



Express Scripts Medicare (PDP) 2019 Formulary (List of Covered Drugs)

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

Formulary ID Number: 19057, v5

This formulary was updated on 08/24/2018. For more recent information or to price a medication, you can visit us on the Web at express-scripts.com. Or you can contact **Express Scripts Medicare®** (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

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

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

This document includes the list of the covered drugs (formulary) for our plan, which is current as of August 24, 2018. For more recent information, please contact us. Our contact information, along with the date we last updated the formulary, appears above and on the back cover.

You must use network pharmacies to fill your prescriptions to get the most from your benefit. Benefits, premium and/or copayments/coinsurance may change on January 1, 2020. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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

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

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

What is the Express Scripts Medicare formulary?

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

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

Can my drug coverage change?

- Generally, if you are taking a drug covered by your plan in 2019, Express Scripts Medicare will not discontinue or reduce coverage of the drug during the 2019 coverage year, except when a new, less expensive generic drug becomes available or new information about the safety or effectiveness of a drug is released or the drug is removed from the market. (See bullets below for more information on changes that affect members currently taking the drug.) Other types of formulary changes, such as removing a drug from our plan’s formulary, will not affect members who are currently taking the drug. It will remain available at the same copayment or coinsurance amount for those members taking it for the remainder of the coverage year.
- **New generic drugs.** We may immediately remove a brand-name drug on our formulary if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our formulary, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
 - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on the steps you may take to request an exception, and you can also find information in the section below entitled “How do I request an exception to the formulary?”
- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.
- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost-sharing tier. Or we may make changes based on new clinical guidelines.

If we remove drugs from our formulary or add prior authorization, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, if applicable, we must notify affected members of the change at least 30 days before the change becomes effective or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

How do I use the formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 104. The Index provides an alphabetical list of all of the drugs included in this document. Both brand-name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the “Drug Name” column of the list.

What are generic drugs?

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

Are there any restrictions on my coverage?

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

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

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

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

If Drug A does not work for you, we will then cover Drug B. These drugs are noted with “ST” next to them in the formulary.

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

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

What if my drug is not listed on this formulary?

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

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

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

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

How do I request an exception to the formulary?

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

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

You should contact us to ask for an initial coverage decision for an exception, utilization restriction exception or to ask the plan to cover a drug that is not currently covered. **When you are requesting an exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber’s supporting

statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

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

How do I request an appeal?

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

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

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

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

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

For each of your drugs that is not on our formulary, or if your ability to get drugs is limited, we will cover a temporary transition supply when you go to a network pharmacy. This temporary transition supply will be for a one-month supply. If your prescription is written for fewer days, we’ll allow refills to provide up to a maximum of a one-month supply of medication. After your first refill of a one-month supply, we will not pay for these drugs, even if you have been a plan member less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary, or if your ability to get your drug is limited but you are past the first 90 days of membership in our plan, we will cover a minimum of a 31-day emergency transition supply of that drug while you pursue an exception.

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

- When you enter a long-term care facility
- When you leave a long-term care facility
- When you are discharged from a hospital
- When you leave a skilled nursing facility

- When you cancel hospice care
- When you are discharged from a psychiatric hospital with a medication regimen that is highly individualized

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

Other coverage that your plan may provide

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

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

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

Formulary

The formulary that begins on page 1 provides coverage information about some of the drugs covered by this plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 104.

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

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

Your Costs

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

- **Your coverage stage.** Your plan has different stages of coverage. In each stage, the amount you pay for a drug may change. Please refer to your other plan documents for more information about your specific prescription drug benefit.

- **The drug tier for your drug.** Each covered drug is in one of four drug tiers. Each tier may have a different cost-sharing amount. The “Drug Tiers” chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

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

Drug Tiers

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

If you qualify for Extra Help

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

For more information

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

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

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

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

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

List of abbreviations

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

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

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

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

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

Drug Name	Drug Tier	Requirements /Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	4	PA; MO
AMBISOME	4	PA; MO
<i>amphotericin b</i>	1	PA; MO
ANCOBON	4	MO
CANCIDAS	4	PA; MO
<i>caspofungin</i>	4	PA
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA ORAL	4	MO
DIFLUCAN	3	MO
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 100 MG	4	MO
ERAXIS(WATER DILUENT) INTRAVENOUS RECON SOLN 50 MG	3	MO
<i>fluconazole</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	1	
<i>flucytosine</i>	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>griseofulvin microsize</i>	1	MO
<i>griseofulvin ultramicrosize</i>	1	MO
GRIS-PEG (ULTRAMICROSIZ E)	3	MO
<i>itraconazole</i>	1	MO
<i>ketoconazole oral</i>	1	MO
MYCAMINE	4	MO
NOXAFIL ORAL	4	MO
<i>nystatin oral suspension</i>	1	MO
<i>nystatin oral tablet</i>	1	MO
ORAVIG	3	MO
SPORANOX ORAL CAPSULE	3	MO
SPORANOX ORAL SOLUTION	2	MO
<i>terbinafine hcl oral</i>	1	MO
VFEND	4	MO
VFEND IV	3	MO
<i>voriconazole intravenous</i>	1	MO
<i>voriconazole oral</i>	4	MO
ANTIVIRALS		
<i>abacavir</i>	1	MO
<i>abacavir-lamivudine</i>	4	MO
<i>abacavir-lamivudine-zidovudine</i>	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>acyclovir oral capsule</i>	1	MO
<i>acyclovir oral suspension 200 mg/5 ml</i>	1	MO
<i>acyclovir oral tablet</i>	1	MO
<i>acyclovir sodium intravenous solution</i>	1	PA; MO
<i>adefovir</i>	4	MO
<i>amantadine hcl</i>	1	MO
APTIVUS ORAL CAPSULE	4	MO
APTIVUS ORAL SOLUTION	4	
<i>atazanavir oral capsule 150 mg, 200 mg</i>	1	MO
<i>atazanavir oral capsule 300 mg</i>	4	MO
ATRIPLA	4	MO
BARACLUDE	4	MO
BIKTARVY	4	MO
COMBIVIR	4	MO
COMPLERA	4	MO
CRIXIVAN ORAL CAPSULE 200 MG, 400 MG	2	MO
DAKLINZA	4	PA; MO; QL (28 per 28 days)
DESCOVY	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>didanosine oral capsule, delayed release(dr/ec) 200 mg, 250 mg, 400 mg</i>	1	MO
EDURANT	4	MO
<i>efavirenz oral capsule 200 mg</i>	4	MO
<i>efavirenz oral capsule 50 mg</i>	1	MO
<i>efavirenz oral tablet</i>	4	MO
EMTRIVA	2	MO
<i>entecavir</i>	4	MO
EPCLUSA	4	PA; MO; QL (28 per 28 days)
EPIVIR	3	MO
EPIVIR HBV ORAL SOLUTION	2	MO
EPIVIR HBV ORAL TABLET	3	MO
EPZICOM	4	MO
EVOTAZ	4	MO
<i>famciclovir</i>	1	MO
FLUMADINE ORAL TABLET	3	MO
<i>fosamprenavir</i>	4	MO
FUZEON SUBCUTANEOUS RECON SOLN	4	MO
GENVOYA	4	MO
HARVONI	4	PA; MO; QL (28 per 28 days)

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

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

Drug Name	Drug Tier	Requirements /Limits
<i>lopinavir-ritonavir</i>	1	MO
MAVYRET	4	PA; MO; QL (84 per 28 days)
<i>moderiba</i>	1	MO
<i>moderiba oral tablets,dose pack 200 mg (28)- 400 mg (28), 400-400 mg (28)-mg (28)</i>	1	MO
<i>moderiba dose pack oral tablets,dose pack 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	4	MO
<i>nevirapine oral tablet</i>	1	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO
NORVIR ORAL CAPSULE	2	
NORVIR ORAL POWDER IN PACKET	2	MO
NORVIR ORAL SOLUTION	2	MO
NORVIR ORAL TABLET	3	MO
ODEFSEY	4	MO
<i>oseltamivir</i>	1	MO
PREVYMIS ORAL	4	MO; QL (30 per 30 days)
PREZCOBIX	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
PREZISTA ORAL SUSPENSION	4	MO
PREZISTA ORAL TABLET 150 MG, 75 MG	2	MO
PREZISTA ORAL TABLET 600 MG, 800 MG	4	MO
REBETOL ORAL SOLUTION	2	MO
RELENZA DISKHALER	2	MO
RESCRIPTOR	2	MO
RETROVIR ORAL CAPSULE	3	MO
RETROVIR ORAL SYRUP	3	MO
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	4	MO
REYATAZ ORAL POWDER IN PACKET	4	MO
<i>ribasphere oral capsule</i>	1	MO
<i>ribasphere oral tablet 200 mg, 400 mg</i>	1	MO
<i>ribasphere oral tablet 600 mg</i>	4	MO
<i>ribasphere ribapak oral tablets, dose pack 200 mg (7)-400 mg (7)</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>ribasphere ribapak oral tablets, dose pack 400-400 mg (28)-mg (28), 600-400 mg (28)-mg (28), 600-600 mg (28)-mg (28)</i>	4	MO
<i>ribavirin oral capsule</i>	1	MO
<i>ribavirin oral tablet 200 mg</i>	1	MO
<i>rimantadine</i>	1	MO
<i>ritonavir</i>	1	MO
SELZENTRY	2	MO
SOVALDI	4	PA; MO; QL (28 per 28 days)
<i>stavudine oral capsule</i>	1	MO
STRIBILD	4	MO
SUSTIVA ORAL CAPSULE 200 MG	4	MO
SUSTIVA ORAL CAPSULE 50 MG	3	MO
SUSTIVA ORAL TABLET	4	MO
SYMFI	4	MO
SYMFI LO	4	MO
TAMIFLU	3	MO
TECHNIVIE	4	PA; MO; QL (56 per 28 days)
<i>tenofovir disoproxil fumarate</i>	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
TIVICAY ORAL TABLET 10 MG	2	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	4	MO
TRIUMEQ	4	MO
TRIZIVIR	4	MO
TRUVADA	4	MO
TYBOST	3	MO
<i>valacyclovir oral tablet 1 gram</i>	1	MO; QL (120 per 30 days)
<i>valacyclovir oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
VALCYTE	4	MO
<i>valganciclovir</i>	4	MO
VALTREX ORAL TABLET 1 GRAM	3	MO; QL (120 per 30 days)
VALTREX ORAL TABLET 500 MG	3	MO; QL (60 per 30 days)
VEMLIDY	4	MO
VIDEX 4 GRAM PEDIATRIC	2	MO
VIDEX EC	3	MO
VIEKIRA PAK	4	PA; MO; QL (112 per 28 days)
VIEKIRA XR	4	PA; MO; QL (84 per 28 days)
VIRACEPT ORAL TABLET	4	MO
VIRAMUNE	3	MO
VIRAMUNE XR	3	MO

Drug Name	Drug Tier	Requirements /Limits
VIREAD	4	MO
VOSEVI	4	PA; MO; QL (28 per 28 days)
ZEPATIER	4	PA; MO; QL (28 per 28 days)
ZERIT ORAL CAPSULE 15 MG	3	
ZERIT ORAL CAPSULE 20 MG, 30 MG, 40 MG	3	MO
ZERIT ORAL RECON SOLN	3	MO
ZIAGEN	3	MO
<i>zidovudine</i>	1	MO
ZOVIRAX ORAL CAPSULE	3	MO
ZOVIRAX ORAL SUSPENSION	3	MO
ZOVIRAX ORAL TABLET 800 MG	3	MO
CEPHALOSPORINS		
AVYCAZ	4	MO
<i>cefactor oral capsule</i>	1	MO
<i>cefactor oral suspension for reconstitution 125 mg/5 ml, 250 mg/5 ml</i>	1	MO
<i>cefactor oral suspension for reconstitution 375 mg/5 ml</i>	1	

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

Drug Name	Drug Tier	Requirements /Limits
<i>cefaclor oral tablet extended release 12 hr</i>	1	MO
<i>cefadroxil oral capsule</i>	1	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	MO
<i>cefadroxil oral tablet</i>	1	MO
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	1	MO
<i>cefazolin injection recon soln 10 gram</i>	1	
<i>cefdinir</i>	1	MO
<i>cefepime</i>	1	MO
<i>cefixime</i>	1	MO
<i>cefotaxime injection recon soln 1 gram, 2 gram, 500 mg</i>	1	
<i>cefotetan injection</i>	1	
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	MO
<i>cefoxitin intravenous recon soln 10 gram</i>	1	
<i>cefpodoxime</i>	1	MO
<i>cefprozil</i>	1	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	MO
<i>ceftazidime injection recon soln 6 gram</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	1	MO
<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>cefuroxime axetil oral tablet</i>	1	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	MO
<i>cefuroxime sodium intravenous recon soln 7.5 gram</i>	1	
<i>cephalexin</i>	1	MO
MAXIPIME INJECTION	3	MO
SUPRAX ORAL CAPSULE	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 100 MG/5 ML, 200 MG/5 ML	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	3	
SUPRAX ORAL TABLET,CHEWABLE	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
TAZICEF INJECTION RECON SOLN 1 GRAM	3	
TAZICEF INJECTION RECON SOLN 2 GRAM, 6 GRAM	3	MO
TEFLARO	4	MO
ZERBAXA	4	
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin</i>	1	MO
<i>clarithromycin</i>	1	MO
DIFICID	4	MO
<i>e.e.s. 400 oral tablet</i>	1	MO
E.E.S. GRANULES	3	MO
ERYPED 200	3	MO
ERYPED 400	3	MO
<i>ery-tab oral tablet, delayed release (dr/ec) 250 mg, 333 mg</i>	1	MO
ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG	2	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	2	MO

Drug Name	Drug Tier	Requirements /Limits
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	MO
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO
<i>erythromycin oral capsule, delayed release (dr/ec)</i>	1	MO
<i>erythromycin oral tablet</i>	1	MO
ZITHROMAX	3	MO
ZITHROMAX TRI-PAK	3	MO
ZITHROMAX Z-PAK	3	MO
MISCELLANEOUS ANTIINFECTIVES		
ALBENZA	4	MO
ALINIA ORAL SUSPENSION FOR RECONSTITUTION	2	MO
ALINIA ORAL TABLET	4	MO
<i>amikacin injection solution 500 mg/2 ml</i>	1	MO
<i>atovaquone</i>	4	MO
<i>atovaquone-proguanil</i>	1	MO
AZACTAM	3	MO
<i>aztreonam injection recon soln 1 gram</i>	1	MO
BENZNIDAZOLE	2	

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

Drug Name	Drug Tier	Requirements /Limits
BETHKIS	4	PA; MO; QL (224 per 28 days)
BILTRICIDE	4	MO
CAYSTON	4	MO; LA; QL (84 per 28 days)
<i>chloroquine phosphate</i>	1	MO
CLEOCIN HCL	3	MO
CLEOCIN IN 5 % DEXTROSE INTRAVENOUS PIGGYBACK 300 MG/50 ML, 600 MG/50 ML	3	MO
CLEOCIN IN 5 % DEXTROSE INTRAVENOUS PIGGYBACK 900 MG/50 ML	3	
CLEOCIN INJECTION	3	MO
CLEOCIN PEDIATRIC	3	MO
<i>clindamycin hcl</i>	1	MO
<i>clindamycin in 5 % dextrose</i>	1	MO
<i>clindamycin palmitate hcl</i>	1	MO
<i>clindamycin phosphate injection</i>	1	MO
<i>clindamycin phosphate intravenous solution 600 mg/4 ml</i>	1	

Drug Name	Drug Tier	Requirements /Limits
COARTEM	2	MO
<i>colistin (colistimethate na)</i>	1	MO
CUBICIN	4	MO
DALVANCE	3	MO
<i>dapsone oral</i>	1	MO
<i>daptomycin intravenous recon soln 500 mg</i>	4	MO
DARAPRIM	4	PA; MO
DORIPENEM INTRAVENOUS RECON SOLN 500 MG	3	
EMVERM	4	MO
<i>ethambutol</i>	1	MO
FLAGYL	3	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>	1	MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml</i>	1	
<i>gentamicin injection solution 40 mg/ml</i>	1	MO
<i>hydroxychloroquine</i>	1	MO
<i>imipenem-cilastatin</i>	1	MO
INVANZ INJECTION	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>isoniazid oral</i>	1	MO
<i>ivermectin</i>	1	MO
KITABIS PAK	4	MO
<i>linezolid</i>	4	MO
<i>linezolid in dextrose 5%</i>	4	
MALARONE	3	MO
MALARONE PEDIATRIC	3	MO
<i>mefloquine</i>	1	MO
MEPRON	4	MO
<i>meropenem</i>	1	MO
MERREM INTRAVENOUS RECON SOLN 500 MG	3	MO
<i>metronidazole in nacl (iso-os)</i>	1	MO
<i>metronidazole oral</i>	1	MO
MYAMBUTOL ORAL TABLET 400 MG	3	MO
MYCOBUTIN	3	MO
NEBUPENT	2	PA; MO; QL (1 per 28 days)
<i>neomycin</i>	1	MO
<i>paromomycin</i>	1	MO
PASER	2	MO
PENTAM	3	MO
PLAQUENIL	3	MO
<i>polymyxin b sulfate</i>	1	MO
PRIFTIN	2	MO

Drug Name	Drug Tier	Requirements /Limits
PRIMAQUINE	2	MO
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	3	MO
<i>pyrazinamide</i>	1	MO
QUALAQUIN	3	MO
<i>quinine sulfate</i>	1	MO
<i>rifabutin</i>	1	MO
RIFADIN ORAL CAPSULE 150 MG	3	MO
RIFAMATE	3	MO
<i>rifampin</i>	1	MO
RIFATER	3	MO
SIRTURO	4	MO; LA
SIVEXTRO INTRAVENOUS	4	
SIVEXTRO ORAL	4	MO
SOLOSEC	3	MO
STREPTOMYCIN	2	MO
STROMECTOL	3	MO
<i>tigecycline</i>	4	
TINDAMAX ORAL TABLET 500 MG	3	MO
<i>tinidazole</i>	1	MO
TOBI	4	PA; MO; QL (280 per 28 days)
TOBI PODHALER INHALATION CAPSULE	4	QL (224 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	4	MO; QL (224 per 28 days)
<i>tobramycin in 0.225 % nacl</i>	4	PA; MO; QL (280 per 28 days)
<i>tobramycin sulfate injection solution</i>	1	MO
TRECTOR	2	MO
TYGACIL	4	MO
VABOMERE	3	
VANCOGIN	4	MO
<i>vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg</i>	1	MO
<i>vancomycin oral capsule 125 mg</i>	1	MO
<i>vancomycin oral capsule 250 mg</i>	4	MO
XIFAXAN ORAL TABLET 200 MG	4	MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	4	MO; QL (60 per 30 days)
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	4	MO
ZYVOX ORAL	4	MO
PENICILLINS		
<i>amoxicillin oral capsule</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>amoxicillin oral suspension for reconstitution</i>	1	MO
<i>amoxicillin oral tablet</i>	1	MO
<i>amoxicillin oral tablet, chewable 125 mg, 250 mg</i>	1	MO
<i>amoxicillin-pot clavulanate</i>	1	MO
<i>ampicillin oral capsule 500 mg</i>	1	MO
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	1	MO
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	MO
BICILLIN C-R	2	MO
BICILLIN L-A	2	MO
<i>dicloxacillin</i>	1	MO
<i>nafcillin injection recon soln 1 gram</i>	1	MO
<i>nafcillin injection recon soln 10 gram</i>	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml</i>	1	
<i>oxacillin in dextrose(iso-osm) intravenous piggyback 2 gram/50 ml</i>	1	MO
<i>oxacillin injection recon soln 1 gram</i>	1	
<i>oxacillin injection recon soln 10 gram</i>	4	
<i>oxacillin injection recon soln 2 gram</i>	1	MO
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML	2	
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 3 MILLION UNIT/50 ML	2	MO
<i>penicillin g potassium injection recon soln 20 million unit</i>	1	MO
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>penicillin g sodium</i>	1	MO
<i>penicillin v potassium</i>	1	MO
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram</i>	1	MO
UNASYN INJECTION RECON SOLN 15 GRAM	3	
UNASYN INJECTION RECON SOLN 3 GRAM	3	MO
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	3	
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 3.375 GRAM/50 ML	3	MO
ZOSYN INTRAVENOUS RECON SOLN 40.5 GRAM	3	MO
QUINOLONES		
AVELOX	3	MO
AVELOX IN NACL (ISO-OSMOTIC)	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
BAXDELA INTRAVENOUS	4	
BAXDELA ORAL	4	MO
CIPRO ORAL SUSPENSION, MIC ROCAPSULE RECON	3	MO
CIPRO ORAL TABLET 250 MG, 500 MG	3	MO
<i>ciprofloxacin</i>	1	
<i>ciprofloxacin (mixture)</i>	1	MO
<i>ciprofloxacin hcl oral</i>	1	MO
<i>ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml</i>	1	MO
LEVAQUIN ORAL TABLET 500 MG, 750 MG	3	MO
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	MO
<i>levofloxacin intravenous</i>	1	MO
<i>levofloxacin oral</i>	1	MO
MOXIFLOXACIN IN NACL (ISO-OSM)	1	
<i>moxifloxacin oral</i>	1	MO
<i>ofloxacin oral tablet 300 mg</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>ofloxacin oral tablet 400 mg</i>	1	MO
SULFA'S / RELATED AGENTS		
BACTRIM	3	MO
BACTRIM DS	3	MO
<i>sulfadiazine</i>	1	MO
<i>sulfamethoxazole-trimethoprim oral</i>	1	MO
TETRACYCLINES		
<i>demeclocycline</i>	1	MO
DORYX MPC	3	ST; MO
DORYX ORAL TABLET, DELAYED RELEASE (DR/EC) 200 MG, 50 MG	3	ST; MO
<i>doxy-100</i>	1	MO
<i>doxycycline hyclate oral capsule</i>	1	MO
<i>doxycycline hyclate oral tablet 100 mg, 150 mg, 20 mg, 75 mg</i>	1	MO
<i>doxycycline hyclate oral tablet, delayed release (dr/ec)</i>	1	MO
<i>doxycycline monohydrate oral capsule</i>	1	MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>doxycycline monohydrate oral tablet</i>	1	MO
MINOCIN ORAL CAPSULE 100 MG, 50 MG	3	ST; MO
<i>minocycline oral capsule</i>	1	MO
<i>minocycline oral tablet</i>	1	MO
<i>minocycline oral tablet extended release 24 hr 115 mg, 65 mg</i>	4	MO
<i>minocycline oral tablet extended release 24 hr 135 mg, 45 mg, 90 mg</i>	1	MO
<i>morgidox oral capsule 50 mg</i>	1	MO
ORACEA	3	ST; MO
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	4	ST; MO
<i>soloxide</i>	1	
TARGADOX	3	ST; MO
<i>tetracycline</i>	1	MO
VIBRAMYCIN ORAL CAPSULE 100 MG	3	ST; MO

Drug Name	Drug Tier	Requirements /Limits
VIBRAMYCIN ORAL SUSPENSION FOR RECONSTITUTION	3	MO
VIBRAMYCIN ORAL SYRUP	2	MO
XIMINO	3	ST; MO
URINARY TRACT AGENTS		
FURADANTIN	3	
HIPREX	3	MO
MACROBID	3	MO
MACRODANTIN	3	MO
<i>methenamine hippurate</i>	1	MO
MONUROL	3	MO
<i>nitrofurantoin</i>	1	MO
<i>nitrofurantoin macrocrystal</i>	1	MO
<i>nitrofurantoin monohyd/m-cryst</i>	1	MO
<i>trimethoprim</i>	1	MO

ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS

ADJUNCTIVE AGENTS

<i>leucovorin calcium oral</i>	1	MO
MESNEX ORAL	4	MO
XGEVA	4	PA; MO

ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS

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

Drug Name	Drug Tier	Requirements /Limits
AFINITOR	4	PA; MO; QL (30 per 30 days)
AFINITOR DISPERZ	4	PA; MO
ALECENSA	4	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	4	PA; MO; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	4	PA; MO; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	4	PA; MO; QL (30 per 30 days)
<i>anastrozole</i>	1	MO
ARIMIDEX	3	MO
AROMASIN	3	MO
ASTAGRAF XL	3	PA; MO
AZASAN	3	PA; MO
<i>azathioprine</i>	1	PA; MO
<i>bexarotene</i>	4	PA; MO
<i>bicalutamide</i>	1	MO
BOSULIF ORAL TABLET 100 MG	4	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	4	PA; MO; QL (30 per 30 days)
CABOMETYX	4	PA; MO; LA

Drug Name	Drug Tier	Requirements /Limits
CALQUENCE	4	PA; MO; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	4	PA; MO; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	4	PA; MO; LA; QL (30 per 30 days)
CASODEX	3	MO
CELLCEPT ORAL CAPSULE	3	PA; MO
CELLCEPT ORAL SUSPENSION FOR RECONSTITUTION	4	PA; MO
CELLCEPT ORAL TABLET	4	PA; MO
COMETRIQ	4	PA; MO
COTELLIC	4	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide oral capsule</i>	1	PA; MO
<i>cyclosporine modified</i>	1	PA; MO
<i>cyclosporine oral capsule</i>	1	PA; MO
DROXIA	2	MO
ELIGARD	3	PA; MO
ELIGARD (3 MONTH)	3	PA; MO
ELIGARD (4 MONTH)	3	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
ELIGARD (6 MONTH)	3	PA; MO
EMCYT	4	MO
ENVARUSUS XR	3	PA; MO
ERIVEDGE	4	PA; MO; QL (30 per 30 days)
ERLEADA	4	PA; MO
<i>exemestane</i>	1	MO
FARESTON	4	MO
FARYDAK ORAL CAPSULE 10 MG	4	PA; MO; QL (12 per 21 days)
FARYDAK ORAL CAPSULE 15 MG, 20 MG	4	PA; MO; QL (6 per 21 days)
FEMARA	3	MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 120 MG	4	PA; MO
FIRMAGON KIT W DILUENT SYRINGE SUBCUTANEOUS RECON SOLN 80 MG	2	PA; MO
<i>flutamide</i>	1	MO
<i>gengraf oral capsule 100 mg, 25 mg</i>	1	PA; MO
<i>gengraf oral solution</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
GILOTRIF	4	PA; MO; QL (30 per 30 days)
GLEEVEC ORAL TABLET 100 MG	4	PA; MO; QL (180 per 30 days)
GLEEVEC ORAL TABLET 400 MG	4	PA; MO; QL (60 per 30 days)
GLEOSTINE ORAL CAPSULE 10 MG, 100 MG, 40 MG	2	MO
HEXALEN	4	MO
HYDREA	3	MO
<i>hydroxyurea</i>	1	MO
IBRANCE	4	PA; MO; QL (21 per 28 days)
ICLUSIG ORAL TABLET 15 MG	4	PA; MO; QL (60 per 30 days)
ICLUSIG ORAL TABLET 45 MG	4	PA; MO; QL (30 per 30 days)
IDHIFA	4	PA; MO; LA; QL (30 per 30 days)
<i>imatinib oral tablet 100 mg</i>	4	PA; MO; QL (180 per 30 days)
<i>imatinib oral tablet 400 mg</i>	4	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	4	PA; MO; QL (120 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
IMBRUVICA ORAL CAPSULE 70 MG	4	PA; MO; QL (30 per 30 days)
IMBRUVICA ORAL TABLET	4	PA; MO; QL (30 per 30 days)
IMURAN	3	PA; MO
INLYTA ORAL TABLET 1 MG	4	PA; MO; QL (180 per 30 days)
INLYTA ORAL TABLET 5 MG	4	PA; MO; QL (120 per 30 days)
IRESSA	4	PA; MO; QL (30 per 30 days)
JAKAFI	4	PA; MO; QL (60 per 30 days)
KISQALI	4	PA; MO
KISQALI FEMARA CO-PACK	4	PA; MO
LENVIMA	4	PA; MO
<i>letrozole</i>	1	MO
LEUKERAN	2	MO
<i>leuprolide subcutaneous kit</i>	4	MO
LONSURF	4	PA; MO
LUPRON DEPOT	4	PA; MO
LUPRON DEPOT (3 MONTH)	4	PA; MO
LUPRON DEPOT (4 MONTH)	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
LUPRON DEPOT (6 MONTH)	4	PA; MO
LYNPARZA ORAL CAPSULE	4	PA; MO; QL (480 per 30 days)
LYNPARZA ORAL TABLET	4	PA; MO; QL (120 per 30 days)
LYSODREN	2	MO
MATULANE	4	MO
MEGACE ES	4	PA; MO
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml</i>	1	PA; MO
<i>megestrol oral tablet</i>	1	PA; MO
MEKINIST ORAL TABLET 0.5 MG	4	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	4	PA; MO; QL (30 per 30 days)
<i>mercaptopurine</i>	1	MO
<i>methotrexate sodium</i>	1	PA; MO
<i>methotrexate sodium (pf) injection solution</i>	1	PA; MO
<i>mycophenolate mofetil oral capsule</i>	1	PA; MO
<i>mycophenolate mofetil oral suspension for reconstitution</i>	4	PA; MO
<i>mycophenolate mofetil oral tablet</i>	1	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>mycophenolate sodium</i>	1	PA; MO
MYFORTIC	3	PA; MO
NEORAL	3	PA; MO
NERLYNX	4	PA; MO; LA
NEXAVAR	4	PA; MO; LA; QL (120 per 30 days)
NILANDRON	4	MO
<i>nilutamide</i>	4	MO
NINLARO ORAL CAPSULE 2.3 MG	4	PA; MO; QL (6 per 28 days)
NINLARO ORAL CAPSULE 3 MG	4	PA; MO; QL (4 per 28 days)
NINLARO ORAL CAPSULE 4 MG	4	PA; MO; QL (3 per 28 days)
<i>octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml</i>	4	MO
<i>octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml</i>	1	MO
ODOMZO	4	PA; MO; LA; QL (30 per 30 days)
POMALYST	4	PA; MO; LA
PROGRAF ORAL CAPSULE 0.5 MG, 1 MG	3	PA; MO
PROGRAF ORAL CAPSULE 5 MG	4	PA; MO
PURIXAN	4	MO

Drug Name	Drug Tier	Requirements /Limits
RAPAMUNE ORAL SOLUTION	4	PA; MO
RAPAMUNE ORAL TABLET 0.5 MG	3	PA; MO
RAPAMUNE ORAL TABLET 1 MG, 2 MG	4	PA; MO
REVLIMID	4	PA; MO; LA; QL (28 per 28 days)
RUBRACA	4	PA; MO; LA; QL (120 per 30 days)
RYDAPT	4	PA; MO
SANDIMMUNE ORAL CAPSULE	3	PA; MO
SANDIMMUNE ORAL SOLUTION	2	PA; MO
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML	4	MO
SANDOSTATIN INJECTION SOLUTION 50 MCG/ML, 500 MCG/ML	3	MO
SIGNIFOR	4	MO
<i>sirolimus oral tablet 0.5 mg, 1 mg</i>	1	PA; MO
<i>sirolimus oral tablet 2 mg</i>	4	PA; MO
SOLTAMOX	2	MO
SOMATULINE DEPOT	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	4	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG	4	PA; MO; QL (90 per 30 days)
SPRYCEL ORAL TABLET 70 MG	4	PA; MO; QL (60 per 30 days)
STIVARGA	4	PA; MO; QL (84 per 28 days)
SUTENT	4	PA; MO; QL (30 per 30 days)
SYNRIBO	4	PA; MO
TABLOID	2	MO
<i>tacrolimus oral</i>	1	PA; MO
TAFINLAR	4	PA; MO; QL (120 per 30 days)
TAGRISO	4	PA; MO; LA; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO
TARCEVA ORAL TABLET 100 MG, 150 MG	4	PA; MO; QL (30 per 30 days)
TARCEVA ORAL TABLET 25 MG	4	PA; MO; QL (60 per 30 days)
TARGRETIN	4	PA; MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	4	PA; MO; QL (112 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
TASIGNA ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
THALOMID	4	PA; MO
TRELSTAR	4	PA; MO
<i>tretinoin (chemotherapy)</i>	4	MO
TREXALL	3	PA; MO
TYKERB	4	PA; MO; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 10 MG, 50 MG	2	PA; MO; LA
VENCLEXTA ORAL TABLET 100 MG	4	PA; MO; LA
VENCLEXTA STARTING PACK	4	PA; MO; LA; QL (42 per 180 days)
VERZENIO	4	PA; MO; LA; QL (60 per 30 days)
VOTRIENT	4	PA; MO; QL (120 per 30 days)
XALKORI	4	PA; MO; QL (60 per 30 days)
XATMEP	4	PA; MO
XERMELO	4	PA; MO; LA; QL (90 per 30 days)
XTANDI	4	PA; MO; QL (120 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
YONSA	4	PA; QL (120 per 30 days)
ZEJULA	4	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	4	PA; MO; QL (240 per 30 days)
ZOLINZA	4	MO
ZORTRESS	4	PA; MO
ZYDELIG	4	PA; MO; QL (60 per 30 days)
ZYKADIA	4	PA; MO; QL (150 per 30 days)
ZYTIGA ORAL TABLET 250 MG	4	PA; MO; QL (120 per 30 days)
ZYTIGA ORAL TABLET 500 MG	4	PA; MO; QL (60 per 30 days)

AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH

ANTICONVULSANTS

APTIOM ORAL TABLET 200 MG, 400 MG, 800 MG	3	MO
APTIOM ORAL TABLET 600 MG	4	MO
BANZEL	4	MO
BRIVIACT INTRAVENOUS	3	
BRIVIACT ORAL	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>carbamazepine oral capsule, er multiphase 12 hr</i>	1	MO
<i>carbamazepine oral suspension 100 mg/5 ml</i>	1	MO
<i>carbamazepine oral tablet</i>	1	MO
<i>carbamazepine oral tablet extended release 12 hr</i>	1	MO
<i>carbamazepine oral tablet, chewable</i>	1	MO
CARBATROL	3	MO
CELONTIN ORAL CAPSULE 300 MG	2	MO
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clonazepam oral tablet 2 mg</i>	1	PA; MO; QL (300 per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	1	PA; MO; QL (300 per 30 days)
DEPAKOTE	3	MO
DEPAKOTE ER	3	MO
DEPAKOTE SPRINKLES	3	MO
DIASTAT	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
DIASTAT ACUDIAL	3	MO
DILANTIN 30 MG	2	MO
DILANTIN EXTENDED 100 MG	3	MO
DILANTIN INFATABS 50 MG	3	MO
DILANTIN-125 125 MG/5 ML	3	MO
<i>divalproex</i>	1	MO
<i>epitol</i>	1	MO
EQUETRO	3	MO
<i>ethosuximide</i>	1	MO
<i>felbamate oral suspension</i>	4	MO
<i>felbamate oral tablet</i>	1	MO
FELBATOL	4	MO
FYCOMPA ORAL SUSPENSION	4	MO
FYCOMPA ORAL TABLET	2	MO
<i>gabapentin oral capsule 100 mg</i>	1	PA; MO; QL (1080 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>gabapentin oral capsule 400 mg</i>	1	PA; MO; QL (270 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	1	PA; MO; QL (2160 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>gabapentin oral tablet 600 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>gabapentin oral tablet 800 mg</i>	1	PA; MO; QL (120 per 30 days)
GABITRIL	3	MO
GRALISE 30-DAY STARTER PACK	2	PA; MO; QL (78 per 180 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	PA; MO; QL (30 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	2	PA; MO; QL (90 per 30 days)
KEPPRA ORAL	3	MO
KEPPRA XR	3	MO
KLONOPIN ORAL TABLET 0.5 MG, 1 MG	3	PA; MO; QL (90 per 30 days)
KLONOPIN ORAL TABLET 2 MG	3	PA; MO; QL (300 per 30 days)
LAMICTAL ODT	3	MO
LAMICTAL ORAL TABLET	3	MO
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
LAMICTAL STARTER (BLUE) KIT	3	MO
LAMICTAL STARTER (GREEN) KIT	3	MO
LAMICTAL STARTER (ORANGE) KIT	3	MO
LAMICTAL XR	3	MO
LAMICTAL XR STARTER (BLUE)	3	MO
LAMICTAL XR STARTER (GREEN)	3	MO
LAMICTAL XR STARTER (ORANGE)	3	MO
<i>lamotrigine oral tablet</i>	1	MO
<i>lamotrigine oral tablet extended release 24hr</i>	1	MO
<i>lamotrigine oral tablet, chewable dispersible</i>	1	MO
<i>lamotrigine oral tablet, disintegrating</i>	1	MO
<i>lamotrigine oral tablets, dose pack</i>	1	MO
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO
<i>levetiracetam oral tablet</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 165 MG, 82.5 MG	3	PA; MO; QL (30 per 30 days)
LYRICA CR ORAL TABLET EXTENDED RELEASE 24 HR 330 MG	3	PA; MO; QL (60 per 30 days)
LYRICA ORAL CAPSULE 100 MG, 150 MG, 200 MG, 25 MG, 50 MG, 75 MG	2	PA; MO; QL (90 per 30 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	2	PA; MO; QL (60 per 30 days)
LYRICA ORAL SOLUTION	2	PA; MO; QL (900 per 30 days)
MYSOLINE	4	MO
NEURONTIN ORAL CAPSULE 100 MG	3	PA; MO; QL (1080 per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	3	PA; MO; QL (360 per 30 days)
NEURONTIN ORAL CAPSULE 400 MG	3	PA; MO; QL (270 per 30 days)
NEURONTIN ORAL SOLUTION	3	PA; MO; QL (2160 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
NEURONTIN ORAL TABLET 600 MG	3	PA; MO; QL (180 per 30 days)
NEURONTIN ORAL TABLET 800 MG	3	PA; MO; QL (120 per 30 days)
ONFI ORAL SUSPENSION	4	PA; MO; QL (480 per 30 days)
ONFI ORAL TABLET 10 MG, 20 MG	4	PA; MO; QL (60 per 30 days)
<i>oxcarbazepine</i>	1	MO
OXTELLAR XR	3	MO
PEGANONE	2	MO
<i>phenobarbital</i>	1	PA; MO
PHENYTEK	3	MO
<i>phenytoin oral suspension 125 mg/5 ml</i>	1	MO
<i>phenytoin oral tablet, chewable</i>	1	MO
<i>phenytoin sodium extended</i>	1	MO
<i>primidone</i>	1	MO
QUDEXY XR	3	PA; MO
<i>roweepra</i>	1	MO
<i>roweepra xr</i>	1	
SABRIL	4	MO; LA
SPRITAM	3	MO
TEGRETOL ORAL SUSPENSION	3	MO

Drug Name	Drug Tier	Requirements /Limits
TEGRETOL ORAL TABLET	3	MO
TEGRETOL XR	3	MO
<i>tiagabine</i>	1	MO
TOPAMAX	3	PA; MO
<i>topiramate oral capsule, sprinkle</i>	1	PA; MO
TOPIRAMATE ORAL CAPSULE, SPRINKLE, ER 24HR	3	PA; MO
<i>topiramate oral tablet</i>	1	PA; MO
TRILEPTAL	3	MO
TROKENDI XR ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 25 MG, 50 MG	3	PA; MO
TROKENDI XR ORAL CAPSULE, EXTENDED RELEASE 24HR 200 MG	4	PA; MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
<i>vigabatrin</i>	4	MO; LA
VIMPAT ORAL SOLUTION	2	MO
VIMPAT ORAL TABLET	2	MO
ZARONTIN	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	3	PA; MO
<i>zonisamide</i>	1	PA; MO
ANTIPARKINSONISM AGENTS		
APOKYN	4	MO; LA
AZILECT	3	MO
<i>benztropine oral</i>	1	PA; MO
<i>bromocriptine</i>	1	MO
<i>carbidopa</i>	1	MO
<i>carbidopa-levodopa</i>	1	MO
<i>carbidopa-levodopa-entacapone</i>	1	MO
COMTAN	3	MO
DUOPA	3	PA; MO
ELDEPRYL	3	
<i>entacapone</i>	1	MO
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 137 MG	4	PA; MO; QL (60 per 30 days)
GOCOVRI ORAL CAPSULE,EXTENDED RELEASE 24HR 68.5 MG	4	PA; MO; QL (30 per 30 days)
LODOSYN	3	MO
MIRAPEX	3	MO
MIRAPEX ER	3	MO
NEUPRO	2	MO
OSMOLEX ER	3	PA
PARLODEL	3	MO
<i>pramipexole</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>rasagiline</i>	1	MO
REQUIP XL ORAL TABLET EXTENDED RELEASE 24 HR 4 MG, 8 MG	3	MO
<i>ropinirole</i>	1	MO
RYTARY	3	MO
<i>selegiline hcl</i>	1	MO
SINEMET	3	MO
SINEMET CR	3	MO
STALEVO 100	3	MO
STALEVO 125	3	MO
STALEVO 150	3	MO
STALEVO 200	3	MO
STALEVO 50	3	MO
STALEVO 75	3	MO
TASMAR ORAL TABLET 100 MG	4	MO
<i>tolcapone</i>	4	MO
ZELAPAR	3	MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR (2 PACK)	3	PA; MO; QL (2 per 30 days)
<i>almotriptan malate oral tablet 12.5 mg</i>	1	MO; QL (24 per 28 days)
<i>almotriptan malate oral tablet 6.25 mg</i>	1	MO; QL (18 per 28 days)
AMERGE	3	MO; QL (18 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
CAFERGOT	3	MO
<i>dihydroergotamine nasal</i>	1	MO; QL (8 per 28 days)
<i>eletriptan</i>	1	MO; QL (18 per 28 days)
<i>ergotamine-caffeine</i>	1	MO
FROVA	3	MO; QL (27 per 28 days)
<i>frovatriptan</i>	1	MO; QL (27 per 28 days)
IMITREX NASAL SPRAY, NON-AEROSOL 20 MG/ACTUATION	3	MO; QL (18 per 28 days)
IMITREX NASAL SPRAY, NON-AEROSOL 5 MG/ACTUATION	3	MO; QL (36 per 28 days)
IMITREX ORAL	3	MO; QL (18 per 28 days)
IMITREX STATDOSE KIT REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	3	MO; QL (8 per 28 days)
IMITREX STATDOSE SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	3	MO; QL (8 per 28 days)
IMITREX SUBCUTANEOUS	3	MO; QL (8 per 28 days)
MAXALT ORAL TABLET 10 MG	3	MO; QL (36 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
MAXALT-MLT	3	MO; QL (36 per 28 days)
<i>migergot</i>	1	MO
MIGRANAL	3	MO; QL (8 per 28 days)
<i>naratriptan</i>	1	MO; QL (18 per 28 days)
ONZETRA XSAIL	3	MO; QL (32 per 28 days)
RELPAK	3	MO; QL (18 per 28 days)
<i>rizatriptan</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 20 mg/actuation</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/actuation</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan succinate oral</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan succinate subcutaneous cartridge</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous pen injector</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan succinate subcutaneous solution</i>	1	MO; QL (8 per 28 days)
<i>sumatriptan-naproxen</i>	1	MO; QL (18 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
TREXIMET ORAL TABLET 10-60 MG	3	MO; QL (9 per 28 days)
TREXIMET ORAL TABLET 85-500 MG	3	MO; QL (18 per 28 days)
ZEMBRACE SYMTOUCH	4	MO; QL (8 per 28 days)
<i>zolmitriptan</i>	1	MO; QL (18 per 28 days)
ZOMIG	3	MO; QL (18 per 28 days)
ZOMIG ZMT	3	MO; QL (18 per 28 days)

MISCELLANEOUS NEUROLOGICAL THERAPY

AMPYRA	4	PA; MO; LA
ARICEPT	3	MO
AUBAGIO	4	PA; MO
AUSTEDO ORAL TABLET 12 MG, 9 MG	4	PA; MO; LA; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG	4	PA; MO; LA; QL (60 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	4	PA; MO; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	4	PA; MO; QL (12 per 28 days)
<i>donepezil</i>	1	MO
EXELON TRANSDERMAL	3	MO

Drug Name	Drug Tier	Requirements /Limits
<i>galantamine</i>	1	MO
GILENYA ORAL CAPSULE 0.5 MG	4	PA; MO
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	4	PA; MO; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	4	PA; MO; QL (12 per 28 days)
<i>glatopa subcutaneous syringe 20 mg/ml</i>	4	PA; MO; QL (30 per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	4	PA; MO; QL (12 per 28 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 300 MG	3	PA; MO; QL (30 per 30 days)
HORIZANT ORAL TABLET EXTENDED RELEASE 600 MG	3	PA; MO; QL (60 per 30 days)
INGREZZA	4	PA; MO; LA; QL (30 per 30 days)
KEVEYIS	4	PA; MO
<i>memantine oral capsule, sprinkle, er 24hr</i>	1	PA; MO
<i>memantine oral solution</i>	1	PA; MO
<i>memantine oral tablet</i>	1	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
MEMANTINE ORAL TABLETS,DOSE PACK	3	PA; MO
NAMENDA ORAL TABLET	3	PA; MO
NAMENDA TITRATION PAK	3	PA; MO
NAMENDA XR	3	PA; MO
NAMZARIC	2	PA; MO
NUEDEXTA	2	PA; MO
RAZADYNE ER	3	MO
RAZADYNE ORAL TABLET	3	MO
<i>rivastigmine</i>	1	MO
<i>rivastigmine tartrate</i>	1	MO
TECFIDERA	4	PA; MO; LA
<i>tetrabenazine oral tablet 12.5 mg</i>	4	PA; MO; QL (240 per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	4	PA; MO; QL (120 per 30 days)
XENAZINE ORAL TABLET 12.5 MG	4	PA; MO; LA; QL (240 per 30 days)
XENAZINE ORAL TABLET 25 MG	4	PA; MO; LA; QL (120 per 30 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
<i>baclofen oral tablet 10 mg, 20 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
BACLOFEN ORAL TABLET 5 MG	3	MO
<i>cyclobenzaprine oral tablet</i>	1	PA; MO
DANTRIUM ORAL CAPSULE 25 MG, 50 MG	3	MO
<i>dantrolene</i>	1	MO
FEXMID	3	PA; MO
MESTINON ORAL	4	MO
MESTINON TIMESPAN	4	MO
<i>pyridostigmine bromide</i>	1	MO
<i>tizanidine</i>	1	MO
ZANAFLEX	3	MO
NARCOTIC ANALGESICS		
ABSTRAL	4	PA; MO; QL (120 per 30 days)
<i>acetaminophen-codeine oral solution 120-12 mg/5 ml</i>	1	MO; QL (4500 per 30 days)
<i>acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg</i>	1	MO; QL (360 per 30 days)
<i>acetaminophen-codeine oral tablet 300-60 mg</i>	1	MO; QL (180 per 30 days)
ACTIQ	4	PA; MO; QL (120 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
ARYMO ER	3	PA; MO; QL (120 per 30 days)
BELBUCA	3	PA; MO; QL (60 per 30 days)
<i>buprenorphine hcl sublingual</i>	1	MO
BUPRENORPHINE TRANSDERMAL PATCH WEEKLY 10 MCG/HOUR, 15 MCG/HOUR, 20 MCG/HOUR, 5 MCG/HOUR	3	PA; MO; QL (4 per 28 days)
BUTRANS	3	PA; MO; QL (4 per 28 days)
<i>codeine sulfate oral tablet</i>	1	MO; QL (180 per 30 days)
DILAUDID ORAL LIQUID	3	MO; QL (2400 per 30 days)
DILAUDID ORAL TABLET	3	MO; QL (180 per 30 days)
DOLOPHINE ORAL TABLET 10 MG	3	PA; MO; QL (120 per 30 days)
DOLOPHINE ORAL TABLET 5 MG	3	PA; MO; QL (240 per 30 days)
DURAGESIC TRANSDERMAL PATCH 72 HOUR 100 MCG/HR, 75 MCG/HR	4	PA; MO; QL (10 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
DURAGESIC TRANSDERMAL PATCH 72 HOUR 12 MCG/HR, 25 MCG/HR, 50 MCG/HR	3	PA; MO; QL (10 per 30 days)
<i>duramorph (pf) injection solution 0.5 mg/ml</i>	1	MO; QL (4000 per 30 days)
<i>duramorph (pf) injection solution 1 mg/ml</i>	1	QL (2000 per 30 days)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL 100-4 MG, 60-2.4 MG, 80-3.2 MG	4	PA; MO; QL (90 per 30 days)
EMBEDA ORAL CAPSULE,ORAL ONLY,EXT.REL PELL 20-0.8 MG, 30-1.2 MG, 50-2 MG	3	PA; MO; QL (90 per 30 days)
<i>endocet oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 12 MG, 8 MG	3	PA; MO; QL (60 per 30 days)
EXALGO ER ORAL TABLET EXTENDED RELEASE 24 HR 16 MG, 32 MG	4	PA; MO; QL (60 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>fentanyl citrate</i>	4	PA; MO; QL (120 per 30 days)
<i>fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 37.5 mcg/hour, 50 mcg/hr, 62.5 mcg/hour, 75 mcg/hr</i>	1	PA; MO; QL (10 per 30 days)
<i>fentanyl transdermal patch 72 hour 87.5 mcg/hour</i>	4	PA; MO; QL (10 per 30 days)
FENTORA	4	PA; MO; QL (120 per 30 days)
HYCET	3	QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg, 7.5-200 mg</i>	1	MO; QL (50 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml), 10 mg/ml</i>	1	MO; QL (240 per 30 days)
<i>hydromorphone injection syringe 2 mg/ml</i>	1	QL (1200 per 30 days)
<i>hydromorphone oral liquid</i>	1	MO; QL (2400 per 30 days)
<i>hydromorphone oral tablet</i>	1	MO; QL (180 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr 12 mg, 8 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>hydromorphone oral tablet extended release 24 hr 16 mg, 32 mg</i>	4	PA; MO; QL (60 per 30 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 100 MG, 120 MG, 80 MG	4	PA; MO; QL (60 per 30 days)
HYSINGLA ER ORAL TABLET,ORAL ONLY,EXT.REL.24 HR 20 MG, 30 MG, 40 MG, 60 MG	3	PA; MO; QL (60 per 30 days)
IBUDONE ORAL TABLET 10-200 MG	3	MO; QL (50 per 30 days)
<i>ibuprofen-oxycodone</i>	1	MO; QL (28 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
KADIAN ORAL CAPSULE,EXTENDED.RELEASE PELLETS 10 MG, 100 MG, 20 MG, 30 MG, 40 MG, 50 MG, 60 MG, 80 MG	3	PA; MO; QL (90 per 30 days)
KADIAN ORAL CAPSULE,EXTENDED.RELEASE PELLETS 200 MG	4	PA; MO; QL (90 per 30 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 100 MCG/SPRAY	4	PA; MO; QL (45 per 30 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 300 MCG/SPRAY	4	PA; QL (23 per 30 days)
LAZANDA NASAL SPRAY,NON-AEROSOL 400 MCG/SPRAY	4	PA; MO; QL (30 per 30 days)
<i>levorphanol tartrate</i>	1	MO; QL (120 per 30 days)
<i>lorcet (hydrocodone)</i>	1	MO; QL (360 per 30 days)
<i>lorcet hd</i>	1	MO; QL (360 per 30 days)
<i>lorcet plus oral tablet 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	1	PA; MO; QL (600 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	1	PA; MO; QL (1200 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>methadone oral tablet 10 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>methadone oral tablet 5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>morphine concentrate oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine injection syringe 10 mg/ml</i>	1	MO; QL (200 per 30 days)
<i>morphine injection syringe 2 mg/ml</i>	1	MO; QL (1000 per 30 days)
<i>morphine injection syringe 4 mg/ml</i>	1	MO; QL (500 per 30 days)
<i>morphine injection syringe 5 mg/ml</i>	1	QL (400 per 30 days)
<i>morphine injection syringe 8 mg/ml</i>	1	QL (250 per 30 days)
<i>morphine oral capsule, er multiphase 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>morphine oral capsule,extend.release pellets</i>	1	PA; MO; QL (90 per 30 days)
<i>morphine oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine oral tablet</i>	1	MO; QL (180 per 30 days)
<i>morphine oral tablet extended release 100 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>morphine oral tablet extended release 15 mg, 200 mg, 30 mg, 60 mg</i>	1	PA; MO; QL (120 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
MS CONTIN ORAL TABLET EXTENDED RELEASE 100 MG, 200 MG, 60 MG	4	PA; MO; QL (120 per 30 days)
MS CONTIN ORAL TABLET EXTENDED RELEASE 15 MG, 30 MG	3	PA; MO; QL (120 per 30 days)
NORCO	3	MO; QL (360 per 30 days)
OPANA ORAL TABLET 10 MG	3	MO; QL (360 per 30 days)
OPANA ORAL TABLET 5 MG	3	MO; QL (180 per 30 days)
OXAYDO	4	MO; QL (360 per 30 days)
<i>oxycodone oral capsule</i>	1	MO; QL (360 per 30 days)
<i>oxycodone oral concentrate</i>	1	MO; QL (180 per 30 days)
<i>oxycodone oral solution</i>	1	MO; QL (1200 per 30 days)
<i>oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg</i>	1	MO; QL (180 per 30 days)
<i>oxycodone oral tablet 5 mg</i>	1	MO; QL (360 per 30 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 20 MG, 40 MG	3	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 15 MG, 30 MG, 60 MG	3	PA; QL (90 per 30 days)
OXYCODONE ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	4	PA; MO; QL (60 per 30 days)
<i>oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>oxycodone-aspirin</i>	1	MO; QL (360 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 10 MG, 15 MG, 20 MG, 30 MG, 40 MG, 60 MG	2	PA; MO; QL (90 per 30 days)
OXYCONTIN ORAL TABLET,ORAL ONLY,EXT.REL.12 HR 80 MG	4	PA; MO; QL (60 per 30 days)
<i>oxymorphone oral tablet 10 mg</i>	1	MO; QL (360 per 30 days)
<i>oxymorphone oral tablet 5 mg</i>	1	MO; QL (180 per 30 days)
<i>oxymorphone oral tablet extended release 12 hr</i>	1	PA; MO; QL (90 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>panlor(acetam-caff-dihydrocod)</i>	1	QL (300 per 30 days)
PERCOCET ORAL TABLET 10-325 MG, 2.5-325 MG, 5-325 MG, 7.5-325 MG	3	MO; QL (360 per 30 days)
PRIMLEV	3	MO; QL (390 per 30 days)
ROXICODONE ORAL TABLET 15 MG, 30 MG	3	MO; QL (180 per 30 days)
ROXICODONE ORAL TABLET 5 MG	3	QL (360 per 30 days)
SUBSYS	4	PA; MO; QL (120 per 30 days)
TREZIX ORAL CAPSULE 320.5-30-16 MG	3	MO; QL (300 per 30 days)
TYLENOL-CODEINE #3	3	MO; QL (360 per 30 days)
TYLENOL-CODEINE #4	3	MO; QL (180 per 30 days)
<i>vicodin</i>	1	MO; QL (390 per 30 days)
<i>vicodin es</i>	1	MO; QL (390 per 30 days)
<i>vicodin hp</i>	1	MO; QL (390 per 30 days)
XTAMPZA ER	3	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ZOHYDRO ER CAPSULE, ORAL ONLY, ER 12HR	3	PA; MO; QL (90 per 30 days)
NON-NARCOTIC ANALGESICS		
ARTHROTEC 50	3	ST; MO
ARTHROTEC 75	3	ST; MO
BUNAVAIL BUCCAL FILM 2.1-0.3 MG	3	ST; MO; QL (30 per 30 days)
BUNAVAIL BUCCAL FILM 4.2-0.7 MG, 6.3-1 MG	3	ST; MO; QL (60 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	MO; QL (90 per 30 days)
<i>butorphanol tartrate nasal</i>	1	MO; QL (10 per 28 days)
CAMBIA	3	ST; MO; QL (9 per 30 days)
CELEBREX	3	MO
<i>celecoxib</i>	1	MO
CONZIP	3	PA; MO; QL (30 per 30 days)
DAYPRO	3	ST; MO
<i>diclofenac potassium</i>	1	MO
<i>diclofenac sodium oral</i>	1	MO
<i>diclofenac sodium topical drops</i>	1	MO; QL (300 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>diclofenac sodium topical gel 1 %</i>	1	MO; QL (1000 per 28 days)
<i>diclofenac-misoprostol</i>	1	MO
<i>diflunisal</i>	1	MO
DUEXIS	3	ST; MO
<i>etodolac</i>	1	MO
EVZIO INJECTION AUTO-INJECTOR 2 MG/0.4 ML	3	MO; QL (0.8 per 30 days)
FELDENE	3	ST; MO
FENOPROFEN ORAL CAPSULE 400 MG	3	ST; MO
<i>fenopropfen oral tablet</i>	1	MO
FLECTOR	3	PA; MO; QL (60 per 30 days)
<i>flurbiprofen</i>	1	MO
<i>ibu oral tablet 600 mg, 800 mg</i>	1	MO
<i>ibuprofen oral suspension</i>	1	MO
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	MO
<i>ketoprofen oral capsule 75 mg</i>	1	MO
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	1	MO
LODINE ORAL TABLET	3	ST

Drug Name	Drug Tier	Requirements /Limits
LUCEMYRA	4	
<i>meclofenamate</i>	1	MO
<i>mefenamic acid</i>	1	MO
<i>meloxicam oral tablet 15 mg</i>	1	MO
<i>meloxicam oral tablet 7.5 mg</i>	1	MO; QL (30 per 30 days)
MOBIC ORAL TABLET 15 MG	3	ST; MO
MOBIC ORAL TABLET 7.5 MG	3	ST; MO; QL (30 per 30 days)
<i>nabumetone</i>	1	MO
<i>naloxone</i>	1	MO
<i>naltrexone</i>	1	MO
NAPRELAN CR	3	ST; MO
<i>naproxen</i>	1	MO
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	MO
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	1	MO
NARCAN NASAL SPRAY, NON-AEROSOL 4 MG/ACTUATION	2	MO; QL (2 per 28 days)
NUCYNTA ER	3	PA; MO; QL (60 per 30 days)
NUCYNTA ORAL TABLET 100 MG	3	MO; QL (181 per 30 days)
NUCYNTA ORAL TABLET 50 MG	3	MO; QL (362 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
NUCYNTA ORAL TABLET 75 MG	3	MO; QL (242 per 30 days)
<i>oxaprozin</i>	1	MO
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	4	ST; MO; QL (224 per 28 days)
<i>piroxicam</i>	1	MO
<i>profeno</i>	1	
SPRIX	3	ST
SUBOXONE SUBLINGUAL FILM 12-3 MG	2	MO; QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	2	MO; QL (360 per 30 days)
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	2	MO; QL (90 per 30 days)
<i>sulindac</i>	1	MO
TIVORBEX	3	ST; MO; QL (90 per 30 days)
<i>tolmetin oral capsule</i>	1	MO
<i>tolmetin oral tablet 600 mg</i>	1	MO
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	3	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	3	PA; MO; QL (30 per 30 days)
<i>tramadol oral tablet</i>	1	MO; QL (240 per 30 days)
<i>tramadol oral tablet extended release 24 hr</i>	1	PA; MO; QL (30 per 30 days)
<i>tramadol oral tablet, er multiphase 24 hr</i>	1	PA; MO; QL (30 per 30 days)
<i>tramadol-acetaminophen</i>	1	MO; QL (240 per 30 days)
ULTRACET	3	MO; QL (240 per 30 days)
ULTRAM	3	MO; QL (240 per 30 days)
VIMOVO	4	ST; MO
VIVITROL	4	MO
VIVLODEX ORAL CAPSULE 10 MG	3	ST; MO
VIVLODEX ORAL CAPSULE 5 MG	3	ST; MO; QL (30 per 30 days)
VOLTAREN TOPICAL	3	ST; MO; QL (1000 per 28 days)
ZIPSOR	3	ST; MO
ZORVOLEX	3	ST; MO

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

Drug Name	Drug Tier	Requirements /Limits
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9-0.71 MG, 5.7-1.4 MG	3	ST; MO; QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	3	ST; MO; QL (60 per 30 days)

PSYCHOTHERAPEUTIC DRUGS

ABILIFY MAINTENA	4	MO
ABILIFY ORAL TABLET	4	MO; QL (30 per 30 days)
ADDERALL ORAL TABLET 20 MG, 5 MG, 7.5 MG	3	MO
ADDERALL XR	3	MO
ADZENYS ER	3	
ADZENYS XR-ODT	3	MO
AMBIEN	3	ST; MO; QL (30 per 30 days)
AMBIEN CR	3	ST; MO; QL (30 per 30 days)
<i>amitriptyline</i>	1	PA; MO
<i>amoxapine</i>	1	PA; MO
ANAFRANIL	3	PA; MO
ALENZIN	3	MO; QL (30 per 30 days)
APTENSIO XR	3	MO

Drug Name	Drug Tier	Requirements /Limits
<i>aripiprazole oral solution</i>	4	MO
<i>aripiprazole oral tablet</i>	1	MO; QL (30 per 30 days)
<i>aripiprazole oral tablet, disintegrating</i>	4	MO; QL (60 per 30 days)
ARISTADA	4	MO
<i>armodafinil</i>	1	PA; MO
ATIVAN ORAL TABLET 0.5 MG, 1 MG	3	PA; MO; QL (90 per 30 days)
ATIVAN ORAL TABLET 2 MG	3	PA; MO; QL (150 per 30 days)
<i>atomoxetine</i>	1	MO
BELSOMRA	3	ST; MO; QL (30 per 30 days)
BRISDELLE	3	MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet</i>	1	MO
<i>bupropion hcl oral tablet extended release 12 hr</i>	1	MO; QL (60 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (30 per 30 days)
<i>bupirone</i>	1	MO
CELEXA ORAL TABLET	3	MO; QL (30 per 30 days)
<i>chlorpromazine oral</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>citalopram oral solution</i>	1	MO
<i>citalopram oral tablet</i>	1	MO; QL (30 per 30 days)
<i>clomipramine</i>	1	PA; MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clozapine oral tablet</i>	1	MO
<i>clozapine oral tablet, disintegrating 100 mg, 12.5 mg, 25 mg</i>	1	
CLOZAPINE ORAL TABLET, DISINTEGRATING 150 MG, 200 MG	3	
CLOZARIL	3	
CONCERTA	3	MO
CYMBALTA	3	MO; QL (60 per 30 days)
DAYTRANA	3	MO
<i>desipramine</i>	1	PA; MO
DESOXYN	3	PA; MO

