | Tier 1 | MM |
| alfuzosin ext-rel | Tier 1 | MM |
| Alkeran | Tier 2 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| allopurinol | Tier 1 | MM |
| Alora | Tier 3 | QL MM 24 patches/84 days |
| Alphagan P | | QL Drug is not covered, but if covered through medical review process, QL of 30 mL/90 days will apply. |
| alprazolam | Tier 1 | |
| alprazolam ext-rel | Tier 1 | |
| Alsuma | | QL Drug is not covered, but if covered through medical review process, QL of 4 injections (4 vials)/30 days will apply. |
| Alvesco | | QL Drug is not covered, but if covered through medical review process, QL of 80 mcg: 3 inhalers/90 days; 160 mcg: 6 inhalers/90 days will apply. |
| amantadine | Tier 1 | MM |
| Ambien | | QL Drug is not covered, but if covered through medical review process, QL of 30 tablets/90 days will apply. |
| Ambien CR | | QL Drug is not covered, but if covered through medical review process, QL of 30 tablets/90 days will apply. |
| amcinonide cream, lotion 0.1% | Tier 1 | |
| Amcinonide ointment | Tier 2 | |
| Amerge | | QL Drug is not covered, but if covered through medical review process, QL of 9 tablets/30 days will apply. |
| Amethia Lo | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Amethyst | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| amiloride | Tier 1 | MM |
| amiloride/hydrochlorothiazide | Tier 1 | MM |
| amiodarone | Tier 1 | MM |
| Amitiza | Tier 3 | |

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|---|--------|---|
| amitriptyline | Tier 1 | |
| amlodipine | Tier 1 | MM |
| amlodipine/atorvastatin | Tier 2 | MM |
| amlodipine/benazepril | Tier 1 | MM |
| ammonium lactate 12% | Tier 1 | |
| Amnesteem | Tier 1 | |
| Amoxapine | Tier 3 | |
| amoxicillin | Tier 1 | |
| amoxicillin/clavulanate | Tier 1 | |
| amphetamine/dextroamphetamine mixed salts | Tier 1 | |
| amphetamine/dextroamphetamine mixed salts ext-rel | Tier 1 | |
| ampicillin | Tier 1 | |
| Ampyra | Tier 2 | SP PA QL 60 tablets/30 days, Call Accredo at 1-877-238-8387 |
| Amturnide | Tier 3 | MM |
| anagrelide | Tier 1 | MM |
| Analpram-HC | Tier 3 | |
| anastrozole | Tier 1 | MM Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| AndroGel | Tier 3 | and see year geoup. |
| Anzemet | Tier 3 | QL tablets: 3 tablets/7 days; injection: 5 mL/7 days |
| Apidra | Tier 2 | MM |
| Aplenzin | Tier 3 | STPA Step Therapy Prior Authorization required for members 18 years of age or older. |
| Apokyn | Tier 3 | for memoers to years of age of order. |
| Apri | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for |
| | | your group. |
| Apriso | Tier 2 | MM |
| Aptivus | Tier 2 | MM |
| Aranelle | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Aranesp | Tier 3 | SP QL 4 mL/30 days, Call Accredo at 1-877-238-8387 |
| Arcalyst | Tier 2 | SP PA QL Call Caremark at 1-800-237-2767, 5 vials/initial 28 days; thereafter, 4 vials/28 days |
| Armour Thyroid | Tier 2 | MM |
| Asacol HD | Tier 2 | MM |
| Asmanex | Tier 3 | QL MM 6 Twisthalers/90 days |
| atenolol | Tier 1 | MM |
| atenolol/chlorthalidone | Tier 1 | MM |
| atorvastatin | Tier 1 | MM |
| atovaquone/proguanil | Tier 2 | |
| Atripla | Tier 2 | MM |
| Atrovent HFA | Tier 3 | QL MM 6 inhalers/90 days |
| Atrovent Nasal Aerosol | 1101 3 | QL Drug is not covered, but if covered through medical review process, QL of 6 nasal spray units/90 days will apply. |

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- Prior Authorization QL - Quantity Limitation Program MM - Managed Mail

| Aubagio | Tier 2 | SP PA QL 28 tablets/28 days, Call Accredo at 1- 877-238-8387 |
|----------------------|--------|---|
| Auvi-Q | Tier 3 | QL 2 units/fill |
| Avandia | | QL Drug is not covered, but if covered through medical review process, QL of 2 mg: 180 tablets/90 days; 4 mg: 180 tablets/90 days; 8 mg: 90 tablets/90 days, Drug is not covered, but if covered through medical review process, QL of 2 mg: 180 tablets/90 days; 4 mg: 180 tablets/90 days; 8 mg: 90 tablets/90 days |
| Avandia | Tier 3 | QL Drug is not covered, but if covered through medical review process, QL of 2 mg: 180 tablets/90 days; 4 mg: 180 tablets/90 days; 8 mg: 90 tablets/90 days, Drug is not covered, but if covered through medical review process, QL of 2 mg: 180 tablets/90 days; 4 mg: 180 tablets/90 days; 8 mg: 90 tablets/90 days |
| Aviane | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Avita | Tier 1 | PA Prior Authorization required for members 26 years of age or older. |
| Avodart | Tier 3 | MM |
| Avonex | Tier 3 | SP QL 4 syringes or 4 vials/28 days, Call Accredo at 1-877-238-8387 |
| Avonex Pen | Tier 3 | SP QL Call Accredo at 1-877-238-8387, 4 pens/28 days |
| Axert | | QL Drug is not covered, but if covered through medical review process, QL of 6 tablets/30 days will apply. |
| AzaSite | Tier 3 | QL 1 bottle/7 days |
| azathioprine | Tier 1 | MM |
| azelastine eye drops | Tier 1 | |
| azelastine spray | Tier 1 | QL 3 nasal spray units/90 days |
| Azelex | Tier 3 | QL 90 grams/90 days |
| azithromycin | Tier 1 | |
| Azopt | Tier 3 | QL MM 30 mL/90 days |

<u>B</u>

| Drug Name | Tier | Pharmacy Program |
|---------------------------------|--------|---|
| bacitracin eye ointment | Tier 1 | |
| baclofen | Tier 1 | MM |
| balsalazide | Tier 1 | |
| Banzel | Tier 2 | QL MM 200 mg tablets: 1440 tablets/90 days; 400 mg tablets: 720 tablets/90 days; 40 mg/mL suspension: 4 bottles/30 days |
| Baraclude | Tier 2 | MM |
| BD insulin syringes and needles | Tier 2 | MM |
| Beconase AQ | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal spray units/90 days will apply. |
| benazepril | Tier 1 | MM |
| benazepril/hydrochlorothiazide | Tier 1 | MM |
| Benicar | Tier 2 | MM |

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| Benlysta | Medical Benefit | PA Covered under the medical benefit. |
|--|--------------------|--|
| Benzaclin | | QL Drug is not covered, but if covered through medical review process, QL of 75 grams/90 days will apply. |
| benzocaine/antipyrine otic | Tier 1 | |
| benzonatate | Tier 1 | |
| benzoyl peroxide | Tier 1 | |
| benztropine | Tier 1 | MM |
| Berinert | Medical Benefit | SI For home infusion services call Caremark at 1-800-237-2767. Covered under the medical benefit. |
| Besivance | | QL Drug is not covered, but if covered through medical review process, QL of 1 bottle/5 days will apply. |
| betamethasone dipropionate augmented cream 0.05% | Tier 1 | |
| betamethasone dipropionate augmented gel, ointment 0.05% | Tier 1 | |
| betamethasone dipropionate cream, lotion, ointment 0.05% | Tier 1 | |
| betamethasone valerate cream, lotion, ointment 0.1% | Tier 1 | |
| betamethasone valerate foam 0.12% | Tier 1 | |
| Betaseron | Tier 3 | SP QL 15 vials/30 days, Call Accredo at 1-877- 238-8387 |
| betaxolol | Tier 1 | MM |
| bethanechol | Tier 1 | |
| Bethkis | Tier 3 | |
| Betoptic S | Tier 3 | MM |
| Beyaz | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| bicalutamide | Tier 1 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| BiferaRx | Tier 3 | date for your group. |
| bisoprolol | Tier 1 | MM |
| bisoprolol/hydrochlorothiazide | Tier 1 | MM |
| Blephamide SOP | Tier 3 | |
| Boniva IV | Medical Benefit | PA Covered under the medical benefit. |
| Bosulif | Tier 2 | SP PA QL 100 mg: 120 tablets/30 days; 500 mg: 30 tablets/30 days, Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Botulinum Toxins | Medical | PA Prior Authorization. Examples include Botox, |
| | Benefit | Dysport, Myobloc and Xeomin. Covered under the medical benefit. |
| Bravelle | Tier 3 | SP PA SP PA Call Village Pharmacy at 1-866-890 -8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657- |
| Brilinta | Tier 3 | 0500 MM |
| brimonidine | 1101 3 | QL |
| brimonidine eye drops 0.15% | Tier 1 | QL MM 30 mL/90 days |
| ormoniume cyc drops 0.13/0 | 1101 1 | QL MINI 30 IIIL/70 days |

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| brimonidine eye drops 0.2% | Tier 1 | MM |
|-------------------------------------|--------------|--|
| bromfenac sodium eye drops | Tier 1 | |
| bromocriptine | Tier 1 | MM |
| budesonide delayed-release capsules | Tier 1 | |
| budesonide inhalation suspension | | QL Step Therapy Prior Authorization required for members 18 years of age or older., 180 unit-dose vials/90 days |
| budesonide inhalation suspension | Tier 1 | QL MM Step Therapy Prior Authorization required for members 18 years of age or older., 180 unit-dose vials/90 days |
| bumetanide | Tier 1 | MM |
| buprenorphine | Tier 1 | PA |
| buprenorphine/naloxone SL tablets | Tier 1 | PA |
| Buproban (generic of Zyban) | No copayment | QL Annual limit of 180 tablets/90 days |
| bupropion | Tier 1 | |
| bupropion (generic of Zyban) | No copayment | QL Annual limit of 180 tablets/90 days |
| bupropion ext-rel | Tier 1 | |
| bupropion XL | Tier 1 | |
| buspirone | Tier 1 | |
| butalbital compound | Tier 1 | |
| butalbital/acetaminophen | Tier 1 | |
| butalbital/acetaminophen/caffeine | Tier 1 | |
| butalbital/aspirin/caffeine | Tier 1 | |
| butorphanol nasal spray | Tier 1 | QL 3 bottles (9 mL total)/30 days |
| Butrans | | QL Drug is not covered, but if covered through medical review process, QL or 4 patches/30 days will apply. |
| Bydureon | Tier 3 | MM |
| Byetta | Tier 3 | MM |
| | | |

<u>C</u>

| Drug Name | Tier | Pharmacy Program |
|---------------------------------|--------|--|
| cabergoline | Tier 1 | |
| calcipotriene topical | Tier 1 | QL 1 tube or 1 bottle/day |
| calcitonin-salmon nasal spray | Tier 1 | |
| calcitriol (1,25-D3) | Tier 1 | MM |
| calcitriol ointment | Tier 2 | |
| calcium acetate capsules | Tier 1 | MM |
| Cambia | | QL Drug is not covered, but if covered through medical review process, QL of 9 packets/30 days will apply. |
| Camila | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Canasa | Tier 3 | |
| candesartan | Tier 2 | MM |
| candesartan/hydrochlorothiazide | Tier 2 | MM |

