



Express Scripts Medicare (PDP) 2024 Formulary (List of Covered Drugs)

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

Formulary ID Number: 24237, v7

This formulary was updated on 08/22/2023. 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.

Important Message About What You Pay for Vaccines – Our plan covers most Part D vaccines at no cost to you. If your plan has a deductible, there is no deductible for covered vaccines. Call Customer Service for more information.

Important Message About What You Pay for Insulin – You won't pay more than \$35 for a one-month supply for each insulin product covered by our plan, no matter its cost-sharing tier. If your plan covers insulin at a lower cost-sharing amount, you will pay the lower amount. If your plan has a deductible, there is no deductible for covered insulins.

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 22, 2023. 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, 2025. The formulary and/or pharmacy network may change at any time. You will receive notice when necessary.

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

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

What is the Express Scripts Medicare formulary?

The list of drugs covered by the plan is also known as the “formulary.” It contains a list of 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?

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

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

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

This drug list was updated in August 2023.

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

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost-sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

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

How do I use the formulary?

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

Medical Condition

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

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 145. 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.

This drug list was updated in August 2023.

- **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 approved, this would lower the amount you must pay for your drug. In certain Express Scripts Medicare plans, you cannot ask us to change the cost-sharing tier for any drug in the specialty tier, if applicable.

- 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 a formulary, tier or utilization restriction exception. **When you are requesting an exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

Generally, your request for an exception will only be approved if the alternative drugs that are 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:

This drug list was updated in August 2023.

- 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 145.

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

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

Your Costs

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

This drug list was updated in August 2023.

- **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 three 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.

If you qualify for Extra Help

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

For more information

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

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

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

This drug list was updated in August 2023.

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

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

List of abbreviations

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

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

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

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

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

V: This vaccine is provided to adults at no cost when used based on recommendations by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP).

Drug Name	Drug Tier	Requirements/Limits
ANTI - INFECTIVES		
ANTIFUNGAL AGENTS		
ABELCET	3	PA; MO
AMBISOME	3	PA
<i>amphotericin b</i>	1	PA; MO
ANCOBON	3	MO
CANCIDAS	3	
<i>casprofungin</i>	1	
<i>clotrimazole mucous membrane</i>	1	MO
CRESEMBA ORAL	3	PA
DIFLUCAN ORAL SUSPENSION FOR RECONSTITUTION	3	MO
DIFLUCAN ORAL TABLET 100 MG, 150 MG, 200 MG	3	MO
ERAXIS(WATER DILUENT)	3	MO
<i>fluconazole</i>	1	MO
<i>fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>fluconazole in nacl (iso-osm) intravenous piggyback 400 mg/200 ml</i>	1	PA
<i>flucytosine</i>	1	MO
<i>griseofulvin microsize</i>	1	MO
<i>griseofulvin ultramicrosize</i>	1	MO
<i>itraconazole oral capsule</i>	1	MO; QL (120 per 30 days)
<i>itraconazole oral solution</i>	1	MO
<i>ketoconazole oral</i>	1	MO
<i>micafungin</i>	1	MO
NOXAFIL ORAL SUSP,DELAYED RELEASE FOR RECON	3	PA; MO; QL (32 per 30 days)
NOXAFIL ORAL SUSPENSION	3	PA; MO; QL (630 per 30 days)
NOXAFIL ORAL TABLET,DELAYED RELEASE (DR/EC)	3	PA; MO; QL (96 per 30 days)
<i>nystatin oral</i>	1	MO
<i>posaconazole oral suspension</i>	1	PA; MO; QL (630 per 30 days)
<i>posaconazole oral tablet, delayed release (dr/ec)</i>	1	PA; MO; QL (96 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
SPORANOX ORAL CAPSULE	3	MO; QL (120 per 30 days)
SPORANOX ORAL SOLUTION	3	MO
<i>terbinafine hcl oral</i>	1	MO
TOLSURA	3	PA; MO; QL (120 per 30 days)
VFEND	3	PA; MO
VFEND IV	3	PA; MO
VIVJOA	3	PA; QL (18 per 84 days)
<i>voriconazole</i>	1	PA; MO
ANTIVIRALS		
<i>abacavir</i>	1	MO
<i>abacavir-lamivudine</i>	1	MO
<i>acyclovir oral capsule</i>	1	MO
<i>acyclovir oral suspension 200 mg/5 ml</i>	1	MO
<i>acyclovir oral tablet</i>	1	MO
<i>acyclovir sodium intravenous solution</i>	1	PA; MO
<i>adefovir</i>	1	MO
<i>amantadine hcl</i>	1	MO
APTIVUS	2	MO
<i>atazanavir</i>	1	MO
BARACLUDE	3	MO
BIKTARVY	3	MO
CIMDUO	3	MO
COMBIVIR	3	MO