Drug Name	Drug Tier	Requirements /Limits
DESVENLAFAXIN E ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	3	MO; QL (120 per 30 days)
DESVENLAFAXIN E ORAL TABLET EXTENDED RELEASE 24 HR 50 MG	3	MO; QL (30 per 30 days)
<i>desvenlafaxine succinate</i>	1	MO; QL (30 per 30 days)
DEXEDRINE SPANSULE	3	MO
<i>dexmethylphenidate</i>	1	MO
<i>dextroamphetamine oral capsule, extended release</i>	1	MO
<i>dextroamphetamine oral tablet</i>	1	MO
<i>dextroamphetamine-amphetamine</i>	1	MO
<i>diazepam intensol</i>	1	PA; MO; QL (240 per 30 days)
<i>diazepam oral solution 5 mg/5 ml (1 mg/ml)</i>	1	PA; MO; QL (1200 per 30 days)
<i>diazepam oral tablet</i>	1	PA; MO; QL (120 per 30 days)
<i>doxepin oral</i>	1	PA; MO
<i>duloxetine oral capsule, delayed release(dr/ec) 20 mg, 30 mg, 60 mg</i>	1	MO; QL (60 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>duloxetine oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO; QL (90 per 30 days)
DYANAVEL XR	3	MO
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG	3	MO; QL (30 per 30 days)
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG	3	MO; QL (90 per 30 days)
EMSAM	4	MO
<i>ergoloid</i>	1	MO
<i>escitalopram oxalate oral solution</i>	1	MO
<i>escitalopram oxalate oral tablet</i>	1	MO; QL (30 per 30 days)
<i>eszopiclone</i>	1	ST; MO; QL (30 per 30 days)
EVEKEO	3	PA; MO
FANAPT ORAL TABLET 1 MG, 2 MG, 4 MG	3	MO; QL (60 per 30 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 6 MG, 8 MG	4	MO; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	3	MO; QL (8 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
FAZACLO ORAL TABLET,DISINTEGRATING 100 MG	4	
FAZACLO ORAL TABLET,DISINTEGRATING 12.5 MG, 150 MG, 200 MG, 25 MG	3	
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	2	MO; QL (28 per 28 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	2	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 20 mg</i>	1	MO
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluoxetine oral capsule,delayed release(dr/ec)</i>	1	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	1	MO
<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral tablet 20 mg, 60 mg</i>	1	MO
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>fluvoxamine oral capsule, extended release 24hr</i>	1	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 per 30 days)
FOCALIN	3	MO
FOCALIN XR	3	MO
FORFIVO XL	3	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	3	MO
GEODON ORAL	4	MO; QL (60 per 30 days)
<i>guanidine</i>	1	MO
HALDOL	3	MO
HALDOL DECANOATE	3	MO
<i>haloperidol</i>	1	MO
<i>haloperidol decanoate</i>	1	MO
<i>haloperidol lactate injection</i>	1	MO
<i>haloperidol lactate intramuscular</i>	1	
<i>haloperidol lactate oral</i>	1	MO
HETLIOZ	4	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
<i>imipramine hcl</i>	1	PA; MO
<i>imipramine pamoate</i>	1	PA; MO
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG, 3 MG, 9 MG	4	MO; QL (30 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	4	MO; QL (60 per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML, 156 MG/ML, 234 MG/1.5 ML, 78 MG/0.5 ML	4	MO
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	3	MO
INVEGA TRINZA	4	MO
KAPVAY	3	MO
KHEDEZLA ORAL TABLET EXTENDED RELEASE 24HR 100 MG	3	MO; QL (120 per 30 days)
KHEDEZLA ORAL TABLET EXTENDED RELEASE 24HR 50 MG	3	MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	4	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	4	MO; QL (60 per 30 days)
LEXAPRO ORAL TABLET	3	MO; QL (30 per 30 days)
<i>lithium carbonate</i>	1	MO
<i>lithium citrate oral solution 8 meq/5 ml</i>	1	MO
LITHOBID	3	MO
<i>lorazepam oral concentrate</i>	1	PA; MO; QL (150 per 30 days)
<i>lorazepam oral tablet 0.5 mg, 1 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>lorazepam oral tablet 2 mg</i>	1	PA; MO; QL (150 per 30 days)
<i>loxapine succinate</i>	1	MO
LUNESTA	3	ST; MO; QL (30 per 30 days)
<i>maprotiline</i>	1	MO
MARPLAN	2	MO
<i>metadate er</i>	1	MO
<i>methamphetamine</i>	1	PA; MO
METHYLIN ORAL SOLUTION	3	MO
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>methylphenidate hcl oral capsule, er biphasic 50-50</i>	1	MO
<i>methylphenidate hcl oral solution</i>	1	MO
<i>methylphenidate hcl oral tablet</i>	1	MO
<i>methylphenidate hcl oral tablet extended release</i>	1	MO
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg, 27 mg, 36 mg, 54 mg</i>	1	MO
METHYLPHENIDATE HCL ORAL TABLET EXTENDED RELEASE 24HR 72 MG	3	MO
<i>methylphenidate hcl oral tablet, chewable</i>	1	MO
<i>mirtazapine</i>	1	MO
<i>modafinil</i>	1	PA; MO
MYDAYIS	3	MO
NARDIL	3	MO
<i>nefazodone</i>	1	MO
NORPRAMIN ORAL TABLET 10 MG, 25 MG	3	PA; MO
<i>nortriptyline</i>	1	PA; MO
NUPLAZID ORAL TABLET 17 MG	4	PA; MO
NUVIGIL	3	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>olanzapine intramuscular</i>	1	MO
<i>olanzapine oral</i>	1	MO; QL (30 per 30 days)
<i>olanzapine-fluoxetine</i>	1	MO
ORAP ORAL TABLET 1 MG	3	MO
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg</i>	1	MO; QL (30 per 30 days)
<i>paliperidone oral tablet extended release 24hr 6 mg</i>	1	MO; QL (60 per 30 days)
<i>paliperidone oral tablet extended release 24hr 9 mg</i>	4	MO; QL (30 per 30 days)
PAMELOR	3	PA; MO
PARNATE	3	MO
<i>paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg</i>	1	MO; QL (30 per 30 days)
<i>paroxetine hcl oral tablet 30 mg</i>	1	MO; QL (60 per 30 days)
<i>paroxetine hcl oral tablet extended release 24 hr</i>	1	MO; QL (60 per 30 days)
<i>paroxetine mesylate(menop.sym)</i>	1	MO; QL (30 per 30 days)
PAXIL CR	3	MO; QL (60 per 30 days)
PAXIL ORAL SUSPENSION	3	MO

Drug Name	Drug Tier	Requirements /Limits
PAXIL ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO; QL (30 per 30 days)
PAXIL ORAL TABLET 30 MG	3	MO; QL (60 per 30 days)
<i>perphenazine</i>	1	MO
PEXEVA ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO; QL (30 per 30 days)
PEXEVA ORAL TABLET 30 MG	3	MO; QL (60 per 30 days)
<i>phenelzine</i>	1	MO
<i>pimozide</i>	1	MO
PRISTIQ	3	MO; QL (30 per 30 days)
<i>procentra</i>	1	MO
<i>protriptyline</i>	1	MO
PROVIGIL	4	PA; MO
PROZAC ORAL CAPSULE 10 MG	3	MO; QL (30 per 30 days)
PROZAC ORAL CAPSULE 20 MG	3	MO
PROZAC ORAL CAPSULE 40 MG	3	MO; QL (60 per 30 days)
<i>quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg</i>	1	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	1	MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
QUILLICHEW ER	3	MO
QUILLIVANT XR	3	MO
REMERON ORAL TABLET 15 MG, 30 MG	3	MO
REMERON SOLTAB	3	MO
REXULTI	4	MO; QL (30 per 30 days)
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 12.5 MG/2 ML, 25 MG/2 ML	2	MO
RISPERDAL CONSTA INTRAMUSCULAR SYRINGE 37.5 MG/2 ML, 50 MG/2 ML	4	MO
RISPERDAL ORAL SOLUTION	3	MO
RISPERDAL ORAL TABLET 0.25 MG, 0.5 MG, 1 MG, 2 MG, 3 MG	3	MO; QL (60 per 30 days)
RISPERDAL ORAL TABLET 4 MG	3	MO; QL (120 per 30 days)
<i>risperidone oral solution</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet 4 mg</i>	1	MO; QL (120 per 30 days)
<i>risperidone oral tablet, disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg</i>	1	MO; QL (60 per 30 days)
<i>risperidone oral tablet, disintegrating 4 mg</i>	1	MO; QL (120 per 30 days)
RITALIN	3	MO
RITALIN LA ORAL CAPSULE, ER BIPHASIC 50-50 10 MG, 20 MG, 30 MG, 40 MG	3	MO
ROZEREM	2	MO; QL (30 per 30 days)
SAPHRIS (BLACK CHERRY)	2	MO; QL (60 per 30 days)
SARAFEM ORAL TABLET 10 MG, 20 MG	3	MO
SEROQUEL ORAL TABLET 100 MG, 200 MG, 25 MG, 50 MG	3	MO; QL (90 per 30 days)
SEROQUEL ORAL TABLET 300 MG, 400 MG	3	MO; QL (60 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 150 MG, 200 MG	3	MO; QL (30 per 30 days)
SEROQUEL XR ORAL TABLET EXTENDED RELEASE 24 HR 300 MG, 400 MG, 50 MG	3	MO; QL (60 per 30 days)
<i>sertraline oral concentrate</i>	1	MO
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
SILENOR	3	MO; QL (30 per 30 days)
SONATA ORAL CAPSULE 10 MG	3	ST; MO; QL (60 per 30 days)
SONATA ORAL CAPSULE 5 MG	3	ST; MO; QL (30 per 30 days)
STRATTERA	3	MO
SURMONTIL	3	PA; MO
SYMBYAX	3	MO
<i>thioridazine</i>	1	MO
<i>thiothixene</i>	1	MO
TOFRANIL	3	PA; MO
TRANXENE T-TAB ORAL TABLET 7.5 MG	3	PA; MO; QL (360 per 30 days)
<i>tranylcypromine</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	1	MO
<i>trimipramine</i>	1	PA; MO
TRINTELLIX	2	MO; QL (30 per 30 days)
VALIUM	3	PA; MO; QL (120 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	1	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet</i>	1	MO; QL (90 per 30 days)
VENLAFAXINE ORAL TABLET EXTENDED RELEASE 24HR	3	MO; QL (30 per 30 days)
VERSACLOZ	4	
VIIBRYD ORAL TABLET	2	MO; QL (30 per 30 days)
VIIBRYD ORAL TABLETS, DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 180 days)
VRAYLAR ORAL CAPSULE	4	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE, DOSE PACK	3	MO; QL (7 per 30 days)
VYVANSE	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
WELLBUTRIN SR	3	MO; QL (60 per 30 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 150 MG	3	MO; QL (90 per 30 days)
WELLBUTRIN XL ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	3	MO; QL (30 per 30 days)
XYREM	4	PA; MO; LA
<i>zaleplon oral capsule 10 mg</i>	1	ST; MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 mg</i>	1	ST; MO; QL (30 per 30 days)
<i>zenzedi oral tablet 10 mg, 5 mg</i>	1	MO
ZENZEDI ORAL TABLET 15 MG, 2.5 MG, 20 MG, 30 MG, 7.5 MG	3	MO
<i>ziprasidone hcl</i>	1	MO; QL (60 per 30 days)
ZOLOFT ORAL TABLET 100 MG, 50 MG	3	MO; QL (60 per 30 days)
ZOLOFT ORAL TABLET 25 MG	3	MO; QL (30 per 30 days)
<i>zolpidem oral</i>	1	ST; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ZYPREXA INTRAMUSCULAR	3	MO
ZYPREXA ORAL TABLET 10 MG, 2.5 MG, 5 MG, 7.5 MG	3	MO; QL (30 per 30 days)
ZYPREXA ORAL TABLET 15 MG, 20 MG	4	MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	2	MO
ZYPREXA ZYDIS ORAL TABLET, DISINTEGRATING 10 MG, 5 MG	3	MO; QL (30 per 30 days)
ZYPREXA ZYDIS ORAL TABLET, DISINTEGRATING 15 MG, 20 MG	4	MO; QL (30 per 30 days)

CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

<i>amiodarone oral</i>	1	MO
BETAPACE AF	3	MO
<i>dofetilide</i>	1	MO
<i>flecainide</i>	1	MO
<i>mexiletine</i>	1	MO
MULTAQ	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>pacerone oral tablet 100 mg, 200 mg, 400 mg</i>	1	MO
<i>propafenone</i>	1	MO
<i>quinidine gluconate oral</i>	1	MO
<i>quinidine sulfate oral tablet</i>	1	MO
RYTHMOL SR	3	MO
<i>sorine oral tablet 120 mg, 160 mg, 80 mg</i>	1	MO
<i>sorine oral tablet 240 mg</i>	1	
<i>sotalol af oral tablet 120 mg</i>	1	MO
<i>sotalol oral tablet 160 mg, 240 mg, 80 mg</i>	1	MO
SOTYLIZE	2	MO
TIKOSYN	3	MO
ANTIHYPERTENSIVE THERAPY		
ACCUPRIL	3	MO
ACCURETIC	3	MO
<i>acebutolol</i>	1	MO
ADALAT CC	3	MO
<i>afeditab cr</i>	1	MO
ALDACTAZIDE	3	MO
ALDACTONE	3	MO
ALTACE	3	MO
<i>amiloride</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>amiloride-hydrochlorothiazide</i>	1	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO
<i>amlodipine-valsartan</i>	1	MO
<i>amlodipine-valsartan-hcthiazid</i>	1	MO
ATACAND	3	ST; MO
ATACAND HCT	3	ST; MO
<i>atenolol</i>	1	MO
<i>atenolol-chlorthalidone</i>	1	MO
AVALIDE	3	ST; MO
AVAPRO	3	ST; MO
AZOR	3	ST; MO
<i>benazepril</i>	1	MO
<i>benazepril-hydrochlorothiazide</i>	1	MO
BENICAR	3	ST; MO
BENICAR HCT	3	ST; MO
<i>betaxolol oral</i>	1	MO
BIDIL	2	MO
<i>bisoprolol fumarate</i>	1	MO
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide</i>	1	MO
BYSTOLIC	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
BYVALSON	2	MO
CALAN ORAL TABLET 120 MG	3	MO
CALAN ORAL TABLET 80 MG	3	
CALAN SR ORAL TABLET EXTENDED RELEASE 120 MG, 240 MG	3	MO
<i>candesartan</i>	1	MO
<i>candesartan-hydrochlorothiazid</i>	1	MO
<i>captopril</i>	1	MO
<i>captopril-hydrochlorothiazide</i>	1	MO
CARDIZEM CD ORAL CAPSULE,EXTENDED RELEASE 24HR 120 MG, 180 MG, 240 MG, 360 MG	3	MO
CARDIZEM LA	3	MO
CARDIZEM ORAL TABLET 120 MG, 30 MG, 60 MG	3	MO
CARDURA ORAL TABLET 1 MG, 2 MG, 4 MG	3	ST; MO; QL (30 per 30 days)
CARDURA ORAL TABLET 8 MG	3	ST; MO; QL (60 per 30 days)
CARDURA XL	3	ST; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
CAROSPIR	3	MO
<i>cartia xt</i>	1	MO
<i>carvedilol</i>	1	MO
<i>carvedilol phosphate</i>	1	MO
CATAPRES	3	MO
CATAPRES-TTS-1	3	MO; QL (4 per 28 days)
CATAPRES-TTS-2	3	MO; QL (4 per 28 days)
CATAPRES-TTS-3	3	MO; QL (4 per 28 days)
<i>chlorothiazide</i>	1	MO
<i>chlorthalidone oral tablet 25 mg, 50 mg</i>	1	MO
<i>clonidine</i>	1	MO; QL (4 per 28 days)
<i>clonidine hcl oral tablet</i>	1	MO
COREG	3	MO
COREG CR	3	MO
CORGARD	3	MO
CORZIDE	3	MO
COZAAR	3	ST; MO
DEMSEER	4	PA; MO
DIBENZYLINE	4	PA; MO
<i>diltiazem hcl oral capsule,extended release 12 hr</i>	1	MO
<i>diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	1	MO
<i>diltiazem hcl oral tablet</i>	1	MO
<i>dilt-xr</i>	1	MO
DIOVAN	3	ST; MO
DIOVAN HCT	3	ST; MO
DIURIL	3	MO
<i>doxazosin oral tablet 1 mg, 2 mg, 4 mg</i>	1	MO; QL (30 per 30 days)
<i>doxazosin oral tablet 8 mg</i>	1	MO; QL (60 per 30 days)
DUTOPROL	3	MO
DYAZIDE	3	MO
DYRENIUM	3	MO
EDARBI	2	MO
EDARBYCLOR	2	MO
EDECIN	4	MO
<i>enalapril maleate</i>	1	MO
<i>enalapril-hydrochlorothiazide</i>	1	MO
<i>eplerenone</i>	1	MO
<i>eprosartan</i>	1	MO
<i>ethacrynic acid</i>	4	MO
EXFORGE	3	ST; MO
EXFORGE HCT	3	ST; MO
<i>felodipine</i>	1	MO
<i>fosinopril</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>fosinopril-hydrochlorothiazide</i>	1	MO
<i>furosemide injection</i>	1	MO
<i>furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)</i>	1	MO
<i>furosemide oral tablet</i>	1	MO
<i>hydralazine oral</i>	1	MO
<i>hydrochlorothiazide</i>	1	MO
HYZAAR	3	ST; MO
<i>indapamide</i>	1	MO
INDERAL LA	3	MO
INNOPRAN XL	3	MO
INSPRA	3	MO
<i>irbesartan</i>	1	MO
<i>irbesartan-hydrochlorothiazide</i>	1	MO
<i>isradipine</i>	1	MO
<i>labetalol oral</i>	1	MO
LASIX	3	MO
<i>lisinopril</i>	1	MO
<i>lisinopril-hydrochlorothiazide</i>	1	MO
LOPRESSOR HCT	3	
LOPRESSOR ORAL TABLET 100 MG	3	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
LOTENSIN ORAL TABLET 10 MG, 20 MG, 40 MG	3	MO
LOTREL ORAL CAPSULE 10-20 MG, 10-40 MG, 5-10 MG, 5-20 MG	3	MO
<i>matzim la</i>	1	MO
MAXZIDE	3	MO
MAXZIDE-25MG	3	MO
<i>methyclothiazide</i>	1	MO
<i>methyldopa</i>	1	MO
<i>metolazone</i>	1	MO
<i>metoprolol succinate</i>	1	MO
<i>metoprolol ta-hydrochlorothiaz</i>	1	MO
<i>metoprolol tartrate oral tablet 100 mg, 25 mg, 50 mg</i>	1	MO
MICARDIS	3	ST; MO
MICARDIS HCT	3	ST; MO
MICROZIDE	3	MO
MINIPRESS	3	MO
<i>minoxidil oral</i>	1	MO
<i>moexipril</i>	1	MO
<i>moexipril-hydrochlorothiazide</i>	1	MO
<i>nadolol</i>	1	MO
<i>nadolol-bendroflumethiazide</i>	1	MO
<i>nicardipine oral</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>nifedipine oral tablet extended release</i>	1	MO
<i>nifedipine oral tablet extended release 24hr</i>	1	MO
<i>nimodipine</i>	1	MO
<i>nisoldipine</i>	1	MO
NORVASC	3	MO
NYMALIZE ORAL SOLUTION 30 MG/10 ML	4	
<i>olmesartan</i>	1	MO
<i>olmesartan-amlodipin-hcthiazid</i>	1	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.125 MG	3	PA; MO
ORENITRAM ORAL TABLET EXTENDED RELEASE 0.25 MG, 1 MG, 2.5 MG, 5 MG	4	PA; MO
<i>perindopril erbumine</i>	1	MO
<i>phenoxybenzamine</i>	4	PA; MO
<i>pindolol</i>	1	MO
<i>prazosin</i>	1	MO
PRINIVIL ORAL TABLET 10 MG, 20 MG, 5 MG	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
PROCARDIA XL	3	MO
<i>propranolol oral</i>	1	MO
<i>propranolol-hydrochlorothiazid</i>	1	MO
QBRELIS	3	MO
<i>quinapril</i>	1	MO
<i>quinapril-hydrochlorothiazide</i>	1	MO
<i>ramipril</i>	1	MO
<i>spironolactone</i>	1	MO
<i>spironolacton-hydrochlorothiaz</i>	1	MO
SULAR ORAL TABLET EXTENDED RELEASE 24 HR 17 MG, 34 MG, 8.5 MG	3	MO
TARKA ORAL TABLET, IR - ER, BIPHASIC 24HR 2-180 MG, 2-240 MG, 4-240 MG	3	MO
<i>taztia xt</i>	1	MO
TEKTURNA	2	MO
TEKTURNA HCT	2	MO
<i>telmisartan</i>	1	MO
<i>telmisartan-amlodipine</i>	1	MO
<i>telmisartan-hydrochlorothiazid</i>	1	MO
TENORETIC 100	3	MO
TENORETIC 50	3	MO

Drug Name	Drug Tier	Requirements /Limits
TENORMIN	3	MO
<i>terazosin oral capsule 1 mg, 2 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>terazosin oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
TIAZAC	3	MO
<i>timolol maleate oral</i>	1	MO
TOPROL XL	3	MO
<i>torseamide oral</i>	1	MO
<i>trandolapril</i>	1	MO
<i>trandolapril-verapamil</i>	1	MO
<i>triamterene-hydrochlorothiazid oral capsule 37.5-25 mg</i>	1	MO
<i>triamterene-hydrochlorothiazid oral tablet</i>	1	MO
TRIBENZOR	3	ST; MO
TWYNSTA	3	ST; MO
UPTRAVI	4	PA; MO; LA
<i>valsartan</i>	1	MO
<i>valsartan-hydrochlorothiazide</i>	1	MO
VASERETIC	3	MO
VASOTEC	3	MO
<i>verapamil oral</i>	1	MO
VERELAN	3	MO
VERELAN PM	3	MO
ZESTORETIC	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
ZESTRIL	3	MO
ZIAC	3	MO
COAGULATION THERAPY		
AGGRENOX	3	MO
ARIXTRA SUBCUTANEOUS SYRINGE 10 MG/0.8 ML, 5 MG/0.4 ML, 7.5 MG/0.6 ML	4	MO
ARIXTRA SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	3	MO
<i>aspirin-dipyridamole</i>	1	MO
BEVYXXA	3	
BRILINTA	2	MO
<i>cilostazol</i>	1	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO
COUMADIN ORAL	3	MO
<i>dipyridamole oral</i>	1	MO
DOPTELET	4	PA; MO; LA
EFFIENT	3	MO
ELIQUIS	2	MO
<i>enoxaparin subcutaneous syringe</i>	1	MO
<i>fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml</i>	4	MO

Drug Name	Drug Tier	Requirements /Limits
<i>fondaparinux subcutaneous syringe 2.5 mg/0.5 ml</i>	1	MO
FRAGMIN SUBCUTANEOUS SOLUTION	4	MO
FRAGMIN SUBCUTANEOUS SYRINGE 10,000 ANTI-XA UNIT/ML, 12,500 ANTI-XA UNIT/0.5 ML, 15,000 ANTI- XA UNIT/0.6 ML, 18,000 ANTI-XA UNIT/0.72 ML, 7,500 ANTI-XA UNIT/0.3 ML	4	MO
FRAGMIN SUBCUTANEOUS SYRINGE 2,500 ANTI-XA UNIT/0.2 ML, 5,000 ANTI- XA UNIT/0.2 ML	3	MO
<i>heparin (porcine) injection solution</i>	1	MO
<i>jantoven</i>	1	MO
LOVENOX SUBCUTANEOUS SYRINGE	3	MO
<i>pentoxifylline</i>	1	MO
PLAVIX ORAL TABLET 75 MG	3	MO
PRADAXA	3	MO
<i>prasugrel</i>	1	MO
PROMACTA	4	PA; MO; LA

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

Drug Name	Drug Tier	Requirements /Limits
SAVAYSA	3	MO
TAVALISSE	4	PA; MO; LA; QL (60 per 30 days)
<i>warfarin</i>	1	MO
XARELTO	2	MO
YOSPRALA	3	MO
ZONTIVITY	2	MO
LIPID/CHOLESTEROL LOWERING AGENTS		
ALTOPREV	3	ST; MO; QL (30 per 30 days)
<i>amlodipine-atorvastatin</i>	1	MO; QL (30 per 30 days)
ANTARA ORAL CAPSULE 30 MG, 90 MG	3	MO
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)
CADUET ORAL TABLET 10-10 MG, 10-20 MG, 10-40 MG, 10-80 MG, 5-10 MG, 5-20 MG, 5-40 MG, 5-80 MG	3	ST; MO; QL (30 per 30 days)
<i>cholestyramine (with sugar) oral powder in packet</i>	1	MO
<i>cholestyramine light oral powder</i>	1	MO
<i>colesevelam oral tablet</i>	1	MO
COLESTID ORAL PACKET	3	MO

Drug Name	Drug Tier	Requirements /Limits
COLESTID ORAL TABLET	3	MO
<i>colestipol oral packet</i>	1	MO
<i>colestipol oral tablet</i>	1	MO
CRESTOR	3	ST; MO; QL (30 per 30 days)
<i>ezetimibe</i>	1	MO
<i>ezetimibe-simvastatin</i>	1	MO; QL (30 per 30 days)
<i>fenofibrate micronized</i>	1	MO
<i>fenofibrate nanocrystallized</i>	1	MO
FENOFIBRATE ORAL CAPSULE	3	MO
<i>fenofibrate oral tablet</i>	1	MO
<i>fenofibric acid</i>	1	MO
<i>fenofibric acid (choline)</i>	1	MO
FENOGLIDE	3	MO
FIBRICOR	3	MO
FLOLIPID	3	ST; MO; QL (300 per 30 days)
<i>fluvastatin oral capsule 20 mg</i>	1	MO; QL (30 per 30 days)
<i>fluvastatin oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluvastatin oral tablet extended release 24 hr</i>	1	MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>gemfibrozil</i>	1	MO
JUXTAPID	4	PA; MO; LA
KYNAMRO	4	PA; MO; LA
LESCOL XL	3	ST; MO; QL (30 per 30 days)
LIPITOR	3	ST; MO; QL (30 per 30 days)
LIPOFEN	3	MO
LIVALO	2	MO; QL (30 per 30 days)
LOPID	3	MO
<i>lovastatin oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>lovastatin oral tablet 20 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
LOVAZA	3	ST; MO
<i>niacin oral tablet extended release 24 hr</i>	1	MO
NIACOR	3	MO
NIASPAN EXTENDED-RELEASE	3	MO
<i>omega-3 acid ethyl esters</i>	3	ST; MO
PRALUENT SUBCUTANEOUS PEN INJECTOR 150 MG/ML	4	PA; MO; QL (2 per 28 days)
PRALUENT PEN SUBCUTANEOUS PEN INJECTOR 75 MG/ML	4	PA; MO; QL (4 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
PRAVACHOL ORAL TABLET 20 MG, 40 MG, 80 MG	3	ST; MO; QL (30 per 30 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite oral powder in packet</i>	1	MO
QUESTRAN LIGHT ORAL POWDER	3	MO
QUESTRAN ORAL POWDER IN PACKET	3	MO
REPATHA	4	PA; MO; QL (3 per 28 days)
REPATHA PUSHTRONEX	4	PA; MO; QL (3.5 per 28 days)
REPATHA SURECLICK	4	PA; MO; QL (3 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
<i>simvastatin</i>	1	MO; QL (30 per 30 days)
TRICOR	3	MO
TRIGLIDE ORAL TABLET 160 MG	3	MO
TRILIPIX	3	MO
VASCEPA	2	MO
VYTORIN 10-10	3	ST; MO; QL (30 per 30 days)
VYTORIN 10-20	3	ST; MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
VYTORIN 10-40	3	ST; MO; QL (30 per 30 days)
VYTORIN 10-80	3	ST; MO; QL (30 per 30 days)
WELCHOL	3	MO
ZETIA	3	MO
ZOCOR	3	ST; MO; QL (30 per 30 days)
ZYPITAMAG	3	ST; MO; QL (30 per 30 days)

MISCELLANEOUS CARDIOVASCULAR AGENTS

CORLANOR	2	PA; MO
<i>digitek</i>	1	MO
<i>digox</i>	1	MO
<i>digoxin oral solution 50 mcg/ml</i>	1	MO
<i>digoxin oral tablet</i>	1	MO
ENTRESTO	2	MO; QL (60 per 30 days)

LANOXIN ORAL TABLET 125 MCG, 250 MCG	3	MO
LANOXIN ORAL TABLET 187.5 MCG, 62.5 MCG	2	MO
RANEXA	2	MO
VECAMYL	4	

NITRATES

GONITRO	3	MO
---------	---	----

Drug Name	Drug Tier	Requirements /Limits
ISORDIL	3	MO
ISORDIL TITRADOSE ORAL TABLET 5 MG	3	MO
<i>isosorbide dinitrate oral tablet</i>	1	MO
<i>isosorbide dinitrate oral tablet extended release</i>	1	
<i>isosorbide mononitrate</i>	1	MO
MINITRAN	3	MO
<i>nitro-bid</i>	1	MO
NITRO-DUR	3	MO
<i>nitroglycerin sublingual</i>	1	MO
<i>nitroglycerin transdermal patch 24 hour</i>	1	MO
<i>nitroglycerin translingual spray, non-aerosol</i>	1	MO
NITROSTAT	3	MO

DERMATOLOGICALS/TOPICAL THERAPY

ANTIPSORIATIC / ANTISEBORRHEIC

<i>acitretin oral capsule 10 mg</i>	1	MO
<i>acitretin oral capsule 17.5 mg, 25 mg</i>	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>calcipotriene</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene-betamethasone</i>	1	MO; QL (400 per 30 days)
<i>calcitriol topical</i>	1	MO
COSENTYX	4	PA; MO
COSENTYX (2 SYRINGES)	4	PA; MO
COSENTYX PEN	4	PA; MO
COSENTYX PEN (2 PENS)	4	PA; MO
DOVONEX TOPICAL	3	MO; QL (120 per 30 days)
ENSTILAR	4	MO; QL (60 per 30 days)
<i>selenium sulfide topical lotion</i>	1	MO
SILIQ	4	PA; MO
SORIATANE ORAL CAPSULE 10 MG, 25 MG	4	MO
SORILUX	3	MO; QL (120 per 30 days)
STELARA	4	PA; MO
TACLONEX	3	MO; QL (400 per 30 days)
TALTZ AUTOINJECTOR	4	PA; MO
TALTZ SYRINGE	4	PA; MO
TREMFYA	4	PA; MO
VECTICAL	3	MO
MISCELLANEOUS DERMATOLOGICALS		

Drug Name	Drug Tier	Requirements /Limits
ALDARA	3	ST; MO
<i>ammonium lactate</i>	1	MO
CARAC	4	MO
CONDYLOX TOPICAL GEL	2	MO
<i>diclofenac sodium topical gel 3 %</i>	4	PA; MO; QL (100 per 28 days)
<i>doxepin topical</i>	4	MO; QL (45 per 30 days)
DUPIXENT	4	PA; MO
EFUDEX TOPICAL CREAM	3	ST; MO
ELIDEL	3	PA; MO; QL (100 per 30 days)
EUCRISA	3	PA; MO; QL (120 per 30 days)
FLUOROURACIL TOPICAL CREAM 0.5 %	4	ST; MO
<i>fluorouracil topical cream 5 %</i>	1	MO
<i>fluorouracil topical solution</i>	1	MO
<i>imiquimod</i>	1	MO
<i>lidocaine hcl mucous membrane jelly</i>	1	MO; QL (60 per 30 days)
<i>lidocaine hcl mucous membrane solution 4 % (40 mg/ml)</i>	1	MO
<i>lidocaine topical adhesive patch, medicated</i>	1	PA; MO; QL (90 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>lidocaine topical ointment</i>	1	MO; QL (36 per 30 days)
<i>lidocaine viscous</i>	1	MO
<i>lidocaine-prilocaine topical cream</i>	1	MO; QL (30 per 30 days)
LIDODERM	3	PA; MO; QL (90 per 30 days)
<i>methoxsalen</i>	4	MO
OXSORALEN ULTRA	4	MO
PANRETIN	4	MO
PICATO	4	MO
PLIAGLIS	3	MO
<i>podofilox</i>	1	MO
PROTOPIC	3	PA; MO; QL (100 per 30 days)
<i>prudoxin</i>	1	MO; QL (45 per 30 days)
REGRANEX	4	MO
SANTYL	2	MO
SILVADENE	3	MO
<i>silver sulfadiazine</i>	1	MO
<i>ssd</i>	1	MO
<i>tacrolimus topical</i>	1	PA; MO; QL (100 per 30 days)
TOLAK	3	MO
VALCHLOR	4	MO
VEREGEN	3	MO

Drug Name	Drug Tier	Requirements /Limits
ZONALON	3	MO; QL (45 per 30 days)
ZYCLARA	4	ST; MO
THERAPY FOR ACNE		
ABSORICA ORAL CAPSULE 10 MG, 20 MG, 30 MG, 35 MG, 40 MG	4	MO
ABSORICA ORAL CAPSULE 25 MG	4	
ACANYA TOPICAL GEL WITH PUMP	3	MO
ACZONE TOPICAL GEL	3	MO
<i>adapalene topical cream</i>	1	PA; MO
<i>adapalene topical gel</i>	1	PA; MO
<i>adapalene-benzoyl peroxide</i>	1	PA; MO
AKTIPAK	3	MO
<i>amnestem</i>	1	MO
ATRALIN	3	PA; MO
<i>avita topical cream</i>	1	PA; MO
AVITA TOPICAL GEL	3	PA; MO
AZELEX	3	MO
BENZACLIN PUMP	3	MO
BENZAMYCIN	3	MO
<i>claravis</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
CLEOCIN T TOPICAL GEL	3	MO
CLEOCIN T TOPICAL LOTION	3	MO
CLEOCIN T TOPICAL SOLUTION	3	
CLEOCIN T TOPICAL SWAB	3	MO
<i>clindacin p</i>	1	MO
CLINDAGEL	3	MO
<i>clindamycin phosphate topical foam</i>	1	MO
<i>clindamycin phosphate topical gel</i>	1	MO
<i>clindamycin phosphate topical lotion</i>	1	MO
<i>clindamycin phosphate topical solution</i>	1	MO
<i>clindamycin phosphate topical swab</i>	1	MO
<i>clindamycin-benzoyl peroxide topical gel</i>	1	MO
<i>clindamycin-tretinoin</i>	1	PA; MO
<i>dapsone topical</i>	1	MO
DIFFERIN TOPICAL CREAM	3	PA; MO