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| capecitabine | Tier 1 | SP QL 150 mg: 84 capsules/14 days; 500 mg: 168 capsules/14 days, Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective |
|-------------------------------|--------------|--|
| | | date for your group. |
| Caprelsa | Tier 2 | PA QL 100 mg: 60 tablets/30 days; 300 mg: 30 tablets/30 days, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| captopril | Tier 1 | MM |
| captopril/hydrochlorothiazide | Tier 1 | MM |
| Carac | Tier 3 | |
| Carbaglu | Tier 2 | PA |
| carbamazepine | Tier 1 | MM |
| carbamazepine ext-rel | Tier 1 | MM |
| carbidopa/levodopa | Tier 1 | MM |
| carbidopa/levodopa ext-rel | Tier 1 | MM |
| carbidopa/levodopa/entacapone | Tier 1 | MM |
| carisoprodol | Tier 1 | |
| carvedilol | Tier 1 | MM |
| Cayston | Tier 3 | |
| cefaclor | Tier 1 | |
| Cefaclor ext-rel | Tier 2 | |
| cefadroxil | Tier 1 | |
| cefdinir | Tier 1 | |
| cefepime | Tier 1 | |
| cefpodoxime suspension | Tier 1 | |
| cefpodoxime tablets | Tier 1 | |
| cefprozil | Tier 1 | |
| cefuroxime axetil | Tier 1 | |
| Celebrex | Tier 3 | PA |
| Cenestin | Tier 3 | MM |
| cephalexin | Tier 1 | |
| Cerezyme | Medical | PA SI Covered under the medical benefit., For |
| | Benefit | home infusion services call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767. |
| Cesamet | Tier 3 | QL 18 capsules/7 days |
| Cetrotide | Tier 3 | SP PA Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| cevimeline | Tier 1 | |
| Chantix | No copayment | QL Annual limit of 24 weeks |
| chloral hydrate | Tier 1 | |
| chlordiazepoxide | Tier 1 | |
| chlordiazepoxide/clidinium | Tier 1 | |
| chlorhexidine gluconate | Tier 1 | |
| chloroquine | Tier 1 | |
| chlorpromazine | Tier 1 | |
| chlorthalidone | Tier 1 | MM |
| chlorzoxazone | Tier 1 | |
| cholestyramine | Tier 1 | MM |

Boldface - indicates generic availability.
SP - Designated Specialty Pharmacy
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SI - Specialty Infusion

PA - Prior Authorization QL - Quantity Limitation Program MM - Managed Mail

| | | East Opaacoa: 12/22/2011 |
|---|--------------------|---|
| chorionic gonadotropin | Tier 1 | SP Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| ciclopirox cream, lotion | Tier 1 | |
| ciclopirox topical solution 8% | | QL 1 bottle/30 days |
| ciclopirox topical solution 8% | Tier 1 | QL 1 bottle/30 days |
| cilostazol | Tier 1 | |
| cimetidine | Tier 1 | |
| Cimzia prefilled syringe | Tier 2 | SP PA QL 2 injections/28 days, Cimzia syringes are covered under the pharmacy benefit, prior authorization applies. Cimzia vials are covered under the medical benefit only, prior authorization applies., Call Accredo at 1-877-238-8387 |
| Cimzia prefilled syringe | Tier 3 | SP PA QL 2 injections/28 days, Cimzia syringes are covered under the pharmacy benefit, prior authorization applies. Cimzia vials are covered under the medical benefit only, prior authorization applies., Call Accredo at 1-877-238-8387 |
| Cimzia vial | Medical | PA Cimzia vials are covered under the medical |
| | Benefit | benefit, prior authorization applies. Available to providers through Accredo, call 1-877-238-8387. Cimzia syringes are covered under the pharmacy benefit, prior authorization applies. |
| Cinryze | Medical Benefit | PA SI Covered under the medical benefit., For home infusion services call Caremark at 1-800-237 -2767. |
| Cipro HC Otic | Tier 3 | |
| Cipro suspension | Tier 3 | |
| Ciprodex | Tier 3 | |
| ciprofloxacin ext-rel | Tier 1 | |
| ciprofloxacin eye drops, eye ointment | Tier 1 | |
| ciprofloxacin tablets | Tier 1 | |
| citalopram | Tier 1 | |
| Claravis | Tier 1 | |
| clarithromycin | Tier 1 | |
| clarithromycin ext-rel | Tier 1 | |
| clemastine 2.68 mg | Tier 1 | |
| Climara Pro | Tier 3 | QL MM 12 patches/84 days |
| clindamycin | Tier 1 | |
| clindamycin 1%/benzoyl peroxide 5% | Tier 1 | |
| clindamycin gel, lotion, solution | Tier 1 | |
| clindamycin palmitate oral solution | Tier 1 | |
| clindamycin phosphate foam 1% | Tier 1 | |
| clindamycin vaginal cream | Tier 1 | |
| clindamycin/benzoyl peroxide | | QL |
| clindamycin/benzoyl peroxide gel | Tier 1 | QL 100 grams/90 days |
| Clindesse | Tier 3 | |
| clobetasol propionate 0.05%/emollient foam | Tier 1 | |
| clobetasol propionate cream, ointment 0.05% | Tier 1 | |
| clobetasol propionate foam 0.05% | Tier 1 | |
| clobetasol propionate lotion, shampoo 0.05% | Tier 1 | |
| clocortolone pivalate cream 0.1% | Tier 1 | |
| clomiphene | Tier 1 | |
| clomipramine | Tier 1 | |
| clonazepam | Tier 1 | |
| clonidine | Tier 1 | MM |
| clonidine ext-rel | Tier 1 | |

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| clonidine patch | Tier 1 | MM |
|--|---------------|---|
| clopidogrel | Tier 1 | MM |
| clorazepate | Tier 1 | 141141 |
| clotrimazole | Tier 1 | |
| clotrimazole troches | Tier 1 | |
| clotrimazole/betamethasone | Tier 1 | |
| clozapine | Tier 1 | |
| Coartem | Tier 2 | QL 24 tablets/180 days |
| codeine sulfate | Tier 1 | QL 24 tablets/180 days |
| codeine/acetaminophen | Tier 1 | |
| codeine/chlorpheniramine/pseudoephedrine | Tier 1 | |
| codeine/guaifenesin | Tier 1 | |
| | Tier 1 | |
| codeine/guaifenesin/pseudoephedrine | | |
| codeine/promethazine | Tier 1 | MM |
| colchicine/probenecid | Tier 1 Tier 2 | |
| Colcrys | | QL MM 60 tablets/30 days |
| colestipol | Tier 1 | MM |
| Colocort | Tier 1 | 107 |
| CombiPatch | Tier 3 | MM |
| Combivent Respimat | Tier 3 | QL MM 6 inhalers/90 days |
| Cometriq | Tier 2 | PA Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Complera | Tier 2 | MM |
| Copaxone 20 mg/mL prefilled syringe | Tier 3 | SP QL Call Accredo at 1-877-238-8387, 1 kit (30 syringes)/30 days |
| Cortifoam | Tier 3 | |
| cortisone acetate | Tier 1 | |
| Corvite 150 | Tier 3 | |
| Cosopt | | QL Drug is not covered, but if covered through medical review process, QL of 30 mL/90 days will apply. |
| Cosopt PF | Tier 3 | MM |
| Creon | Tier 3 | MM |
| Crixivan | Tier 2 | MM |
| cromolyn sodium eye drops | Tier 1 | |
| cromolyn sodium nebulizer solution | Tier 1 | QL MM 360 unit-dose vials/90 days |
| Cuprimine | Tier 3 | • |
| Cuvposa Solution | | QL Drug is not covered, but if covered through medical review process, QL of 3 bottles/90 days will apply. |
| cyanocobalamin injection | Tier 1 | |
| cyclobenzaprine | Tier 1 | |
| cyclophosphamide tablets | Tier 1 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| cyclosporine | Tier 1 | MM |
| cyclosporine, modified | Tier 1 | MM |
| cyproheptadine | Tier 1 | |
| Cystaran | Tier 2 | SP Call Accredo at 1-877-238-8387 |
| Cyto-Q | Tier 3 | |

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\mathbf{D}

| Drug Name | Tier | Pharmacy Program |
|--|---------|--|
| Daliresp | Tier 3 | MM |
| danazol | Tier 1 | |
| dantrolene | Tier 1 | |
| dapsone | Tier 1 | |
| Daytrana | Tier 3 | STPA |
| Delzicol | Tier 2 | |
| desipramine | Tier 1 | |
| desmopressin spray, tablets | Tier 1 | MM |
| desonide cream, lotion, ointment 0.05% | Tier 1 | |
| desoximetasone cream, ointment 0.05% | Tier 1 | |
| desoximetasone cream, ointment 0.25%, gel 0.05% | Tier 1 | |
| Detrol LA | Tier 3 | STPA MM |
| dexamethasone | Tier 1 | |
| dexamethasone sodium phosphate eye drops, eye ointment | Tier 1 | |
| Dexferrum | Medical | |
| DUMUTUM | Benefit | |
| Dexilant | Denom | QL Drug is not covered, but if covered through medical review process, QL of 90 capsules/90 days will apply. |
| dexmethylphenidate | Tier 1 | win appry. |
| dexmethylphenidate ext-rel 15mg, 30mg (Focalin XR 15mg, 30mg = | | |
| NC) | 1101 2 | |
| dextroamphetamine | Tier 1 | |
| dextroamphetamine ext-rel | Tier 1 | |
| dextroamphetamine solution | Tier 1 | |
| dextromethorphan/brompheniramine/pseudoephedrine | Tier 1 | |
| dextromethorphan/promethazine | Tier 1 | |
| diazepam | Tier 1 | |
| diazepam rectal gel | Tier 1 | QL 1 kit (2 units)/30 days |
| diclofenac potassium | Tier 1 | QD 1 kit (2 dints)//50 days |
| diclofenac sodium 3% gel | Tier 1 | |
| diclofenac sodium delayed-rel | Tier 1 | |
| diclofenac sodium delayed-rel/misoprostol | Tier 1 | |
| diclofenac sodium eye drops | Tier 1 | |
| dicloxacillin | Tier 1 | |
| dicyclomine | Tier 1 | |
| didanosine delayed-rel | Tier 1 | MM |
| Differin lotion 0.1% | Tier 3 | PA Prior Authorization required for members 26 |
| Differin fotion 0.1 /0 | TICI 3 | years of age or older. |
| Dificid | Tier 3 | PA |
| diflorasone diacetate cream 0.05% | Tier 1 | |
| diflorasone diacetate circum 0.05% | Tier 1 | |
| diflunisal | Tier 1 | |
| digoxin | Tier 1 | MM |
| digoxin ped elixir | Tier 1 | MM |
| dihydroergotamine injection | Tier 1 | ***** |
| dihydroergotamine spray | Tier 1 | QL 1 box (8 vials)/30 days |
| diltiazem | Tier 1 | MM |
| diltiazem ext-rel | Tier 1 | MM |
| Diovan | Tier 2 | MM |
| Diovan | 1101 4 | |
| Dipentum | Tier 3 | MM |

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- Prior Authorization QL - Quantity Limitation Program MM - Managed Mail

| dipivefrin eye drops | Tier 1 | |
|---|--------|--|
| dipyridamole | Tier 1 | MM |
| disopyramide | Tier 1 | MM |
| disulfiram | Tier 1 | 141141 |
| divalproex sodium delayed-rel | Tier 1 | MM |
| divalproex sodium ext-rel | Tier 1 | MM |
| divalproex sodium sprinkle 125 mg | Tier 1 | MM |
| donepezil | Tier 1 | MM |
| dorzolamide HCl | Tiel 1 | QL |
| dorzolamide HCl eye drops | Tier 1 | QL MM 30 mL/90 days |
| dorzolamide HCl/timolol maleate | Tier i | · · · · · · · · · · · · · · · · · · · |
| | TP' 1 | QL |
| dorzolamide HCl/timolol maleate eye drops | Tier 1 | QL MM 30 mL/90 days |
| doxazosin | Tier 1 | MM |
| doxepin | Tier 1 | 107 |
| doxercalciferol | Tier 1 | MM |
| doxycycline hyclate | Tier 1 | |
| doxycycline monohydrate | Tier 1 | |
| dronabinol | Tier 1 | |
| Droxia | Tier 2 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Dulera | | QL MM Drug is not covered, but if covered through medical review process, QL of 3 inhalers/90 days will apply. |
| duloxetine delayed-rel | Tier 2 | QL 20 mg: 180 capsules/90 days; 30 mg: 270 capsules/90 days; 60 mg: 180 capsules/90 days |
| Duoneb | | QL Drug is not covered, but if covered through medical review process, QL of 360 unit-dose vials/90 days will apply. |
| Duragesic | | QL Drug is not covered, but if covered through medical review process, QL of 10 patches/30 days will apply. |
| Dymista | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal sprays/90 days will apply. |
| | | 11 7 |