Drug Name	Drug Tier	Requirements/Limits
COMPLERA	3	MO
<i>darunavir ethanolate</i>	1	MO
DELSTRIGO	3	MO
DESCOVY	3	MO
DOVATO	3	MO
EDURANT	2	MO
<i>efavirenz</i>	1	MO
<i>efavirenz-emtricitabin-tenofovir</i>	1	MO
<i>efavirenz-lamivudine-tenofovir disoproxil fumarate</i>	1	MO
<i>emtricitabine</i>	1	MO
<i>emtricitabine-tenofovir (tdf)</i>	1	MO
EMTRIVA ORAL CAPSULE	3	MO
EMTRIVA ORAL SOLUTION	2	MO
<i>entecavir</i>	1	MO
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	2	PA; MO; QL (28 per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	2	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 200-50 MG	2	PA; MO; QL (56 per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	2	PA; MO; QL (28 per 28 days)
EPIVIR	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EPZICOM	3	MO
<i>etravirine</i>	1	MO
EVOTAZ	3	MO
<i>famciclovir</i>	1	MO
<i>fosamprenavir</i>	1	MO
FUZEON SUBCUTANEOUS RECON SOLN	2	MO
GENVOYA	3	MO
HARVONI ORAL PELLETS IN PACKET 33.75- 150 MG	2	PA; MO; QL (28 per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	2	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 45-200 MG	2	PA; MO; QL (56 per 28 days)
HARVONI ORAL TABLET 90-400 MG	2	PA; MO; QL (28 per 28 days)
INTELENCE	3	MO
ISENTRESS	2	MO
ISENTRESS HD	3	MO
JULUCA	3	MO
KALETRA	3	MO
<i>lamivudine</i>	1	MO
<i>lamivudine- zidovudine</i>	1	MO
LEDIPASVIR- SOFOSBUVIR	3	PA; MO; QL (28 per 28 days)
LEXIVA	3	MO

Drug Name	Drug Tier	Requirements/Limits
LIVTENCITY	3	PA; LA; QL (120 per 30 days)
<i>lopinavir-ritonavir</i>	1	MO
<i>maraviroc</i>	1	MO
MAVYRET ORAL PELLETS IN PACKET	3	PA; MO; QL (168 per 28 days)
MAVYRET ORAL TABLET	3	PA; MO; QL (84 per 28 days)
<i>nevirapine oral suspension</i>	1	
<i>nevirapine oral tablet</i>	1	MO
<i>nevirapine oral tablet extended release 24 hr</i>	1	MO
NORVIR ORAL POWDER IN PACKET	3	MO
ODEFSEY	3	MO
<i>oseltamivir</i>	1	MO
PIFELTRO	3	MO
PREVYMIS ORAL	2	PA; MO; QL (30 per 30 days)
PREZCOBIX	3	MO
PREZISTA ORAL SUSPENSION	3	MO
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
RELENZA DISKHALER	3	MO
RETROVIR ORAL CAPSULE	3	MO
RETROVIR ORAL SYRUP	3	MO
REYATAZ ORAL CAPSULE 200 MG, 300 MG	3	MO
REYATAZ ORAL POWDER IN PACKET	2	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
RUKOBIA	3	MO
SELZENTRY ORAL SOLUTION	2	MO
SELZENTRY ORAL TABLET 150 MG, 300 MG	3	MO
SELZENTRY ORAL TABLET 25 MG, 75 MG	2	MO
SITAVIG	3	MO
SOFOSBUVIR-VELPATASVIR	3	PA; MO; QL (28 per 28 days)
SOVALDI ORAL PELLETS IN PACKET 150 MG	3	PA; MO; QL (28 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
SOVALDI ORAL PELLETS IN PACKET 200 MG	3	PA; MO; QL (56 per 28 days)
SOVALDI ORAL TABLET 200 MG	3	PA; MO; QL (56 per 28 days)
SOVALDI ORAL TABLET 400 MG	3	PA; MO; QL (28 per 28 days)
STRIBILD	3	MO
SUNLENCA ORAL	3	
SYMFI	3	MO
SYMFI LO	3	MO
SYMTUZA	3	MO
TAMIFLU	3	MO
<i>tenofovir disoproxil fumarate</i>	1	MO
TIVICAY ORAL TABLET 10 MG	2	MO
TIVICAY ORAL TABLET 25 MG, 50 MG	3	MO
TIVICAY PD	3	MO
TRIUMEQ	3	MO
TRIUMEQ PD	3	MO
TRIZIVIR	3	MO
TRUVADA	3	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)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
VALCYTE	3	MO
<i>valganciclovir</i>	1	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	2	MO
VIRACEPT ORAL TABLET	3	MO
VIREAD	3	MO
VOSEVI	2	PA; MO; QL (28 per 28 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	2	MO
ZEPATIER	3	PA; MO; QL (28 per 28 days)
ZIAGEN	3	MO
<i>zidovudine</i>	1	MO
CEPHALOSPORINS		
AVYCAZ	3	PA; MO
<i>cefaclor oral capsule</i>	1	MO
<i>cefaclor oral suspension for reconstitution 125 mg/5 ml</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>cefaclor oral suspension for reconstitution 250 mg/5 ml, 375 mg/5 ml</i>	1	
<i>cefaclor oral tablet extended release 12 hr</i>	1	MO
<i>cefadroxil oral capsule</i>	1	MO
<i>cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml</i>	1	MO
<i>cefadroxil oral tablet</i>	1	MO
<i>cefazolin injection recon soln 1 gram, 500 mg</i>	1	MO
<i>cefazolin injection recon soln 10 gram</i>	1	
<i>cefdinir</i>	1	MO
<i>cefepime injection</i>	1	MO
<i>cefixime</i>	1	MO
<i>cefoxitin intravenous recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>cefoxitin intravenous recon soln 10 gram</i>	1	PA
<i>cefpodoxime</i>	1	MO
<i>cefprozil</i>	1	MO
<i>ceftazidime injection recon soln 1 gram, 2 gram</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>ceftazidime injection recon soln 6 gram</i>	1	PA
<i>ceftriaxone injection recon soln 1 gram, 2 gram, 250 mg, 500 mg</i>	1	MO
<i>ceftriaxone injection recon soln 10 gram</i>	1	
<i>cefuroxime axetil oral tablet</i>	1	MO
<i>cefuroxime sodium injection recon soln 750 mg</i>	1	PA; MO
<i>cefuroxime sodium intravenous recon soln 1.5 gram</i>	1	PA; MO
<i>cephalexin</i>	1	MO
SUPRAX ORAL CAPSULE	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 200 MG/5 ML	3	MO
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	3	
SUPRAX ORAL TABLET, CHEWABLE	3	MO
<i>tazicef injection</i>	1	PA; MO
TEFLARO	3	PA; MO
ZERBAXA	3	PA