Drug Name	Drug Tier	Requirements /Limits
DIFFERIN TOPICAL GEL 0.1 %	3	PA; MO
DIFFERIN TOPICAL GEL WITH PUMP	3	PA; MO
DIFFERIN TOPICAL LOTION	3	PA; MO
DUAC	3	MO
EPIDUO FORTE	3	PA; MO
EPIDUO TOPICAL GEL WITH PUMP	3	PA; MO
<i>ery pads</i>	1	MO
<i>erygel</i>	1	MO
<i>erythromycin with ethanol topical gel</i>	1	MO
<i>erythromycin with ethanol topical solution</i>	1	MO
<i>erythromycin-benzoyl peroxide</i>	1	MO
EVOCLIN	3	MO
FABIOR	3	MO
FINACEA	3	ST; MO
<i>isotretinoin</i>	1	
METROCREAM	3	ST; MO
METROGEL TOPICAL GEL 1 %	3	ST; MO
METROLOTION	3	ST; MO
<i>metronidazole topical cream</i>	1	MO
<i>metronidazole topical gel</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>metronidazole topical lotion</i>	1	MO
MIRVASO TOPICAL GEL WITH PUMP	3	PA; MO
<i>myorisan oral capsule 10 mg, 20 mg, 40 mg</i>	1	MO
<i>myorisan oral capsule 30 mg</i>	1	
<i>neuac</i>	1	MO
NORITATE	4	ST; MO
ONEXTON TOPICAL GEL WITH PUMP	3	MO
RETIN-A	3	PA; MO
RETIN-A MICRO	3	PA; MO
RETIN-A MICRO TOPICAL GEL WITH PUMP 0.06 %, 0.08 %	3	PA; MO
RHOFADE	3	PA; MO
SOOLANTRA	3	ST; MO
<i>tazarotene</i>	1	PA; MO
TAZORAC TOPICAL CREAM 0.05 %	2	PA; MO
TAZORAC TOPICAL CREAM 0.1 %	3	PA; MO
TAZORAC TOPICAL GEL	2	PA; MO
<i>tretinoin microspheres topical gel</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>tretinoin topical</i>	1	PA; MO
<i>zenatane</i>	1	MO
ZIANA	3	PA; MO
TOPICAL ANTIBACTERIALS		
BACTROBAN TOPICAL CREAM	3	
CORTISPORIN TOPICAL	3	MO
<i>gentamicin topical</i>	1	MO
KLARON	3	MO
<i>mupirocin</i>	1	MO
<i>mupirocin calcium</i>	1	MO
NEO-SYNALAR	3	MO
<i>sulfacetamide sodium (acne)</i>	1	MO
SULFAMYLON TOPICAL CREAM	2	MO
SULFAMYLON TOPICAL PACKET	4	MO
TOPICAL ANTIFUNGALS		
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (45 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	1	MO
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)
<i>econazole</i>	1	MO; QL (85 per 28 days)
ERTACZO	3	MO; QL (60 per 28 days)
EXELDERM	3	MO
EXTINA	3	MO; QL (100 per 28 days)
JUBLIA	3	MO
KERYDIN	3	MO
<i>ketoconazole topical cream</i>	1	MO; QL (60 per 28 days)
<i>ketoconazole topical foam</i>	1	MO; QL (100 per 28 days)
<i>ketoconazole topical shampoo</i>	1	MO; QL (120 per 28 days)
LOPROX (AS OLAMINE) TOPICAL CREAM	3	QL (90 per 28 days)
LOPROX TOPICAL SHAMPOO	3	MO; QL (120 per 28 days)
LOTRISONE TOPICAL CREAM	3	MO; QL (45 per 28 days)
LUZU	3	MO; QL (60 per 28 days)
MENTAX	3	MO

Drug Name	Drug Tier	Requirements /Limits
<i>naftifine</i>	1	MO; QL (60 per 28 days)
NAFTIN TOPICAL CREAM 2 %	3	MO; QL (60 per 28 days)
NAFTIN TOPICAL GEL	2	MO; QL (60 per 28 days)
NIZORAL TOPICAL SHAMPOO	3	MO; QL (120 per 28 days)
<i>nyamyc</i>	1	MO
<i>nystatin topical cream</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical ointment</i>	1	MO; QL (30 per 28 days)
<i>nystatin topical powder</i>	1	MO
<i>nystatin-triamcinolone</i>	1	MO; QL (60 per 28 days)
<i>nystop</i>	1	MO
<i>oxiconazole</i>	1	MO; QL (60 per 28 days)
OXISTAT TOPICAL CREAM	3	MO; QL (60 per 28 days)
OXISTAT TOPICAL LOTION	3	MO
TOPICAL ANTIVIRALS		
<i>acyclovir topical</i>	1	PA; MO; QL (30 per 30 days)
DENAVIR	2	MO
XERESE	3	MO
ZOVIRAX TOPICAL CREAM	4	PA; MO; QL (5 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
ZOVIRAX TOPICAL OINTMENT	4	PA; MO; QL (30 per 30 days)
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream</i>	1	MO
ALA-SCALP	3	MO
<i>alclometasone</i>	1	MO
<i>amcinonide topical cream</i>	1	MO
<i>amcinonide topical lotion</i>	1	MO
<i>amcinonide topical ointment</i>	1	
<i>apexicon e</i>	1	MO
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate</i>	1	MO
<i>betamethasone, augmented</i>	1	MO
CAPEX	2	MO
<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical cream</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical gel</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical lotion</i>	1	MO; QL (118 per 28 days)
<i>clobetasol topical ointment</i>	1	MO; QL (120 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>clobetasol topical shampoo</i>	1	MO; QL (236 per 28 days)
<i>clobetasol topical spray,non-aerosol</i>	1	MO; QL (125 per 28 days)
<i>clobetasol-emollient topical cream</i>	1	MO; QL (120 per 28 days)
CLOBEX TOPICAL LOTION	3	MO; QL (118 per 28 days)
CLOBEX TOPICAL SHAMPOO	3	MO; QL (236 per 28 days)
CLOBEX TOPICAL SPRAY, NON-AEROSOL	3	MO; QL (125 per 28 days)
<i>clodan</i>	1	MO; QL (236 per 28 days)
CLODERM	3	MO
CORDRAN TAPE LARGE ROLL	3	MO
CUTIVATE TOPICAL LOTION	3	MO
DESONATE	3	MO
<i>desonide</i>	1	MO
DESOWEN	3	MO
<i>desoximetasone topical cream</i>	1	MO
<i>desoximetasone topical gel</i>	1	MO
<i>desoximetasone topical ointment</i>	1	MO
<i>diflorasone</i>	1	MO
DIPROLENE TOPICAL OINTMENT	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
ELOCON TOPICAL CREAM	3	MO
ELOCON TOPICAL OINTMENT	3	MO
<i>fluocinolone and shower cap</i>	1	MO
<i>fluocinolone topical cream</i>	1	MO
<i>fluocinolone topical ointment</i>	1	MO
<i>fluocinolone topical solution</i>	1	MO
<i>fluocinonide topical cream 0.1 %</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical gel</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical ointment</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide topical solution</i>	1	MO; QL (120 per 30 days)
<i>fluocinonide-e</i>	1	MO; QL (120 per 30 days)
<i>flurandrenolide</i>	1	MO
<i>fluticasone topical</i>	1	MO
<i>halobetasol propionate</i>	1	MO
HALOG	3	MO
<i>hydrocortisone butyrate topical cream</i>	1	MO
<i>hydrocortisone butyrate topical ointment</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>hydrocortisone butyrate topical solution</i>	1	MO
<i>hydrocortisone topical cream 1 %, 2.5 %</i>	1	MO
<i>hydrocortisone topical lotion 2.5 %</i>	1	MO
<i>hydrocortisone topical ointment 1 %, 2.5 %</i>	1	MO
<i>hydrocortisone valerate</i>	1	MO
IMPOYZ	3	MO; QL (120 per 28 days)
KENALOG TOPICAL	3	MO
LOCOID LIPOCREAM	3	MO
LOCOID TOPICAL LOTION	3	MO
LOCOID TOPICAL SOLUTION	3	MO
<i>mometasone topical</i>	1	MO
<i>nolix topical cream</i>	1	
<i>nolix topical lotion</i>	1	MO
OLUX	3	MO; QL (100 per 28 days)
PANDEL	3	MO
<i>prednicarbate</i>	1	MO
PSORCON	3	
SERNIVO	4	MO
SYNALAR TOPICAL CREAM	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
TEXACORT	3	MO
TOPICORT	3	MO
<i>triamcinolone acetonide topical aerosol</i>	1	MO
<i>triamcinolone acetonide topical cream</i>	1	MO
<i>triamcinolone acetonide topical lotion</i>	1	MO
<i>triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %</i>	1	MO
<i>trianex</i>	1	MO
<i>triderm topical cream 0.1 %</i>	1	MO
TRIDESILON	3	MO
ULTRAVATE TOPICAL CREAM	3	MO
ULTRAVATE TOPICAL LOTION	4	MO
ULTRAVATE TOPICAL OINTMENT	3	MO
VANOS	4	MO; QL (120 per 30 days)
TOPICAL SCABICIDES / PEDICULICIDES		
ELIMITE	3	
EURAX	3	MO
<i>lindane topical shampoo</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>malathion</i>	1	MO
NATROBA	3	MO
OVIDE	3	MO
<i>permethrin topical cream</i>	1	MO
SKLICE	2	MO
DIAGNOSTICS / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
<i>acamprosate</i>	1	MO
ACTONEL ORAL TABLET 30 MG	3	ST; MO; QL (30 per 30 days)
AGRYLIN	3	MO
<i>alendronate oral tablet 40 mg</i>	1	MO; QL (30 per 30 days)
<i>anagrelide</i>	1	MO
ANTABUSE	3	MO
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	4	MO; LA
AURYXIA	4	MO
BUPHENYL	4	MO
CARBAGLU	4	MO; LA
CARNITOR ORAL	3	MO
<i>cevimeline</i>	1	MO
CHEMET	2	PA; MO
CLINIMIX 4.25%/D5W SULFIT FREE	2	PA

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

Drug Name	Drug Tier	Requirements /Limits
CLINIMIX E 2.75%/D10W SUL FREE	3	PA
CLINIMIX E 2.75%/D5W SULF FREE	3	PA
<i>d10 %-0.45 % sodium chloride</i>	1	
<i>d2.5 %-0.45 % sodium chloride</i>	1	
<i>d5 % and 0.9 % sodium chloride</i>	1	MO
<i>d5 %-0.45 % sodium chloride</i>	1	MO
<i>dextrose 10 % and 0.2 % nacl</i>	1	
<i>dextrose 10 % in water (d10w)</i>	1	MO
<i>dextrose 5 % in water (d5w) intravenous parenteral solution</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>dextrose 5%-0.3 % sod.chloride</i>	1	
<i>dextrose with sodium chloride</i>	1	
<i>disulfiram</i>	1	MO
ENDARI	4	PA; MO
<i>etidronate disodium oral tablet 400 mg</i>	1	MO
EVOXAC	3	MO
EXJADE	4	PA; MO; LA

Drug Name	Drug Tier	Requirements /Limits
FERRIPROX ORAL SOLUTION	4	PA
FERRIPROX ORAL TABLET	4	PA; MO
FOSRENOL	3	MO
GLASSIA	4	MO; LA
INCRELEX	4	MO; LA
JADENU	4	PA; MO
JADENU SPRINKLE	4	PA; MO
<i>kionex (with sorbitol)</i>	1	MO
<i>lanthanum</i>	1	MO
<i>levocarnitine (with sugar)</i>	1	MO
<i>levocarnitine oral tablet</i>	1	MO
LITHOSTAT	3	MO
<i>midodrine</i>	1	MO
NORTHERA	4	PA; MO
NUTRESTORE	3	MO
ORFADIN ORAL CAPSULE 10 MG, 2 MG, 5 MG	4	LA
ORFADIN ORAL CAPSULE 20 MG	4	MO; LA
ORFADIN ORAL SUSPENSION	4	MO; LA
<i>pilocarpine hcl oral</i>	1	MO
PROLASTIN-C INTRAVENOUS RECON SOLN	4	LA

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

Drug Name	Drug Tier	Requirements /Limits
PROLASTIN-C INTRAVENOUS SOLUTION	4	MO; LA
RAVICTI	4	MO
RENAGEL ORAL TABLET 800 MG	3	MO
REVELA	4	MO
RILUTEK	4	MO
<i>riluzole</i>	1	MO
<i>risedronate oral tablet 30 mg</i>	1	MO; QL (30 per 30 days)
SALAGEN (PILOCARPINE)	3	MO
<i>sevelamer carbonate oral powder in packet</i>	4	MO
<i>sevelamer carbonate oral tablet</i>	1	MO
<i>sodium chloride 0.9 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride irrigation</i>	1	MO
<i>sodium phenylbutyrate</i>	4	MO
<i>sodium polystyrene sulfonate oral powder</i>	1	MO
<i>sps (with sorbitol) oral</i>	1	MO
SYPRINE	4	PA; MO
THIOLA	4	MO
<i>trientine</i>	4	PA; MO
VELPHORO	4	MO

Drug Name	Drug Tier	Requirements /Limits
VELTASSA	2	MO
XURIDEN	4	MO
ZEMAIRA	4	MO; LA
SMOKING DETERRENTS		
<i>bupropion hcl (smoking deter)</i>	1	MO
CHANTIX	2	MO
CHANTIX CONTINUING MONTH BOX	2	MO
CHANTIX STARTING MONTH BOX	2	MO
NICOTROL	3	MO
NICOTROL NS	3	MO
ZYBAN	3	MO
EAR, NOSE / THROAT MEDICATIONS		
MISCELLANEOUS AGENTS		
ASTEPRO NASAL SPRAY, NON-AEROSOL	3	MO; QL (60 per 30 days)
<i>azelastine nasal</i>	1	MO; QL (60 per 30 days)
BACTROBAN NASAL	2	
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)
<i>olopatadine nasal</i>	1	MO; QL (30.5 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
PATANASE	3	MO; QL (30.5 per 30 days)
<i>periogard</i>	1	MO
<i>triamcinolone acetonide dental</i>	1	MO
MISCELLANEOUS OTIC PREPARATIONS		
<i>acetic acid otic (ear)</i>	1	MO
CETRAXAL	3	MO
<i>ciprofloxacin hcl otic (ear)</i>	1	MO
<i>floxin otic (ear) drops</i>	1	
<i>fluocinolone acetonide oil</i>	1	MO
<i>hydrocortisone-acetic acid</i>	1	MO
<i>ofloxacin otic (ear)</i>	1	MO
OTIC STEROID / ANTIBIOTIC		
CIPRO HC	3	MO
CIPRODEX	2	MO
COLY-MYCIN S	3	MO
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO
OTOVEL	2	MO
ENDOCRINE/DIABETES		
ADRENAL HORMONES		
ACTHAR H.P.	4	PA; MO
CORTEF	3	MO
<i>cortisone</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>dexamethasone intensol</i>	1	MO
<i>dexamethasone oral elixir</i>	1	MO
<i>dexamethasone oral tablet</i>	1	MO
DEXPAK 13 DAY	3	MO
EMFLAZA	4	PA; MO; LA
<i>fludrocortisone</i>	1	MO
<i>hydrocortisone oral</i>	1	MO
MEDROL	3	PA; MO
MEDROL (PAK)	3	MO
<i>methylprednisolone oral tablet</i>	1	PA; MO
<i>methylprednisolone oral tablets,dose pack</i>	1	MO
MILLIPRED ORAL SOLUTION	3	MO
<i>millipred oral tablet</i>	1	PA; MO
ORAPRED ODT	3	PA; MO
<i>prednisolone oral solution 15 mg/5 ml</i>	1	MO
<i>prednisolone sodium phosphate oral solution 10 mg/5 ml, 20 mg/5 ml (4 mg/ml), 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)</i>	1	MO
<i>prednisolone sodium phosphate oral tablet,disintegrating</i>	1	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>prednisone intensol</i>	1	PA; MO
<i>prednisone oral solution</i>	1	MO
<i>prednisone oral tablet</i>	1	PA; MO
<i>prednisone oral tablets, dose pack</i>	1	MO
RAYOS	4	PA; MO
TAPERDEX	3	
<i>veripred 20</i>	1	MO
ANTITHYROID AGENTS		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
<i>propylthiouracil</i>	1	MO
TAPAZOLE	3	MO
DIABETES THERAPY		
<i>acarbose oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>acarbose oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>acarbose oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
ACTOPLUS MET	3	MO; QL (90 per 30 days)
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 15-1,000 MG	3	MO; QL (60 per 30 days)
ACTOPLUS MET XR ORAL TABLET, ER MULTIPHASE 24 HR 30-1,000 MG	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ACTOS	3	MO; QL (30 per 30 days)
ADLYXIN SUBCUTANEOUS PEN INJECTOR 10 MCG/0.2 ML- 20 MCG/0.2 ML	3	PA; MO; QL (6 per 180 days)
ADLYXIN SUBCUTANEOUS PEN INJECTOR 20 MCG/0.2 ML	3	PA; MO; QL (6 per 30 days)
ADMELOG SOLOSTAR U-100 INSULIN	3	ST; MO
ADMELOG U-100 INSULIN LISPRO	3	ST; MO
AFREZZA INHALATION CARTRIDGE WITH INHALER 12 UNIT, 4 UNIT, 4 UNIT (30)/ 8 UNIT (60), 4 UNIT (90)/ 8 UNIT (90), 4 UNIT/8 UNIT/ 12 UNIT (60), 8 UNIT, 8 UNIT (60)/ 12 UNIT (30)	3	MO
ALCOHOL PADS	2	MO
ALOGLIPTIN	3	ST; MO; QL (30 per 30 days)
ALOGLIPTIN-METFORMIN	3	ST; MO; QL (60 per 30 days)
ALOGLIPTIN-PIOGLITAZONE	3	MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
AMARYL ORAL TABLET 1 MG	3	MO; QL (240 per 30 days)
AMARYL ORAL TABLET 2 MG	3	MO; QL (120 per 30 days)
AMARYL ORAL TABLET 4 MG	3	MO; QL (60 per 30 days)
APIDRA SOLOSTAR U-100 INSULIN	3	ST; MO
APIDRA U-100 INSULIN	3	ST; MO
AVANDIA ORAL TABLET 2 MG, 4 MG	3	MO; QL (60 per 30 days)
BASAGLAR KWIKPEN U-100 INSULIN	3	ST; MO
BYDUREON	2	PA; MO; QL (4 per 28 days)
BYDUREON BCISE	2	PA; MO; QL (4 per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	2	PA; MO; QL (1.2 per 30 days)
CYCLOSET	3	MO; QL (180 per 30 days)
DUETACT	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
FARXIGA ORAL TABLET 10 MG	2	MO; QL (30 per 30 days)
FARXIGA ORAL TABLET 5 MG	2	MO; QL (60 per 30 days)
FIASP FLEXTOUCH U-100 INSULIN	3	ST; MO
FIASP U-100 INSULIN	3	ST; MO
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 1,000 MG	4	MO; QL (75 per 30 days)
FORTAMET ORAL TABLET EXTENDED RELEASE 24HR 500 MG	4	MO; QL (150 per 30 days)
GAUZE PADS 2 X 2	2	MO
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)
<i>glimepiride oral tablet 2 mg</i>	1	MO; QL (120 per 30 days)
<i>glimepiride oral tablet 4 mg</i>	1	MO; QL (60 per 30 days)
<i>glipizide oral tablet 10 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide oral tablet 5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 10 mg</i>	1	MO; QL (60 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>glipizide oral tablet extended release 24hr 2.5 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide oral tablet extended release 24hr 5 mg</i>	1	MO; QL (120 per 30 days)
<i>glipizide-metformin oral tablet 2.5-250 mg</i>	1	MO; QL (240 per 30 days)
<i>glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg</i>	1	MO; QL (120 per 30 days)
GLUCAGEN HYPOKIT	2	MO
GLUCAGON EMERGENCY KIT (HUMAN)	2	MO
GLUCOPHAGE ORAL TABLET 1,000 MG	3	MO; QL (75 per 30 days)
GLUCOPHAGE ORAL TABLET 500 MG	3	MO; QL (150 per 30 days)
GLUCOPHAGE ORAL TABLET 850 MG	3	MO; QL (90 per 30 days)
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 500 MG	3	MO; QL (120 per 30 days)
GLUCOPHAGE XR ORAL TABLET EXTENDED RELEASE 24 HR 750 MG	3	MO; QL (75 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
GLUCOTROL ORAL TABLET 10 MG	3	MO; QL (120 per 30 days)
GLUCOTROL ORAL TABLET 5 MG	3	MO; QL (240 per 30 days)
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG	3	MO; QL (60 per 30 days)
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 2.5 MG	3	MO; QL (240 per 30 days)
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 5 MG	3	MO; QL (120 per 30 days)
GLUMETZA ORAL TABLET,ER GAST.RETENTION 24 HR 500 MG	4	MO; QL (120 per 30 days)
GLYSET ORAL TABLET 100 MG	3	MO; QL (90 per 30 days)
GLYSET ORAL TABLET 25 MG	3	MO; QL (360 per 30 days)
GLYSET ORAL TABLET 50 MG	3	MO; QL (180 per 30 days)
GLYXAMBI	2	MO; QL (30 per 30 days)
HUMALOG JUNIOR KWIKPEN U-100	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
HUMALOG KWIKPEN INSULIN	2	MO
HUMALOG MIX 50-50 INSULN U-100	2	MO
HUMALOG MIX 50-50 KWIKPEN	2	MO
HUMALOG MIX 75-25 KWIKPEN	2	MO
HUMALOG MIX 75-25(U-100)INSULN	2	MO
HUMALOG U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 INSULIN	2	MO
HUMULIN 70/30 U-100 KWIKPEN	2	MO
HUMULIN N NPH INSULIN KWIKPEN	2	MO
HUMULIN N NPH U-100 INSULIN	2	MO
HUMULIN R REGULAR U-100 INSULN	2	MO
HUMULIN R U-500 (CONC) INSULIN	2	MO
HUMULIN R U-500 (CONC) KWIKPEN	2	MO
INSULIN PEN NEEDLE	2	MO

Drug Name	Drug Tier	Requirements /Limits
INSULIN SYRINGE (DISP) U-100 0.3 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE	2	MO
INVOKAMET ORAL TABLET 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET ORAL TABLET 50-500 MG	2	MO; QL (120 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 150-1,000 MG, 150-500 MG, 50-1,000 MG	2	MO; QL (60 per 30 days)
INVOKAMET XR ORAL TABLET, IR - ER, BIPHASIC 24HR 50-500 MG	2	MO; QL (120 per 30 days)
INVOKANA ORAL TABLET 100 MG	2	MO; QL (90 per 30 days)
INVOKANA ORAL TABLET 300 MG	2	MO; QL (30 per 30 days)
JANUMET	2	MO; QL (60 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	2	MO; QL (30 per 30 days)

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

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

Drug Name	Drug Tier	Requirements /Limits
LEVEMIR FLEXTOUCH U-100 INSULN	3	ST; MO
LEVEMIR U-100 INSULIN	3	ST; MO
<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)
<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
<i>metformin oral tablet 850 mg</i>	1	MO; QL (90 per 30 days)
<i>metformin oral tablet extended release 24 hr 500 mg</i>	1	MO; QL (120 per 30 days)
<i>metformin oral tablet extended release 24 hr 750 mg</i>	1	MO; QL (75 per 30 days)
<i>metformin oral tablet extended release (osm) 24 hr 1,000 mg</i>	4	MO; QL (75 per 30 days)
<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	1	MO; QL (150 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg</i>	4	MO; QL (60 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 500 mg</i>	4	MO; QL (120 per 30 days)
<i>migliitol oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>migliitol oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>migliitol oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
<i>nateglinide oral tablet 120 mg</i>	1	MO; QL (90 per 30 days)
<i>nateglinide oral tablet 60 mg</i>	1	MO; QL (180 per 30 days)
NEEDLES, INSULIN DISP.,SAFETY	2	MO
NESINA	3	ST; MO; QL (30 per 30 days)
NOVOFINE 32	2	MO
NOVOFINE AUTOCOVER	2	MO
NOVOLIN 70/30 U-100 INSULIN	3	ST; MO
NOVOLIN N NPH U-100 INSULIN	3	ST; MO
NOVOLIN R REGULAR U-100 INSULIN	3	ST; MO
NOVOLOG FLEXPEN U-100 INSULIN	3	ST; MO
NOVOLOG MIX 70-30 U-100 INSULIN	3	ST; MO
NOVOLOG MIX 70-30FLEXPEN U-100	3	ST; MO
NOVOLOG PENFILL U-100 INSULIN	3	ST; MO
NOVOLOG U-100 INSULIN ASPART	3	ST; MO

Drug Name	Drug Tier	Requirements /Limits
OMNIPOD INSULIN MANAGEMENT	3	MO
OMNIPOD INSULIN REFILL	3	MO
ONGLYZA	2	MO; QL (30 per 30 days)
OSENI	3	MO; QL (30 per 30 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML)	2	PA; MO; QL (1.5 per 28 days)
OZEMPIC SUBCUTANEOUS PEN INJECTOR 1 MG/0.75 ML (2 MG/1.5 ML)	2	PA; MO; QL (3 per 28 days)
<i>pioglitazone</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-glimepiride</i>	1	MO; QL (30 per 30 days)
<i>pioglitazone-metformin</i>	1	MO; QL (90 per 30 days)
PRANDIN ORAL TABLET 1 MG	3	MO; QL (480 per 30 days)
PRANDIN ORAL TABLET 2 MG	3	MO; QL (240 per 30 days)
PRECOSE ORAL TABLET 100 MG	3	MO; QL (90 per 30 days)
PRECOSE ORAL TABLET 25 MG	3	MO; QL (360 per 30 days)
PRECOSE ORAL TABLET 50 MG	3	MO; QL (180 per 30 days)
PROGLYCEM	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
QTERN	3	MO; QL (30 per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>repaglinide oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)
<i>repaglinide-metformin</i>	1	MO; QL (150 per 30 days)
RIOMET	2	MO; QL (765 per 30 days)
SEGLUROMET ORAL TABLET 2.5-1,000 MG, 7.5-1,000 MG, 7.5-500 MG	2	MO; QL (60 per 30 days)
SEGLUROMET ORAL TABLET 2.5-500 MG	2	MO; QL (120 per 30 days)
SOLIQUA 100/33	2	MO
STARLIX ORAL TABLET 120 MG	3	MO; QL (90 per 30 days)
STARLIX ORAL TABLET 60 MG	3	MO; QL (180 per 30 days)
STEGLATRO	2	MO; QL (30 per 30 days)
STEGLUJAN	3	MO; QL (30 per 30 days)
SYMLINPEN 120	4	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	4	PA; MO; QL (6 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
SYNJARDY ORAL TABLET 12.5-1,000 MG, 12.5-500 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
SYNJARDY ORAL TABLET 5-500 MG	2	MO; QL (120 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	2	MO; QL (30 per 30 days)
TANZEUM	3	PA; MO; QL (4 per 28 days)
<i>tolazamide oral tablet 250 mg</i>	1	MO; QL (120 per 30 days)
<i>tolazamide oral tablet 500 mg</i>	1	MO; QL (60 per 30 days)
<i>tolbutamide</i>	1	MO; QL (180 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	2	MO
TOUJEO SOLOSTAR U-300 INSULIN	2	MO
TRADJENTA	3	ST; MO; QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100	3	ST; MO

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

Drug Name	Drug Tier	Requirements /Limits
TRESIBA FLEXTOUCH U-200	3	ST; MO
TRULICITY	3	PA; MO; QL (2 per 28 days)
VGO 20	2	MO
VGO 30	2	MO
VGO 40	2	MO
VICTOZA 2-PAK	2	PA; MO; QL (9 per 30 days)
VICTOZA 3-PAK	2	PA; MO; QL (9 per 30 days)
XIGDUO XR ORAL TABLET, IR-ER, BIPHASIC 24HR 10-1,000 MG	2	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR-ER, BIPHASIC 24HR 10-500 MG, 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
XULTOPHY 100/3.6	4	MO; QL (15 per 30 days)
MISCELLANEOUS HORMONES		
ANADROL-50	4	PA; MO
ANDRODERM	2	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP 20.25 MG/1.25 GRAM (1.62 %)	2	PA; MO; QL (150 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (25 MG/2.5GRAM)	3	PA; MO; QL (75 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1 % (50 MG/5 GRAM)	3	PA; MO; QL (300 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (20.25 MG/1.25 GRAM)	2	PA; MO; QL (37.5 per 30 days)
ANDROGEL TRANSDERMAL GEL IN PACKET 1.62 % (40.5 MG/2.5 GRAM)	2	PA; MO; QL (150 per 30 days)
AVEED	3	PA; MO; LA
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon)</i>	1	MO
<i>calcitriol oral</i>	1	MO
CERDELGA	4	MO
<i>danazol</i>	1	MO
DDAVP NASAL	3	MO
DDAVP ORAL	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
DEPO-TESTOSTERONE	3	PA; MO
<i>desmopressin nasal spray, non-aerosol</i>	1	MO
<i>desmopressin oral</i>	1	MO
<i>doxercalciferol oral</i>	1	MO
FORTESTA	3	PA; MO; QL (120 per 30 days)
JYNARQUE	4	PA; MO; LA
KORLYM	4	PA; MO
KUVAN	4	PA; MO
METHITEST	3	MO
<i>methyltestosterone oral capsule</i>	4	MO
<i>miglustat</i>	4	MO; LA
MYALEPT	4	PA; MO; LA
NATPARA	4	PA; MO; LA
NOCTIVA	3	PA; MO; QL (3.8 per 30 days)
<i>oxandrolone oral tablet 10 mg</i>	4	PA; MO
<i>oxandrolone oral tablet 2.5 mg</i>	1	PA; MO
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	4	PA; MO; LA; QL (15 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	4	PA; MO; LA; QL (4 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	4	PA; MO; LA; QL (60 per 30 days)
<i>paricalcitol oral</i>	1	MO
RAYALDEE	4	MO
ROCALTROL	3	MO
SAMSCA	4	PA; MO
SENSIPAR ORAL TABLET 30 MG	2	MO
SENSIPAR ORAL TABLET 60 MG, 90 MG	4	MO
SOMAVERT	4	MO
STIMATE	2	MO
STRIANT	3	PA; MO; QL (60 per 30 days)
SYNAREL	4	MO
TESTIM	3	PA; MO; QL (300 per 30 days)
<i>testosterone cypionate</i>	1	PA; MO
<i>testosterone enanthate</i>	1	PA; MO
TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP 10 MG/0.5 GRAM /ACTUATION	3	PA; MO; QL (120 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
<i>testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in packet</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal solution in metered pump w/app</i>	1	PA; MO; QL (180 per 30 days)
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; MO; QL (300 per 30 days)
VOGELXO TRANSDERMAL GEL IN PACKET	3	PA; MO; QL (300 per 30 days)
ZAVESCA	4	MO; LA
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	3	MO
THYROID HORMONES		
CYTOMEL	3	MO
LEVO-T	3	
<i>levothyroxine oral</i>	1	MO
<i>levoxyl oral tablet 100 mcg, 112 mcg, 125 mcg, 137 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO
<i>liothyronine oral</i>	1	MO
SYNTHROID	3	MO