<u>E</u>

| Drug Name | Tier | Pharmacy Program |
|-----------------------|--------------------|---|
| E.E.S. 200 suspension | Tier 3 | |
| econazole | Tier 1 | |
| Edluar | | QL STPA Drug is not covered, but if covered through medical review process, QL of 10 capsules/30 days will apply. |
| Edurant | Tier 2 | MM |
| Effer-K | Tier 3 | MM |
| Effient | Tier 3 | MM |
| Egrifta | Tier 3 | SP PA Call Accredo at 1-877-238-8387 |
| Elaprase | Medical Benefit | SI Covered under the medical benefit. For home infusion services call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767. |
| Elelyso | Medical Benefit | PA Covered under the medical benefit. |
| Elidel | Tier 3 | QL STPA 1 tube/day |
| Eligard | Tier 2 | |

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| Eliquis | Tier 3 | QL MM 60 tablets/30 days |
|-------------------------------|------------------|---|
| Ella | Tier 3 | QL 1 tablet/fill, Contraceptive covered without |
| | | copayment under Women's Health Preventive |
| | | Services Initiative. Please contact your plan |
| | | sponsor / employer about applicability and |
| | | effective date for your group. |
| Elmiron | Tier 3 | |
| Emcyt | Tier 2 | SP Oral cancer medications may be covered |
| | | without copayment under the Massachusetts oral |
| | | cancer therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| | | date for your group., Call Accredo at 1-877-238- |
| | | 8387 |
| Emend | Tier 3 | QL 40 mg: 1 capsule/7 days; 80 mg: 2 capsules/7 |
| T. | E. 3 | days; 125 mg: 1 capsule/7 days; 1 dosepack/7 days |
| Emsam | Tier 3 | STPA Step Therapy Prior Authorization required |
| Ending | Т: 2 | for members 18 years of age and older. MM |
| Emtriva | Tier 2 | |
| Enablex | Tier 3 | MM |
| enalapril | Tier 1 | MM |
| enalapril/hydrochlorothiazide | Tier 1 | MM |
| Enbrel | Tier 3 | SP PA QL 25 mg: 8 vials/28 days; 50 mg: 4 |
| г | т. 2 | syringes/28 days, Call Accredo at 1-877-238-8387 |
| Enjuvia . | Tier 3 | MM |
| enoxaparin | Tier 1 | QL 60 ampules or syringes/30 days |
| Enpresse | Tier 1 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| entacapone | Tier 1 | your group. MM |
| Epaned | Tier 3 | IAIIAI |
| epinastine eye drops | Tier 1 | |
| epinephrine | Tier 1 | QL 2 injectors/fill |
| EpiPen EpiPen | Tier 3 | QL 2 single-dose auto-injectors/fill |
| Epiren Jr. | Tier 3 | QL 2 single-dose auto-injectors/fill |
| Epirei Ji. Episil | Tier 2 | QL 4 bottles/30 days |
| Episii Epivir-HBV solution | Tier 2 | MM |
| | | |
| eplerenone | Tier 1 | MM |
| Epogen | Tier 3 | SP QL 10 vials/14 days, Call Accredo at 1-877- 238-8387 |
| epoprostenol sodium | Medical | PA SI Call Accredo at 1-866-344-4874, Covered |
| epopi ostenoi soutum | Benefit | under the medical benefit. |
| eprosartan | Tier 1 | MM |
| Epzicom | Tier 2 | MM |
| Equetro | Tier 3 | MM |
| | | 141141 |
| 1 | | |
| ergocalciferol (D2) | Tier 1 | SDDA Cell Aparado et 1 977 229 9297 C1 |
| 1 | | SP PA Call Accredo at 1-877-238-8387, Oral |
| ergocalciferol (D2) | Tier 1 | cancer medications may be covered without |
| ergocalciferol (D2) | Tier 1 | cancer medications may be covered without copayment under the Massachusetts oral cancer |
| ergocalciferol (D2) | Tier 1 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan |
| ergocalciferol (D2) | Tier 1 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective |
| ergocalciferol (D2) Erivedge | Tier 1 Tier 2 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| ergocalciferol (D2) | Tier 1 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM Contraceptive covered without copayment |
| ergocalciferol (D2) Erivedge | Tier 1 Tier 2 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM Contraceptive covered without copayment under Women's Health Preventive Services |
| ergocalciferol (D2) Erivedge | Tier 1 Tier 2 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / |
| ergocalciferol (D2) Erivedge | Tier 1 Tier 2 | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM Contraceptive covered without copayment under Women's Health Preventive Services |

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16

| Drug Name | Tier | Pharmacy Program |
|--|--------------------|--|
| <u>F</u> | | |
| Extavia | Tier 3 | SP QL 15 vials/30 days, Call Accredo at 1-877-238-8387 |
| | | without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| exemestane | Tier 1 | MM Oral cancer medications may be covered without consyment under the Massachusetts oral |
| Exelon solution | Tier 2 | MM |
| Exelon Patch | Tier 2 | MM |
| Exalgo | | QL Drug is not covered, but if covered through medical review process, QL of 30 tablets/30 days will apply. |
| | | Preventive Services |
| Evista | Tier 2 | MM No copayment required for women under |
| Evamist | Tier 3 | QL MM 1 bottle/fill |
| Eurax | Tier 3 | Accredo, Call 1-6//-258-858/. |
| Euflexxa | Medical Benefit | SP PA Call Accredo at 1-877-238-8387, Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| | | medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| etoposide capsules | Tier 1 | SP Call Accredo at 1-877-238-8387, Oral cancer |
| etodolac ext-rel | Tier 1 | |
| etodolac | Tier 1 | |
| etidronate | Tier 1 | |
| ethosuximide | Tier 1 | MM |
| ethambutol | Tier 1 | |
| estropipate | Tier 1 | MM |
| estrogens, esterified/methyltestosterone | Tier 1 | MM |
| estradiol/norethindrone acetate | Tier 1 | MM |
| estradiol estradiol | Tier 1 | MM |
| Estrace cream | Tier 3 | MM |
| esomeprazole strontium delayed-rel 49.3 mg estazolam | Tier 2 | |
| escitalopram | Tier 1 Tier 2 | |
| erythromycins | Tier 1 | |
| erythromycin/sulfisoxazole | Tier 1 | |
| erythromycin/benzoyl peroxide | Tier 1 | |
| erythromycin solution | Tier 1 | |
| erythromycin gel 2% | Tier 1 | |
| erythromycin eye ointment | Tier 1 | |
| erythromycin ethylsuccinate tablets | Tier 1 | |
| ** | | |

| Drug Name | Her | Pnarmacy Program |
|-----------|---------|---|
| Fabior | Tier 3 | PA Prior Authorization required for members 26 |
| | | years of age or older. |
| Fabrazyme | Medical | PA SI Covered under the medical benefit., For |
| | Benefit | home infusion services call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767. |

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| Factor Products, various | Medical | PA SI Examples include, but are not limited to: |
|--|---------------|--|
| | Benefit | Advate, BeneFix, Corifact, Feiba, Helixate FS, |
| | | Hemofil M, Kogenate FS, NovoSeven RT, |
| | | Recombinate, Rixubis, Wilate, Xyntha; Call |
| | | Caremark at 1-800-237-2767., Covered under the |
| famciclovir | Tier 1 | medical benefit. QL 125 mg: 21 tablets/7 days; 250 mg: 60 |
| Tameletovii | Tiel I | tablets/30 days; 500 mg: 21 tablets/7 days |
| famotidine | Tier 1 | thorough of days, 500 mg. 21 thorough days |
| Fareston | Tier 2 | MM Oral cancer medications may be covered |
| | | without copayment under the Massachusetts oral |
| | | cancer therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| F 1 1 | т. о | date for your group. |
| Faslodex | Tier 2 | MM |
| felbamate | Tier 1 | MM |
| felodipine ext-rel | Tier 1 | MM |
| Femhrt 0.5 mg/2.5 mcg | Tier 3Tier 1 | MM MM |
| fenofibrate 43 mg, 130 mg fenofibrate 48 mg, 145 mg | Tier 2 | MM |
| fenofibrate 54 mg, 145 mg fenofibrate 54 mg, 67 mg, 134 mg, 160 mg, 200 mg | Tier 1 | MM |
| fenofibric acid delayed-rel | Tier 1 | IVIIVI |
| | Tier 1 | OL 120 yeits (Isllinous)/20 days |
| fentanyl citrate lollipop fentanyl transdermal | Tier i | QL 120 units (lollipops)/30 days OL |
| fentanyl transdermal patch | Tier 1 | QL QL 10 patches/30 days |
| Fentora | 1101 1 | QL Drug is not covered, but if covered through |
| Tentora | | medical review process, QL of 28 buccal tablets/30 |
| | | days will apply. |
| Ferriprox | Tier 2 | PA QL 30 tablets/30 days |
| finasteride 5 mg | Tier 1 | MM Covered for men only, all ages. Not covered |
| | | for women (no exceptions). |
| Firazyr | Tier 2 | SP PA QL 1 unit (3 mL)/fill, Call Caremark at 1- |
| Fig. DVDLG | | 800-237-2767 |
| First-BXN Compounding Kit | Tier 3 | |
| First-Duke's Mouthwash | Tier 3 | |
| First-Mary's Mouthwash | Tier 3 | OL 200 1/20 1 |
| First-Omeprazole | Tier 3 | QL 300 mL/30 days |
| flavoxate flecainide | Tier 1 Tier 1 | MM |
| Flolan | Medical | PA SI Call Accredo at 1-866-344-4874, Covered |
| riolali | Benefit | under the medical benefit. |
| Flonase | Deficit | QL Drug is not covered, but if covered through |
| 11011100 | | medical review process, QL of 3 nasal spray |
| | | units/90 days will apply. |
| Flovent Diskus | | QL Drug is not covered, but if covered through |
| | | medical review process, QL of 6 diskus/90 days |
| | | will apply. |
| Flovent HFA | Tier 3 | QL MM 6 inhalers/90 days |
| fluconazole | Tier 1 | |
| fludrocortisone | Tier 1 | 01.101.0 |
| flunisolide nasal spray | Tier 1 | QL MM 3 nasal spray units/90 days |
| fluocinolone acetonide cream, ointment 0.025% | Tier 1 | |
| fluocinolone acetonide solution 0.01% | Tier 1 | |
| fluocinonide cream 0.1% | Tier 1 | |
| fluocinonide cream, gel, ointment, solution 0.05% | Tier 1 | M 10 121 6 2 |
| fluoride drops | Tier 1 | No copayment required for children age 6 months through age 6. |

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| fluoride tablets | Tier 1 | No copayment required for children age 6 months through age 6. |
|--|--------|--|
| fluorometholone eye drops, eye ointment | Tier 1 | |
| Fluoroplex | Tier 3 | |
| fluorouracil | Tier 1 | |
| fluoxetine | Tier 1 | |
| Fluoxetine 60 mg | Tier 2 | |
| fluoxetine delayed-rel | Tier 1 | |
| fluphenazine | Tier 1 | |
| flurazepam | Tier 1 | |
| flurbiprofen | Tier 1 | |
| flurbiprofen eye drops | Tier 1 | |
| flutamide | Tier 1 | Oral cancer medications may be covered without |
| | | copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| fluticasone nasal spray | | QL 3 nasal spray units/90 days |
| fluticasone nasal spray | Tier 1 | QL MM 3 nasal spray units/90 days |
| fluticasone propionate cream, lotion 0.05%, ointment 0.005% | Tier 1 | |
| fluvastatin | Tier 1 | MM |
| fluvoxamine | Tier 1 | |
| fluvoxamine ext-rel | Tier 2 | |
| Focalin XR 15mg, 30mg = NC (dexmethylphenidate ext-rel 15mg, 30mg) | Tier 2 | |
| Focalin XR 5 mg, 10 mg, 20 mg, 25 mg, 35 mg, 40 mg | Tier 3 | STPA |
| folic acid 1 mg | Tier 1 | MM No copayment required for women age 12 through age 52. |
| Follistim AQ | Tier 3 | SP PA Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| fondaparinux | Tier 1 | QL 30 syringes/30 days |
| Foradil | Tier 3 | QL MM 3 units/90 days |
| Forfivo XL | Tier 3 | STPA Step Therapy Prior Authorization required for members 18 years of age and older. |
| Forteo | Tier 3 | SP PA Call Accredo at 1-877-238-8387 |
| Fortical | Tier 3 | |
| fosinopril | Tier 1 | MM |
| fosinopril/hydrochlorothiazide | Tier 1 | MM |
| Fosrenol | Tier 3 | MM |
| Fragmin | Tier 3 | QL 30 syringes or 4 MDV/30 days |
| Frova | Tier 3 | QL STPA 9 tablets/30 days |
| Fulyzaq | Tier 2 | PA |
| furosemide | Tier 1 | MM |
| Fuzeon | Tier 3 | SP Call Accredo at 1-877-238-8387 |
| $\underline{\mathbf{G}}$ | | |
| Drug Name | Tier | Pharmacy Program |
| gabapentin | Tier 1 | MM |
| galantamine | Tier 1 | MM |
| galantamine ext-rel | Tier 1 | MM |
| galantamine oral solution | Tier 1 | MM |
| Galzin | Tier 3 | |