Drug Name	Drug Tier	Requirements/Limits
ERYTHROMYCINS / OTHER MACROLIDES		
<i>azithromycin intravenous</i>	1	PA; MO
<i>azithromycin oral packet</i>	1	MO
<i>azithromycin oral suspension for reconstitution</i>	1	MO
<i>azithromycin oral tablet 250 mg (6 pack), 500 mg (3 pack)</i>	1	
<i>azithromycin oral tablet 250 mg, 500 mg, 600 mg</i>	1	MO
<i>clarithromycin</i>	1	MO
DIFICID ORAL SUSPENSION FOR RECONSTITUTION	3	QL (136 per 10 days)
DIFICID ORAL TABLET	2	MO; QL (20 per 10 days)
<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/lec) 250 mg, 333 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ERY-TAB ORAL TABLET, DELAYED RELEASE (DR/EC) 500 MG	3	MO
<i>erythrocin (as stearate) oral tablet 250 mg</i>	1	MO
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	3	PA; MO
<i>erythromycin ethylsuccinate oral suspension for reconstitution</i>	1	MO
<i>erythromycin ethylsuccinate oral tablet</i>	1	MO
<i>erythromycin oral</i>	1	MO
ZITHROMAX INTRAVENOUS	3	PA; MO
ZITHROMAX ORAL PACKET	3	MO
ZITHROMAX ORAL SUSPENSION FOR RECONSTITUTION	3	MO
ZITHROMAX ORAL TABLET 250 MG, 500 MG	3	MO
ZITHROMAX TRI-PAK	3	MO
ZITHROMAX Z-PAK	3	MO

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS ANTIINFECTIVES		
AEMCOLO	3	MO; QL (12 per 30 days)
<i>albendazole</i>	1	MO
<i>amikacin injection solution 500 mg/2 ml</i>	1	PA; MO
ARIKAYCE	3	PA; LA
<i>atovaquone</i>	1	MO
<i>atovaquone-proguanil</i>	1	MO
AZACTAM	3	PA; MO
<i>aztreonam</i>	1	PA; MO
BENZNIDAZOLE	3	MO
BETHKIS	3	PA; MO; QL (224 per 28 days)
BILTRICIDE	3	MO
CAYSTON	2	PA; MO; LA; QL (84 per 56 days)
<i>chloroquine phosphate</i>	1	MO
CLEOCIN HCL	3	MO
CLEOCIN PEDIATRIC	3	MO
<i>clindamycin hcl</i>	1	MO
<i>clindamycin in 5% dextrose</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin pediatric</i>	1	MO
<i>clindamycin phosphate injection</i>	1	PA; MO
<i>clindamycin phosphate intravenous</i>	1	PA; MO
COARTEM	3	MO
<i>colistin (colistimethate na)</i>	1	PA; MO; QL (30 per 10 days)
CUBICIN RF	3	MO
DALVANCE	3	PA; MO
<i>dapsone oral</i>	1	MO
DAPTOMYCIN INTRAVENOUS RECON SOLN 350 MG	2	MO
<i>daptomycin intravenous recon soln 500 mg</i>	1	MO
DARAPRIM	3	PA
EMVERM	2	MO
<i>ertapenem</i>	1	PA; MO; QL (14 per 14 days)
<i>ethambutol</i>	1	MO
FIRVANQ	3	QL (450 per 10 days)
FLAGYL ORAL CAPSULE	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/50 ml</i>	1	PA; MO
<i>gentamicin in nacl (iso-osm) intravenous piggyback 80 mg/100 ml</i>	1	PA
<i>gentamicin injection solution 40 mg/ml</i>	1	PA; MO
HUMATIN	3	MO
<i>hydroxychloroquine</i>	1	MO
<i>imipenem-cilastatin</i>	1	PA; MO
IMPAVIDO	3	PA; MO
INVANZ INJECTION	3	PA; MO; QL (14 per 14 days)
<i>isoniazid oral</i>	1	MO
<i>ivermectin oral</i>	1	PA; MO; QL (20 per 30 days)
KITABIS PAK	3	PA; MO; QL (280 per 28 days)
KRINTAFEL	3	MO
LAMPIT	3	MO
<i>linezolid</i>	1	MO
<i>linezolid in dextrose 5%</i>	1	PA; MO
MALARONE	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
MALARONE PEDIATRIC	3	MO
<i>mefloquine</i>	1	MO
MEPRON	3	MO
<i>meropenem intravenous recon soln 1 gram</i>	1	PA; MO; QL (30 per 10 days)
<i>meropenem intravenous recon soln 500 mg</i>	1	PA; MO; QL (10 per 10 days)
<i>metronidazole in nacl (iso-os)</i>	1	PA; MO
<i>metronidazole oral</i>	1	MO
MYAMBUTOL ORAL TABLET 400 MG	3	MO
MYCOBUTIN	3	MO
NEBUPENT	3	PA; MO; QL (1 per 28 days)
<i>neomycin</i>	1	MO
<i>nitazoxanide</i>	1	MO
<i>paromomycin</i>	1	MO
PENTAM	3	MO
<i>pentamidine inhalation</i>	1	PA; MO; QL (1 per 28 days)
<i>pentamidine injection</i>	1	MO
PLAQUENIL	3	MO
<i>polymyxin b sulfate</i>	1	PA; MO
<i>praziquantel</i>	1	MO
PRETOMANID	3	PA
PRIFTIN	2	MO