Drug Name	Drug Tier	Requirements /Limits
THYROLAR-1	3	MO
THYROLAR-1/2	3	MO
THYROLAR-1/4	3	MO
THYROLAR-2	3	MO
THYROLAR-3	3	MO
TIROSINT	3	MO
<i>unithroid oral tablet 100 mcg, 112 mcg, 125 mcg, 150 mcg, 175 mcg, 200 mcg, 25 mcg, 300 mcg, 50 mcg, 75 mcg, 88 mcg</i>	1	MO

GASTROENTEROLOGY

ANTIDIARRHEALS / ANTISPASMODICS

CUVPOSA	3	MO
<i>dicyclomine oral capsule</i>	1	MO
<i>dicyclomine oral solution</i>	1	MO
<i>dicyclomine oral tablet</i>	1	MO
<i>diphenoxylate-atropine</i>	1	MO
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO
LOMOTIL	3	MO
<i>loperamide oral capsule</i>	1	MO
<i>methscopolamine</i>	1	MO
MYTESI	3	MO
ROBINUL FORTE	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
ROBINUL ORAL	3	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
ACTIGALL	3	MO
AKYNZEO (FOSNETUPITANT)	3	
<i>alosetron</i>	4	MO
AMITIZA	2	MO
ANUSOL-HC TOPICAL	3	MO
<i>aprepitant</i>	1	PA; MO
APRISO	3	MO
ASACOL HD	2	MO
AZULFIDINE	3	MO
AZULFIDINE EN-TABS	3	MO
<i>balsalazide</i>	1	MO
BONJESTA	3	MO
<i>budesonide oral</i>	4	MO
CANASA	3	MO
CESAMET	4	PA; MO
CHENODAL	4	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	4	PA; MO
CHOLBAM ORAL CAPSULE 50 MG	4	PA; MO; QL (120 per 30 days)
CIMZIA	4	PA; MO
CIMZIA POWDER FOR RECONST	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
CIMZIA STARTER KIT	4	PA; MO
CLENPIQ	3	ST; MO
COLAZAL	4	MO
<i>colocort</i>	1	MO
COLYTE WITH FLAVOR PACKS ORAL RECON SOLN 240-22.72-6.72 -5.84 GRAM	3	ST; MO
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	2	MO
CREON ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 12,000-38,000 - 60,000 UNIT, 24,000-76,000 - 120,000 UNIT, 3,000-9,500- 15,000 UNIT, 6,000-19,000 -30,000 UNIT	2	MO
CREON ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 36,000-114,000-180,000 UNIT	4	MO
<i>cromolyn oral</i>	1	MO
CYSTADANE	4	MO
DELZICOL ORAL CAPSULE (WITH DEL REL TABLETS)	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
DIPENTUM	4	MO
<i>dronabinol oral capsule 10 mg</i>	4	PA; MO
<i>dronabinol oral capsule 2.5 mg, 5 mg</i>	1	PA; MO
EMEND ORAL CAPSULE	3	PA; MO
EMEND ORAL CAPSULE,DOSE PACK	3	PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	2	PA; MO
ENTOCORT EC	4	MO
<i>enulose</i>	1	MO
GASTROCROM	3	MO
GATTEX 30-VIAL	4	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>gavilyte-n</i>	1	MO
<i>generlac</i>	1	MO
GIAZO	4	MO
GOLYTELY	3	ST; MO
<i>granisetron hcl oral</i>	1	PA; MO
<i>hydrocortisone rectal</i>	1	MO
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	MO
KRISTALOSE	3	MO

Drug Name	Drug Tier	Requirements /Limits
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO
LIALDA	3	MO
LINZESS	2	MO
LOTRONEX	4	MO
MARINOL ORAL CAPSULE 10 MG, 5 MG	4	PA; MO
MARINOL ORAL CAPSULE 2.5 MG	3	PA; MO
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO
<i>mesalamine oral tablet,delayed release (dr/ec) 1.2 gram</i>	1	MO
MESALAMINE ORAL TABLET,DELAYED RELEASE (DR/EC) 800 MG	3	MO
<i>mesalamine rectal</i>	1	MO
<i>metoclopramide hcl oral</i>	1	MO
MICORT-HC TOPICAL CREAM WITH PERINEAL APPLICATOR 2.5 %	3	MO
MOVANTIK	2	MO
MOVIPREP	3	MO
NULYTELY WITH FLAVOR PACKS	3	ST; MO

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

Drug Name	Drug Tier	Requirements /Limits
OICALIVA	4	PA; MO; LA; QL (30 per 30 days)
<i>ondansetron</i>	1	PA; MO
<i>ondansetron hcl oral solution</i>	1	PA; MO
<i>ondansetron hcl oral tablet 24 mg</i>	1	PA
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	PA; MO
OSMOPREP	3	MO
PANCREAZE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-6,200- 10,850 UNIT, 21,000-54,700-83,900 UNIT, 4,200-14,200- 24,600 UNIT	3	ST; MO
<i>peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram</i>	1	MO
<i>peg 3350-electrolytes oral recon soln 240-22.72-6.72 -5.84 gram</i>	1	
<i>peg-electrolyte</i>	1	

Drug Name	Drug Tier	Requirements /Limits
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	2	MO
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	4	MO
PERTZYE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 16,000-57,500-60,500 UNIT	4	ST; MO
PERTZYE ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 4,000-14,375-15,125 UNIT, 8,000-28,750- 30,250 UNIT	3	ST; MO
<i>polyethylene glycol 3350 oral powder</i>	1	MO
PREPOPIK	3	ST; MO
<i>prochlorperazine</i>	1	MO
<i>prochlorperazine maleate oral</i>	1	MO
<i>procto-med hc</i>	1	MO
<i>procto-pak</i>	1	MO
<i>proctosol hc topical</i>	1	MO
<i>proctozone-hc</i>	1	MO
RECTIV	2	MO
REGLAN ORAL	3	MO
RELISTOR ORAL	4	MO

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

Drug Name	Drug Tier	Requirements /Limits
RELISTOR SUBCUTANEOUS SOLUTION	4	MO
RELISTOR SUBCUTANEOUS SYRINGE	4	MO
REMICADE	4	PA; MO
ROWASA RECTAL ENEMA KIT	3	MO
SANCUSO	4	MO
<i>scopolamine base</i>	1	MO
SUCRAID	4	MO
<i>sulfasalazine</i>	1	MO
SUPREP BOWEL PREP KIT	2	MO
SYMPROIC	2	MO
SYNDROS	4	PA; MO
TRANSDERM-SCOP	3	MO
<i>trilyte with flavor packets</i>	1	MO
TRULANCE	3	MO
UCERIS ORAL	4	MO
UCERIS RECTAL	3	MO
URSO 250	3	MO
URSO FORTE	3	MO
<i>ursodiol</i>	1	MO
VARUBI ORAL	2	PA; MO
VIBERZI	4	MO
VIOKACE	2	MO

Drug Name	Drug Tier	Requirements /Limits
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-51,000 - 82,000 UNIT, 20,000-63,000-84,000 UNIT, 25,000-79,000-105,000 UNIT, 25,000-85,000-136,000 UNIT, 3,000-10,000-16,000 UNIT, 5,000-17,000 -27,000 UNIT, 5,000-17,000- 24,000 UNIT	2	MO
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 40,000-126,000-168,000 UNIT	4	MO
ZOFRAN ODT	3	PA; MO
ZOFRAN ORAL TABLET 8 MG	3	PA; MO
ZUPLENZ	3	PA; MO
ULCER THERAPY		
ACIPHEX	3	MO
ACIPHEX SPRINKLE	3	MO; QL (30 per 30 days)
<i>amoxicil-clarithromy-lansopraz</i>	1	MO; QL (112 per 30 days)
CARAFATE	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>cimetidine</i>	1	MO
<i>cimetidine hcl oral</i>	1	MO
CYTOTEC	3	MO
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 30 MG	3	MO; QL (30 per 30 days)
DEXILANT ORAL CAPSULE,BIPHAS E DELAYED RELEAS 60 MG	3	MO
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO
ESOMEPRAZOLE STRONTIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 49.3 MG	3	MO
<i>famotidine oral suspension</i>	1	MO
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO
<i>lansoprazole oral capsule,delayed release(dr/ec) 15 mg</i>	1	MO; QL (30 per 30 days)
<i>lansoprazole oral capsule,delayed release(dr/ec) 30 mg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>lansoprazole oral tablet,disintegrat, delay rel 15 mg</i>	1	MO; QL (30 per 30 days)
<i>lansoprazole oral tablet,disintegrat, delay rel 30 mg</i>	1	MO
<i>misoprostol</i>	1	MO
NEXIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 20 MG	3	MO; QL (30 per 30 days)
NEXIUM ORAL CAPSULE,DELAY ED RELEASE(DR/EC) 40 MG	3	MO
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 MG	2	MO; QL (30 per 30 days)
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	2	MO
<i>nizatidine</i>	1	MO
OMECLAMOX-PAK	3	MO; QL (80 per 28 days)
<i>omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>omeprazole oral capsule,delayed release(dr/ec) 40 mg</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>omeprazole-sodium bicarbonate oral capsule 20-1.1 mg-gram</i>	4	MO; QL (30 per 30 days)
<i>omeprazole-sodium bicarbonate oral capsule 40-1.1 mg-gram</i>	4	MO
<i>omeprazole-sodium bicarbonate oral packet 20-1,680 mg</i>	4	MO; QL (30 per 30 days)
<i>omeprazole-sodium bicarbonate oral packet 40-1,680 mg</i>	4	MO
<i>pantoprazole oral tablet, delayed release (dr/ec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet, delayed release (dr/ec) 40 mg</i>	1	MO
PEPCID	3	MO
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 15 MG	3	MO; QL (30 per 30 days)
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 30 MG	3	MO
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 15 MG	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAY REL 30 MG	3	MO
PREVPAC	3	MO; QL (112 per 30 days)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON	3	MO
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	3	MO
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC) 20 MG	3	MO; QL (30 per 30 days)
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC) 40 MG	3	MO
PYLERA	2	MO
<i>rabeprazole</i>	1	MO
<i>ranitidine hcl oral capsule</i>	1	MO
<i>ranitidine hcl oral syrup</i>	1	MO
<i>ranitidine hcl oral tablet 150 mg, 300 mg</i>	1	MO
<i>sucralfate oral tablet</i>	1	MO
ZANTAC ORAL TABLET 300 MG	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
ZEGERID ORAL CAPSULE 20-1.1 MG-GRAM	4	MO; QL (30 per 30 days)
ZEGERID ORAL CAPSULE 40-1.1 MG-GRAM	4	MO
ZEGERID ORAL PACKET 20-1,680 MG	4	MO; QL (30 per 30 days)
ZEGERID ORAL PACKET 40-1,680 MG	4	MO

IMMUNOLOGY, VACCINES / BIOTECHNOLOGY

BIOTECHNOLOGY DRUGS

ACTIMMUNE	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 300 MCG/ML, 60 MCG/ML	4	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 25 MCG/ML, 40 MCG/ML	3	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 10 MCG/0.4 ML, 25 MCG/0.42 ML, 40 MCG/0.4 ML	3	PA; MO

Drug Name	Drug Tier	Requirements /Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE 100 MCG/0.5 ML, 150 MCG/0.3 ML, 200 MCG/0.4 ML, 300 MCG/0.6 ML, 500 MCG/ML, 60 MCG/0.3 ML	4	PA; MO
ARCALYST	4	PA; MO
AVONEX (WITH ALBUMIN)	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	4	PA; MO; QL (4 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	4	PA; MO; QL (4 per 28 days)
BETASERON SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)
EGRIFTA SUBCUTANEOUS RECON SOLN 1 MG	4	PA; MO
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
EPOGEN INJECTION SOLUTION 20,000 UNIT/ML	4	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
EXTAVIA SUBCUTANEOUS KIT	4	PA; MO; QL (15 per 28 days)
EXTAVIA SUBCUTANEOUS RECON SOLN	4	PA; QL (15 per 28 days)
GENOTROPIN	4	PA; MO
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.2 MG/0.25 ML	3	PA; MO
GENOTROPIN MINIQUICK SUBCUTANEOUS SYRINGE 0.4 MG/0.25 ML, 0.6 MG/0.25 ML, 0.8 MG/0.25 ML, 1 MG/0.25 ML, 1.2 MG/0.25 ML, 1.4 MG/0.25 ML, 1.6 MG/0.25 ML, 1.8 MG/0.25 ML, 2 MG/0.25 ML	4	PA; MO
GRANIX	4	PA; MO
HUMATROPE	4	PA; MO
INTRON A INJECTION RECON SOLN	4	PA; MO
INTRON A INJECTION SOLUTION 10 MILLION UNIT/ML	2	PA; MO

Drug Name	Drug Tier	Requirements /Limits
INTRON A INJECTION SOLUTION 6 MILLION UNIT/ML	4	PA; MO
LEUKINE INJECTION RECON SOLN	4	MO
NEULASTA SUBCUTANEOUS SYRINGE	4	PA; MO
NEUPOGEN	4	PA; MO
NORDITROPIN FLEXPRO	4	PA; MO
NUTROPIN AQ NUSPIN	4	PA; MO
OMNITROPE	4	PA; MO
PEGASYS PROCLICK SUBCUTANEOUS PEN INJECTOR 180 MCG/0.5 ML	4	MO; QL (2 per 28 days)
PEGASYS SUBCUTANEOUS SOLUTION	4	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	4	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)

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

Drug Name	Drug Tier	Requirements /Limits
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	4	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 63 MCG/0.5 ML- 94 MCG/0.5 ML	4	PA; MO; QL (1 per 180 days)
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/2 ML, 3,000 UNIT/ML, 4,000 UNIT/ML	2	PA; MO
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	4	PA; MO
REBIF (WITH ALBUMIN)	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 22 MCG/0.5 ML, 44 MCG/0.5 ML	4	PA; MO; QL (6 per 28 days)
REBIF REBIDOSE SUBCUTANEOUS PEN INJECTOR 8.8MCG/0.2ML-22 MCG/0.5ML (6)	4	PA; MO; QL (4.2 per 180 days)
REBIF TITRATION PACK	4	PA; MO; QL (4.2 per 180 days)
SAIZEN	4	PA; MO

Drug Name	Drug Tier	Requirements /Limits
SAIZEN SAIZENPREP	4	PA; MO
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	4	PA; MO
SYLATRON	4	MO
ZARXIO	4	PA; MO
ZOMACTON SUBCUTANEOUS RECON SOLN 10 MG	4	PA; MO
ZOMACTON SUBCUTANEOUS RECON SOLN 5 MG	3	PA; MO
ZORBTIVE	4	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT) (PF)	2	MO
BCG VACCINE, LIVE (PF)	2	MO
BEXSERO	2	MO
BIVIGAM	4	PA; MO
BOOSTRIX TDAP	2	MO
CARIMUNE NF NANOFILTERED INTRAVENOUS RECON SOLN 6 GRAM	4	PA; MO
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
ENGERIX-B PEDIATRIC (PF) INTRAMUSCULAR SYRINGE	2	PA; MO
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	4	PA; MO
GAMMAGARD LIQUID	4	PA; MO
GAMMAGARD S- D (IGA < 1 MCG/ML)	4	PA; MO
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	4	PA; MO
GAMMAPLEX	4	PA; MO
GAMMAPLEX (WITH SORBITOL)	4	PA; MO
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	4	PA; MO
GARDASIL 9 (PF)	2	MO
GRASTEK	2	PA; MO
HAVRIX (PF) INTRAMUSCULAR SUSPENSION	2	MO

Drug Name	Drug Tier	Requirements /Limits
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	2	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	2	
HIBERIX (PF)	2	MO
IMOVAX RABIES VACCINE (PF)	2	MO
INFANRIX (DTAP) (PF) INTRAMUSCULAR SUSPENSION	2	MO
IPOL	2	MO
IXIARO (PF)	2	MO
KINRIX (PF) INTRAMUSCULAR SUSPENSION	2	
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	2	MO
MENVEO A-C-Y- W-135-DIP (PF)	2	MO
M-M-R II (PF)	2	MO
OCTAGAM	4	PA; MO
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	3	PA; MO
PEDIARIX (PF)	2	MO

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

Drug Name	Drug Tier	Requirements /Limits
PEDVAX HIB (PF)	2	MO
PRIVIGEN	4	PA; MO
PROQUAD (PF)	2	MO
QUADRACEL (PF)	2	MO
RABAVERT (PF)	2	MO
RAGWITEK	2	MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	2	PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 10 MCG/ML	2	PA; MO
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE 5 MCG/0.5 ML	2	PA
ROTARIX	2	
ROTATEQ VACCINE	2	MO
SHINGRIX (PF)	2	MO
TENIVAC (PF) INTRAMUSCULAR SYRINGE	2	MO
TETANUS, DIPHTHERIA TOX PED(PF)	2	MO
TETANUS-DIPHTHERIA TOXOIDS-TD	2	MO

Drug Name	Drug Tier	Requirements /Limits
TRUMENBA	2	MO
TWINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
TYPHIM VI INTRAMUSCULAR SOLUTION	2	
TYPHIM VI INTRAMUSCULAR SYRINGE	2	MO
VAQTA (PF)	2	MO
VARIVAX (PF)	2	MO
VARIZIG INTRAMUSCULAR SOLUTION	2	MO
YF-VAX (PF)	2	MO
ZOSTAVAX (PF)	2	MO

MUSCULOSKELETAL / RHEUMATOLOGY

GOUT THERAPY

<i>allopurinol</i>	1	MO
COLCHICINE	3	ST; MO
COLCRYS	2	MO
DUZALLO	3	ST; MO
MITIGARE	2	MO
<i>probenecid</i>	1	MO
<i>probenecid-colchicine</i>	1	MO
ULORIC	2	ST; MO
ZURAMPIC	3	ST; MO
ZYLOPRIM	3	MO

OSTEOPOROSIS THERAPY

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

Drug Name	Drug Tier	Requirements /Limits
ACTONEL ORAL TABLET 150 MG	3	ST; MO; QL (1 per 30 days)
ACTONEL ORAL TABLET 35 MG	3	ST; MO; QL (4 per 28 days)
ACTONEL ORAL TABLET 5 MG	3	ST; MO; QL (30 per 30 days)
<i>alendronate oral solution</i>	1	MO; QL (1286 per 30 days)
<i>alendronate oral tablet 10 mg, 5 mg</i>	1	MO; QL (30 per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
ATELVIA	3	ST; MO; QL (4 per 28 days)
BINOSTO	3	ST; MO; QL (4 per 28 days)
BONIVA ORAL	3	ST; MO; QL (1 per 30 days)
EVISTA	3	MO
FORTEO	4	PA; MO; QL (2.4 per 28 days)
FOSAMAX ORAL TABLET 70 MG	3	ST; MO; QL (4 per 28 days)
FOSAMAX PLUS D	3	ST; MO; QL (4 per 28 days)
<i>ibandronate oral</i>	1	MO; QL (1 per 30 days)
PROLIA	2	PA; MO
<i>raloxifene</i>	1	MO
<i>risedronate oral tablet 150 mg</i>	1	MO; QL (1 per 30 days)

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

OTHER RHEUMATOLOGICALS

ACTEMRA	4	PA; MO
ARAVA	4	MO; QL (30 per 30 days)
BENLYSTA SUBCUTANEOUS	4	PA; MO
CUPRIMINE	4	MO
DEPEN TITRATABS	4	MO
ENBREL MINI	4	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	4	PA; MO; QL (16 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	4	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	4	PA; MO; QL (8 per 28 days)

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

Drug Name	Drug Tier	Requirements /Limits
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML (6 PACK)	4	PA; MO; QL (6 per 180 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML, 80 MG/0.8 ML	4	PA; MO; QL (3 per 180 days)
HUMIRA PEDIATRIC CROHN'S START SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	4	PA; MO; QL (2 per 180 days)
HUMIRA PEN	4	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHN'S-UC-HS START SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	4	PA; MO; QL (6 per 180 days)
HUMIRA PEN PSORIASIS-UVEITIS SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.8 ML	4	PA; MO; QL (4 per 180 days)

Drug Name	Drug Tier	Requirements /Limits
HUMIRA SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 10 MG/0.2 ML, 20 MG/0.2 ML, 20 MG/0.4 ML	4	PA; MO; QL (2 per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	4	PA; MO; QL (4 per 28 days)
KEVZARA SUBCUTANEOUS SYRINGE	4	PA; MO; QL (2.28 per 28 days)
KINERET	4	PA; MO
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
OLUMIANT	4	PA; MO; QL (30 per 30 days)
ORENCIA	4	PA; MO
ORENCIA (WITH MALTOSE)	4	PA; MO
ORENCIA CLICKJECT	4	PA; MO
OTEZLA	4	PA; MO
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	4	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
OTREXUP (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.4 ML, 12.5 MG/0.4 ML, 15 MG/0.4 ML, 17.5 MG/0.4 ML, 20 MG/0.4 ML, 22.5 MG/0.4 ML, 25 MG/0.4 ML	3	MO
RASUVO (PF) SUBCUTANEOUS AUTO-INJECTOR 10 MG/0.2 ML, 12.5 MG/0.25 ML, 15 MG/0.3 ML, 17.5 MG/0.35 ML, 20 MG/0.4 ML, 22.5 MG/0.45 ML, 25 MG/0.5 ML, 30 MG/0.6 ML, 7.5 MG/0.15 ML	2	MO
RIDAURA	4	MO
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (55 per 30 days)
SIMPONI	4	PA; MO
XELJANZ ORAL TABLET 5 MG	4	PA; MO
XELJANZ XR	4	PA; MO
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
ACTIVELLA	3	PA; MO
ALORA	3	PA; MO; QL (8 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
<i>amabelz</i>	1	PA; MO
ANGELIQ	3	PA; MO
AYGESTIN	3	MO
<i>camila</i>	1	MO
CLIMARA	3	PA; MO; QL (4 per 28 days)
CLIMARA PRO	3	PA; MO
COMBIPATCH	3	PA; MO
CRINONE VAGINAL GEL 4 %	3	MO
CRINONE VAGINAL GEL 8 %	3	PA; MO
<i>deblitane</i>	1	MO
DELESTROGEN	3	MO
DEPO-ESTRADIOL	3	MO
DEPO-PROVERA INTRAMUSCULA R SUSPENSION 150 MG/ML	3	MO
DEPO-PROVERA INTRAMUSCULA R SUSPENSION 400 MG/ML	2	MO
DEPO-SUBQ PROVERA 104	3	MO
DIVIGEL TRANSDERMAL GEL IN PACKET 1 MG/GRAM (0.1 %)	3	PA; MO; QL (30 per 30 days)
DUAVEE	2	MO
ELESTRIN	3	PA; MO
<i>errin</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
ESTRACE ORAL	3	PA; MO
ESTRACE VAGINAL	3	MO
<i>estradiol oral</i>	1	PA; MO
<i>estradiol transdermal patch semiweekly</i>	1	PA; MO; QL (8 per 28 days)
<i>estradiol transdermal patch weekly</i>	1	PA; MO; QL (4 per 28 days)
<i>estradiol vaginal</i>	1	MO
<i>estradiol valerate intramuscular oil 20 mg/ml, 40 mg/ml</i>	1	MO
<i>estradiol-norethindrone acet</i>	1	PA; MO
ESTRING	2	MO
<i>estropipate oral tablet 0.75 mg, 1.5 mg</i>	1	PA; MO
EVAMIST	3	PA; MO; QL (16.2 per 30 days)
FEMHRT LOW DOSE	3	PA; MO
FEMRING	3	MO
<i>fyavolv</i>	1	PA; MO
<i>jinteli</i>	1	PA; MO
<i>jolivette</i>	1	MO
<i>lyza</i>	1	MO
<i>medroxyprogesterone</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
MENEST ORAL TABLET 0.3 MG, 0.625 MG, 1.25 MG	2	PA; MO
MENOSTAR	3	PA; MO; QL (4 per 28 days)
<i>mimvey</i>	1	PA; MO
<i>mimvey lo</i>	1	PA; MO
MINIVELLE	3	PA; MO; QL (8 per 28 days)
<i>nora-be</i>	1	MO
<i>norethindrone (contraceptive)</i>	1	MO
<i>norethindrone acetate</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg</i>	1	PA; MO
<i>norlyroc</i>	1	
ORTHO MICRONOR	3	MO
PREFEST	3	PA; MO
PREMARIN ORAL	2	MO
PREMARIN VAGINAL	2	MO
PREMPHASE	3	PA; MO
PREMPRO	3	PA; MO
<i>progesterone micronized</i>	1	MO
PROMETRIUM	3	MO
PROVERA	3	MO
<i>sharobel</i>	1	MO
VAGIFEM	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
VIVELLE-DOT	3	PA; MO; QL (8 per 28 days)
<i>yuvafem</i>	1	MO
MISCELLANEOUS OB/GYN		
AVC	3	MO
CLEOCIN VAGINAL CREAM	3	MO
CLEOCIN VAGINAL SUPPOSITORY	2	MO
<i>clindamycin phosphate vaginal</i>	1	MO
CLINDESSE	3	MO
GYNAZOLE-1	3	MO
INTRAROSA	3	MO
LUPANETA PACK (1 MONTH)	4	MO
LUPANETA PACK (3 MONTH)	4	MO
LYSTEDA	3	MO
METROGEL VAGINAL	3	MO
<i>metronidazole vaginal</i>	1	MO
<i>miconazole-3 vaginal suppository</i>	1	MO
NUVARING	3	MO
OSPHENA	3	MO
<i>terconazole</i>	1	MO
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO
<i>xulane</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>altavera (28)</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO
<i>amethia</i>	1	MO
<i>amethia lo</i>	1	MO
<i>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>ashlyna</i>	1	MO
<i>aubra</i>	1	MO
<i>aviane</i>	1	MO
<i>balziva (28)</i>	1	MO
BEYAZ	3	MO
<i>blisovi 24 fe</i>	1	MO
<i>blisovi fe 1.5/30 (28)</i>	1	MO
<i>blisovi fe 1/20 (28)</i>	1	MO
<i>briellyn</i>	1	MO
<i>camrese lo</i>	1	MO
<i>caziant (28)</i>	1	MO
<i>cryselle (28)</i>	1	MO
<i>cyclafem 1/35 (28)</i>	1	MO
<i>cyclafem 7/7/7 (28)</i>	1	MO
<i>delyla (28)</i>	1	
<i>desog-e.estradiol/e.estradiol</i>	1	MO
<i>desogestrel-ethinyl estradiol</i>	1	

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

Drug Name	Drug Tier	Requirements /Limits
<i>drospirenone-e.estradiol-lm,fa oral tablet 3-0.02-0.451 mg (24) (4)</i>	1	MO
<i>drospirenone-ethinyl estradiol</i>	1	MO
<i>emoquette</i>	1	MO
<i>enpresse</i>	1	MO
<i>enskyce</i>	1	MO
<i>estarylla</i>	1	MO
<i>ethynodiol diac-eth estradiol</i>	1	
<i>falmina (28)</i>	1	MO
<i>fayosim</i>	1	MO
<i>femynor</i>	1	MO
GENERESS FE	3	MO
<i>gianvi (28)</i>	1	MO
<i>introvale</i>	1	MO
<i>isibloom</i>	1	MO
<i>juleber</i>	1	MO
<i>junel 1.5/30 (21)</i>	1	MO
<i>junel 1/20 (21)</i>	1	MO
<i>junel fe 1.5/30 (28)</i>	1	MO
<i>junel fe 1/20 (28)</i>	1	MO
<i>junel fe 24</i>	1	MO
<i>kaitlib fe</i>	1	MO
<i>kariva (28)</i>	1	MO
<i>kelnor 1/35 (28)</i>	1	MO
<i>kelnor 1-50</i>	1	MO
<i>kimidess (28)</i>	1	MO
<i>kurvelo</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.10 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	1	MO
<i>l norgest/e.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	1	
<i>larin 1.5/30 (21)</i>	1	MO
<i>larin 1/20 (21)</i>	1	MO
<i>larin fe 1.5/30 (28)</i>	1	MO
<i>larin fe 1/20 (28)</i>	1	MO
<i>larissia</i>	1	MO
<i>layolis fe</i>	1	MO
<i>leena 28</i>	1	MO
<i>lessina</i>	1	MO
<i>levonest (28)</i>	1	MO
<i>levonorgestrel-ethinyl estrad</i>	1	MO
<i>levonorg-eth estrad triphasic</i>	1	MO
<i>levora-28</i>	1	MO
LO LOESTRIN FE	3	MO
LOESTRIN 1.5/30 (21)	3	MO
LOESTRIN 1/20 (21)	3	MO
LOESTRIN FE 1.5/30 (28-DAY)	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
LOESTRIN FE 1/20 (28-DAY)	3	MO
<i>loryna (28)</i>	1	MO
LOSEASONIQUE	3	MO
<i>low-ogestrel (28)</i>	1	MO
<i>luteria (28)</i>	1	MO
<i>marlissa</i>	1	MO
<i>melodetta 24 fe</i>	1	MO
<i>mibelas 24 fe</i>	1	MO
<i>microgestin 1.5/30 (21)</i>	1	MO
<i>microgestin 1/20 (21)</i>	1	MO
<i>microgestin fe 1.5/30 (28)</i>	1	MO
<i>microgestin fe 1/20 (28)</i>	1	MO
<i>mili</i>	1	
MINASTRIN 24 FE	3	MO
<i>mononessa (28)</i>	1	MO
NATAZIA	3	MO
<i>necon 0.5/35 (28)</i>	1	MO
<i>necon 7/7/7 (28)</i>	1	MO
<i>nikki (28)</i>	1	MO
<i>noreth-ethinyl estradiol-iron</i>	1	MO
<i>norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg</i>	1	MO

Drug Name	Drug Tier	Requirements /Limits
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (24)/75 mg (4)</i>	1	MO
<i>norethindrone-e.estradiol-iron oral tablet,chewable</i>	1	MO
<i>norgestimate-ethinyl estradiol</i>	1	MO
<i>nortrel 0.5/35 (28)</i>	1	MO
<i>nortrel 1/35 (21)</i>	1	MO
<i>nortrel 1/35 (28)</i>	1	MO
<i>nortrel 7/7/7 (28)</i>	1	MO
<i>ocella</i>	1	MO
<i>ogestrel (28)</i>	1	MO
<i>orsythia</i>	1	MO
ORTHO TRI-CYCLEN (28)	3	MO
ORTHO TRI-CYCLEN LO (28)	3	MO
ORTHO-CYCLEN (28)	3	MO
ORTHO-NOVUM 1/35 (28)	3	MO
ORTHO-NOVUM 7/7/7 (28)	3	MO
<i>pimtrea (28)</i>	1	MO
<i>pirmella oral tablet 1-35 mg-mcg</i>	1	MO
<i>portia</i>	1	MO
<i>previfem</i>	1	MO
QUARTETTE	3	MO
<i>quasense</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>reclipsen (28)</i>	1	MO
<i>rivelsa</i>	1	MO
SAFYRAL	3	MO
SEASONIQUE	3	MO
<i>setlakin</i>	1	MO
<i>sprintec (28)</i>	1	MO
<i>sronyx</i>	1	MO
<i>syeda</i>	1	MO
<i>tarina fe 1/20 (28)</i>	1	MO
<i>tri-legest fe</i>	1	MO
<i>tri-lo-estarylla</i>	1	MO
<i>tri-lo-sprintec</i>	1	MO
<i>tri-mili</i>	1	
<i>trinessa (28)</i>	1	MO
TRI-NORINYL (28)	3	MO
<i>tri-previfem (28)</i>	1	MO
<i>tri-sprintec (28)</i>	1	MO
<i>trivora (28)</i>	1	MO
<i>tri-vylibra</i>	1	
<i>tydemy</i>	1	MO
<i>velivet triphasic regimen (28)</i>	1	MO
<i>vestura (28)</i>	1	MO
<i>vienva</i>	1	MO
<i>vyfemla (28)</i>	1	MO
<i>vylibra</i>	1	
<i>wymzya fe</i>	1	MO
YASMIN (28)	3	MO
YAZ (28)	3	MO