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ganciclovir

- Prior Authorization QL - Quantity Limitation Program MM - Managed Mail

Tier 1

MM

| Ganirelix | Tier 3 | SP PA Call Village Pharmacy at 1-866-890-8930 |
|------------------------------------|---------|--|
| Gamenx | Her 5 | or Freedom Drug at 1-877-585-4560 or Walgreens |
| | | Specialty Pharmacy, LLC at 1-866-657-0500 |
| gastrinex NF | Tier 1 | |
| gatifloxacin eye drops | Tier 2 | QL 1 bottle/7 days |
| Gattex | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 30 vials/30 days (either 1 kit of 30 vials or 30 |
| Gel-One | Medical | individual 1-vial kits) SP Call Accredo at 1-877-238-8387. Drug is not |
| GCI One | Benefit | covered, but if covered through medical review process, SP program applies. Medical benefit only. Please refer to the Medical Necessity Guidelines for Viscosupplements for Osteoarthritis. |
| gemfibrozil | Tier 1 | MM |
| Generess Fe | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| gentamicin | Tier 1 | |
| gentamicin eye drops, eye ointment | Tier 1 | |
| Gianvi | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Gilenya | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 28 tablets/28 days |
| Gilotrif | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Gleevec | Tier 2 | SP Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., Call Accredo at 1-877-238-8387 |
| glimepiride | Tier 1 | MM |
| glipizide | Tier 1 | MM |
| glipizide ext-rel | Tier 1 | MM |
| glipizide/metformin | Tier 1 | MM |
| Glucagon | Tier 3 | |
| glyburide | Tier 1 | MM |
| glyburide, micronized | Tier 1 | MM |
| glyburide/metformin | Tier 1 | MM |
| Glyset | Tier 3 | MM |
| Gonal-F | Tier 3 | SP PA SP PA Call Village Pharmacy at 1-866-890 -8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657- 0500 |
| granisetron tablets | Tier 1 | QL 6 tablets/7 days |
| Granisol | Tier 2 | QL 45 mL/7 days |
| Granix prefilled syringe | Tier 2 | SP QL 10 syringes/14 days, Call Accredo at 1-877 -238-8387 |
| griseofulvin microsize | Tier 1 | |
| griseofulvin ultramicrosize | Tier 1 | |

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| guanfacine | Tier 1 | MM |
|------------|--------|----|

<u>H</u>

| Drug Name | Tier | Pharmacy Program |
|--|--------------------|--|
| halobetasol propionate cream, ointment 0.05% | Tier 1 | |
| haloperidol | Tier 1 | |
| Humalog | Tier 2 | MM |
| Humira | Tier 3 | SP PA QL Call Accredo at 1-877-238-8387, 2 syringes/28 days; One Crohn's Disease / Ulcerative Colitis starter pack (6 pens) as a one-time fill only; One Psoriasis starter pack (4 pens) as a one-time fill only. |
| Humulin | Tier 2 | MM |
| Hyalgan | Medical Benefit | SP Call Accredo at 1-877-238-8387. Drug is not covered, but if covered through medical review process, SP program applies. Medical benefit only. Please refer to the Medical Necessity Guidelines for Viscosupplements for Osteoarthritis. |
| Hycamtin capsules | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 0.25 mg: 15 capsules/21 days; 1 mg: 25 capsules/21 days, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| hydralazine | Tier 1 | MM |
| hydrochlorothiazide | Tier 1 | MM |
| hydrocodone polistirex/chlorpheniramine polistirex | Tier 1 | |
| hydrocodone/acetaminophen | Tier 1 | |
| hydrocodone/homatropine | Tier 1 | |
| hydrocortisone | Tier 1 | |
| hydrocortisone butyrate cream, ointment, solution 0.1% | Tier 1 | |
| hydrocortisone butyrate lipid cream 0.1% | Tier 1 | |
| hydrocortisone cream | Tier 1 | |
| hydrocortisone cream 2.5% | Tier 1 | |
| hydrocortisone enema | Tier 1 | |
| hydrocortisone lotion 1% | Tier 1 | |
| hydrocortisone valerate cream, ointment 0.2% | Tier 1 | |
| hydrocortisone/pramoxine/emollient kit | Tier 2 | |
| hydromorphone | Tier 1 | |
| hydroxychloroquine | Tier 1 | |
| hydroxyurea | Tier 1 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| hydroxyzine HCl | Tier 1 | |
| hyoscyamine sulfate | Tier 1 | |
| hyoscyamine sulfate ext-rel | Tier 1 | |

<u>I</u>

| Drug Name | Tier | Pharmacy Program |
|---------------------|--------|------------------|
| ibandronate | Tier 1 | MM |
| ibuprofen (Rx Only) | Tier 1 | |

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NC - Non Covered Drugs NTM - New-to-Market

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| | | <u>I</u> |
|--|------------------|---|
| Iclusig | Tier 2 | PA QL 15 mg: 60 tablets/30 days; 45 mg: 30 tablets/30 days, Oral cancer medications may be covered without copayment under the |
| | | Massachusetts oral cancer therapy mandate. Please |
| | | contact your sponsor/employer about applicability and effective date for your group. |
| Ilaris | Medical | PA Covered under the medical benefit. Available |
| | Benefit | through Accredo, call 1-877-238-8387. |
| Imbruvica | Tier 2 | PA Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| imipramine HCl | Tier 1 | |
| imiquimod | Tier 1 | QL 1 box: 12 single-use packets/28 days |
| Imitrex | | QL Drug is not covered, but if covered through medical review process, QL will apply. Injectable: 4 injections (2 kits)/30 days or 4 injections (4 vials)/30 days; Nasal spray: 2 boxes = 12 units/30 days (5 mg); 1 box = 6 units/30 days (20 mg); Tablets: 9 tablets/30 days. |
| Immune Globulin (IVIG, SCIG), various | Medical | PA SI Covered under the medical benefit., |
| | Benefit | Examples include, but are not limited to: Bivigam, |
| | | Carimune, Flebogamma, Gammagard S/D, |
| | | Gammaplex, Gamunex-C, Hizentra, Privigen; For home infusion services call Coram Healthcare at 1- |
| | | 800-422-7312 or Caremark at 1-800-237-2767. |
| Incivek | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| Increlex | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| indapamide | Tier 1 | MM |
| indomethacin | Tier 1 | |
| indomethacin ext-rel | Tier 1 | |
| Infed | Medical | |
| | Benefit | |
| Inlyta | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral |
| | | cancer medications may be covered without |
| | | copayment under the Massachusetts oral cancer |
| | | therapy mandate. Please contact your plan sponsor/employer about applicability and effective |
| | | date for your group. |
| Insulin Pen Needles | Tier 2 | date for your group. |
| Intelence | Tier 2 | MM |
| Intron A | Tier 3 | SP PA Call Accredo at 1-877-238-8387 or |
| | | Caremark at 1-800-237-2767 |
| Intuniv | Tier 3 | QL MM 90 tablets/90 days |
| Invirase | Tier 2 | MM |
| Invokana | Tier 3 | |
| ipratropium nasal spray | | QL 6 nasal spray units/90 days |
| ipratropium nasal spray | Tier 1 | QL MM 6 nasal spray units/90 days |
| ipratropium nebulizer solution | Tier 1 | QL MM 360 unit-dose vials/90 days |
| | | QL 360 unit-dose vials/90 days |
| ipratropium/albuterol nebulizer solution | TP: 1 | |
| ipratropium/albuterol nebulizer solution | Tier 1 | QL MM 360 unit-dose vials/90 days |
| ipratropium/albuterol nebulizer solution irbesartan | Tier 1 | QL MM 360 unit-dose vials/90 days MM |
| ipratropium/albuterol nebulizer solution irbesartan irbesartan/hydrochlorothiazide | Tier 1 Tier 1 | QL MM 360 unit-dose vials/90 days |
| ipratropium/albuterol nebulizer solution irbesartan | Tier 1 | QL MM 360 unit-dose vials/90 days MM |

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| | | Last Opuated. 12/22/2014 |
|--------------------------------------|--------------------|---|
| Isentress | Tier 2 | QL MM 360 tablets/90 days; Chewable tablets: 100 mg: 180 chewable tablets/30 days; 25 mg: 720 chewable tablets/30 days |
| isoniazid | Tier 1 | |
| Isopto Carpine 8% | Tier 3 | MM |
| isosorbide dinitrate ext-rel tablets | Tier 1 | MM |
| isosorbide mononitrate ext-rel | Tier 1 | MM |
| itraconazole capsules | Tier 1 | PA |
| <u>J</u> | | |
| Drug Name | Tier | Pharmacy Program |
| Jakafi | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral |
| | | cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Januvia | Tier 3 | QL MM 90 tablets/90 days |
| Jentadueto | Tier 2 | |
| Jinteli | Tier 1 | MM |
| Jolessa | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Junel | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Junel Fe | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Juxtapid | Tier 2 | PA QL 5 mg, 10 mg: 28 capsules/38 days; 20 mg: 84 capsules/28 days |
| <u>K</u> | | |
| Drug Name | Tier | Pharmacy Program |
| Kadian 10 mg, 200 mg | Tier 3 | QL 60 capsules/30 days |
| Kaletra | Tier 2 | MM |
| Kalydeco | Tier 2 | PA QL 60 tablets/30 days |
| Kariva | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| ketoconazole | Tier 1 | |
| ketoconazole shampoo | Tier 1 | |
| ketorolac tromethamine eye drops | Tier 1 | anni an |
| Kineret | Tier 3 | SP PA QL 28 syringes/28 days, Call Accredo at 1-877-238-8387 |
| Korlym | Tier 2 | PA QL 120 tablets/30 days |
| Krystexxa | Medical Benefit | PA Covered under the medical benefit. |

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| Kuvan | Tier 2 | SP PA Call Accredo at 1-877-238-8387 |
|---------|--------|--|
| Kynamro | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 4 vials or prefilled syringes/28 days |

$\underline{\mathbf{L}}$

| Drug Name | Tier | Pharmacy Program |
|--|------------------|---|
| labetalol | Tier 1 | MM |
| lactulose | Tier 1 | |
| Lamisil Oral Granules | Tier 3 | QL 125 mg packets: 56 packets/28 days; 187.5 mg packets: 28 packets/28 days. Annual limit of 12 weeks applies. |
| lamivudine | Tier 1 | MM |
| lamivudine tablets | Tier 1 | MM |
| lamivudine/zidovudine | Tier 1 | MM |
| lamotrigine - chewable dispersible tablets | Tier 1 | MM |
| lamotrigine dispersible tablets | Tier 1 | MM |
| lamotrigine ext-rel | Tier 2 | QL MM 25 mg: 90 tablets/90 days; 50 mg:90 tablets/90 days; 100 mg: 90 tablets/90 days; 200 mg: 270 tablets/90 days; 250 mg: 180 tablets/90 days; 300 mg: 180 tablets/90 days |
| lamotrigine tablets | Tier 1 | MM |
| lansoprazole delayed-rel | Tier 3 | |
| lansoprazole soluble tablets | Tier 3 | |
| Lantus | Tier 2 | MM |
| latanoprost eye drops | Tier 1 | QL MM 15 mL/90 days |
| Latuda | | QL Drug is not covered, but if covered through medical review process, QL of 30 tablets/30 days (20 mg), 30 tablets/30 days (40 mg); 30 tablets/30 days (60 mg); 60 tablets/30 days (80 mg); 30 tablets/30 days (120 mg) will apply. |
| Lazanda | | QL Drug is not covered, but if covered through medical review process, QL of 1 box (4 bottles)/28 days will apply. |
| leflunomide | Tier 1 | |
| Letairis | Tier 2 | SP PA Call Accredo at 1-866-344-4874 |
| letrozole | Tier 1 | MM Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| leucovorin | Tier 1 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Leukeran | Tier 2 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Leukine | Tier 3 | SP QL Call Accredo at 1-877-238-8387, 6 vials/14 days |
| leuprolide acetate | Tier 1 | |
| levalbuterol nebulizer solution | Tier 1 | QL MM 270 unit-dose vials/90 days |
| | | |
| Levemir levetiracetam | Tier 2 Tier 1 | MM MM |