Drug Name	Drug Tier	Requirements/Limits
PRIMAQUINE	3	MO
PRIMAXIN IV INTRAVENOUS RECON SOLN 500 MG	3	PA; MO
<i>pyrazinamide</i>	1	MO
<i>pyrimethamine</i>	1	PA; MO
QUALAQUIN	3	MO
<i>quinine sulfate</i>	1	MO
<i>rifabutin</i>	1	MO
<i>rifampin</i>	1	MO
SIRTURO	3	PA; LA
SIVEXTRO INTRAVENOUS	3	PA
SIVEXTRO ORAL	3	MO
SOLOSEC	3	MO
STREPTOMYCIN	3	PA; MO; QL (60 per 30 days)
STROMECTOL	3	PA; MO; QL (20 per 30 days)
<i>tigecycline</i>	1	PA; MO
<i>tinidazole</i>	1	MO
TOBI	3	PA; MO; QL (280 per 28 days)
TOBI PODHALER	2	MO; QL (224 per 56 days)
<i>tobramycin in 0.225 % nacl</i>	1	PA; MO; QL (280 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>tobramycin inhalation</i>	1	PA; MO; QL (224 per 28 days)
<i>tobramycin sulfate injection solution</i>	1	PA; MO
TRECTOR	3	MO
TYGACIL	3	PA; MO
VABOMERE	3	PA
VANCOGIN ORAL CAPSULE 125 MG	3	PA; MO; QL (40 per 10 days)
VANCOGIN ORAL CAPSULE 250 MG	3	PA; MO; QL (80 per 10 days)
<i>vancomycin intravenous recon soln 1,000 mg</i>	1	PA; MO; QL (20 per 10 days)
<i>vancomycin intravenous recon soln 10 gram</i>	1	PA; QL (2 per 10 days)
<i>vancomycin intravenous recon soln 500 mg</i>	1	PA; MO; QL (10 per 10 days)
<i>vancomycin intravenous recon soln 750 mg</i>	1	PA; MO; QL (27 per 10 days)
<i>vancomycin oral capsule 125 mg</i>	1	PA; MO; QL (40 per 10 days)
<i>vancomycin oral capsule 250 mg</i>	1	PA; MO; QL (80 per 10 days)
VANCOMYCIN ORAL RECON SOLN 25 MG/ML	3	QL (450 per 10 days)

Drug Name	Drug Tier	Requirements/Limits
<i>vancomycin oral recon soln 50 mg/ml</i>	1	MO; QL (450 per 10 days)
XENLETA INTRAVENOUS	3	
XENLETA ORAL	3	MO
XIFAXAN ORAL TABLET 200 MG	2	MO; QL (9 per 30 days)
XIFAXAN ORAL TABLET 550 MG	2	MO; QL (90 per 30 days)
ZEMDRI	3	PA
ZYVOX INTRAVENOUS PIGGYBACK 600 MG/300 ML	3	PA; MO
ZYVOX ORAL	3	MO
PENICILLINS		
<i>amoxicillin oral capsule</i>	1	MO
<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