Drug Name	Drug Tier	Requirements /Limits
<i>zarah</i>	1	MO
<i>zenchent (28)</i>	1	MO
<i>zovia 1/35e (28)</i>	1	MO
OPHTHALMOLOGY		
ANTIBIOTICS		
AZASITE	2	MO
<i>bacitracin ophthalmic (eye)</i>	1	MO
<i>bacitracin-polymyxin b ophthalmic (eye)</i>	1	MO
BESIVANCE	2	MO
CILOXAN	3	MO
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO
<i>erythromycin ophthalmic (eye)</i>	1	MO
<i>gatifloxacin</i>	1	MO
<i>gentak ophthalmic (eye) ointment</i>	1	MO
<i>gentamicin ophthalmic (eye) drops</i>	1	MO
<i>levofloxacin ophthalmic (eye)</i>	1	MO
MOXEZA	3	MO
<i>moxifloxacin ophthalmic (eye)</i>	1	MO
NATACYN	2	MO
<i>neomycin-bacitracin-polymyxin</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>neomycin-polymyxin-gramicidin</i>	1	MO
OCUFLOX	3	MO
<i>ofloxacin ophthalmic (eye)</i>	1	MO
<i>polymyxin b sulf-trimethoprim</i>	1	MO
POLYTRIM	3	MO
<i>tobramycin</i>	1	MO
TOBREX	3	MO
VIGAMOX	3	MO
ZYMAXID	3	MO
ANTIVIRALS		
<i>trifluridine</i>	1	MO
VIROPTIC	3	MO
ZIRGAN	3	MO
BETA-BLOCKERS		
BETAGAN OPTHALMIC (EYE) DROPS 0.5 %	3	MO
<i>betaxolol ophthalmic (eye)</i>	1	MO
BETIMOL	3	MO
BETOPTIC S	3	MO
<i>carteolol</i>	1	MO
ISTALOL	3	MO
<i>levobunolol ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>metipranolol</i>	1	

Drug Name	Drug Tier	Requirements /Limits
<i>timolol maleate ophthalmic (eye)</i>	1	MO
TIMOPTIC OCUDOSE (PF)	3	MO
TIMOPTIC-XE OPTHALMIC (EYE) GEL FORMING SOLUTION 0.25 %	3	MO
MISCELLANEOUS OPTHALMOLOGICS		
ALOCRIL	3	MO
ALOMIDE	3	MO
<i>atropine ophthalmic (eye) drops</i>	1	MO
<i>azelastine ophthalmic (eye)</i>	1	MO
BEPREVE	3	MO
BLEPH-10	3	MO
BLEPHAMIDE	3	MO
BLEPHAMIDE S.O.P.	3	MO
<i>cromolyn ophthalmic (eye)</i>	1	MO
CYSTARAN	4	MO
ELESTAT	3	MO
EMADINE	3	MO
<i>epinastine</i>	1	MO
ISOPTO CARPINE	3	MO
LACRISERT	3	MO
LASTACAFT	3	MO
<i>olopatadine ophthalmic (eye)</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
PATADAY	3	MO
PATANOL	3	MO
PAZEO	2	MO
PHOSPHOLINE IODIDE	2	MO
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO
RESTASIS	2	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	2	MO; QL (5.5 per 30 days)
<i>sulfacetamide sodium ophthalmic (eye)</i>	1	MO
<i>sulfacetamide-prednisolone</i>	1	MO
XIIDRA	3	MO; QL (60 per 30 days)
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
ACULAR	3	MO
ACULAR LS	3	MO
ACUVAIL (PF)	3	MO
BROMSITE	2	MO
<i>diclofenac sodium ophthalmic (eye)</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
ILEVRO	2	MO
<i>ketorolac ophthalmic (eye)</i>	1	MO
NEVANAC	3	MO
PROLENSA	2	MO

Drug Name	Drug Tier	Requirements /Limits
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide</i>	1	MO
<i>methazolamide</i>	1	MO
OTHER GLAUCOMA DRUGS		
AZOPT	3	MO
<i>bimatoprost ophthalmic (eye)</i>	1	MO
COMBIGAN	2	MO
COSOPT	3	MO
COSOPT (PF)	3	MO
<i>dorzolamide</i>	1	MO
<i>dorzolamide-timolol</i>	1	MO
<i>latanoprost</i>	1	MO
LUMIGAN OPTHALMIC (EYE) DROPS 0.01 %	2	MO
RHOPRESSA	2	MO
SIMBRINZA	3	MO
TRAVATAN Z	2	MO
TRUSOPT	3	MO
VYZULTA	3	MO
XALATAN	3	ST; MO
ZIOPTAN (PF)	3	ST; MO
STEROID-ANTIBIOTIC COMBINATIONS		
MAXITROL	3	MO
<i>neomycin-bacitracin-poly-hc</i>	1	MO
<i>neomycin-polymyxin b-dexameth</i>	1	MO

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

Drug Name	Drug Tier	Requirements /Limits
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	1	MO
PRED-G	3	MO
PRED-G S.O.P.	3	MO
TOBRADEX	3	MO
TOBRADEX ST	3	MO
<i>tobramycin-dexamethasone</i>	1	MO
ZYLET	2	MO

STEROIDS

ALREX	3	MO
<i>dexamethasone sodium phosphate ophthalmic (eye)</i>	1	MO
DUREZOL	3	MO
FLAREX	3	MO
<i>fluorometholone</i>	1	MO
FML FORTE	3	MO
FML LIQUIFILM	3	MO
FML S.O.P.	3	MO
LOTEMAX	2	MO
MAXIDEX	3	MO
OMNIPRED	3	MO
PRED FORTE	3	MO
PRED MILD	3	MO
<i>prednisolone acetate</i>	1	MO
<i>prednisolone sodium phosphate ophthalmic (eye)</i>	1	MO

SYMPATHOMIMETICS

Drug Name	Drug Tier	Requirements /Limits
ALPHAGAN P OPTHALMIC (EYE) DROPS 0.1 %	2	MO
ALPHAGAN P OPTHALMIC (EYE) DROPS 0.15 %	3	MO
<i>apraclonidine</i>	1	MO
<i>brimonidine</i>	1	MO
IOPIDINE	3	MO

RESPIRATORY AND ALLERGY

ANTI-HISTAMINE / ANTI-ALLERGENIC AGENTS

AUVI-Q	4	ST; MO; QL (4 per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	1	MO
CLARINEX ORAL SYRUP	3	MO
CLARINEX ORAL TABLET	3	MO; QL (30 per 30 days)
CLARINEX-D 12 HOUR	3	MO; QL (60 per 30 days)
<i>desloratadine</i>	1	MO; QL (30 per 30 days)
EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.15 ML, 0.3 % NOT MADE BY MYLAN	3	ST; MO; QL (4 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
EPINEPHRINE INJECTION AUTO-INJECTOR 0.15 MG/0.3 ML, 0.3 MG/0.3 ML (MANUFACTURED BY MYLAN SPECIALTY)	2	MO; QL (4 per 30 days)
EPIPEN	2	MO; QL (4 per 30 days)
EPIPEN 2-PAK	2	MO; QL (4 per 30 days)
EPIPEN JR	2	MO; QL (4 per 30 days)
EPIPEN JR 2-PAK	2	MO; QL (4 per 30 days)
<i>hydroxyzine hcl oral tablet</i>	1	PA; MO
<i>levocetirizine oral solution</i>	1	MO
<i>levocetirizine oral tablet</i>	1	MO; QL (30 per 30 days)
<i>promethazine oral</i>	1	PA; MO
SEMPREX-D	3	MO
PULMONARY AGENTS		
ACCOLATE	3	MO
<i>acetylcysteine</i>	1	PA; MO
ADCIRCA	4	PA; MO; QL (60 per 30 days)
ADEMPAS	4	PA; MO; LA
ADVAIR DISKUS	2	MO; QL (60 per 30 days)
ADVAIR HFA	2	MO; QL (12 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
AIRDUO RESPICLICK	3	MO; QL (60 per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/3 ml (0.083%), 5 mg/ml</i>	1	PA; MO
<i>albuterol sulfate oral</i>	1	MO
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	3	MO; QL (12.2 per 30 days)
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	3	MO; QL (6.1 per 30 days)
ANORO ELLIPTA	2	MO; QL (60 per 30 days)
ARCAPTA NEOHALER	2	MO; QL (30 per 30 days)
ARMONAIR RESPICLICK	3	MO; QL (60 per 30 days)
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 200 MCG/ACTUATION	2	MO; QL (30 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
ARNUITY ELLIPTA INHALATION BLISTER WITH DEVICE 50 MCG/ACTUATION	2	QL (30 per 30 days)
ASMANEX HFA	2	MO; QL (13 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (30 DOSES), 220 MCG (30 DOSES), 220 MCG (60 DOSES)	2	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG (7 DOSES)	2	QL (4 per 28 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (120 DOSES)	2	MO; QL (2 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG (14 DOSES)	2	QL (2 per 28 days)

Drug Name	Drug Tier	Requirements /Limits
ATROVENT HFA	2	MO; QL (25.8 per 30 days)
BECONASE AQ	3	MO; QL (50 per 30 days)
BERINERT INTRAVENOUS KIT	4	PA; MO
BEVESPI AEROSPHERE	2	MO; QL (10.7 per 30 days)
BREO ELLIPTA	2	MO; QL (60 per 30 days)
BROVANA	3	PA; MO
<i>budesonide inhalation</i>	1	PA; MO
CINRYZE	4	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	PA; MO
DALIRESP	3	PA; MO
DULERA	2	MO; QL (13 per 30 days)
DYMISTA	2	MO; QL (23 per 30 days)
ESBRIET ORAL CAPSULE	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 267 MG	4	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 801 MG	4	PA; MO; QL (90 per 30 days)
FASENRA	4	PA; MO
FIRAZYR	4	PA; MO

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

Drug Name	Drug Tier	Requirements /Limits
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION , 50 MCG/ACTUATION	2	MO; QL (60 per 30 days)
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	2	MO; QL (240 per 30 days)
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION	2	MO; QL (12 per 30 days)
FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION	2	MO; QL (24 per 30 days)
FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
<i>flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)</i>	1	MO; QL (50 per 30 days)
<i>fluticasone nasal</i>	1	MO; QL (16 per 30 days)
FLUTICASONE-SALMETEROL	3	MO; QL (60 per 30 days)
HAEGARDA	4	PA; MO; LA
INCRUSE ELLIPTA	3	ST; MO; QL (30 per 30 days)
<i>ipratropium bromide inhalation</i>	1	PA; MO

Drug Name	Drug Tier	Requirements /Limits
<i>ipratropium-albuterol</i>	1	PA; MO
KALBITOR	4	MO
KALYDECO ORAL GRANULES IN PACKET	4	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	4	PA; MO; QL (60 per 30 days)
LETAIRIS	4	PA; MO; LA
<i>levalbuterol hcl</i>	1	PA; MO
LEVALBUTEROL TARTRATE	3	ST; MO; QL (30 per 30 days)
LONHALA MAGNAIR REFILL	4	MO; QL (60 per 30 days)
LONHALA MAGNAIR STARTER	4	MO; QL (60 per 30 days)
<i>metaproterenol</i>	1	MO
<i>mometasone nasal</i>	1	MO; QL (34 per 30 days)
<i>montelukast</i>	1	MO
NASONEX	3	MO; QL (34 per 30 days)
NUCALA	4	PA; MO; LA; QL (1 per 28 days)
OFEV	4	PA; MO; QL (60 per 30 days)
OMNARIS	3	MO; QL (12.5 per 30 days)
OPSUMIT	4	PA; MO; LA

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

Drug Name	Drug Tier	Requirements /Limits
ORKAMBI ORAL TABLET	4	PA; MO; QL (112 per 28 days)
PERFOROMIST	2	PA; MO
PROAIR HFA	3	ST; MO; QL (17 per 30 days)
PROAIR RESPICLICK	3	ST; MO; QL (2 per 30 days)
PROVENTIL HFA	3	ST; MO; QL (13.4 per 30 days)
PULMICORT	3	PA; MO
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 180 MCG/ACTUATION	2	MO; QL (2 per 30 days)
PULMICORT FLEXHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 90 MCG/ACTUATION	2	MO; QL (1 per 30 days)
PULMOZYME	4	PA; MO
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	2	MO; QL (4.9 per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	2	MO; QL (8.7 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
QVAR	2	MO; QL (17.4 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	2	MO; QL (10.6 per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	2	MO; QL (21.2 per 30 days)
REVATIO ORAL SUSPENSION FOR RECONSTITUTION	4	PA; MO; QL (224 per 30 days)
REVATIO ORAL TABLET	4	PA; MO; QL (90 per 30 days)
RUCONEST	4	PA; MO
SEEBRI NEOHALER	3	ST; MO; QL (60 per 30 days)
SEREVENT DISKUS	2	MO; QL (60 per 30 days)
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; MO; QL (90 per 30 days)
SINGULAIR	3	MO
SPIRIVA RESPIMAT	2	MO; QL (4 per 30 days)

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

Drug Name	Drug Tier	Requirements /Limits
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	2	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)
SYMBICORT	2	MO; QL (10.2 per 30 days)
SYMDEKO	4	PA; MO; QL (56 per 28 days)
<i>terbutaline oral</i>	1	MO
THEO-24	2	MO
<i>theophylline oral solution</i>	1	MO
<i>theophylline oral tablet extended release 12 hr 100 mg, 200 mg, 300 mg</i>	1	MO
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
TRACLEER	4	PA; MO; LA
TRELEGY ELLIPTA	3	PA; MO; QL (60 per 30 days)
<i>triamcinolone acetonide nasal</i>	1	MO; QL (16.5 per 30 days)
TUDORZA PRESSAIR	2	MO; QL (1 per 30 days)
UTIBRON NEOHALER	3	MO; QL (60 per 30 days)
VENTAVIS	4	PA; MO
VENTOLIN HFA	2	MO; QL (36 per 30 days)

Drug Name	Drug Tier	Requirements /Limits
XHANCE	3	MO; QL (32 per 30 days)
XOLAIR	4	PA; MO; LA; QL (6 per 28 days)
XOPENEX CONCENTRATE	3	PA; MO
XOPENEX HFA	3	ST; MO; QL (30 per 30 days)
XOPENEX INHALATION SOLUTION FOR NEBULIZATION 0.31 MG/3 ML	3	PA
XOPENEX INHALATION SOLUTION FOR NEBULIZATION 0.63 MG/3 ML, 1.25 MG/3 ML	3	PA; MO
<i>zafirlukast</i>	1	MO
ZETONNA	3	MO; QL (6.1 per 30 days)
<i>zileuton</i>	4	MO
ZYFLO	4	MO
ZYFLO CR	4	MO

UROLOGICALS

ANTICHOLINERGICS / ANTISPASMODICS

<i>darifenacin</i>	1	MO
DETROL	3	MO
DETROL LA	3	MO

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

Drug Name	Drug Tier	Requirements /Limits
DITROPAN XL ORAL TABLET EXTENDED RELEASE 24HR 10 MG, 5 MG	3	MO
ENABLEX	3	MO
<i>flavoxate</i>	1	MO
GELNIQUE TRANSDERMAL GEL IN METERED-DOSE PUMP 100 MG/GRAM (10 %)	3	MO; QL (30 per 30 days)
MYRBETRIQ	2	MO
<i>oxybutynin chloride</i>	1	MO
OXYTROL	3	MO; QL (8 per 28 days)
<i>tolterodine</i>	1	MO
TOVIAZ	2	MO
<i>trospium</i>	1	MO
VESICARE	2	MO
BENIGN PROSTATIC HYPERPLASIA(BPH) THERAPY		
<i>alfuzosin</i>	1	MO
AVODART	3	MO
<i>dutasteride</i>	1	MO
<i>dutasteride-tamsulosin</i>	1	MO
<i>finasteride oral tablet 5 mg</i>	1	MO
FLOMAX	3	ST; MO
JALYN	3	MO
PROSCAR	3	MO

Drug Name	Drug Tier	Requirements /Limits
RAPAFLO	2	ST; MO
<i>tamsulosin</i>	1	MO
UROXATRAL	3	ST; MO
MISCELLANEOUS UROLOGICALS		
<i>bethanechol chloride</i>	1	MO
CIALIS ORAL TABLET 2.5 MG, 5 MG	3	PA; MO; QL (30 per 30 days)
CYSTAGON	2	MO; LA
ELMIRON	2	MO
<i>potassium citrate</i>	1	MO
URECHOLINE	3	MO
UROCIT-K 10	3	MO
UROCIT-K 15	3	MO
UROCIT-K 5	3	MO
VITAMINS, HEMATINICS / ELECTROLYTES		
ELECTROLYTES		
<i>calcium acetate oral capsule</i>	1	MO
<i>calcium acetate oral tablet 667 mg</i>	1	MO
<i>klor-con</i>	1	MO
<i>klor-con 10</i>	1	MO
<i>klor-con 8</i>	1	MO
<i>klor-con m10</i>	1	MO
<i>klor-con m15</i>	1	MO
<i>klor-con m20</i>	1	MO
<i>klor-con sprinkle</i>	1	MO

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

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

Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml</i>	1	MO
<i>potassium chloride in water intravenous piggyback 20 meq/100 ml, 40 meq/100 ml</i>	1	
<i>potassium chloride intravenous solution</i>	1	MO
<i>potassium chloride oral capsule, extended release</i>	1	MO
<i>potassium chloride oral liquid</i>	1	MO
<i>potassium chloride oral tablet extended release</i>	1	MO
<i>potassium chloride oral tablet,er particles/crystals</i>	1	MO
<i>potassium chloride-0.45 % nacl</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride-d5-0.3%nacl intravenous parenteral solution 20 meq/l</i>	1	

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

Drug Name	Drug Tier	Requirements /Limits
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 20 meq/l</i>	1	MO
<i>potassium chloride-d5-0.9%nacl intravenous parenteral solution 40 meq/l</i>	1	
<i>sodium chloride 0.45 % intravenous parenteral solution</i>	1	MO
<i>sodium chloride 3 %</i>	1	MO
<i>sodium chloride 5 %</i>	1	
<i>sodium chloride intravenous parenteral solution 2.5 meq/ml</i>	1	MO
<i>sodium lactate intravenous</i>	1	
TPN ELECTROLYTES	3	
MISCELLANEOUS NUTRITION PRODUCTS		
AMINOSYN 7 % WITH ELECTROLYTES	2	PA
AMINOSYN 8.5 %- ELECTROLYTES	2	PA
AMINOSYN II 10 %	2	PA
AMINOSYN II 15 %	2	PA
AMINOSYN II 8.5 %	2	PA

Drug Name	Drug Tier	Requirements /Limits
AMINOSYN II 8.5 %- ELECTROLYTES	2	PA
AMINOSYN-HBC 7%	2	PA
AMINOSYN-PF 10 %	2	PA
AMINOSYN-PF 7 % (SULFITE-FREE)	2	PA
AMINOSYN-RF 5.2 %	2	PA
CLINIMIX 5%/D15W SULFITE FREE	2	PA
CLINIMIX 5%/D25W SULFITE-FREE	2	PA
CLINIMIX 2.75%/D5W SULFIT FREE	2	PA
CLINIMIX 4.25%/D10W SULF FREE	2	PA
CLINIMIX 4.25%- D20W SULF-FREE	2	PA
CLINIMIX 4.25%- D25W SULF-FREE	2	PA
CLINIMIX 5%- D20W(SULFITE-FREE)	2	PA
CLINIMIX E 4.25%/D10W SUL FREE	3	PA

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

Drug Name	Drug Tier	Requirements /Limits
CLINIMIX E 4.25%/D25W SUL FREE	3	PA
CLINIMIX E 4.25%/D5W SULF FREE	3	PA
CLINIMIX E 5%/D15W SULFIT FREE	3	PA
CLINIMIX E 5%/D20W SULFIT FREE	3	PA
CLINIMIX E 5%/D25W SULFIT FREE	3	PA
CLINISOL SF 15 %	3	PA; MO
FREAMINE HBC 6.9 %	3	PA
HEPATAMINE 8%	2	PA
<i>intralipid intravenous emulsion 20 %</i>	1	PA
INTRALIPID INTRAVENOUS EMULSION 30 %	3	PA
IONOSOL-MB IN D5W	2	
ISOLYTE-P IN 5 % DEXTROSE	2	
ISOLYTE-S	2	
NEPHRAMINE 5.4 %	2	PA
NORMOSOL-M IN 5 % DEXTROSE	3	

Drug Name	Drug Tier	Requirements /Limits
NORMOSOL-R PH 7.4	2	
NUTRILIPID	3	PA
PLASMA-LYTE 148	2	
PLASMA-LYTE A	2	
<i>plenamine</i>	1	PA
<i>premasol 10 %</i>	1	PA; MO
PREMASOL 6 %	2	PA
PROCALAMINE 3%	3	PA
PROSOL 20 %	3	PA; MO
<i>travasol 10 %</i>	1	PA; MO
TROPHAMINE 10 %	2	PA; MO
TROPHAMINE 6%	2	PA
VITAMINS / HEMATINICS		
FLUORIDE (SODIUM) ORAL TABLET	3	MO
PRENATAL VITAMIN ORAL TABLET	3	MO

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

Index

A		
abacavir	1	
abacavir-lamivudine	1	
abacavir-lamivudine- zidovudine	1	
ABELCET	1	
ABILIFY	34	
ABILIFY MAINTENA	34	
ABSORICA	53	
ABSTRAL	26	
acamprosate	59	
ACANYA	53	
acarbose	63	
ACCOLATE	95	
ACCUPRIL	43	
ACCURETIC	43	
acebutolol	43	
acetaminophen-codeine	26	
acetazolamide	93	
acetic acid	62	
acetylcysteine	95	
ACIPHEX	76	
ACIPHEX SPRINKLE	76	
acitretin	51	
ACTEMRA	84	
ACTHAR H.P.	62	
ACTHIB (PF)	81	
ACTIGALL	73	
ACTIMMUNE	79	
ACTIQ	26	
ACTIVELLA	86	
ACTONEL	59, 84	
ACTOPLUS MET	63	
ACTOPLUS MET XR	63	
ACTOS	63	
ACULAR	93	
ACULAR LS	93	
ACUVAIL (PF)	93	
acyclovir	2, 56	
acyclovir sodium	2	
ACZONE	53	
ADACEL(TDAP ADOLESN/ADULT)(PF) 81		
ADALAT CC	43	
adapalene	53	
adapalene-benzoyl peroxide	53	
ADCIRCA	95	
ADDERALL	34	
ADDERALL XR	34	
adefovir	2	
ADEMPAS	95	
ADLYXIN	63	
ADMELOG SOLOSTAR U- 100 INSULIN	63	
ADMELOG U-100 INSULIN LISPRO	63	
ADVAIR DISKUS	95	
ADVAIR HFA	95	
ADZENYS ER	34	
ADZENYS XR-ODT	34	
afeditab cr	43	
AFINITOR	14	
AFINITOR DISPERZ	14	
AFREZZA	63	
AGGRENOLX	48	
AGRYLIN	59	
AIMOVIG AUTOINJECTOR (2 PACK)	23	
AIRDUO RESPICLICK	95	
AKTIPAK	53	
AKYNZEO (FOSNETUPITANT)	73	
ala-cort	57	
ALA-SCALP	57	
ALBENZA	7	
albuterol sulfate	95	
alclometasone	57	
ALCOHOL PADS	63	
ALDACTAZIDE	43	
ALDACTONE	43	
ALDARA	52	
ALECENSA	14	
alendronate	59, 84	
alfuzosin	100	
ALINIA	7	
allopurinol	83	
almotriptan malate	23	
ALOCRIAL	92	
ALOGLIPTIN	63	
ALOGLIPTIN-METFORMIN	63	
ALOGLIPTIN- PIOGLITAZONE	63	
ALOMIDE	92	
ALORA	86	
alosetron	73	
ALPHAGAN P	94	
ALREX	94	
ALTACE	43	
altavera (28)	88	
ALTOPREV	49	
ALUNBRIG	14	
ALVESCO	95	
alyacen 1/35 (28)	88	
amabelz	86	
amantadine hcl	2	
AMARYL	64	
AMBIEN	34	
AMBIEN CR	34	
AMBISOME	1	
amcinonide	57	
AMERGE	23	
amethia	88	
amethia lo	88	
amikacin	7	
amiloride	43	
amiloride-hydrochlorothiazide	43	
AMINOSYN 7 % WITH ELECTROLYTES	102	
AMINOSYN 8.5 %- ELECTROLYTES	102	
AMINOSYN II 10 %	102	
AMINOSYN II 15 %	102	
AMINOSYN II 8.5 %	102	
AMINOSYN II 8.5 %- ELECTROLYTES	102	
AMINOSYN-HBC 7%	102	
AMINOSYN-PF 10 %	102	

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

AMINOSYN-PF 7 % (SULFITE-FREE).....	102	apri.....	88	ATROVENT HFA.....	96
AMINOSYN-RF 5.2 %.....	102	APRISO.....	73	AUBAGIO.....	25
amiodarone.....	42	APTENSIO XR.....	34	aubra.....	88
AMITIZA.....	73	APTIOM.....	19	AUGMENTIN.....	10
amitriptyline.....	34	APTIVUS.....	2	AURYXIA.....	59
amlodipine.....	43	ARALAST NP.....	59	AUSTEDO.....	25
amlodipine-atorvastatin.....	49	aranelle (28).....	88	AUVI-Q.....	94
amlodipine-benazepril.....	43	ARANESP (IN POLYSORBATE).....	79	AVALIDE.....	43
amlodipine-olmesartan.....	43	ARAVA.....	84	AVANDIA.....	64
amlodipine-valsartan.....	43	ARCALYST.....	79	AVAPRO.....	43
amlodipine-valsartan-hcthiazyd	43	ARCAPTA NEOHALER.....	95	AVC.....	88
ammonium lactate.....	52	ARICEPT.....	25	AVEED.....	70
amnesteem.....	53	ARIMIDEX.....	14	AVELOX.....	11
amoxapine.....	34	aripiprazole.....	34	AVELOX IN NAACL (ISO- OSMOTIC).....	11
amoxicil-clarithromy-lansopraz	76	ARISTADA.....	34	aviane.....	88
amoxicillin.....	10	ARIXTRA.....	48	avita.....	53
amoxicillin-pot clavulanate..	10	armodafinil.....	34	AVITA.....	53
amphotericin b.....	1	ARMONAIR RESPICLICK	95	AVODART.....	100
ampicillin.....	10	ARNUITY ELLIPTA....	95, 96	AVONEX.....	79
ampicillin sodium.....	10	AROMASIN.....	14	AVONEX (WITH ALBUMIN)	79
ampicillin-sulbactam.....	10	ARTHROTEC 50.....	31	AVYCAZ.....	5
AMPYRA.....	25	ARTHROTEC 75.....	31	AYGESTIN.....	86
ANADROL-50.....	70	ARYMO ER.....	27	AZACTAM.....	7
ANAFRANIL.....	34	ASACOL HD.....	73	AZASAN.....	14
anagrelide.....	59	ashlyna.....	88	AZASITE.....	91
anastrozole.....	14	ASMANEX HFA.....	96	azathioprine.....	14
ANCOBON.....	1	ASMANEX TWISTHALER	96	azelastine.....	61, 92
ANDRODERM.....	70	aspirin-dipyridamole.....	48	AZELEX.....	53
ANDROGEL.....	70	ASTAGRAF XL.....	14	AZILECT.....	23
ANGELIQ.....	86	ASTEPRO.....	61	azithromycin.....	7
ANORO ELLIPTA.....	95	ATACAND.....	43	AZOPT.....	93
ANTABUSE.....	59	ATACAND HCT.....	43	AZOR.....	43
ANTARA.....	49	atazanavir.....	2	aztreonam.....	7
ANUSOL-HC.....	73	ATELVIA.....	84	AZULFIDINE.....	73
apexicon e.....	57	atenolol.....	43	AZULFIDINE EN-TABS ...	73
APIDRA SOLOSTAR U-100 INSULIN.....	64	atenolol-chlorthalidone.....	43	B	
APIDRA U-100 INSULIN...	64	ATIVAN.....	34	bacitracin.....	91
APLENZIN.....	34	atomoxetine.....	34	bacitracin-polymyxin b.....	91
APOKYN.....	23	atorvastatin.....	49	baclofen.....	26
apraclonidine.....	94	atovaquone.....	7	BACLOFEN.....	26
aprepitant.....	73	atovaquone-proguanil.....	7	BACTRIM.....	12
		ATRALIN.....	53	BACTRIM DS.....	12
		ATRIPLA.....	2	BACTROBAN.....	55
		atropine.....	92		

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

BACTROBAN NASAL.....	61	BIKTARVY	2	C	
balsalazide	73	BILTRICIDE.....	8	cabergoline	70
balziva (28).....	88	bimatoprost.....	93	CABOMETYX.....	14
BANZEL	19	BINOSTO.....	84	CADUET.....	49
BARACLUDE	2	bisoprolol fumarate.....	43	CAFERGOT	24
BASAGLAR KWIKPEN U-		bisoprolol-hydrochlorothiazide		CALAN	44
100 INSULIN.....	64	.....	43	CALAN SR	44
BAXDELA.....	12	BIVIGAM	81	calcipotriene	52
BCG VACCINE, LIVE (PF)	81	BLEPH-10.....	92	calcipotriene-betamethasone	52
BECONASE AQ.....	96	BLEPHAMIDE	92	calcitonin (salmon)	70
BELBUCA	27	BLEPHAMIDE S.O.P.....	92	calcitriol.....	52, 70
BELSOMRA	34	blisovi 24 fe.....	88	calcium acetate	100
benazepril	43	blisovi fe 1.5/30 (28)	88	CALQUENCE.....	14
benazepril-hydrochlorothiazide		blisovi fe 1/20 (28)	88	CAMBIA	31
.....	43	BONIVA	84	camila	86
BENICAR	43	BONJESTA	73	camrese lo.....	88
BENICAR HCT	43	BOOSTRIX TDAP.....	81	CANASA.....	73
BENLYSTA	84	BOSULIF	14	CANCIDAS.....	1
BENZACLIN PUMP	53	BREO ELLIPTA	96	candesartan	44
BENZAMYCIN	53	briellyn.....	88	candesartan-hydrochlorothiazid	
BENZNIDAZOLE	7	BRILINTA	48	.....	44
benztropine	23	brimonidine	94	CAPEX	57
BEPREVE	92	BRISDELLE	34	CAPRELSA.....	14
BERINERT	96	BRIVIACT	19	captopril.....	44
BESIVANCE	91	bromocriptine	23	captopril-hydrochlorothiazide	
BETAGAN.....	92	BROMSITE.....	93	.....	44
betamethasone dipropionate.	57	BROVANA	96	CARAC	52
betamethasone valerate	57	budesonide.....	73, 96	CARAFATE	76
betamethasone, augmented...	57	bumetanide	43	CARBAGLU	59
BETAPACE AF	42	BUNAVAIL	31	carbamazepine	19
BETASERON	79	BUPHENYL.....	59	CARBATROL.....	19
betaxolol	43, 92	BUPRENORPHINE.....	27	carbidopa	23
bethanechol chloride	100	buprenorphine hcl.....	27	carbidopa-levodopa	23
BETHKIS	8	buprenorphine-naloxone.....	31	carbidopa-levodopa-	
BETIMOL	92	bupropion hcl.....	34	entacapone	23
BETOPTIC S	92	bupropion hcl (smoking deter)		CARDIZEM	44
BEVESPI AEROSPHERE...	96	.....	61	CARDIZEM CD.....	44
BEVYXXA	48	buspirone	34	CARDIZEM LA	44
bexarotene	14	butorphanol tartrate	31	CARDURA.....	44
BEXSERO.....	81	BUTRANS	27	CARDURA XL	44
BEYAZ	88	BYDUREON.....	64	CARIMUNE NF	
bicalutamide	14	BYDUREON BCISE	64	NANOFILTERED.....	81
BICILLIN C-R	10	BYETTA	64	CARNITOR.....	59
BICILLIN L-A	10	BYSTOLIC	43	CAROSPIR.....	44
BIDIL	43	BYVALSON	44	carteolol	92