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| levetiracetam ext-rel | Tier 1 | MM |
|--------------------------------|--------|---|
| levobunolol eye drops | Tier 1 | MM |
| levocarnitine | Tier 1 | |
| levofloxacin | Tier 1 | |
| levofloxacin eye drops | Tier 1 | |
| Levora | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Levothroid | Tier 1 | MM |
| levothyroxine | Tier 1 | MM |
| Levoxyl | Tier 1 | MM |
| Lexiva | Tier 2 | MM |
| Lialda | Tier 2 | |
| lidocaine patch 5% | Tier 1 | QL 30 patches/30 days |
| lidocaine viscous | Tier 1 | |
| lidocaine/prilocaine cream | Tier 1 | QL 1 tube/30 days |
| Lidovir | Tier 3 | QL 1 kit/30 days |
| lindane | Tier 1 | |
| Linzess | Tier 3 | QL 30 capsules/30 days |
| liothyronine | Tier 1 | • |
| lisinopril | Tier 1 | MM |
| lisinopril/hydrochlorothiazide | Tier 1 | MM |
| lithium carbonate | Tier 1 | |
| lithium carbonate ext-rel | Tier 1 | |
| Lithium Citrate | Tier 2 | |
| Lo Loestrin Fe | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Lo Minastrin Fe | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Lomedia 24 Fe | Tier 1 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| lomustine | Tier 1 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| loperamide | Tier 1 | and James Grant. |
| lorazepam | Tier 1 | |
| losartan | Tier 1 | MM |
| losartan/hydrochlorothiazide | Tier 1 | MM |
| Lotemax | Tier 3 | |
| lovastatin | Tier 1 | MM |
| Low-Ogestrel | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |

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| Lumigan | Tier 3 | QL STPA MM 15 mL/90 days |
|--------------|---------|---|
| Lumizyme | Medical | SI Covered under the medical benefit. For home |
| | Benefit | infusion services call Coram Healthcare at 1-800- |
| | | 422-7312 or Caremark at 1-800-237-2767. |
| Lunesta | Tier 3 | QL STPA 30 tablets/90 days |
| Lupron Depot | Tier 3 | |
| Lutera | Tier 1 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| | | your group. |
| Lyrica | Tier 3 | STPA MM |

\mathbf{M}

| Drug Name | Tier | Pharmacy Program |
|---------------------------------------|--------------------|--|
| Makena | Medical Benefit | PA Covered under the medical benefit. |
| malathion lotion 0.5% | Tier 1 | |
| maprotiline | Tier 1 | |
| Marplan | Tier 3 | |
| Matulane | Tier 2 | Drug is available through Accredo 1-866-344-4874. Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Maxair Autohaler | Tier 3 | QL MM 3 units/90 days |
| Maxaron Forte | Tier 3 | |
| meclizine | Tier 1 | |
| meclofenamate | Tier 1 | |
| medroxyprogesterone acetate | Tier 1 | MM |
| medroxyprogesterone acetate 150 mg/mL | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| mefenamic acid | Tier 1 | |
| mefloquine | Tier 1 | |
| megestrol acetate | Tier 1 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Mekinist | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| meloxicam | Tier 1 | QL 90 tablets/90 days |
| Menopur | Tier 3 | SP PA Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| Mephyton | Tier 3 | |

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| mercaptopurine | Tier 1 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
|---|--------|--|
| mesalamine rectal suspension | Tier 1 | date for your group. |
| Mestinon Timespan | Tier 3 | |
| metaproterenol tablets | Tier 1 | MM |
| metaxalone 800 mg | Tier 1 | 171171 |
| metformin | Tier 1 | MM |
| metformin ext-rel | Tier 1 | MM |
| methadone | Tier 1 | 272272 |
| methamphetamine | Tier 1 | |
| methazolamide | Tier 1 | MM |
| methimazole | Tier 1 | MM |
| methocarbamol | Tier 1 | 11111 |
| methotrexate | Tier 1 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| methyldopa | Tier 1 | MM |
| methylergonovine | Tier 1 | |
| Methylin chewable tablets | Tier 3 | |
| methylphenidate | Tier 1 | |
| methylphenidate ext-rel | Tier 1 | |
| methylphenidate HCl ER (generic for Concerta) | Tier 2 | |
| methylphenidate oral solution | Tier 1 | |
| methylprednisolone | Tier 1 | |
| metipranolol eye drops | Tier 1 | MM |
| metoclopramide | Tier 1 | |
| metolazone | Tier 1 | MM |
| metoprolol | Tier 1 | MM |
| metoprolol succinate ext-rel | Tier 1 | MM |
| metoprolol/hydrochlorothiazide | Tier 1 | MM |
| metronidazole | Tier 1 | |
| metronidazole cream, gel, lotion | Tier 1 | |
| metronidazole vaginal cream | Tier 1 | |
| mexiletine | Tier 1 | MM |
| Microgestin | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Microgestin Fe | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| midodrine | Tier 1 | MM |
| Minastrin 24 Fe | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| minocycline | Tier 1 | |
| minocycline SR | Tier 2 | |
| mirtazapine | Tier 1 | |

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| mirtazapine orally disintegrating | Tier 1 | |
|---|--------------------|---|
| misoprostol | Tier 1 | |
| modafinil | Tier 2 | QL MM 180 tablets/90 days |
| moexipril | Tier 1 | MM |
| moexipril/hydrochlorothiazide | Tier 1 | MM |
| mometasone cream, lotion, ointment 0.1% | Tier 1 | |
| Mononessa | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| montelukast | Tier 1 | QL MM 90 tablets/90 days |
| morphine sulfate | Tier 1 | |
| morphine sulfate beads | Tier 1 | QL 60 capsules/30 days |
| morphine sulfate ext-rel | Tier 1 | QL 90 tablets/30 days; 60 capsules/30 days (20 mg, 30 mg, 50 mg, 60 mg, 80 mg, 100 mg) |
| morphine sulfate suppositories 5 mg, 10 mg, 20 mg | Tier 1 | |
| Morphine suppositories 30 mg | Tier 2 | |
| Moxeza | | QL Drug is not covered, but if covered through medical review process, QL of 1 bottle/10 days will apply. |
| moxifloxacin | Tier 2 | |
| Mozobil | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| MS Contin | | QL Drug is not covered, but if covered through medical review process, QL of 90 tablets/30 days will apply. |
| Multaq | Tier 3 | MM |
| mupirocin | Tier 1 | |
| mycophenolate mofetil | Tier 1 | MM |
| mycophenolate sodium | Tier 1 | MM |
| Myleran tablets | Tier 2 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Myozyme | Medical Benefit | SI Covered under the medical benefit. For home infusion services call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767. |
| Myrbetriq | Tier 3 | STPA |

 $\underline{\mathbf{N}}$

| Drug Name | Tier | Pharmacy Program |
|-----------------------|---------|---|
| nabumetone | Tier 1 | |
| nadolol | Tier 1 | MM |
| Naglazyme | Medical | SI Covered under the medical benefit. For home |
| | Benefit | infusion services call Coram Healthcare at 1-800- |
| | | 422-7312 or Caremark at 1-800-237-2767. |
| naltrexone | Tier 1 | |
| Namenda | Tier 2 | MM |
| Namenda XR | Tier 2 | |
| naphazoline eye drops | Tier 1 | |
| naproxen | Tier 1 | |
| naproxen sodium | Tier 1 | |
| naratriptan | ' | QL 9 tablets/30 days |

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| naratriptan | Tier 1 | QL 9 tablets/30 days |
|---|--------|---|
| Nasonex | 1 | QL Drug is not covered, but if covered through |
| | | medical review process, QL of 6 nasal spray |
| | | units/90 days will apply. |
| Natazia | Tier 3 | Contraceptive covered without copayment under |
| | | Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about |
| | | applicability and effective date for your group. |
| nateglinide | Tier 1 | MM |
| Nebusal 6% | Tier 2 | |
| Necon 0.5/35 | Tier 1 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| N. 1/05 | | your group. |
| Necon 1/35 | Tier 1 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| | | your group. |
| Necon 1/50 | Tier 1 | MM Contraceptive covered without copayment |
| 100011730 | 1101 1 | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| | | your group. |
| Necon 10/11 | Tier 2 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| Necon 7/7/7 | Tier 1 | your group. MM Contraceptive covered without copayment |
| Necoli //// | 1161 1 | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| | | your group. |
| nefazodone | Tier 1 | |
| neomycin/polymyxin B/bacitracin/hydrocortisone eye ointment | Tier 1 | |
| neomycin/polymyxin B/dexamethasone eye drops, eye ointment | Tier 1 | |
| neomycin/polymyxin B/gramicidin eye drops | Tier 1 | |
| neomycin/polymyxin B/hydrocortisone eye drops | Tier 1 | |
| neomycin/polymyxin B/hydrocortisone otic | Tier 1 | |
| Neulasta | Tier 3 | SP QL Call Accredo at 1-877-238-8387, 1 |
| NT. | т: 2 | syringe/14 days |
| Neumega | Tier 3 | GD OL G II A 1 1 1 077 220 0207 10 11 |
| Neupogen | Tier 3 | SP QL Call Accredo at 1-877-238-8387, 10 vials |
| Neupro | Tier 3 | (1 mL and 1.6 mL)/14 days QL MM 30 patches/30 days |
| Nevanac | Tier 3 | QL WW 30 pateries/30 days |
| nevirapine | Tier 1 | MM |
| Nexavar | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, Oral |
| TICAUTUI | 1101 2 | cancer medications may be covered without |
| | | copayment under the Massachusetts oral cancer |
| | | therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| | | date for your group., 120 tablets/30 days |
| | | |
| Nexium | | QL Drug is not covered, but if covered through |
| Nexium | | |

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| Next Choice | Tier 1 | Coverage only for members 16 years of age and under. |
|--------------------------------|--------------------|--|
| Next Choice One Dose | Tier 1 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| niacin ext-rel | Tier 2 | MM |
| nicardipine | Tier 1 | MM |
| Nicotrol Inhaler | No copayment | QL Annual limit: 90 days/year; Max 168 units/fill |
| Nicotrol NS Spray | No copayment | QL Annual limit: 90 days/year; Max 4 units/fill |
| nifedipine | Tier 1 | MM |
| nifedipine ext-rel | Tier 1 | MM |
| Nilandron | Tier 2 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| nimodipine | Tier 1 | MM |
| nisoldipine ext-rel | Tier 1 | MM |
| Nitro-Dur 0.3 mg/hr, 0.8 mg/hr | Tier 2 | MM |
| nitrofurantoin | Tier 1 | |
| nitrofurantoin macrocrystals | Tier 1 | |
| nitrofurantoin suspension | Tier 1 | |
| nitroglycerin transdermal | Tier 1 | MM |
| Nitrostat | Tier 2 | |
| nizatidine | Tier 1 | |
| Norditropin Products | Tier 3 | SP PA Call Caremark at 1-800-237-2767. Applies to all Norditropin products including Norditropin Flexpro and Norditropin Nordiflex. |
| norethindrone acetate | Tier 1 | <u> </u> |
| Norpace CR | Tier 3 | MM |
| Nortrel 0.5/35 | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Nortrel 1/35 | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Nortrel 7/7/7 | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| nortriptyline | Tier 1 | O TITE |
| Norvir | Tier 2 | MM |
| Novarel | Tier 1 | SP PA SP Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| Novolin | Tier 2 | MM |
| Novolog | Tier 2 | MM |
| Nplate | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |