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg</i>	1	PA; MO
<i>ampicillin-sulbactam injection recon soln 1.5 gram, 3 gram</i>	1	PA; MO
<i>ampicillin-sulbactam injection recon soln 15 gram</i>	1	PA
AUGMENTIN ES-600	3	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	3	MO
BICILLIN C-R	2	PA; MO
BICILLIN L-A	3	PA; MO
<i>dicloxacillin</i>	1	MO
<i>nafcillin injection recon soln 1 gram, 2 gram</i>	1	PA; MO
<i>nafcillin injection recon soln 10 gram</i>	1	PA
<i>oxacillin in dextrose(iso-osm)</i>	1	PA
<i>oxacillin injection recon soln 1 gram, 10 gram</i>	1	PA
<i>oxacillin injection recon soln 2 gram</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
PENICILLIN G POT IN DEXTROSE INTRAVENOUS PIGGYBACK 2 MILLION UNIT/50 ML, 3 MILLION UNIT/50 ML	3	PA
<i>penicillin g potassium injection recon soln 20 million unit</i>	1	PA; MO
<i>penicillin g procaine intramuscular syringe 1.2 million unit/2 ml</i>	1	PA; MO
<i>penicillin g sodium</i>	1	PA; MO
<i>penicillin v potassium</i>	1	MO
<i>piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram</i>	1	MO
<i>piperacillin-tazobactam intravenous recon soln 40.5 gram</i>	1	
UNASYN INJECTION RECON SOLN 15 GRAM	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
UNASYN INJECTION RECON SOLN 3 GRAM	3	PA; MO
ZOSYN IN DEXTROSE (ISO-OSM) INTRAVENOUS PIGGYBACK 2.25 GRAM/50 ML	3	
QUINOLONES		
BAXDELA INTRAVENOUS	3	PA
BAXDELA ORAL	3	MO
CIPRO ORAL SUSPENSION,MI CROCAPSULE RECON	3	
CIPRO ORAL TABLET 250 MG, 500 MG	3	MO
<i>ciprofloxacin hcl oral</i>	1	MO
<i>ciprofloxacin in 5% dextrose intravenous piggyback 200 mg/100 ml</i>	1	PA; MO
<i>levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml</i>	1	PA; MO
<i>levofloxacin oral</i>	1	MO
<i>moxifloxacin oral</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>moxifloxacin-sod.chloride(iso)</i>	1	PA; MO
<i>ofloxacin oral tablet 300 mg, 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) 50 MG	3	ST; MO
<i>doxy-100</i>	1	PA; MO
<i>doxycycline hyclate oral capsule</i>	1	MO
<i>doxycycline hyclate oral tablet</i>	1	MO
<i>doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg, 150 mg, 200 mg, 50 mg, 75 mg</i>	1	MO
DOXYCYCLINE HYCLATE ORAL TABLET,DELAYED RELEASE (DR/EC) 80 MG	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>doxycycline monohydrate oral capsule</i>	1	MO
DOXYCYCLINE MONOHYDRATE ORAL CAPSULE, IR - DELAY REL, BIPHASE	3	ST; MO
<i>doxycycline monohydrate oral suspension for reconstitution</i>	1	MO
<i>doxycycline monohydrate oral tablet</i>	1	MO
<i>minocycline oral capsule</i>	1	MO
<i>minocycline oral tablet</i>	1	MO
<i>minocycline oral tablet extended release 24 hr</i>	1	MO
MINOLIRA ER	3	ST; MO
NUZYRA INTRAVENOUS	3	PA
NUZYRA ORAL	3	
ORACEA	3	ST; MO
SEYSARA	3	ST; MO
SOLODYN ORAL TABLET EXTENDED RELEASE 24 HR 105 MG, 115 MG, 55 MG, 65 MG, 80 MG	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
TARGADOX	3	ST; MO
<i>tetracycline</i>	1	MO
VIBRAMYCIN (CALCIUM)	3	MO
VIBRAMYCIN (MONO)	3	
VIBRAMYCIN ORAL CAPSULE 100 MG	3	ST; MO
XIMINO	3	ST; MO
URINARY TRACT AGENTS		
<i>fosfomycin tromethamine</i>	1	MO
HIPREX	3	MO
MACROBID	3	MO
MACRODANTIN	3	MO
<i>methenamine hippurate</i>	1	MO
<i>nitrofurantoin</i>	1	MO
<i>nitrofurantoin macrocrystal</i>	1	MO
<i>nitrofurantoin monohydrate-cryst</i>	1	MO
<i>trimethoprim</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
ADJUNCTIVE AGENTS		
<i>leucovorin calcium oral</i>	1	MO
MESNEX ORAL	2	MO
XGEVA	2	PA; MO
ANTINEOPLASTIC / IMMUNOSUPPRESSANT DRUGS		
<i>abiraterone oral tablet 250 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>abiraterone oral tablet 500 mg</i>	1	PA; MO; QL (60 per 30 days)
AFINITOR	3	PA; MO; QL (30 per 30 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG	3	PA; MO; QL (330 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	3	PA; MO; QL (240 per 30 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 5 MG	3	PA; MO; QL (180 per 30 days)
ALECENSA	2	PA; MO; QL (240 per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	3	PA; QL (30 per 30 days)
ALUNBRIG ORAL TABLET 30 MG	3	PA; QL (60 per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	3	PA; QL (30 per 180 days)
ALYMSYS	3	PA; MO
<i>anastrozole</i>	1	MO
ARIMIDEX	3	MO
AROMASIN	3	MO
ASTAGRAF XL	3	PA; MO
AYVAKIT	3	PA; LA; QL (30 per 30 days)
AZASAN	3	PA; MO
<i>azathioprine</i>	1	PA; MO
BALVERSA	2	PA; LA
<i>bexarotene</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>bicalutamide</i>	1	MO
BOSULIF ORAL TABLET 100 MG	3	PA; MO; QL (90 per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	3	PA; MO; QL (30 per 30 days)
BRAFTOVI ORAL CAPSULE 75 MG	3	PA; MO; LA; QL (180 per 30 days)