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

cartia xt.....	44	chloroquine phosphate.....	8	clindamycin phosphate	8, 54, 88
carvedilol.....	44	chlorothiazide.....	44	clindamycin-benzoyl peroxide	.....54
carvedilol phosphate.....	44	chlorpromazine.....	34	clindamycin-tretinoin	54
CASODEX.....	14	chlorthalidone.....	44	CLINDESSE.....	88
casprofungin	1	CHOLBAM.....	73	CLINIMIX 5%/D15W	
CATAPRES.....	44	cholestyramine (with sugar) ..	49	SULFITE FREE	102
CATAPRES-TTS-1.....	44	cholestyramine light	49	CLINIMIX 5%/D25W	
CATAPRES-TTS-2.....	44	CIALIS.....	100	SULFITE-FREE	102
CATAPRES-TTS-3.....	44	ciclopirox.....	55	CLINIMIX 2.75%/D5W	
CAYSTON.....	8	cilostazol.....	48	SULFIT FREE.....	102
caziant (28).....	88	CILOXAN.....	91	CLINIMIX 4.25%/D10W	
cefaclor.....	5, 6	cimetidine.....	77	SULF FREE.....	102
cefadroxil.....	6	cimetidine hcl.....	77	CLINIMIX 4.25%/D5W	
cefazolin.....	6	CIMZIA.....	73	SULFIT FREE.....	102
cefdinir.....	6	CIMZIA POWDER FOR		CLINIMIX 4.25%-D20W	
cefepime.....	6	RECONST.....	73	SULF-FREE	102
cefixime.....	6	CIMZIA STARTER KIT	73	CLINIMIX 4.25%-D25W	
cefotaxime.....	6	CINRYZE.....	96	SULF-FREE	102
cefotetan.....	6	CIPRO.....	12	CLINIMIX 4.25%-D25W	
cefoxitin.....	6	CIPRO HC.....	62	SULF-FREE	102
cefpodoxime.....	6	CIPRODEX.....	62	CLINIMIX 5%-	
cefprozil.....	6	ciprofloxacin.....	12	D20W(SULFITE-FREE)102	
ceftazidime.....	6	ciprofloxacin (mixture).....	12	CLINIMIX E 2.75%/D10W	
ceftriaxone.....	6	ciprofloxacin hcl.....	12, 62, 91	SUL FREE.....	60
cefuroxime axetil.....	6	ciprofloxacin in 5 % dextrose		CLINIMIX E 2.75%/D5W	
cefuroxime sodium.....	6	.....	12	SULF FREE.....	60
CELEBREX.....	31	citalopram.....	35	CLINIMIX E 4.25%/D10W	
celecoxib.....	31	claravis.....	53	SUL FREE.....	102
CELEXA.....	34	CLARINEX.....	94	CLINIMIX E 4.25%/D25W	
CELLCEPT.....	14	CLARINEX-D 12 HOUR	94	SUL FREE.....	103
CELONTIN.....	19	clarithromycin	7	CLINIMIX E 4.25%/D5W	
cephalexin.....	6	CLENPIQ.....	73	SULF FREE.....	103
CERDELGA.....	70	CLEOCIN.....	8, 88	CLINIMIX E 5%/D15W	
CESAMET.....	73	CLEOCIN HCL.....	8	SULFIT FREE.....	103
cetirizine.....	94	CLEOCIN IN 5 %		CLINIMIX E 5%/D20W	
CETRAXAL.....	62	DEXTROSE.....	8	SULFIT FREE.....	103
cevimeline.....	59	CLEOCIN PEDIATRIC.....	8	CLINIMIX E 5%/D25W	
CHANTIX.....	61	CLEOCIN T.....	54	SULFIT FREE.....	103
CHANTIX CONTINUING		CLIMARA.....	86	CLINISOL SF 15 %.....	103
MONTH BOX.....	61	CLIMARA PRO.....	86	clobetasol.....	57
CHANTIX STARTING		clindacin p.....	54	clobetasol-emollient	57
MONTH BOX.....	61	CLINDAGEL.....	54	CLOBEX.....	57
CHEMET.....	59	clindamycin hcl.....	8	clodan.....	57
CHENODAL.....	73	clindamycin in 5 % dextrose ..	8	CLODERM.....	57
chlorhexidine gluconate	61	clindamycin palmitate hcl	8	clomipramine.....	35

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

clonazepam.....	19	CORTISPORIN.....	55	DAKLINZA	2
clonidine	44	CORZIDE.....	44	DALIRESP	96
clonidine hcl	35, 44	COSENTYX.....	52	DALVANCE	8
clopidogrel.....	48	COSENTYX (2 SYRINGES)	52	danazol.....	70
clorazepate dipotassium	35	.....	52	DANTRIUM.....	26
clotrimazole.....	1, 55, 56	COSENTYX PEN	52	dantrolene	26
clotrimazole-betamethasone.....	56	COSENTYX PEN (2 PENS).....	52	dapsone	8, 54
clozapine.....	35	COSOPT.....	93	DAPTACEL (DTAP	
CLOZAPINE.....	35	COSOPT (PF)	93	PEDIATRIC) (PF).....	81
CLOZARIL	35	COTELIC.....	14	daptomycin	8
COARTEM	8	COUMADIN	48	DARAPRIM	8
codeine sulfate.....	27	COZAAR.....	44	darifenacin	99
COLAZAL	73	CREON	73	DAYPRO.....	31
COLCHICINE.....	83	CRESEMBA	1	DAYTRANA.....	35
COLCRYS	83	CRESTOR	49	DDAVP	70
colesevelam	49	CRINONE	86	deblitane	86
COLESTID	49	CRIXIVAN	2	DELESTROGEN	86
colestipol	49	cromolyn.....	73, 92, 96	delyla (28).....	88
colistin (colistimethate na)	8	cryselle (28).....	88	DELZICOL.....	73
colocort.....	73	CUBICIN.....	8	demeclocycline	12
COLY-MYCIN S	62	CUPRIMINE	84	DEMSEER.....	44
COLYTE WITH FLAVOR		CUTIVATE	57	DENAVIR.....	56
PACKS	73	CUVPOSA	72	DEPAKOTE	19
COMBIGAN	93	cyclafem 1/35 (28).....	88	DEPAKOTE ER.....	19
COMBIPATCH.....	86	cyclafem 7/7/7 (28)	88	DEPAKOTE SPRINKLES... ..	19
COMBIVENT RESPIMAT	96	cyclobenzaprine.....	26	DEPEN TITRATABS	84
COMBIVIR.....	2	cyclophosphamide	14	DEPO-ESTRADIOL	86
COMETRIQ	14	CYCLOSET	64	DEPO-PROVERA.....	86
COMPLERA	2	cyclosporine.....	14	DEPO-SUBQ PROVERA	104
compro.....	73	cyclosporine modified	14	.....	86
COMTAN	23	CYMBALTA.....	35	DEPO-TESTOSTERONE... ..	71
CONCERTA	35	CYSTADANE.....	73	DESCOVY	2
CONDYLOX	52	CYTAGON	100	desipramine.....	35
constulose.....	73	CYSTARAN	92	desloratadine.....	94
CONZIP	31	CYTOMEL.....	72	desmopressin	71
COPAXONE.....	25	CYTOTEC.....	77	desog-e.estradiol/e.estradiol	88
CORDRAN TAPE LARGE		D		desogestrel-ethinyl estradiol	88
ROLL	57	d10 %-0.45 % sodium chloride		DESONATE	57
COREG	44	.....	60	desonide.....	57
COREG CR.....	44	d2.5 %-0.45 % sodium		DESOWEN.....	57
CORGARD	44	chloride.....	60	desoximetasone.....	57
CORLANOR.....	51	d5 % and 0.9 % sodium		DESOXYN	35
CORTEF	62	chloride.....	60	DESVENLAFAXINE	35
CORTIFOAM	73	d5 %-0.45 % sodium chloride		desvenlafaxine succinate	35
cortisone	62	.....	60	DETROL	99

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

DETROL LA.....	99	DILANTIN EXTENDED 100		DUETACT	64
dexamethasone	62	MG.....	20	DUEXIS	32
dexamethasone intensol.....	62	DILANTIN INFATABS 50		DULERA.....	96
dexamethasone sodium		MG.....	20	duloxetine	35, 36
phosphate.....	94	DILANTIN-125 125 MG/5		DUOPA	23
DEXEDRINE SPANSULE..	35	ML.....	20	DUPIXENT	52
DEXILANT.....	77	DILAUDID	27	DURAGESIC	27
dexmethylphenidate	35	diltiazem hcl	44, 45	duramorph (pf).....	27
DEXPAK 13 DAY	62	dilt-xr.....	45	DUREZOL	94
dextroamphetamine	35	DIOVAN	45	dutasteride.....	100
dextroamphetamine-		DIOVAN HCT	45	dutasteride-tamsulosin.....	100
amphetamine	35	DIPENTUM	74	DUTOPROL.....	45
dextrose 10 % and 0.2 % nacl		diphenoxylate-atropine.....	72	DUZALLO	83
.....	60	DIPROLENE.....	57	DYANAVEL XR	36
dextrose 10 % in water (d10w)		dipyridamole.....	48	DYAZIDE	45
.....	60	disulfiram.....	60	DYMISTA.....	96
dextrose 5 % in water (d5w)	60	DITROPAN XL	100	DYRENIUM.....	45
dextrose 5%-0.2 % sod		DIURIL	45	E	
chloride.....	60	divalproex.....	20	e.e.s. 400.....	7
dextrose 5%-0.3 %		DIVIGEL.....	86	E.E.S. GRANULES.....	7
sod.chloride	60	dofetilide.....	42	econazole	56
dextrose with sodium chloride		DOLOPHINE	27	EDARBI	45
.....	60	donepezil	25	EDARBYCLOR.....	45
DIASTAT.....	19	DOPTelet.....	48	EDECRIN.....	45
DIASTAT ACUDIAL.....	20	DORIPENEM.....	8	EDURANT	2
diazepam.....	35	DORYX.....	12	efavirenz	2
diazepam intensol.....	35	DORYX MPC	12	EFFEXOR XR.....	36
DIBENZYLINE	44	dorzolamide	93	EFFIENT	48
diclofenac potassium.....	31	dorzolamide-timolol	93	EFUDEX	52
diclofenac sodium ...	31, 32, 52,	DOVONEX	52	EGRIFTA	79
93		doxazosin.....	45	ELDEPRYL.....	23
diclofenac-misoprostol.....	32	doxepin	35, 52	ELESTAT.....	92
dicloxacillin.....	10	doxercalciferol.....	71	ELESTRIN	86
dicyclomine	72	doxy-100.....	12	eletriptan	24
didanosine.....	2	doxycycline hyclate.....	12	ELIDEL	52
DIFFERIN.....	54	doxycycline monohydrate ...	12,	ELIGARD.....	14
DIFICID	7	13		ELIGARD (3 MONTH)	14
diflorasone.....	57	dronabinol.....	74	ELIGARD (4 MONTH)	14
DIFLUCAN.....	1	drosiprenone-e.estradiol-lm.fa		ELIGARD (6 MONTH)	15
diflunisal.....	32	.....	89	ELIMITE	59
digitek.....	51	drosiprenone-ethinyl estradiol		ELIQUIS.....	48
digox.....	51	.....	89	ELMIRON.....	100
digoxin.....	51	DROXIA	14	ELOCON.....	58
dihydroergotamine	24	DUAC.....	54	EMADINE.....	92
DILANTIN 30 MG	20	DUA VEE.....	86	EMBEDA	27

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

EMCYT.....	15	EQUETRO	20	EVISTA.....	84
EMEND.....	74	ERAXIS(WATER DILUENT)		EVOCLIN.....	54
EMFLAZA	62	.....	1	EVOTAZ	2
emoquette	89	ergoloid.....	36	EVOXAC	60
EMSAM	36	ergotamine-caffeine.....	24	EVZIO	32
EMTRIVA.....	2	ERIVEDGE	15	EXALGO ER.....	27
EMVERM	8	ERLEADA	15	EXELDERM	56
ENABLEX	100	errin	86	EXELON	25
enalapril maleate	45	ERTACZO.....	56	exemestane	15
enalapril-hydrochlorothiazide		ery pads.....	54	EXFORGE.....	45
.....	45	erygel.....	54	EXFORGE HCT.....	45
ENBREL	84	ERYPED 200	7	EXJADE	60
ENBREL MINI.....	84	ERYPED 400	7	EXTAVIA	80
ENBREL SURECLICK	84	ery-tab.....	7	EXTINA	56
ENDARI.....	60	ERY-TAB.....	7	ezetimibe.....	49
endocet	27	ERYTHROCIN	7	ezetimibe-simvastatin	49
ENGERIX-B (PF).....	82	erythrocin (as stearate)	7	F	
ENGERIX-B PEDIATRIC		erythromycin	7, 91	FABIOR	54
(PF).....	82	erythromycin ethylsuccinate...7		falmina (28).....	89
enoxaparin	48	erythromycin with ethanol...54		famciclovir.....	2
enpresse	89	erythromycin-benzoyl peroxide		famotidine.....	77
enskyce.....	89	.....	54	FANAPT.....	36
ENSTILAR	52	ESBRIET	96	FARESTON	15
entacapone.....	23	escitalopram oxalate	36	FARXIGA	64
entecavir	2	esomeprazole magnesium.....77		FARYDAK.....	15
ENTOCORT EC	74	ESOMEPRAZOLE		FASENRA.....	96
ENTRESTO	51	STRONTIUM.....	77	fayosim	89
enulose.....	74	estarylla	89	FAZACLO.....	36
ENVARUSUS XR	15	ESTRACE	87	felbamate	20
EPCLUSA	2	estradiol	87	FELBATOL.....	20
EPIDUO	54	estradiol valerate.....	87	FELDENE	32
EPIDUO FORTE.....	54	estradiol-norethindrone acet.87		felodipine.....	45
epinastine.....	92	ESTRING	87	FEMARA	15
EPINEPHRINE	94, 95	estropipate	87	FEMHRT LOW DOSE	87
EPIPEN	95	eszopiclone	36	FEMRING	87
EPIPEN 2-PAK.....	95	ethacrynic acid.....	45	femynor.....	89
EPIPEN JR	95	ethambutol	8	fenofibrate.....	49
EPIPEN JR 2-PAK.....	95	ethosuximide	20	FENOFIBRATE	49
epitol.....	20	ethynodiol diac-eth estradiol 89		fenofibrate micronized.....	49
EPIVIR.....	2	etidronate disodium	60	fenofibrate nanocrystallized .49	
EPIVIR HBV.....	2	etodolac	32	fenofibric acid.....	49
eplerenone	45	EUCRISA.....	52	fenofibric acid (choline)	49
EPOGEN	79	EURAX	59	FENOGLIDE.....	49
eprosartan	45	EVAMIST	87	fenopropfen.....	32
EPZICOM	2	EVEKEO	36	FENOPROFEN	32

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

fentanyl.....	28	flurbiprofen.....	32	GAMUNEX-C.....	82
fentanyl citrate.....	28	flurbiprofen sodium.....	93	GARDASIL 9 (PF).....	82
FENTORA.....	28	flutamide.....	15	GASTROCROM.....	74
FERRIPROX.....	60	fluticasone.....	58, 97	gatifloxacin.....	91
FETZIMA.....	36	FLUTICASONE-		GATTEX 30-VIAL.....	74
FEXMID.....	26	SALMETEROL.....	97	GAUZE PAD.....	64
FIASP FLEXTOUCH U-100		fluvastatin.....	49	gavilyte-c.....	74
INSULIN.....	64	fluvoxamine.....	37	gavilyte-g.....	74
FIASP U-100 INSULIN.....	64	FML FORTE.....	94	gavilyte-n.....	74
FIBRICOR.....	49	FML LIQUIFILM.....	94	GELNIQUE.....	100
FINACEA.....	54	FML S.O.P.....	94	gemfibrozil.....	50
finasteride.....	100	FOCALIN.....	37	GENERESS FE.....	89
FIRAZYR.....	96	FOCALIN XR.....	37	generlac.....	74
FIRMAGON KIT W		fondaparinux.....	48	engraf.....	15
DILUENT SYRINGE.....	15	FORFIVO XL.....	37	GENOTROPIN.....	80
FLAGYL.....	8	FORTAMET.....	64	GENOTROPIN MINIQUICK	
FLAREX.....	94	FORTEO.....	84	.....	80
flavoxate.....	100	FORTESTA.....	71	gentak.....	91
FLEBOGAMMA DIF.....	82	FOSAMAX.....	84	gentamicin.....	8, 55, 91
flecainide.....	42	FOSAMAX PLUS D.....	84	gentamicin in nacl (iso-osm) ..	8
FLECTOR.....	32	fosamprenavir.....	2	GENVOYA.....	2
FLOLIPID.....	49	fosinopril.....	45	GEODON.....	37
FLOMAX.....	100	fosinopril-hydrochlorothiazide		gianvi (28).....	89
FLOVENT DISKUS.....	97	.....	45	GIAZO.....	74
FLOVENT HFA.....	97	FOSRENOL.....	60	GILENYA.....	25
floxin.....	62	FRAGMIN.....	48	GILOTRIF.....	15
fluconazole.....	1	FREAMINE HBC 6.9 %....	103	GLASSIA.....	60
fluconazole in nacl (iso-osm) .	1	FROVA.....	24	glatiramer.....	25
flucytosine.....	1	frovatriptan.....	24	glatopa.....	25
fludrocortisone.....	62	FURADANTIN.....	13	GLEEVEC.....	15
FLUMADINE.....	2	furosemide.....	45	GLEOSTINE.....	15
flunisolide.....	97	FUZEON.....	2	glimepiride.....	64
fluocinolone.....	58	fyavolv.....	87	glipizide.....	64, 65
fluocinolone acetonide oil....	62	FYCOMPA.....	20	glipizide-metformin.....	65
fluocinolone and shower cap	58	G		GLUCAGEN HYPOKIT.....	65
fluocinonide.....	58	gabapentin.....	20	GLUCAGON EMERGENCY	
fluocinonide-e.....	58	GABITRIL.....	20	KIT (HUMAN).....	65
FLUORIDE (SODIUM).....	103	galantamine.....	25	GLUCOPHAGE.....	65
fluorometholone.....	94	GAMMAGARD LIQUID....	82	GLUCOPHAGE XR.....	65
fluorouracil.....	52	GAMMAGARD S-D (IGA < 1		GLUCOTROL.....	65
FLUOROURACIL.....	52	MCG/ML).....	82	GLUCOTROL XL.....	65
fluoxetine.....	36	GAMMAKED.....	82	GLUMETZA.....	65
fluphenazine decanoate.....	36	GAMMAPLEX.....	82	glycopyrrolate.....	72
fluphenazine hcl.....	36	GAMMAPLEX (WITH		GLYSET.....	65
flurandrenolide.....	58	SORBITOL).....	82	GLYXAMBI.....	65

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

GOCOVRI.....	23	HUMALOG MIX 75-25(U-100)INSULN	66	I	
GOLYTELY.....	74	HUMALOG U-100 INSULIN	66	ibandronate	84
GONITRO.....	51	HUMATROPE	80	IBRANCE.....	15
GRALISE	20	HUMIRA.....	85	ibu	32
GRALISE 30-DAY STARTER PACK	20	HUMIRA PEDIATRIC CROHN'S START	85	IBUDONE	28
granisetron hcl.....	74	HUMIRA PEN	85	ibuprofen.....	32
GRANIX	80	HUMIRA PEN CROHN'S-UC-HS START	85	ibuprofen-oxycodone.....	28
GRASTEK	82	HUMIRA PEN PSORIASIS- UVEITIS	85	ICLUSIG	15
griseofulvin microsize	1	HUMULIN 70/30 U-100 INSULIN	66	IDHIFA.....	15
griseofulvin ultramicrosize.....	1	HUMULIN 70/30 U-100 KWIKPEN.....	66	ILEVRO	93
GRIS-PEG (ULTRAMICROSIZE)	1	HUMULIN N NPH INSULIN KWIKPEN.....	66	imatinib.....	15
guanidine	37	HUMULIN N NPH U-100 INSULIN	66	IMBRUVICA	15, 16
GYNAZOLE-1	88	HUMULIN R REGULAR U-100 INSULN	66	imipenem-cilastatin	8
H		HUMULIN R U-500 (CONC) INSULIN	66	imipramine hcl.....	37
HAEGARDA	97	HUMULIN R U-500 (CONC) KWIKPEN.....	66	imipramine pamoate	37
HALDOL	37	HYCET.....	28	imiquimod.....	52
HALDOL DECANOATE...37		hydralazine	45	IMITREX	24
halobetasol propionate.....	58	HYDREA	15	IMITREX STATDOSE KIT REFILL.....	24
HALOG.....	58	hydrochlorothiazide.....	45	IMITREX STATDOSE PEN24	
haloperidol.....	37	hydrocodone-acetaminophen.....	28	IMOVAX RABIES VACCINE (PF).....	82
haloperidol decanoate.....	37	hydrocodone-ibuprofen	28	IMPOYZ.....	58
haloperidol lactate	37	hydrocortisone	58, 62, 74	IMURAN.....	16
HARVONI	2	hydrocortisone butyrate.....	58	INCRELEX	60
HAVRIX (PF)	82	hydrocortisone valerate	58	INCRUSE ELLIPTA.....	97
heparin (porcine).....	48	hydrocortisone-acetic acid....	62	indapamide	45
HEPATAMINE 8%	103	hydrocortisone-pramoxine....	74	INDERAL LA	45
HEPSERA	3	hydromorphone	28	INFANRIX (DTAP) (PF)....	82
HETLIOZ	37	hydromorphone (pf)	28	INGREZZA	25
HEXALEN	15	hydroxychloroquine.....	8	INLYTA	16
HIBERIX (PF)	82	hydroxyurea.....	15	INNOPRAN XL	45
HIPREX	13	hydroxyzine hcl	95	INSBRA	45
HORIZANT	25	HYSINGLA ER	28	INSULIN PEN NEEDLE	66
HUMALOG JUNIOR KWIKPEN U-100	65	HYZAAR	45	INSULIN SYRINGE (DISP) U-100.....	66
HUMALOG KWIKPEN INSULIN.....	66			INTELENCE	3
HUMALOG MIX 50-50 INSULN U-100.....	66			intralipid	103
HUMALOG MIX 50-50 KWIKPEN	66			INTRALIPID.....	103
HUMALOG MIX 75-25 KWIKPEN	66			INTRAROSA	88
				INTRON A	80
				introvale.....	89
				INVANZ.....	8
				INVEGA.....	37
				INVEGA SUSTENNA	37

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

INVEGA TRINZA.....	37	jolivette.....	87	klor-con m10	100
INVIRASE	3	JUBLIA	56	klor-con m15	100
INVOKAMET.....	66	juleber.....	89	klor-con m20	100
INVOKAMET XR.....	66	JULUCA.....	3	klor-con sprinkle.....	100
INVOKANA	66	junel 1.5/30 (21)	89	KOMBIGLYZE XR	67
IONOSOL-MB IN D5W....	103	junel 1/20 (21)	89	KORLYM.....	71
IOPIDINE.....	94	junel fe 1.5/30 (28)	89	KRISTALOSE.....	74
IPOL	82	junel fe 1/20 (28)	89	k-tab.....	101
ipratropium bromide.....	61, 97	junel fe 24.....	89	K-TAB.....	101
ipratropium-albuterol	97	JUXTAPID.....	50	kurvelo.....	89
irbesartan	45	JYNARQUE.....	71	KUVAN.....	71
irbesartan-hydrochlorothiazide	45	K		KYNAMRO	50
IRESSA	16	KADIAN	29	L	
ISENTRESS.....	3	kaitlib fe.....	89	l norgest/e.estradiol-e.estrad.....	89
ISENTRESS HD	3	KALBITOR.....	97	labetalol	45
isibloom.....	89	KALETRA	3	LACRISERT	92
ISOLYTE-P IN 5 %		KALYDECO	97	lactulose.....	74
DEXTROSE	103	KAPVAY	37	LAMICTAL	20
ISOLYTE-S.....	103	kariva (28)	89	LAMICTAL ODT	20
isoniazid	9	KAZANO	67	LAMICTAL STARTER	
ISOPTO CARPINE.....	92	kelnor 1/35 (28).....	89	(BLUE) KIT	21
ISORDIL	51	kelnor 1-50	89	LAMICTAL STARTER	
ISORDIL TITRADOSE.....	51	KENALOG.....	58	(GREEN) KIT	21
isosorbide dinitrate	51	KEPPRA.....	20	LAMICTAL STARTER	
isosorbide mononitrate	51	KEPPRA XR	20	(ORANGE) KIT	21
isotretinoin.....	54	KERYDIN.....	56	LAMICTAL XR.....	21
isradipine	45	ketoconazole.....	1, 56	LAMICTAL XR STARTER	
ISTALOL	92	ketoprofen.....	32	(BLUE).....	21
itraconazole	1	ketorolac	93	LAMICTAL XR STARTER	
ivermectin.....	9	KEVEYIS.....	25	(GREEN).....	21
IXIARO (PF).....	82	KEVZARA.....	85	LAMICTAL XR STARTER	
J		KHEDEZLA.....	37	(ORANGE).....	21
JADENU	60	kimidess (28)	89	lamivudine	3
JADENU SPRINKLE	60	KINERET.....	85	lamivudine-zidovudine	3
JAKAFI.....	16	KINRIX (PF).....	82	lamotrigine.....	21
JALYN	100	kionex (with sorbitol)	60	LANOXIN.....	51
jantoven	48	KISQALI	16	lansoprazole.....	77
JANUMET	66	KISQALI FEMARA CO-		lanthanum	60
JANUMET XR.....	66, 67	PACK	16	LANTUS SOLOSTAR U-100	
JANUVIA	67	KITABIS PAK	9	INSULIN	67
JARDIANCE.....	67	KLARON	55	LANTUS U-100 INSULIN ..	67
JENTADUETO	67	KLONOPIN.....	20	larin 1.5/30 (21).....	89
JENTADUETO XR.....	67	klor-con	100	larin 1/20 (21).....	89
jinteli	87	klor-con 10	100	larin fe 1.5/30 (28).....	89
		klor-con 8	100	larin fe 1/20 (28).....	89

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

larissia.....	89	lidocaine viscous	53	lorcet plus	29
LASIX.....	45	lidocaine-prilocaine	53	loryna (28)	90
LASTACAPT.....	92	LIDODERM.....	53	losartan	45
latanoprost.....	93	lindane	59	losartan-hydrochlorothiazide	45
LATUDA	38	linezolid.....	9	LOSEASONIQUE.....	90
layolis fe.....	89	linezolid in dextrose 5%.....	9	LOTEMAX.....	94
LAZANDA.....	29	LINZESS	74	LOTENSIN.....	46
leena 28	89	liothyronine	72	LOTREL.....	46
leflunomide.....	85	LIPITOR.....	50	LOTRISONE.....	56
LENVIMA	16	LIPOFEN.....	50	LOTRONEX.....	74
LESCOL XL	50	lisinopril.....	45	lovastatin.....	50
lessina.....	89	lisinopril-hydrochlorothiazide		LOVAZA.....	50
LETAIRIS	97	.....	45	LOVENOX.....	48
letrozole.....	16	lithium carbonate.....	38	low-ogestrel (28)	90
leucovorin calcium	13	lithium citrate	38	loxapine succinate	38
LEUKERAN	16	LITHOBID	38	LUCEMYRA.....	32
LEUKINE.....	80	LITHOSTAT	60	LUMIGAN	93
leuprolide.....	16	LIVALO	50	LUNESTA.....	38
levabuterol hcl.....	97	LO LOESTRIN FE.....	89	LUPANETA PACK (1	
LEVALBUTEROL		LOCOID.....	58	MONTH).....	88
TARTRATE	97	LOCOID LIPOCREAM.....	58	LUPANETA PACK (3	
LEVAQUIN	12	LODINE	32	MONTH).....	88
LEVEMIR FLEXTOUCH U-		LODOSYN.....	23	LUPRON DEPOT	16
100 INSULN	67	LOESTRIN 1.5/30 (21).....	89	LUPRON DEPOT (3	
LEVEMIR U-100 INSULIN	67	LOESTRIN 1/20 (21).....	89	MONTH).....	16
levetiracetam	21	LOESTRIN FE 1.5/30 (28-		LUPRON DEPOT (4	
levobunolol.....	92	DAY).....	89	MONTH).....	16
levocarnitine	60	LOESTRIN FE 1/20 (28-DAY)		LUPRON DEPOT (6	
levocarnitine (with sugar).....	60	.....	90	MONTH).....	16
levocetirizine	95	LOMOTIL	72	lutera (28)	90
levofloxacin.....	12, 91	LONHALA MAGNAIR		LUZU	56
levofloxacin in d5w.....	12	REFILL	97	LYNPARZA.....	16
levonest (28).....	89	LONHALA MAGNAIR		LYRICA	21
levonorgestrel-ethinyl estrad	89	STARTER	97	LYRICA CR.....	21
levonorg-eth estrad triphasic	89	LONSURF.....	16	LYSODREN.....	16
levora-28.....	89	loperamide.....	72	LYSTEDA.....	88
levorphanol tartrate	29	LOPID	50	lyza	87
LEVO-T	72	lopinavir-ritonavir	3	M	
levothyroxine.....	72	LOPRESSOR	45	MACROBID.....	13
levoxyl.....	72	LOPRESSOR HCT	45	MACRODANTIN	13
LEXAPRO	38	LOPROX.....	56	magnesium sulfate	101
LEXIVA	3	LOPROX (AS OLAMINE)..	56	MALARONE	9
LIALDA	74	lorazepam	38	MALARONE PEDIATRIC...9	
lidocaine	52, 53	lorcet (hydrocodone)	29	malathion	59
lidocaine hcl	52	lorcet hd.....	29	maprotiline.....	38

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

MARINOL	74	methadone	29	miglustat	71
marlissa.....	90	methamphetamine	38	MIGRANAL.....	24
MARPLAN	38	methazolamide.....	93	mili.....	90
MATULANE	16	methenamine hippurate	13	millipred	62
matzim la	46	methimazole	63	MILLIPRED.....	62
MAVYRET	3	METHITEST.....	71	mimvey	87
MAXALT	24	methotrexate sodium	16	mimvey lo.....	87
MAXALT-MLT	24	methotrexate sodium (pf)	16	MINASTRIN 24 FE	90
MAXIDEX.....	94	methoxsalen.....	53	MINIPRESS	46
MAXIPIME.....	6	methscopolamine.....	72	MINITRAN	51
MAXITROL.....	93	methyclothiazide	46	MINIVELLE	87
MAXZIDE	46	methyl dopa	46	MINOCIN.....	13
MAXZIDE-25MG.....	46	METHYLIN	38	minocycline	13
meclizine	74	methylphenidate hcl	38	minoxidil.....	46
meclofenamate	32	METHYLPHENIDATE HCL		MIRAPEX	23
MEDROL	62	.....	38	MIRAPEX ER.....	23
MEDROL (PAK)	62	methylprednisolone	62	mirtazapine	38
medroxyprogesterone	87	methyltestosterone.....	71	MIRVASO.....	55
mefenamic acid	32	metipranolol.....	92	misoprostol	77
mefloquine.....	9	metoclopramide hcl	74	MITIGARE.....	83
MEGACE ES	16	metolazone.....	46	M-M-R II (PF).....	82
megestrol	16	metoprolol succinate.....	46	MOBIC	32
MEKINIST.....	16	metoprolol ta-hydrochlorothiaz		modafinil.....	38
melodetta 24 fe	90	.....	46	moderiba	3
meloxicam	32	metoprolol tartrate	46	moderiba dose pack	3
memantine	25	METROCREAM.....	54	moexipril.....	46
MEMANTINE	26	METROGEL	54	moexipril-hydrochlorothiazide	
MENACTRA (PF)	82	METROGEL VAGINAL	88	.....	46
MENEST.....	87	METROLOTION	54	mometasone.....	58, 97
MENOSTAR.....	87	metronidazole	9, 54, 55, 88	mononessa (28).....	90
MENTAX.....	56	metronidazole in nacl (iso-os) 9		montelukast.....	97
MENVEO A-C-Y-W-135-DIP		mexiletine	42	MONUROL.....	13
(PF).....	82	mibelas 24 fe	90	morgidox.....	13
MEPRON	9	MICARDIS	46	morphine.....	29
mercaptapurine.....	16	MICARDIS HCT	46	morphine concentrate	29
meropenem	9	miconazole-3	88	MOVANTIK	74
MERREM	9	MICORT-HC.....	74	MOVIPREP	74
mesalamine.....	74	microgestin 1.5/30 (21)	90	MOXEZA	91
MESALAMINE	74	microgestin 1/20 (21)	90	moxifloxacin.....	12, 91
MESNEX	13	microgestin fe 1.5/30 (28)	90	MOXIFLOXACIN IN NACL	
MESTINON	26	microgestin fe 1/20 (28)	90	(ISO-OSM).....	12
MESTINON TIMESPAN	26	MICROZIDE.....	46	MS CONTIN	30
metadate er	38	midodrine.....	60	MULTAQ	42
metaproterenol.....	97	migergot.....	24	mupirocin.....	55
metformin	67	miglitol	67, 68	mupirocin calcium	55