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| Nucynta | | QL Drug is not covered, but if covered through medical review process, QL of 30 tablets/30 days will apply. |
|------------------------|--------|---|
| Nucynta ER | | QL Drug is not covered, but if covered through medical review process, QL of 60 tablets/30 days will apply. |
| Nuedexta | Tier 2 | PA MM |
| Numoisyn | Tier 3 | |
| NuvaRing | Tier 3 | MM |
| Nuvigil | Tier 3 | QL STPA MM 90 tablets/90 days |
| Nymalize | Tier 3 | |
| nystatin | Tier 1 | |
| nystatin/triamcinolone | Tier 1 | |
| \mathbf{O} | | |

| Drug Name | Tier | Pharmacy Program |
|-------------------------------|--------------------|---|
| Ocella | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| ofloxacin | Tier 1 | J - |
| ofloxacin eye drops | Tier 1 | |
| ofloxacin otic | Tier 1 | |
| Ogestrel | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| olanzapine | Tier 1 | |
| olanzapine/fluoxetine | Tier 1 | |
| Olysio | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| omeprazole delayed-rel | Tier 1 | |
| omeprazole/sodium bicarbonate | Tier 1 | |
| ondansetron | Tier 1 | QL oral solution: 90 mL/7 days; 4 mg and 8 mg ODT tablets: 9 tablets/7 days; 4 mg and 8 mg tablets: 9 tablets/7 days; 24 mg tablets: 1 tablet/7 days |
| OneTouch | Tier 2 | MM |
| Onfi | Tier 3 | PA MM |
| Onfi Oral Suspension | Tier 3 | PA |
| Onmel | Tier 3 | PA QL 28 tablets/28 days |
| Onsolis | Tier 2 | SP QL Call Accredo at 1-877-238-8387, 60 buccal films/30 days |
| Opsumit | Tier 2 | SP PA Call Accredo at 1-866-344-4874 |
| Orencia prefilled syringe | Tier 3 | SP PA QL Call Accredo at 1-877-238-8387, 4 syringes/28 days, Orencia syringes are covered under the pharmacy benefit only, prior authorization applies. Orencia vials are covered under the medical benefit only, prior authorization applies. |
| Orencia vial | Medical Benefit | PA Orencia vials are covered under the medical benefit only, prior authorization applies. Available to providers through Accredo, call 1-877-238-8387. Orencia syringes are covered under the pharmacy benefit only, prior authorization applies. |
| Orfadin | Tier 3 | SP PA Call Accredo at 1-866-344-4874 |

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| orphenadrine/aspirin/caffeine | Tier 1 | |
|-------------------------------|--------------------|--|
| Ortho Evra | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about |
| | | applicability and effective date for your group. |
| Ortho Tri-Cyclen Lo | Tier 3 | MM Contraceptive covered without copayment |
| | | under Women's Health Preventive Services |
| | | Initiative. Please contact your plan sponsor / |
| | | employer about applicability and effective date for |
| 0.4 | 36 1' 1 | your group. |
| Orthovisc | Medical Benefit | SP Call Accredo at 1-877-238-8387. Drug is not |
| | Benefit | covered, but if covered through medical review process, SP program applies. Medical benefit only. |
| | | Please refer to the Medical Necessity Guidelines |
| | | for Viscosupplements for Osteoarthritis. |
| Osphena | Tier 3 | |
| Otozin | Tier 3 | |
| Ovidrel | Tier 3 | SP Call Village Pharmacy at 1-866-890-8930 or |
| | | Freedom Drug at 1-877-585-4560 or Walgreens |
| | | Specialty Pharmacy, LLC at 1-866-657-0500 |
| oxandrolone | Tier 1 | |
| oxaprozin | Tier 1 | |
| oxazepam | Tier 1 | |
| oxcarbazepine | Tier 1 | MM |
| Oxsoralen | Tier 3 | |
| Oxsoralen-Ultra | Tier 3 | |
| oxybutynin | Tier 1 | MM |
| oxybutynin ext-rel | Tier 1 | MM |
| oxycodone ext-rel | Tier 1 | QL 120 tablets/30 days |
| oxycodone immediate release | Tier 1 | |
| oxycodone/acetaminophen | Tier 1 | |
| oxycodone/aspirin | Tier 1 | |
| OxyContin | Tier 3 | QL 120 tablets/30 days |
| oxymorphone | Tier 1 | |
| oxymorphone ext-rel | Tier 2 | |
| Oxytrol | Tier 3 | MM |
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| Drug Name | Tier | Pharmacy Program |
|--------------------------|--------|--|
| Pancreaze | Tier 2 | MM |
| pantoprazole delayed-rel | | QL |
| pantoprazole delayed-rel | Tier 1 | |
| paricalcitol | Tier 1 | MM |
| paroxetine HCl | Tier 1 | |
| paroxetine HCl ext-rel | Tier 1 | |
| Patanase | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal spray units/90 days will apply. |
| peg 3350/electrolytes | Tier 1 | |
| Pegasys/Pegasys ProClick | Tier 3 | SP PA QL 4 individual vials/28 days; 1 kit (4 vials/syringes)/28 days; 4 pens/28 days, Call Caremark at 1-800-237-2767 |
| PegIntron | Tier 3 | SP PA QL Call CVS Caremark at 1-800-237- 2767, 4 syringes or vials/28 days |
| penicillin VK | Tier 1 | • |

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| Penlac | | QL Drug is not covered, but if covered through medical review process, QL of 1 bottle/30 days |
|-------------------------------------|---------|--|
| Pennsaid | Tier 3 | will apply. |
| Pentasa Pentasa | Tier 3 | QL 1 bottle/30 days MM |
| pentoxifylline ext-rel | Tier 2 | IVIIVI |
| perindopril | Tier 1 | MM |
| Perjeta | Medical | PA Covered under the medical benefit. |
| | Benefit | PA Covered under the medical benefit. |
| permethrin 5% | Tier 1 | |
| perphenazine | Tier 1 | 207 |
| Pertzye | Tier 3 | MM |
| phenazopyridine | Tier 1 | |
| phenelzine | Tier 1 | |
| phenobarbital | Tier 1 | MM |
| phenylephrine eye drops | Tier 1 | |
| phenylephrine/guaifenesin | Tier 1 | |
| phenytoin | Tier 1 | MM |
| phenytoin sodium ext-rel capsules | Tier 1 | MM |
| Phoslyra | Tier 2 | MM |
| Picato | Tier 3 | QL Picato 0.05%: 1 carton/2-day supply; Picato 0.015%: 1 carton/3-day supply |
| pilocarpine | Tier 1 | |
| pilocarpine eye drops | Tier 1 | MM |
| pindolol | Tier 1 | MM |
| pioglitazone | Tier 1 | MM |
| pioglitazone/glimepiride | Tier 1 | |
| pioglitazone/metformin | Tier 1 | MM |
| piroxicam | Tier 1 | |
| podofilox | Tier 1 | |
| polymyxin B/bacitracin eye ointment | Tier 1 | |
| polymyxin B/trimethoprim eye drops | Tier 1 | |
| Pomalyst | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Portia | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| potassium chloride ext-rel | Tier 1 | MM |
| potassium chloride liquid | Tier 1 | MM |
| potassium citrate | Tier 1 | |
| Potiga | Tier 3 | PA MM |
| Pradaxa | Tier 3 | QL MM 180 tablets/90 days |
| pramipexole | Tier 1 | MM |
| pravastatin | Tier 1 | MM |
| prazosin | Tier 1 | MM |
| Pred Mild | Tier 3 | |
| prednisolone acetate 1% eye drops | Tier 1 | |
| prednisolone sodium phosphate | Tier 1 | |
| prednisolone syrup | Tier 1 | |
| prednisone | Tier 1 | |

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|--------------------------------|---------|--|
| Pregnyl | Tier 1 | SP PA Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens |
| | | Specialty Pharmacy, LLC at 1-866-657-0500 |
| Premarin | Tier 3 | MM |
| Premarin cream | Tier 3 | MM |
| Premphase | Tier 3 | MM |
| Prempro | 11013 | MM |
| Prempro | Tier 3 | MM |
| prenatal vitamins w/folic acid | Tier 1 | 141141 |
| Prepopik | Tier 3 | |
| Prevacid | 1101 3 | QL Drug is not covered, but if covered through |
| Trevueld | | medical review process, QL of 90 capsules/90 days |
| | | will apply. |
| Prezista | Tier 2 | MM |
| Prilosec | | QL Drug is not covered, but if covered through |
| | | medical review process, QL of 90 capsules/90 days |
| | | will apply. |
| primidone | Tier 1 | MM |
| Pristiq | Tier 2 | STPA Step Therapy Prior Authorization required |
| | | for members 18 years of age or older. |
| ProAir HFA | Tier 2 | QL MM 6 inhalers/90 days |
| probenecid | Tier 1 | MM |
| prochlorperazine | Tier 1 | |
| Procrit | Tier 3 | SP QL 10 vials/14 days, Call Accredo at 1-877- 238-8387 |
| ProctoFoam-HC | Tier 3 | |
| progesterone, micronized | Tier 1 | |
| Prolensa | Tier 3 | |
| Prolia | Medical | PA Covered under the medical benefit. |
| | Benefit | |
| Promacta | Tier 2 | SP PA QL 30 tablets/30 days, Call Accredo at 1-877-238-8387 |
| promethazine | Tier 1 | |
| propafenone | Tier 1 | MM |
| propafenone ext-rel | Tier 1 | MM |
| propantheline | Tier 1 | |
| propranolol | Tier 1 | MM |
| propranolol ext-rel | Tier 1 | MM |
| propylthiouracil | Tier 1 | MM |
| Protonix | | QL Drug is not covered, but if covered through |
| | | medical review process, QL of 90 tablets/90 days |
| | | will apply. |
| Protopic | Tier 3 | QL STPA 1 tube/day |
| Provenge | Medical | PA Covered under the medical benefit. |
| | Benefit | |
| Prudoxin | Tier 1 | |
| pseudoephedrine/guaifenesin | Tier 1 | |
| Pulmicort Flexhaler | Tier 3 | QL MM 6 inhalers/90 days |
| Pulmicort Respules | | QL Drug is not covered, but if covered through medical review process, QL of 180 vials/90 days will apply. |
| Pulmozyme | Tier 3 | w III арріу. |
| pyrazinamide | Tier 1 | |
| | | |
| pyridostigmine | Tier 1 | |

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\mathbf{Q}

| Drug Name | Tier | Pharmacy Program |
|---|--------|--|
| Qnasl | | QL Drug is not covered, but if covered through medical review process, QL or 3 nasal spray units/90 days will apply. |
| Quartette | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Quasense | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| quetiapine 100 mg, 200 mg, 300 mg, 400 mg | Tier 1 | |
| quetiapine 25 mg, 50 mg | Tier 1 | PA |
| Quillivant XR | Tier 3 | STPA |
| quinapril | Tier 1 | MM |
| quinapril/hydrochlorothiazide | Tier 1 | MM |
| quinidine gluconate ext-rel | Tier 1 | MM |
| quinidine sulfate | Tier 1 | MM |
| quinidine sulfate ext-rel | Tier 1 | MM |
| quinine sulfate 324 mg | Tier 1 | |
| QVAR | Tier 2 | QL MM 6 inhalers/90 days |

<u>R</u>

| Drug Name | Tier | Pharmacy Program |
|------------------------------|--------------------|--|
| rabeprazole delayed-rel | Tier 2 | |
| ramipril | Tier 1 | MM |
| Ranexa | Tier 3 | MM |
| ranitidine | Tier 1 | |
| Rapamune 1 mg, Rapamune 2 mg | Tier 3 | MM |
| Ravicti | Tier 3 | PA |
| Rayos | | QL Drug is not covered, but if covered through medical review process, QL or 30 tablets/30 days will apply. |
| Rebetol solution | Tier 3 | SP Call Caremark at 1-800-237-2767 |
| Rebif/Rebif Rebidose | Tier 3 | SP QL 12 syringes Or autoinjectors/28 days, Call Accredo at 1-877-238-8387 |
| Reclast | Medical Benefit | PA Covered under the medical benefit. |
| Reclipsen | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Rectiv Ointment | | QL Drug is not covered, but if covered through medical review process, QL of 1 tube/30 days will apply. |
| Refissa | Tier 1 | PA Prior Authorization required for members 26 years of age and older. |
| Relenza | Tier 2 | QL 1 package (20 doses)/365 days |
| Relistor | Tier 3 | |