BRUKINSA	2	PA; LA; QL (120 per 30 days)
CABOMETYX	2	PA; MO; LA; QL (30 per 30 days)
CALQUENCE	2	PA; LA; QL (60 per 30 days)
CALQUENCE (ACALABRUTIN IB MAL)	2	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 100 MG	2	PA; LA; QL (60 per 30 days)
CAPRELSA ORAL TABLET 300 MG	2	PA; LA; QL (30 per 30 days)
CASODEX	3	MO
CELLCEPT	3	PA; MO
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	2	PA; MO; QL (56 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	2	PA; MO; QL (112 per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	2	PA; MO; QL (84 per 28 days)
COPIKTRA	3	PA; LA; QL (60 per 30 days)
COTELLIC	3	PA; MO; LA; QL (63 per 28 days)
<i>cyclophosphamide oral capsule</i>	1	PA; MO
CYCLOPHOSPHAMIDE ORAL TABLET	2	PA; MO
<i>cyclosporine modified oral capsule</i>	1	PA; MO
<i>cyclosporine modified oral solution</i>	1	PA
<i>cyclosporine oral capsule</i>	1	PA; MO
DAURISMO ORAL TABLET 100 MG	3	PA; MO; QL (30 per 30 days)
DAURISMO ORAL TABLET 25 MG	3	PA; MO; QL (60 per 30 days)
DROXIA	2	MO
ELIGARD	2	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ELIGARD (3 MONTH)	2	PA; MO
ELIGARD (4 MONTH)	2	PA; MO
ELIGARD (6 MONTH)	2	PA; MO
EMCYT	3	MO
ENSPRYNG	3	PA; MO
ENVARUSUS XR	3	PA; MO
ERIVEDGE	2	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 240 MG	2	PA; MO; QL (30 per 30 days)
ERLEADA ORAL TABLET 60 MG	2	PA; MO; QL (120 per 30 days)
<i>erlotinib oral tablet 100 mg, 150 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>erlotinib oral tablet 25 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>everolimus (antineoplastic) oral tablet</i>	1	PA; MO; QL (30 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 2 mg</i>	1	PA; MO; QL (330 per 30 days)
<i>everolimus (antineoplastic) oral tablet for suspension 3 mg</i>	1	PA; MO; QL (240 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>everolimus (antineoplastic) oral tablet for suspension 5 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>everolimus (immunosuppressive)</i>	1	PA; MO
<i>exemestane</i>	1	MO
EXKIVITY	3	PA; LA; QL (120 per 30 days)
FARESTON	3	MO
FEMARA	3	MO
FIRMAGON KIT W DILUENT SYRINGE	3	PA; MO
FOTIVDA	3	PA; LA; QL (21 per 28 days)
GAVRETO	2	PA; MO; LA; QL (120 per 30 days)
<i>gefitinib</i>	1	PA; MO; QL (30 per 30 days)
<i>gengraf</i>	1	PA; MO
GILOTRIF	3	PA; MO; QL (30 per 30 days)
GLEEVEC ORAL TABLET 100 MG	3	PA; MO; QL (180 per 30 days)
GLEEVEC ORAL TABLET 400 MG	3	PA; MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
GLEOSTINE	3	MO
HYDREA	3	MO
<i>hydroxyurea</i>	1	MO
IBRANCE	3	PA; MO; QL (21 per 28 days)
ICLUSIG	3	PA; QL (30 per 30 days)
IDHIFA	2	PA; MO; LA; QL (30 per 30 days)
<i>imatinib oral tablet 100 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>imatinib oral tablet 400 mg</i>	1	PA; MO; QL (60 per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	2	PA; QL (120 per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	2	PA; QL (30 per 30 days)
IMBRUVICA ORAL SUSPENSION	2	PA; QL (324 per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	2	PA; QL (30 per 30 days)
IMURAN	3	PA; MO
INLYTA ORAL TABLET 1 MG	2	PA; MO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
INLYTA ORAL TABLET 5 MG	2	PA; MO; QL (120 per 30 days)
INQOVI	3	PA; MO; QL (5 per 28 days)
INREBIC	3	PA; MO; LA; QL (120 per 30 days)
IRESSA	3	PA; MO; QL (30 per 30 days)
JAKAFI	2	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 100 MG	3	PA; MO; QL (60 per 30 days)
JAYPIRCA ORAL TABLET 50 MG	3	PA; MO; QL (30 per 30 days)
KANJINTI	3	PA; MO
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	3	PA; MO; QL (49 per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	3	PA; MO; QL (70 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	3	PA; MO; QL (91 per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	2	PA; MO; QL (21 per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	2	PA; MO; QL (42 per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	2	PA; MO; QL (63 per 28 days)
KLISYRI	3	MO
KOSELUGO	3	PA
KRAZATI	3	PA; QL (180 per 30 days)
<i>lapatinib</i>	1	PA; MO; QL (180 per 30 days)
<i>lenalidomide oral capsule 10 mg, 15 mg, 25 mg, 5 mg</i>	1	PA; MO; QL (28 per 28 days)
<i>lenalidomide oral capsule 2.5 mg, 20 mg</i>	1	PA; QL (28 per 28 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	2	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X 2), 24 MG/DAY(10 MG X 2-4 MG X 1)	2	PA; MO; QL (90 per 30 days)
LENVIMA ORAL CAPSULE 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	2	PA; MO; QL (60 per 30 days)
<i>letrozole</i>	1	MO
LEUKERAN	2	MO
LEUPROLIDE (3 MONTH)	3	PA
<i>leuprolide subcutaneous kit</i>	1	PA; MO
LONSURF	2	PA; MO