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

MYALEPT	71	neomycin-bacitracin-poly-hc	93	nizatidine	77
MYAMBUTOL.....	9	neomycin-bacitracin-		NIZORAL.....	56
MYCAMINE.....	1	polymyxin.....	91	NOCTIVA	71
MYCOBUTIN.....	9	neomycin-polymyxin b-		nolix.....	58
mycophenolate mofetil.....	16	dexameth	93	nora-be.....	87
mycophenolate sodium.....	17	neomycin-polymyxin-		NORCO	30
MYDAYIS	38	gramicidin.....	92	NORDITROPIN FLEXPRO	80
MYFORTIC	17	neomycin-polymyxin-hc	62, 94	noreth-ethinyl estradiol-iron	90
myorisan.....	55	NEORAL.....	17	norethindrone (contraceptive)	
MYRBETRIQ	100	NEO-SYNALAR.....	55	.....	87
MYSOLINE	21	NEPHRAMINE 5.4 %	103	norethindrone acetate.....	87
MYTESI.....	72	NERLYNX.....	17	norethindrone ac-eth estradiol	
N		NESINA	68	.....	87, 90
nabumetone	32	neuac.....	55	norethindrone-e.estradiol-iron	
nadolol.....	46	NEULASTA.....	80	.....	90
nadolol-bendroflumethiazide	46	NEUPOGEN	80	norgestimate-ethinyl estradiol	
nafcillin.....	10	NEUPRO	23	.....	90
naftifine	56	NEURONTIN.....	21, 22	NORITATE	55
NAFTIN	56	NEVANAC	93	norlyroc.....	87
naloxone	32	nevirapine	3	NORMOSOL-M IN 5 %	
naltrexone.....	32	NEXAVAR	17	DEXTROSE	103
NAMENDA	26	NEXIUM.....	77	NORMOSOL-R IN 5 %	
NAMENDA TITRATION		NEXIUM PACKET	77	DEXTROSE	101
PAK.....	26	niacin	50	NORMOSOL-R PH 7.4.....	103
NAMENDA XR.....	26	NIACOR.....	50	NORPRAMIN	38
NAMZARIC.....	26	NIASPAN EXTENDED-		NORTHERA	60
NAPRELAN CR	32	RELEASE	50	nortrel 0.5/35 (28).....	90
naproxen.....	32	nicardipine	46	nortrel 1/35 (21).....	90
naproxen sodium	32	NICOTROL.....	61	nortrel 1/35 (28).....	90
naratriptan.....	24	NICOTROL NS.....	61	nortrel 7/7/7 (28).....	90
NARCAN	32	nifedipine.....	46	nortriptyline	38
NARDIL.....	38	nikki (28).....	90	NORVASC	46
NASONEX.....	97	NILANDRON	17	NORVIR.....	3
NATACYN	91	nilutamide.....	17	NOVOFINE 32.....	68
NATAZIA	90	nimodipine.....	46	NOVOFINE AUTOCOVER	68
nateglinide	68	NINLARO	17	NOVOLIN 70/30 U-100	
NATPARA	71	nisoldipine	46	INSULIN	68
NATROBA	59	nitro-bid.....	51	NOVOLIN N NPH U-100	
NEBUPENT.....	9	NITRO-DUR.....	51	INSULIN.....	68
necon 0.5/35 (28).....	90	nitrofurantoin.....	13	NOVOLIN R REGULAR U-	
necon 7/7/7 (28)	90	nitrofurantoin macrocrystal ..	13	100 INSULN	68
NEEDLES, INSULIN		nitrofurantoin monohyd/m-		NOVOLOG FLEXPEN U-100	
DISP.,SAFETY	68	cryst	13	INSULIN	68
nefazodone	38	nitroglycerin	51	NOVOLOG MIX 70-30 U-100	
neomycin	9	NITROSTAT.....	51	INSULN	68

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

NOVOLOG MIX 70- 30FLEXPEN U-100	68	OMECLAMOX-PAK	77	OSPHENA.....	88
NOVOLOG PENFILL U-100 INSULIN.....	68	omega-3 acid ethyl esters	50	OTEZLA.....	85
NOVOLOG U-100 INSULIN ASPART	68	omeprazole	77	OTEZLA STARTER.....	85
NOXAFIL	1	omeprazole-sodium bicarbonate	78	OTOVEL	62
NUCALA	97	OMNARIS.....	97	OTREXUP (PF).....	86
NUCYNTA	32, 33	OMNIPOD INSULIN MANAGEMENT	68	OVIDE.....	59
NUCYNTA ER	32	OMNIPOD INSULIN REFILL	68	oxacillin	11
NUDEXTA	26	OMNIPRED	94	oxacillin in dextrose(iso-osm)	11
NULYTELY WITH FLAVOR PACKS	74	OMNITROPE.....	80	oxandrolone	71
NUPLAZID.....	38	ondansetron	75	oxaprozin	33
NUTRESTORE.....	60	ondansetron hcl.....	75	OXAYDO.....	30
NUTRILIPID	103	ONEXTON.....	55	oxcarbazepine	22
NUTROPIN AQ NUSPIN ...	80	ONFI.....	22	oxiconazole.....	56
NUVARING.....	88	ONGLYZA.....	68	OXISTAT	56
NUVIGIL	38	ONZETRA XSAIL.....	24	OXSORALEN ULTRA.....	53
nyamyc	56	OPANA	30	OXTELLAR XR	22
NYMALIZE	46	OPSUMIT	97	oxybutynin chloride.....	100
nystatin	1, 56	ORACEA.....	13	oxycodone.....	30
nystatin-triamcinolone.....	56	ORALAIR	82	OXYCODONE.....	30
nystop	56	ORAP	39	oxycodone-acetaminophen ...	30
O		ORAPRED ODT	62	oxycodone-aspirin	30
OICALIVA.....	75	ORAVIG	1	OXYCONTIN	30
ocella	90	ORENCIA	85	oxymorphone	30
OCTAGAM.....	82	ORENCIA (WITH MALTOSE).....	85	OXYTROL	100
octreotide acetate.....	17	ORENCIA CLICKJECT	85	OZEMPIC.....	68
OCUFLOX	92	ORENITRAM	46	P	
ODEFSEY	3	ORFADIN	60	pacerone.....	43
ODOMZO	17	ORKAMBI	98	paliperidone	39
OFEV	97	orsythia	90	PALYNZIQ	71
ofloxacin.....	12, 62, 92	ORTHO MICRONOR.....	87	PAMELOR	39
ogestrel (28).....	90	ORTHO TRI-CYCLEN (28) 90		PANCREAZE.....	75
olanzapine.....	39	ORTHO TRI-CYCLEN LO (28)	90	PANDEL	58
olanzapine-fluoxetine	39	ORTHO-CYCLEN (28)	90	panlor(acetam-caff- dihydrocod).....	31
olmesartan	46	ORTHO-NOVUM 1/35 (28) 90		PANRETIN	53
olmesartan-amlodipin- hcthiaid	46	ORTHO-NOVUM 7/7/7 (28)	90	pantoprazole	78
olmesartan- hydrochlorothiazide.....	46	oseltamivir	3	paricalcitol	71
olopatadine	61, 92	OSENI	68	PARLODEL	23
OLUMIANT.....	85	OSMOLEX ER	23	PARNATE.....	39
OLUX.....	58	OSMOPREP.....	75	paromomycin.....	9
				paroxetine hcl	39
				paroxetine mesylate(menop.sym).....	39
				PASER.....	9

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

PATADAY.....	93	pioglitazone.....	68	pravastatin.....	50
PATANASE.....	62	pioglitazone-glimepiride.....	68	prazosin.....	46
PATANOL.....	93	pioglitazone-metformin.....	68	PRECOSE.....	68
PAXIL.....	39	piperacillin-tazobactam.....	11	PRED FORTE.....	94
PAXIL CR.....	39	pirmella.....	90	PRED MILD.....	94
PAZEO.....	93	piroxicam.....	33	PRED-G.....	94
PEDIARIX (PF).....	82	PLAQUENIL.....	9	PRED-G S.O.P.....	94
PEDVAX HIB (PF).....	83	PLASMA-LYTE 148.....	103	prednicarbate.....	58
peg 3350-electrolytes.....	75	PLASMA-LYTE A.....	103	prednisolone.....	62
PEGANONE.....	22	PLAVIX.....	48	prednisolone acetate.....	94
PEGASYS.....	80	PLEGRIDY.....	80, 81	prednisolone sodium phosphate.....	62, 94
PEGASYS PROCLICK.....	80	plenamine.....	103	prednisone.....	63
peg-electrolyte.....	75	PLIAGLIS.....	53	prednisone intensol.....	63
PENICILLIN G POT IN		podofilox.....	53	PREFEST.....	87
DEXTROSE.....	11	polyethylene glycol 3350.....	75	PREMARIN.....	87
penicillin g potassium.....	11	polymyxin b sulfate.....	9	premasol 10 %.....	103
penicillin g procaine.....	11	polymyxin b sulf-trimethoprim.....	92	PREMASOL 6 %.....	103
penicillin g sodium.....	11	POLYTRIM.....	92	PREMPHASE.....	87
penicillin v potassium.....	11	POMALYST.....	17	PREMPRO.....	87
PENNSAID.....	33	portia.....	90	PRENATAL VITAMIN	
PENTAM.....	9	potassium chlorid-d5-		ORAL TABLET.....	103
PENTASA.....	75	0.45%nacl.....	101	PREPOPIK.....	75
pentoxifylline.....	48	potassium chloride.....	101	PREVACID.....	78
PEPCID.....	78	potassium chloride in 0.9%nacl.....	101	PREVACID SOLUTAB.....	78
PERCOCET.....	31	.....	101	prevalite.....	50
PERFOROMIST.....	98	potassium chloride in 5 % dex.....	101	previfem.....	90
perindopril erbumine.....	46	.....	101	PREVPAC.....	78
perlogard.....	62	potassium chloride in lr-d5.....	101	PREVYMIS.....	3
permethrin.....	59	potassium chloride in water.....	101	PREZCOBIX.....	3
perphenazine.....	39	potassium chloride-0.45 % nacl.....	101	PREZISTA.....	4
PERTZYE.....	75	.....	101	PRIFTIN.....	9
PEXEVA.....	39	potassium chloride-d5-		PRILOSEC.....	78
phenelzine.....	39	0.2%nacl.....	101	PRIMAQUINE.....	9
phenobarbital.....	22	potassium chloride-d5-		PRIMAXIN IV.....	9
phenoxybenzamine.....	46	0.3%nacl.....	101	primidone.....	22
PHENYTEK.....	22	potassium chloride-d5-		PRIMLEV.....	31
phenytoin.....	22	0.9%nacl.....	102	PRINIVIL.....	46
phenytoin sodium extended.....	22	potassium citrate.....	100	PRISTIQ.....	39
PHOSLYRA.....	101	PRADAXA.....	48	PRIVIGEN.....	83
PHOSPHOLINE IODIDE.....	93	PRALUENT PEN.....	50	PROAIR HFA.....	98
PICATO.....	53	pramipexole.....	23	PROAIR RESPICLICK.....	98
pilocarpine hcl.....	60, 93	PRANDIN.....	68	probenecid.....	83
pimozide.....	39	prasugrel.....	48	probenecid-colchicine.....	83
pimtrea (28).....	90	PRAVACHOL.....	50	PROCALAMINE 3%.....	103
pindolol.....	46				

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

PROCARDIA XL	47	Q		RECTIV.....	75
procentra.....	39	QBRELIS	47	REGLAN.....	75
prochlorperazine.....	75	QNASL.....	98	REGRANEX	53
prochlorperazine maleate oral		QTERN.....	69	RELENZA DISKHALER	4
.....	75	QUADRACEL (PF)	83	RELISTOR	75, 76
PROCRIT	81	QUALAQUIN	9	RELPAK.....	24
procto-med hc.....	75	QUARTETTE	90	REMERON.....	40
procto-pak.....	75	quasense.....	90	REMERON SOLTAB	40
proctosol hc	75	QUDEXY XR.....	22	REMICADE	76
proctozone-hc	75	QUESTRAN.....	50	RENAGEL	61
profeno	33	QUESTRAN LIGHT.....	50	REVELA	61
progesterone micronized	87	quetiapine	39, 40	repaglinide	69
PROGLYCEM	68	QUILLICHEW ER.....	40	repaglinide-metformin.....	69
PROGRAF	17	QUILLIVANT XR.....	40	REPATHA.....	50
PROLASTIN-C.....	60, 61	quinapril.....	47	REPATHA PUSHTRONEX	50
PROLENSA	93	quinapril-hydrochlorothiazide		REQUIP XL	23
PROLIA	84	.....	47	RESCRIPTOR.....	4
PROMACTA.....	48	quinidine gluconate	43	RESTASIS.....	93
promethazine	95	quinidine sulfate	43	RESTASIS MULTIDOSE.....	93
PROMETRIUM	87	quinine sulfate	9	RETIN-A	55
propafenone.....	43	QVAR.....	98	RETIN-A MICRO	55
propranolol	47	QVAR REDIHALER.....	98	RETROVIR	4
propranolol-hydrochlorothiazid		R		REVATIO.....	98
.....	47	RABAVERT (PF)	83	REVLIMID.....	17
propylthiouracil	63	rabeprazole	78	REXULTI.....	40
PROQUAD (PF)	83	RAGWITEK.....	83	REYATAZ	4
PROSCAR.....	100	raloxifene.....	84	RHOFADE	55
PROSOL 20 %	103	ramipril	47	RHOPRESSA	93
PROTONIX.....	78	RANEXA	51	ribasphere	4
PROTOPIC	53	ranitidine hcl.....	78	ribasphere ribapak	4
protriptyline.....	39	RAPAFLO.....	100	ribavirin	4
PROVENTIL HFA.....	98	RAPAMUNE.....	17	RIDAURA	86
PROVERA	87	rasagiline	23	rifabutin	9
PROVIGIL	39	RASUVO (PF)	86	RIFADIN.....	9
PROZAC	39	RAVICTI.....	61	RIFAMATE.....	9
prudoxin	53	RAYALDEE	71	rifampin	9
PSORCON	58	RAYOS	63	RIFATER	9
PULMICORT.....	98	RAZADYNE	26	RILUTEK	61
PULMICORT FLEXHALER		RAZADYNE ER.....	26	riluzole.....	61
.....	98	REBETOL	4	rimantadine	4
PULMOZYME	98	REBIF (WITH ALBUMIN).....	81	RIOMET	69
PURIXAN.....	17	REBIF REBIDOSE	81	risedronate	61, 84
PYLERA	78	REBIF TITRATION PACK.....	81	RISPERDAL	40
pyrazinamide	9	reclipsen (28).....	91	RISPERDAL CONSTA	40
pyridostigmine bromide	26	RECOMBIVAX HB (PF)	83		

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

risperidone.....	40	SEGLUROMET	69	soloxide.....	13
RITALIN.....	40	selegiline hcl.....	23	SOLTAMOX.....	17
RITALIN LA.....	40	selenium sulfide.....	52	SOMATULINE DEPOT	17
ritonavir	4	SELZENTRY	4	SOMAVERT	71
rivastigmine.....	26	SEMPREX-D	95	SONATA.....	41
rivastigmine tartrate.....	26	SENSIPAR	71	SOOLANTRA.....	55
rivelsa	91	SEREVENT DISKUS	98	SORIATANE	52
rizatriptan	24	SERNIVO.....	58	SORILUX.....	52
ROBINUL	73	SEROQUEL	40	sorine	43
ROBINUL FORTE	72	SEROQUEL XR.....	41	sotalol	43
ROCALTROL.....	71	SEROSTIM	81	sotalol af	43
ropinirole	23	sertraline	41	SOTYLIZE	43
rosuvastatin.....	50	setlakin.....	91	SOVALDI.....	4
ROTARIX	83	sevelamer carbonate	61	SPIRIVA RESPIMAT.....	98
ROTATEQ VACCINE	83	sharobel	87	SPIRIVA WITH	
ROWASA	76	SHINGRIX (PF).....	83	HANDIHALER.....	99
roweepra	22	SIGNIFOR.....	17	spironolactone.....	47
roweepra xr.....	22	sildenafil (pulmonary arterial		spironolacton-hydrochlorothiaz	
ROXICODONE	31	hypertension).....	98	.....	47
ROZEREM.....	40	SILENOR	41	SPORANOX.....	1
RUBRACA	17	SILIQ.....	52	sprintec (28).....	91
RUCONEST.....	98	SILVADENE.....	53	SPRITAM.....	22
RYDAPT	17	silver sulfadiazine.....	53	SPRIX.....	33
RYTARY	23	SIMBRINZA	93	SPRYCEL.....	18
RYTHMOL SR	43	SIMPONI.....	86	sps (with sorbitol).....	61
S		simvastatin.....	50	sronyx	91
SABRIL.....	22	SINEMET	23	ssd.....	53
SAFYRAL.....	91	SINEMET CR	23	STALEVO 100.....	23
SAIZEN.....	81	SINGULAIR	98	STALEVO 125.....	23
SAIZEN SAIZENPREP.....	81	sirolimus	17	STALEVO 150.....	23
SALAGEN (PILOCARPINE)		SIRTURO.....	9	STALEVO 200.....	23
.....	61	SIVEXTRO	9	STALEVO 50.....	23
SAMSCA	71	SKLICE	59	STALEVO 75.....	23
SANCUSO	76	sodium chloride	61, 102	STARLIX	69
SANDIMMUNE	17	sodium chloride 0.45 %.....	102	stavudine.....	4
SANDOSTATIN.....	17	sodium chloride 0.9 %.....	61	STEGLATRO.....	69
SANTYL	53	sodium chloride 3 %.....	102	STEGLUJAN	69
SAPHRIS (BLACK		sodium chloride 5 %.....	102	STELARA	52
CHERRY)	40	sodium lactate intravenous .	102	STIMATE.....	71
SARAFEM.....	40	sodium phenylbutyrate	61	STIOLTO RESPIMAT.....	99
SAVAYSA	49	sodium polystyrene sulfonate		STIVARGA.....	18
SAVELLA.....	86	.....	61	STRATTERA	41
scopolamine base.....	76	SOLIQUA 100/33	69	STREPTOMYCIN	9
SEASONIQUE.....	91	SOLODYN.....	13	STRIANT	71
SEEBRI NEOHALER	98	SOLOSEC	9	STRIBILD	4

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

STRIVERDI RESPIMAT	99	TACLONEX	52	testosterone	72
STROMEKTOL	9	tacrolimus	18, 53	TESTOSTERONE.....	71
SUBOXONE	33	TAFINLAR	18	testosterone cypionate	71
SUBSYS.....	31	TAGRISSE	18	testosterone enanthate.....	71
SUCRAID	76	TALTZ AUTOINJECTOR ..	52	TETANUS,DIPHThERIA	
sucalfate	78	TALTZ SYRINGE.....	52	TOX PED(PF)	83
SULAR.....	47	TAMIFLU	4	TETANUS-DIPHThERIA	
sulfacetamide sodium.....	93	tamoxifen.....	18	TOXOIDS-TD.....	83
sulfacetamide sodium (acne)	55	tamsulosin.....	100	tetrabenazine.....	26
sulfacetamide-prednisolone..	93	TANZEUM	69	tetracycline	13
sulfadiazine.....	12	TAPAZOLE	63	TEXACORT	59
sulfamethoxazole-trimethoprim		TAPERDEX.....	63	THALOMID.....	18
.....	12	TARCEVA	18	THEO-24	99
SULFAMYLON	55	TARGADOX.....	13	theophylline	99
sulfasalazine	76	TARGRETIN	18	THIOLA	61
sulindac.....	33	tarina fe 1/20 (28).....	91	thioridazine	41
sumatriptan	24	TARKA	47	thiothixene	41
sumatriptan succinate	24	TASIGNA	18	THYROLAR-1	72
sumatriptan-naproxen.....	24	TASMAR	23	THYROLAR-1/2.....	72
SUPRAX.....	6	TAVALISSE	49	THYROLAR-1/4.....	72
SUPREP BOWEL PREP KIT		tazarotene.....	55	THYROLAR-2	72
.....	76	TAZICEF.....	7	THYROLAR-3	72
SURMONTIL	41	TAZORAC	55	tiagabine	22
SUSTIVA	4	taztia xt	47	TIAZAC	47
SUTENT	18	TECFIDERA	26	tigecycline.....	9
syeda.....	91	TECHNIVIE.....	4	TIKOSYN.....	43
SYLATRON.....	81	TEFLARO	7	timolol maleate	47, 92
SYMBICORT	99	TEGRETOL	22	TIMOPTIC OCUDOSE (PF)	
SYMBYAX.....	41	TEGRETOL XR.....	22	.....	92
SYMDEKO	99	TEKTRUNA	47	TIMOPTIC-XE.....	92
SYMFI.....	4	TEKTRUNA HCT	47	TINDAMAX	9
SYMFI LO	4	telmisartan	47	tinidazole	9
SYMLINPEN 120.....	69	telmisartan-amlodipine.....	47	TIROSINT	72
SYMLINPEN 60.....	69	telmisartan-hydrochlorothiazid		TIVICAY.....	5
SYMPROIC	76	.....	47	TIVORBEX.....	33
SYNALAR.....	58	TENIVAC (PF)	83	tizanidine	26
SYNAREL	71	tenofovir disoproxil fumarate.	4	TOBI.....	9
SYNDROS	76	TENORETIC 100.....	47	TOBI PODHALER	9, 10
SYNJARDY	69	TENORETIC 50.....	47	TOBRADEX	94
SYNJARDY XR	69	TENORMIN.....	47	TOBRADEX ST.....	94
SYNRIBO	18	terazosin.....	47	tobramycin.....	92
SYNTHROID.....	72	terbinafine hcl.....	1	tobramycin in 0.225 % nacl..	10
SYPRINE	61	terbutaline.....	99	tobramycin sulfate	10
T		terconazole.....	88	tobramycin-dexamethasone..	94
TABLOID	18	TESTIM.....	71	TOBEX	92

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

TOFRANIL.....	41	TREXIMET.....	25	TYBOST.....	5
TOLAK.....	53	TREZIX.....	31	tydemy.....	91
tolazamide.....	69	triamcinolone acetonide 59, 62, 99		TYGACIL.....	10
tolbutamide.....	69	triamterene-hydrochlorothiazid.....	47	TYKERB.....	18
tolcapone.....	23	trianex.....	59	TYLENOL-CODEINE #3.....	31
tolmetin.....	33	TRIBENZOR.....	47	TYLENOL-CODEINE #4.....	31
tolterodine.....	100	TRICOR.....	50	TYMLOS.....	84
TOPAMAX.....	22	triderm.....	59	TYPHIM VI.....	83
TOPICORT.....	59	TRIDESILON.....	59	U	
topiramate.....	22	trientine.....	61	UCERIS.....	76
TOPIRAMATE.....	22	trifluoperazine.....	41	ULORIC.....	83
TOPROL XL.....	47	trifluridine.....	92	ULTRACET.....	33
torsemide.....	47	TRIGLIDE.....	50	ULTRAM.....	33
TOUJEO MAX U-300 SOLOSTAR.....	69	tri-legest fe.....	91	ULTRAVATE.....	59
TOUJEO SOLOSTAR U-300 INSULIN.....	69	TRILEPTAL.....	22	UNASYN.....	11
TOVIAZ.....	100	TRILIPIX.....	50	unithroid.....	72
TPN ELECTROLYTES.....	102	tri-lo-estarylla.....	91	UPTRAVI.....	47
TRACLEER.....	99	tri-lo-sprintec.....	91	URECHOLINE.....	100
TRADJENTA.....	69	trilyte with flavor packets.....	76	UROCIT-K 10.....	100
tramadol.....	33	trimethoprim.....	13	UROCIT-K 15.....	100
TRAMADOL.....	33	tri-mili.....	91	UROCIT-K 5.....	100
tramadol-acetaminophen.....	33	trimipramine.....	41	UROXATRAL.....	100
trandolapril.....	47	trinessa (28).....	91	URSO 250.....	76
trandolapril-verapamil.....	47	TRI-NORINYL (28).....	91	URSO FORTE.....	76
tranexamic acid.....	88	TRINTELLIX.....	41	ursodiol.....	76
TRANSDERM-SCOP.....	76	tri-previfem (28).....	91	UTIBRON NEOHALER.....	99
TRANXENE T-TAB.....	41	tri-sprintec (28).....	91	V	
tranlycypromine.....	41	TRIUMEQ.....	5	VABOMERE.....	10
travasol 10 %.....	103	trivora (28).....	91	VAGIFEM.....	87
TRAVATAN Z.....	93	tri-vylibra.....	91	valacyclovir.....	5
trazodone.....	41	TRIZIVIR.....	5	VALCHLOR.....	53
TRECTOR.....	10	TROKENDI XR.....	22	VALCYTE.....	5
TRELEGY ELLIPTA.....	99	TROPHAMINE 10 %.....	103	valganciclovir.....	5
TRELSTAR.....	18	TROPHAMINE 6%.....	103	VALIUM.....	41
TREMFYA.....	52	tropium.....	100	valproic acid.....	22
TRESIBA FLEXTOUCH U-100.....	69	TRULANCE.....	76	valproic acid (as sodium salt).....	22
TRESIBA FLEXTOUCH U-200.....	70	TRULICITY.....	70	valsartan.....	47
tretinoin (chemotherapy).....	18	TRUMENBA.....	83	valsartan-hydrochlorothiazide.....	47
tretinoin microspheres.....	55	TRUSOPT.....	93	VALTRESX.....	5
tretinoin topical.....	55	TRUVADA.....	5	VANOCOCIN.....	10
TREXALL.....	18	TUDORZA PRESSAIR.....	99	vancomycin.....	10
		TWINRIX (PF).....	83	vandazole.....	88
		TWYNSTA.....	47	VANOS.....	59

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

VAQTA (PF).....	83	VIEKIRA PAK.....	5	XERESE.....	56
VARIVAX (PF).....	83	VIEKIRA XR.....	5	XERMELO.....	18
VARIZIG.....	83	vienva.....	91	XGEVA.....	13
VARUBI.....	76	vigabatrin.....	22	XHANCE.....	99
VASCEPA.....	50	VIGAMOX.....	92	XIFAXAN.....	10
VASERETIC.....	47	VIIBRYD.....	41	XIGDUO XR.....	70
VASOTEC.....	47	VIMOVO.....	33	XIIDRA.....	93
VECAMYL.....	51	VIMPAT.....	22	XIMINO.....	13
VECTICAL.....	52	VIOKACE.....	76	XOLAIR.....	99
velivet triphasic regimen (28)		VIRACEPT.....	5	XOPENEX.....	99
.....	91	VIRAMUNE.....	5	XOPENEX CONCENTRATE	
VELPHORO.....	61	VIRAMUNE XR.....	5	.....	99
VELTASSA.....	61	VIREAD.....	5	XOPENEX HFA.....	99
VEMLIDY.....	5	VIROPTIC.....	92	XTAMPZA ER.....	31
VENCLEXTA.....	18	VIVELLE-DOT.....	88	XTANDI.....	18
VENCLEXTA STARTING		VIVITROL.....	33	xulane.....	88
PACK.....	18	VIVLODEX.....	33	XULTOPHY 100/3.6.....	70
venlafaxine.....	41	VOGELXO.....	72	XURIDEN.....	61
VENLAFAXINE.....	41	VOLTAREN.....	33	XYREM.....	42
VENTAVIS.....	99	voriconazole.....	1	Y	
VENTOLIN HFA.....	99	VOSEVI.....	5	YASMIN (28).....	91
verapamil.....	47	VOTRIENT.....	18	YAZ (28).....	91
VEREGEN.....	53	VRAYLAR.....	41	YF-VAX (PF).....	83
VERELAN.....	47	vyfemla (28).....	91	YONSA.....	19
VERELAN PM.....	47	vylibra.....	91	YOSPRALA.....	49
veripred 20.....	63	VYTORIN 10-10.....	50	yuvaferm.....	88
VERSACLOZ.....	41	VYTORIN 10-20.....	50	Z	
VERZENIO.....	18	VYTORIN 10-40.....	51	zafirlukast.....	99
VESICARE.....	100	VYTORIN 10-80.....	51	zaleplon.....	42
vestura (28).....	91	VYVANSE.....	41	ZANAFLEX.....	26
VFEND.....	1	VYZULTA.....	93	ZANTAC.....	78
VFEND IV.....	1	W		zarah.....	91
VGO 20.....	70	warfarin.....	49	ZARONTIN.....	22
VGO 30.....	70	WELCHOL.....	51	ZARXIO.....	81
VGO 40.....	70	WELLBUTRIN SR.....	42	ZAVESCA.....	72
VIBERZI.....	76	WELLBUTRIN XL.....	42	ZEGERID.....	79
VIBRAMYCIN.....	13	wymzya fe.....	91	ZEJULA.....	19
vicodin.....	31	X		ZELAPAR.....	23
vicodin es.....	31	XALATAN.....	93	ZELBORAF.....	19
vicodin hp.....	31	XALKORI.....	18	ZEMAIRA.....	61
VICTOZA 2-PAK.....	70	XARELTO.....	49	ZEMBRACE SYMTOUCH.....	25
VICTOZA 3-PAK.....	70	XATMEP.....	18	ZEMPLAR.....	72
VIDEX 4 GRAM PEDIATRIC		XELJANZ.....	86	zenatane.....	55
.....	5	XELJANZ XR.....	86	zenchent (28).....	91
VIDEX EC.....	5	XENAZINE.....	26	ZENPEP.....	76

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

zenzedi.....	42	ZOFRAN.....	76	ZOVIRAX.....	5, 56, 57
ZENZEDI.....	42	ZOFRAN ODT.....	76	ZUBSOLV.....	34
ZEPATIER.....	5	ZOHYDRO ER.....	31	ZUPLENZ.....	76
ZERBAXA.....	7	ZOLINZA.....	19	ZURAMPIC.....	83
ZERIT.....	5	zolmitriptan.....	25	ZYBAN.....	61
ZESTORETIC.....	47	ZOLOFT.....	42	ZYCLARA.....	53
ZESTRIL.....	48	zolpidem.....	42	ZYDELIG.....	19
ZETIA.....	51	ZOMACTON.....	81	ZYFLO.....	99
ZETONNA.....	99	ZOMIG.....	25	ZYFLO CR.....	99
ZIAC.....	48	ZOMIG ZMT.....	25	ZYKADIA.....	19
ZIAGEN.....	5	ZONALON.....	53	ZYLET.....	94
ZIANA.....	55	ZONEGRAN.....	23	ZYLOPRIM.....	83
zidovudine.....	5	zonisamide.....	23	ZYMAXID.....	92
zileuton.....	99	ZONTIVITY.....	49	ZYPITAMAG.....	51
ZIOPTAN (PF).....	93	ZORBTIVE.....	81	ZYPREXA.....	42
ziprasidone hcl.....	42	ZORTRESS.....	19	ZYPREXA RELPREVV.....	42
ZIPSOR.....	33	ZORVOLEX.....	33	ZYPREXA ZYDIS.....	42
ZIRGAN.....	92	ZOSTAVAX (PF).....	83	ZYTIGA.....	19
ZITHROMAX.....	7	ZOSYN.....	11	ZYVOX.....	10
ZITHROMAX TRI-PAK.....	7	ZOSYN IN DEXTROSE (ISO-OSM).....	11		
ZITHROMAX Z-PAK.....	7	zovia 1/35e (28).....	91		
ZOCOR.....	51				

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

This page intentionally blank

This page intentionally blank

This page intentionally blank

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

This formulary was updated on 08/24/2018. For more recent information or to price a medication, you can visit us on the Web at express-scripts.com. Or you can contact **Express Scripts Medicare**[®] (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

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

© 2018 Express Scripts. All Rights Reserved.

F0PA4Z9A