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| Relpax | | QL Drug is not covered, but if covered through medical review process, QL of 6 tablets/30 days will apply. |
|---|--------------------|--|
| Remicade | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| Remodulin | Medical Benefit | PA SI Covered under the medical benefit., Call Accredo at 1-866-344-4874. |
| Renagel | Tier 3 | MM |
| Renvela | Tier 2 | MM |
| repaglinide | Tier 1 | MM |
| Repronex | Tier 3 | SP PA Call Village Pharmacy at 1-866-890-8930 or Freedom Drug at 1-877-585-4560 or Walgreens Specialty Pharmacy, LLC at 1-866-657-0500 |
| Rescriptor | Tier 2 | MM |
| Restasis | Tier 3 | PA MM |
| Revlimid | Tier 3 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Reyataz | Tier 2 | MM |
| Rhinocort Aqua | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal spray units/90 days will apply. |
| ribasphere | Tier 1 | SP Call Caremark at 1-800-237-2767 |
| ribavirin | Tier 1 | SP Call Caremark at 1-800-237-2767 |
| Ridaura | Tier 3 | |
| rifampin | Tier 1 | |
| riluzole | Tier 1 | |
| rimantadine | Tier 1 | |
| risperidone | Tier 1 | |
| risperidone orally disintegrating tablets | Tier 1 | |
| risperidone solution | Tier 1 | |
| Ritalin LA 10 mg | Tier 3 | STPA |
| Rituxan | Medical Benefit | PA Covered under the medical benefit. |
| rivastigmine | Tier 1 | MM |
| rizatriptan | Tier 1 | QL orally disintegrating tablets: 9 tablets/30 days; tablets: 9 tablets/30 days |
| ropinirole | Tier 1 | MM |
| ropinirole ext-rel | Tier 1 | QL MM 90 tablets/90 days |
| Rozerem | Tier 3 | QL STPA 30 tablets/90 days |

<u>S</u>

| Drug Name | Tier | Pharmacy Program |
|-----------------------------|--------|---|
| Sabril | Tier 2 | MM |
| Safyral | Tier 3 | Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| salicylic acid | Tier 1 | |
| salicylic acid liquid 27.5% | Tier 1 | |
| salsalate | Tier 1 | |
| Samsca | Tier 3 | QL 14 tablets/7 days |

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| Sancuso | | QL Drug is not covered, but if covered through |
|---|--------------------|---|
| | | medical review process, QL of 1 patch/7 days will |
| 0 11 | , | apply. |
| Savella | Tr: 0 | QL STPA MM 180 tablets/90 days |
| Savella | Tier 2 | QL STPA MM 180 tablets/90 days |
| selegiline | Tier 1 | MM |
| selenium sulfide shampoo | Tier 1 | OL 100 170 20 11 1/20 1 200 120 |
| Selzentry | Tier 2 | QL MM 150 mg: 60 tablets/30 days; 300 mg: 120 tablets/30 days |
| Sensipar | Tier 3 | MM |
| Serevent Diskus | Tier 2 | QL MM 3 diskus/90 days |
| Serophene | Tier 1 | amp. |
| Seroquel XR | Tier 3 | STPA |
| Serostim | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| sertraline | Tier 1 | |
| Signifor | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 60 ampules/30 days |
| sildenafil 20 mg tablets | Tier 1 | SP PA Call Accredo at 1-866-344-4874 |
| silver sulfadiazine | Tier 1 | |
| Silvrstat | Tier 3 | |
| Simbrinza | Tier 3 | |
| Simponi | Tier 2 | SP PA QL 1 pre-filled syringe or SmartJect autoinjector (50 mg or 100 mg)/28 days, Call Accredo at 1-877-238-8387 |
| Simponi Aria | Medical | PA Covered under the medical benefit. |
| 1 | Benefit | |
| simvastatin | Tier 1 | MM |
| sirolimus 0.5 mg | Tier 1 | MM |
| Sirturo | Tier 2 | PA |
| Skelid | Tier 3 | |
| Sklice | Tier 3 | QL 1 bottle/fill |
| sodium chloride 0.9% for inhalation (Rx Only) | Tier 1 | |
| Soliris | Medical Benefit | PA Covered under the medical benefit. |
| Soltamox | Tier 2 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. No copayment required for women under Preventive Services. |
| Somavert | Tier 3 | PA |
| Sonata | | QL Drug is not covered, but if covered through medical review process, QL of 30 capsules/90 days will apply. |
| sotalol | Tier 1 | MM |
| sotalol AF | Tier 1 | MM |
| Sovaldi | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| spinosad | Tier 1 | QL 1 bottle/fill |
| Spiriva | Tier 3 | QL MM 90 capsules (3 units)/90 days |
| spironolactone | Tier 1 | MM |
| spironolactone/hydrochlorothiazide | Tier 1 | MM |
| Sporanox oral solution | Tier 3 | |
| Sprintec | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |

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|--|------------------|---|
| Sprycel | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., 20 mg, 50 mg, 70 mg, 80 mg 60 tablets/30 days: 60 tablets/30 days (for any combination of strengths); 100 mg, 140 mg: 30 tablets/30 days |
| stavudine | Tier 1 | MM |
| Stavzor | Tier 3 | MM |
| Staxyn | | QL Drug is not covered, but if covered through medical review process, QL or 4 tablets/30 days will apply. |
| Stelara | Medical | PA Covered under the medical benefit. Available |
| | Benefit | through Accredo, call 1-877-238-8387. |
| Stelara prefilled syringe | Tier 2 | SP PA QL 1 injection (prefilled syringe)/84 days, Call Accredo at 1-877-238-8387 |
| Stivarga | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., 84 tablets/28 days |
| Strattera | Tier 3 | QL 10 mg, 18 mg, 25 mg, 40 mg, 60 mg: 180 capsules/90 days; 80 mg & 100 mg: 90 capsules/90 days |
| Striant | Tier 3 | 2 |
| Stribild | Tier 2 | MM |
| Suboxone film | Tier 3 | PA |
| sucralfate | Tier 1 | |
| sulfacetamide 10% eye drops | Tier 1 | |
| sulfacetamide sodium lotion 10% | Tier 1 | |
| sulfacetamide sodium wash 10% | Tier 1 | |
| sulfacetamide/prednisolone phosphate eye drops, eye ointment | Tier 1 | |
| sulfacetamide/sulfur | Tier 1 | |
| sulfadiazine | Tier 1 Tier 1 | |
| sulfamethoxazole/trimethoprim sulfasalazine | Tier 1 | MM |
| sulfasalazine delayed-rel | Tier 1 | MM MM |
| sulfisoxazole | Tier 1 | IVIIVI |
| sulindac | Tier 1 | |
| sumatriptan | 100 1 | QL injection: 4 injections (2 kits)/30 days or 4 injections (4 vials)/30 days; nasal spray: 2 boxes (12 spray unit devices)/30 days (5 mg) or 1 box (6 spray unit devices)/30 days (20 mg); tablets: 9 tablets/30 days |
| sumatriptan | Tier 1 | QL injection: 4 injections (2 kits)/30 days or 4 injections (4 vials)/30 days; nasal spray: 2 boxes (12 spray unit devices)/30 days (5 mg) or 1 box (6 spray unit devices)/30 days (20 mg); tablets: 9 tablets/30 days |
| Sumavel Dosepro | | QL Drug is not covered, but if covered through medical review process, QL of 4 injections/30 days will apply. |

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| Supartz | Medical | SP Call Accredo at 1-877-238-8387. Drug is not |
|-------------------------------------|---------|---|
| | Benefit | covered, but if covered through medical review |
| | | process, SP program applies. Medical benefit only. |
| | | Please refer to the Medical Necessity Guidelines |
| | T: 0 | for Viscosupplements for Osteoarthritis. |
| Sustiva | Tier 2 | MM |
| Sutent | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral |
| | | cancer medications may be covered without |
| | | copayment under the Massachusetts oral cancer |
| | | therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| Sylatron | Tier 2 | date for your group. SP PA QL Call Accredo at 1-877-238-8387, 4 |
| Sylation | Tiel 2 | vials/28 days |
| Symbicort | Tier 2 | QL MM 6 inhalers/90 days |
| SymlinPen | Tier 3 | MM |
| Synagis | Medical | SP PA Covered under the medical benefit. |
| Synagis | Benefit | Available through Accredo, call 1-877-482-5927., |
| | Benefit | Call Accredo at 1-877-238-8387 |
| Synarel | Tier 3 | Can recede at 1 011 230-0301 |
| Synvisc | Medical | SP Call Accredo at 1-877-238-8387. Drug is not |
| - 3 | Benefit | covered, but if covered through medical review |
| | Denem | process, SP program applies. Medical benefit only. |
| | | Please refer to the Medical Necessity Guidelines |
| | | for Viscosupplements for Osteoarthritis. |
| Synvisc-One | Medical | SP Call Accredo at 1-877-238-8387. Drug is not |
| | Benefit | covered, but if covered through medical review |
| | | process, SP program applies. Medical benefit only. |
| | | Please refer to the Medical Necessity Guidelines |
| | | for Viscosupplements for Osteoarthritis. |
| ${f T}$ | | |
| Drug Name | Tier | Pharmacy Program |
| | | |
| Tabloid | Tier 2 | SP Call Accredo at 1-877-238-8387, Oral cancer |
| | | medications may be covered without copayment |
| | | under the Massachusetts oral cancer therapy |
| | | mandate. Please contact your plan sponsor/employer about applicability and effective |
| | | date for your group. |
| tacrolimus | Tier 1 | MM |
| Tafinlar | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral |
| 1 armai | TICL Z | cancer medications may be covered without |
| | | copayment under the Massachusetts oral cancer |
| | | therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| | | date for your group. |
| Tamiflu capsules | Tier 2 | QL 10 capsules/365 days |
| Tamiflu suspension | Tier 3 | QL 180 mL/365 days |
| tamoxifen | Tier 1 | MM Oral cancer medications may be covered |
| ···· · · · · · · · - · · | 1101 1 | without copayment under the Massachusetts oral |
| | | cancer therapy mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| | | date for your group. No copayment required for |
| | | women under Preventive Services. |
| | | |

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Tier 1

MM

NC - Non Covered Drugs NTM - New-to-Market

tamsulosin

| Tarceva | Tier 2 | SP QL Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., 25 mg: 90 tablets/30 days; 100 mg: 30 tablets/30 days; 150 mg: 30 tablets/30 days |
|---|---|---|
| Targretin capsules | Tier 2 | SP Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., Call Accredo at 1-877-238-8387 |
| Targretin gel | Tier 2 | SP Call Accredo at 1-877-238-8387 |
| Tarka | Tier 3 | MM |
| Tasigna | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Tazorac | Tier 3 | PA Prior Authorization required for members 26 years of age or older. |
| Tecfidera | Tier 2 | SP PA QL 60 capsules/30 days, Call Accredo at 1 877-238-8387 |
| Tekamlo | Tier 3 | MM |
| Tekturna | Tier 3 | MM |
| Tekturna HCT | Tier 3 | MM |
| telmisartan | Tier 2 | MM |
| telmisartan/amlodipine | Tier 2 | MM |
| telmisartan/hydrochlorothiazide | Tier 2 | MM |
| temazepam | Tier 1 | |
| temozolomide | Tier 1 | SP QL 5 mg: 15 capsules/21 days; 20 mg: 20 capsules/21 days; 100 mg: 20 capsules/21 days; 140 mg: 15 capsules/21 days; 180 mg: 10 capsules/21 days; 250 mg: 10 capsules/21 days, Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment |
| | | under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group |
| terazosin | Tier 1 | mandate. Please contact your plan |
| terazosin terbinafine tablets | Tier 1 Tier 1 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| terbinafine tablets | | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days |
| terbinafine tablets | Tier 1 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. |
| terbinafine tablets terbutaline terconazole Testim | Tier 1 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. |
| terbinafine tablets terbutaline terconazole Testim | Tier 1 Tier 1 Tier 1 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. |
| terbinafine tablets terbutaline | Tier 1 Tier 1 Tier 1 Tier 3 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. MM SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective |
| terbinafine tablets terbutaline terconazole Testim tetracycline Thalomid | Tier 1 Tier 1 Tier 1 Tier 3 Tier 1 Tier 3 Tier 1 Tier 3 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. MM SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| terbinafine tablets terbutaline terconazole Testim tetracycline | Tier 1 Tier 1 Tier 1 Tier 3 Tier 1 | mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. MM QL 30 tablets/30 days. Annual limit of 90 days applies. MM SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective |

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| thioridazine | Tier 1 | |
|--|--------|---|
| thiothixene | Tier 1 | |
| tiagabine | Tier 1 | MM |
| Tikosyn | Tier 3 | MM |
| Tilia Fe | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| timolol maleate eye drops | Tier 1 | MM |
| timolol maleate gel | Tier 1 | MM |
| tinidazole | Tier 1 | |
| Tirosint | Tier 3 | MM |
| Tivicay | Tier 2 | |
| tizanidine | Tier 1 | MM |
| TOBI Podhaler | Tier 3 | |
| Tobradex 0.3%/0.05% eye drops | Tier 3 | |
| tobramycin eye drops, eye ointment | Tier 1 | |
| tobramycin/dexamethasone 0.3%/0.1% eye drops | Tier 1 | |
| tolterodine | Tier 1 | MM |
| topiramate | Tier 1 | MM |
| torsemide | Tier 1 | MM |
| Tracleer | Tier 3 | SP PA Call Accredo at 1-866-344-4874 |
| Tradjenta | Tier 2 | MM |
| tramadol | Tier 1 | |
| tramadol ext-rel | Tier 1 | |
| trandolapril | Tier 1 | MM |
| tranexamic acid | Tier 1 | QL 30 tablets/28 days |
| Transderm Scop | Tier 3 | |
| tranylcypromine | Tier 1 | |
| Travatan Z | Tier 3 | QL STPA MM 15 mL/90 days |
| travoprost eye drops | Tier 1 | QL MM 15 mL/90 days |
| trazodone | Tier 1 | |
| Trelstar Depot | Tier 3 | |
| Trelstar LA | Tier 3 | |
| tretinoin capsules | Tier 1 | SP Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| tretinoin gel microsphere | Tier 1 | PA Prior Authorization required for members 26 years of age or older. |
| tretinoin topical | Tier 1 | PA |
| Tretin-X | Tier 3 | PA Prior Authorization required for members 26 years of age or older. |
| Trexall | Tier 2 | Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Treximet | | QL Drug is not covered, but if covered through medical review process, QL of 9 tablets/30 days will apply. |
| triamcinolone acetonide cream 0.5% | Tier 1 | |
| triamcinolone acetonide cream, lotion 0.025% | Tier 1 | |
| triamcinolone acetonide cream, lotion, ointment 0.1% | Tier 1 | |

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| triamcinolone nasal spray | Tier 2 | QL MM 3 nasal spray units/90 days |
|---------------------------------|--------------------|--|
| triamcinolone paste | Tier 1 | QL WIVE 5 masar spray units/70 days |
| triamterene/hydrochlorothiazide | Tier 1 | MM |
| triazolam | Tier 1 | 141141 |
| trifluoperazine | Tier 1 | |
| trifluridine eye drops | Tier 1 | |
| trihexyphenidyl | Tier 1 | MM |
| trimethobenzamide | Tier 1 | 141141 |
| trimethoprim | Tier 1 | |
| trimipramine | Tier 1 | |
| Trinessa | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Tri-Sprintec | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Trivora | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| trospium | Tier 1 | MM |
| trospium ext-rel | Tier 1 | MM |
| Trusopt | | QL Drug is not covered, but if covered through medical review process, QL of 30 mL/90 days will apply. |
| Truvada | Tier 2 | MM |
| Tudorza Pressair | Tier 3 | QL 3 inhalers/90 days |
| Tykerb | Tier 2 | SP PA QL 180 tablets/30 days, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., Call Accredo at 1-877-238-8387 |
| Tysabri | Medical | PA Covered under the medical benefit. Available |
| | Benefit | through Accredo, call 1-877-238-8387. |
| Tyvaso | Medical Benefit | PA SI Covered under the medical benefit., Call Accredo at 1-866-344-4874 |
| Tyzeka | Tier 2 | QL MM 30 tablets/30 days |
| <u>U</u> | | |
| Drug Name | Tier | Pharmacy Program |
| ubidecarenone | Tier 1 | PA |
| Uceris | Tier 3 | |
| Ulesfia | Tier 3 | QL 6 bottles/7 days |
| Uloric | Tier 3 | STPA MM |
| Unithroid | Tier 1 | MM |
| ursodiol | Tier 1 | *1*** |
| uibouioi | I ICI I | |

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\mathbf{V}

| Drug Name | Tier | Pharmacy Program |
|-------------------------------|--------------------|--|
| valacyclovir | | QL 90 tablets/90 days |
| valacyclovir | Tier 1 | QL 90 tablets/90 days |
| Valchlor | Tier 2 | PA |
| Valcyte | Tier 3 | MM |
| valproate sodium | Tier 1 | MM |
| valproic acid | Tier 1 | MM |
| valsartan/hydrochlorothiazide | Tier 1 | MM |
| Valtrex | 1101.1 | QL Drug is not covered, but if covered through medical review process, QL of 90 tablets/90 days will apply. |
| vancomycin | Tier 1 | |
| Veletri | Medical | PA SI Covered under the medical benefit., Call |
| | Benefit | Accredo at 1-866-344-4874. |
| Velivet | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| venlafaxine | Tier 1 | your group. |
| venlafaxine ext-rel capsules | Tier 1 | |
| venlafaxine ext-rel tablets | Tier 1 | |
| Venofer Venofer | Medical | |
| Venoter | Benefit | |
| Ventavis | Medical | PA SI Call Accredo at 1-866-344-4874., Covered |
| | Benefit | under the medical benefit. |
| Ventolin | | QL Drug is not covered, but if covered through medical review process, QL of 6 inhalers/90 days will apply. |
| Ventolin HFA | Tier 3 | QL MM 6 inhalers/90 days |
| Ventolin nebulizer solution | | QL Drug is not covered, but if covered through medical review process, QL of 9 dropper bottles (180 mL total)/90 days will apply. |
| Veramyst | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal spray units/90 days will apply. |
| verapamil | Tier 1 | MM |
| verapamil ext-rel | Tier 1 | MM |
| Versacloz | Tier 3 | |
| Vesicare | Tier 3 | MM |
| Victoza | Tier 3 | MM |
| Victrelis | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| Videx | Tier 2 | MM |
| Vimovo | | QL Drug is not covered, but if covered through medical review process, QL of 60 tablets/30 days will apply. |
| Vimpat | Tier 2 | PA QL MM oral solution: 1200 mL/30 days; tablets: 180 tablets/90 days |
| Viracept | Tier 2 | MM |
| Viramune XR | Tier 2 | MM |
| Viread | Tier 2 | MM |
| Vivelle-Dot | Tier 3 | QL MM 24 patches/84 days |
| Vivitrol | Medical Benefit | · · · · · · · · · · · · · · · · · · · |
| Voltaren gel | Tier 3 | QL 2 tubes/1 day |

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| voriconazole tablets | Tier 1 | QL 50 mg: 56 tablets/14 days; 200 mg: 28 tablets/14 days |
|--|--------------------|---|
| Votrient | Tier 2 | SP PA QL 200 mg tablets: 120 tablets/30 days; 400 mg tablets: 60 tablets/30 days, Call Accredo at 1-877-238-8387, Oral cancer medications may be |
| | | covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Vpriv | Medical Benefit | PA SI Call Coram Healthcare at 1-800-422-7312 or Caremark at 1-800-237-2767, Covered under the medical benefit. |
| Vytorin | Tier 2 | MM |
| Vyvanse W | Tier 3 | STPA |
| Drug Name | Tier | Pharmacy Program |
| warfarin | Tier 1 | MM |
| Welchol | Tier 3 | MM |
| <u>X</u> | | |
| Drug Name | Tier | Pharmacy Program |
| Xalkori | Tier 2 | SP PA Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective |
| Xarelto | Tier 3 | date for your group., Call Accredo at 1-877-238-8387 QL MM 10 mg: 35 tablets/fill; 15 mg: 60 |
| | | tablets/30 days; 20 mg: 30 tablets/30 days |
| Xeljanz | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, 60 tablets/30 days |
| Xenazine | Tier 2 | SP PA QL 12.5 mg: 90 tablets/30 days; 25 mg: 120 tablets/30 days, Call Caremark at 1-800-237-2767 |
| Xgeva | Medical Benefit | PA Covered under the medical benefit. |
| Xiaflex | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| Xifaxan | Tier 3 | PA QL 200 mg: 9 tablets/30 days; 550 mg: 60 tablets/30 days |
| Xolair | Medical Benefit | PA Covered under the medical benefit. Available through Accredo, call 1-877-238-8387. |
| Xopenex HFA | Tier 3 | QL MM 6 inhalers/90 days |
| Xopenex inhalation solution, 0.31 mg/3 mL, 0.63 mg/3 mL, 1 | Tier 3 | QL STPA MM |
| Xtandi | Tier 2 | SP PA QL Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group., 120 capsules/30 days |
| Xyrem | Tier 3 | |
| Z | | |
| Drug Name | Tier | Pharmacy Program |
| zafirlukast | Tier 1 | QL MM 180 tablets/90 days |

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| zaleplon | | QL 30 capsules/90 days |
|--------------------------------------|--------------------|--|
| zaleplon | Tier 1 | QL 30 capsules/90 days |
| Zavesca | Tier 3 | SP PA Call Accredo at 1-877-238-8387 |
| Zegerid | | QL Drug is not covered, but if covered through medical review process, QL of 90 capsules/packets/90 days will apply. |
| Zelboraf | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| Zenpep | Tier 3 | MM |
| Zetia | Tier 3 | MM |
| Zetonna | | QL Drug is not covered, but if covered through medical review process, QL of 3 nasal sprays/90 days will apply. |
| zidovudine | Tier 1 | MM |
| Zioptan | Tier 3 | QL STPA MM 90 single-use containers/90 days |
| ziprasidone | Tier 1 | |
| ziprasidone | Tier 2 | |
| Zirgan | Tier 3 | |
| Zoladex | Tier 3 | |
| zoledronic acid (generic of Reclast) | Tier 1 | PA Covered under the medical benefit. |
| zoledronic acid 4 mg/5 mL IV | Medical Benefit | PA Covered under the medical benefit. |
| Zolinza | Tier 2 | SP PA Call Accredo at 1-877-238-8387, Oral cancer medications may be covered without copayment under the Massachusetts oral cancer therapy mandate. Please contact your plan sponsor/employer about applicability and effective date for your group. |
| zolmitriptan | Tier 2 | QL 2.5 mg: 6 tablets/30 days; 5 mg: 6 tablets/30 days |
| zolpidem | Tier 1 | QL 30 tablets/90 days |
| zolpidem tartrate CR | Tier 1 | QL 10 tablets/30 days |
| Zolpimist 5 mg Spray | | QL Drug is not covered, but if covered through medical review process, QL of 1 metered spray unit/30 days will apply. |
| Zometa | Medical Benefit | PA Covered under the medical benefit. |
| zonisamide | Tier 1 | MM |
| Zorbtive | Tier 3 | SP PA Call Caremark at 1-800-237-2767 |
| Zortress | Tier 3 | QL MM 180 tablets/90 days |
| Zovia 1/35 | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Zovia 1/50 | Tier 1 | MM Contraceptive covered without copayment under Women's Health Preventive Services Initiative. Please contact your plan sponsor / employer about applicability and effective date for your group. |
| Zubsolv | Tier 3 | PA |
| Zuplenz | | QL Drug is not covered, but if covered through medical review process, QL of 10 films/7 days wil apply. |

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| Zytiga | Tier 2 | SP PA QL 120 tablets/30 days, Oral cancer |
|--------|--------|--|
| | | medications may be covered without copayment |
| | | under the Massachusetts oral cancer therapy |
| | | mandate. Please contact your plan |
| | | sponsor/employer about applicability and effective |
| | | date for your group., Call Accredo at 1-877-238- |
| | | 8387 |
| Zvvox | Tier 3 | OL 56 tablets/28 days |

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