LORBRENA ORAL TABLET 100 MG	3	PA; MO; QL (30 per 30 days)
LORBRENA ORAL TABLET 25 MG	3	PA; MO; QL (90 per 30 days)
LUMAKRAS	3	PA; MO
LUPKYNIS	3	PA; LA; QL (180 per 30 days)
LUPRON DEPOT (3 MONTH)	3	PA; MO
LUPRON DEPOT (3 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
LUPRON DEPOT (4 MONTH)	3	PA; MO
LUPRON DEPOT (6 MONTH)	3	PA; MO
LUPRON DEPOT-PED (3 MONTH) INTRAMUSCULAR SYRINGE KIT 11.25 MG	3	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR KIT 7.5 MG (PED)	3	PA; MO
LUPRON DEPOT-PED INTRAMUSCULAR SYRINGE KIT	3	PA; MO
LYNPARZA	3	PA; MO; QL (120 per 30 days)
LYSODREN	3	
LYTGOBI	3	PA; LA
MATULANE	2	
<i>megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)</i>	1	PA; MO
<i>megestrol oral tablet</i>	1	PA; MO
MEKINIST ORAL RECON SOLN	3	PA; MO; QL (1200 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
MEKINIST ORAL TABLET 0.5 MG	3	PA; MO; QL (90 per 30 days)
MEKINIST ORAL TABLET 2 MG	3	PA; MO; QL (30 per 30 days)
MEKTOVI	3	PA; MO; LA; QL (180 per 30 days)
<i>mercaptopurine</i>	1	MO
<i>methotrexate sodium</i>	1	PA; MO
<i>methotrexate sodium (pf) injection solution</i>	1	PA; MO
MVASI	3	PA; MO
MYCAPSSA	3	PA; LA
<i>mycophenolate mofetil</i>	1	PA; MO
<i>mycophenolate sodium</i>	1	PA; MO
MYFORTIC	3	PA; MO
NEORAL	3	PA; MO
NERLYNX	2	PA; MO; LA
NEXAVAR	3	PA; MO; LA; QL (120 per 30 days)
NILANDRON	3	PA; MO
<i>nilutamide</i>	1	PA; MO
NINLARO	3	PA; MO; QL (3 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
NUBEQA	2	PA; MO; LA; QL (120 per 30 days)
<i>octreotide acetate injection solution</i>	1	PA; MO
ODOMZO	3	PA; MO; LA; QL (30 per 30 days)
ONTRUZANT INTRAVENOUS RECON SOLN 150 MG	3	PA
ONUREG	3	PA; MO; QL (14 per 28 days)
ORGOVYX	2	PA; LA; QL (30 per 28 days)
ORSERDU ORAL TABLET 345 MG	3	PA; QL (30 per 30 days)
ORSERDU ORAL TABLET 86 MG	3	PA; QL (90 per 30 days)
PEMAZYRE	3	PA; LA; QL (14 per 21 days)
PIQRAY	3	PA; MO
POMALYST	3	PA; MO; LA
PROGRAF ORAL	3	PA; MO
PURIXAN	3	
QINLOCK	3	PA; LA; QL (90 per 30 days)
RAPAMUNE	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
RETEVMO ORAL CAPSULE 40 MG	2	PA; MO; LA; QL (180 per 30 days)
RETEVMO ORAL CAPSULE 80 MG	2	PA; MO; LA; QL (120 per 30 days)
REVLIMID	3	PA; MO; LA; QL (28 per 28 days)
REZLIDHIA	3	PA; QL (60 per 30 days)
REZUROCK	3	PA; LA; QL (30 per 30 days)
RIABNI	3	PA; MO
ROZLYTREK ORAL CAPSULE 100 MG	2	PA; MO; QL (150 per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	2	PA; MO; QL (90 per 30 days)
RUBRACA	3	PA; MO; LA; QL (120 per 30 days)
RUXIENCE	2	PA; MO
RYDAPT	2	PA; MO; QL (224 per 28 days)
SANDIMMUNE ORAL	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
SANDOSTATIN INJECTION SOLUTION 100 MCG/ML, 50 MCG/ML, 500 MCG/ML	3	PA; MO
SCSEMBLIX ORAL TABLET 20 MG	3	PA; MO; QL (600 per 30 days)
SCSEMBLIX ORAL TABLET 40 MG	3	PA; MO; QL (300 per 30 days)
SIGNIFOR	2	PA
SIKLOS	3	MO
<i>sirolimus</i>	1	PA; MO
SOLTAMOX	3	MO
SOMATULINE DEPOT	2	PA; MO
<i>sorafenib</i>	1	PA; MO; QL (120 per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	2	PA; MO; QL (30 per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	2	PA; MO; QL (60 per 30 days)
STIVARGA	2	PA; MO; QL (84 per 28 days)
<i>sunitinib malate</i>	1	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SUTENT	3	PA; MO; QL (30 per 30 days)
SYNRIBO	2	PA
TABLOID	3	MO
TABRECTA	3	PA; MO
<i>tacrolimus oral</i>	1	PA; MO
TAFINLAR ORAL CAPSULE	3	PA; MO; QL (120 per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	3	PA; MO; QL (840 per 28 days)
TAGRISSO	3	PA; MO; LA; QL (30 per 30 days)
TALZENNA ORAL CAPSULE 0.25 MG, 0.5 MG, 0.75 MG, 1 MG	3	PA; MO; QL (30 per 30 days)
<i>tamoxifen</i>	1	MO
TARGRETIN	3	PA; MO
TASIGNA ORAL CAPSULE 150 MG, 200 MG	3	PA; MO; QL (112 per 28 days)
TASIGNA ORAL CAPSULE 50 MG	3	PA; MO; QL (120 per 30 days)
TAZVERIK	3	PA; LA
TEPMETKO	3	PA; LA
THALOMID ORAL CAPSULE 100 MG, 50 MG	3	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
THALOMID ORAL CAPSULE 150 MG, 200 MG	3	PA; MO; QL (56 per 28 days)
TIBSOVO	2	PA
<i>toremifene</i>	1	MO
TRAZIMERA	2	PA; MO
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	3	PA; MO
<i>tretinoin</i> (<i>antineoplastic</i>)	1	MO
TREXALL	3	PA; MO
TUKYSA ORAL TABLET 150 MG	3	PA; LA; QL (120 per 30 days)
TUKYSA ORAL TABLET 50 MG	3	PA; LA; QL (300 per 30 days)
TURALIO ORAL CAPSULE 125 MG	3	PA; LA; QL (120 per 30 days)
TYKERB	3	PA; MO; LA; QL (180 per 30 days)
VENCLEXTA ORAL TABLET 10 MG	3	PA; LA; QL (60 per 30 days)
VENCLEXTA ORAL TABLET 100 MG	3	PA; LA; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
VENCLEXTA ORAL TABLET 50 MG	3	PA; LA; QL (30 per 30 days)
VENCLEXTA STARTING PACK	3	PA; LA; QL (42 per 180 days)
VERZENIO	2	PA; MO; LA; QL (60 per 30 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	3	PA; QL (28 per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	3	PA; QL (56 per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	2	PA; MO; LA; QL (60 per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	2	PA; MO; LA; QL (180 per 30 days)
VITRAKVI ORAL SOLUTION	2	PA; MO; LA; QL (300 per 30 days)
VIZIMPRO	3	PA; MO; QL (30 per 30 days)
VONJO	3	PA; QL (120 per 30 days)
VOTRIENT	2	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
WELIREG	3	PA; LA
XALKORI	3	PA; MO; QL (60 per 30 days)
XATMEP	3	PA; MO
XERMELO	3	PA; LA; QL (84 per 28 days)
XOSPATA	2	PA; LA; QL (90 per 30 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40 MG/WEEK (40 MG X 1), 40MG TWICE WEEK (40 MG X 2), 60 MG/WEEK (60 MG X 1), 60MG TWICE WEEK (120 MG/WEEK), 80 MG/WEEK (40 MG X 2), 80MG TWICE WEEK (160 MG/WEEK)	3	PA; LA
XTANDI ORAL CAPSULE	2	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 40 MG	2	PA; MO; QL (120 per 30 days)
XTANDI ORAL TABLET 80 MG	2	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
YONSA	3	PA; MO; QL (120 per 30 days)
ZEJULA ORAL CAPSULE	3	PA; MO; LA; QL (90 per 30 days)
ZELBORAF	3	PA; MO; QL (240 per 30 days)
ZIRABEV	2	PA; MO
ZOLINZA	2	PA; MO; QL (120 per 30 days)
ZORTRESS	3	PA; MO
ZYDELIG	3	PA; MO; QL (60 per 30 days)
ZYKADIA	3	PA; MO; QL (90 per 30 days)
ZYTIGA ORAL TABLET 250 MG	3	PA; MO; QL (120 per 30 days)
ZYTIGA ORAL TABLET 500 MG	3	PA; MO; QL (60 per 30 days)
AUTONOMIC / CNS DRUGS, NEUROLOGY / PSYCH		
ANTICONVULSANTS		
APTIOM ORAL TABLET 200 MG	3	MO; QL (180 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
APTIOM ORAL TABLET 400 MG	3	MO; QL (90 per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	3	MO; QL (60 per 30 days)
BANZEL	3	PA; MO
BRIVIACT INTRAVENOUS	3	MO; QL (600 per 30 days)
BRIVIACT ORAL SOLUTION	3	MO; QL (600 per 30 days)
BRIVIACT ORAL TABLET	3	MO; QL (60 per 30 days)
<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	3	MO
<i>clobazam oral suspension</i>	1	PA; MO; QL (480 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clobazam oral tablet</i>	1	PA; MO; QL (60 per 30 days)
<i>clonazepam oral tablet 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
<i>clonazepam oral tablet 2 mg</i>	1	MO; QL (300 per 30 days)
<i>clonazepam oral tablet, disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg</i>	1	MO; QL (90 per 30 days)
<i>clonazepam oral tablet, disintegrating 2 mg</i>	1	MO; QL (300 per 30 days)
DEPAKOTE	3	MO
DEPAKOTE ER	3	MO
DEPAKOTE SPRINKLES	3	MO
DIACOMIT	3	PA; LA
DIASTAT	3	MO
DIASTAT ACUDIAL	3	MO
<i>diazepam rectal</i>	1	MO
DILANTIN 30 MG	3	MO
DILANTIN EXTENDED 100 MG	3	MO
DILANTIN INFATABS 50 MG	3	MO
DILANTIN-125 125 MG/5 ML	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>divalproex</i>	1	MO
EPIDIOLEX	3	PA; MO; LA
<i>epitol</i>	1	MO
EPRONTIA	3	PA; MO
EQUETRO	3	MO
<i>ethosuximide</i>	1	MO
<i>felbamate</i>	1	MO
FELBATOL	3	MO
FINTEPLA	3	PA; LA; QL (360 per 30 days)
FYCOMPA ORAL SUSPENSION	3	MO; QL (720 per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	3	MO; QL (30 per 30 days)
FYCOMPA ORAL TABLET 2 MG, 4 MG, 6 MG	3	MO; QL (60 per 30 days)
<i>gabapentin oral capsule 100 mg, 400 mg</i>	1	MO; QL (270 per 30 days)
<i>gabapentin oral capsule 300 mg</i>	1	MO; QL (360 per 30 days)
<i>gabapentin oral solution 250 mg/5 ml</i>	1	MO; QL (2160 per 30 days)
<i>gabapentin oral tablet 600 mg</i>	1	MO; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>gabapentin oral tablet 800 mg</i>	1	MO; QL (120 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	2	PA; MO; QL (30 per 30 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 450 MG, 750 MG, 900 MG	2	PA; MO; QL (60 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	MO; QL (90 per 30 days)
KLONOPIN ORAL TABLET 2 MG	3	MO; QL (300 per 30 days)
<i>lacosamide oral solution</i>	1	MO; QL (1200 per 30 days)
<i>lacosamide oral tablet 100 mg, 150 mg, 200 mg</i>	1	MO; QL (60 per 30 days)
<i>lacosamide oral tablet 50 mg</i>	1	MO; QL (120 per 30 days)
LAMICTAL ODT	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
LAMICTAL ORAL TABLET	3	MO
LAMICTAL ORAL TABLET, CHEWABLE DISPERSIBLE 25 MG, 5 MG	3	MO
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</i>	1	MO
<i>levetiracetam oral solution 100 mg/ml</i>	1	MO
<i>levetiracetam oral tablet</i>	1	MO
<i>levetiracetam oral tablet extended release 24 hr</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
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	3	MO; QL (90 per 30 days)
LYRICA ORAL CAPSULE 225 MG, 300 MG	3	MO; QL (60 per 30 days)
LYRICA ORAL SOLUTION	3	MO; QL (900 per 30 days)
<i>methsuximide</i>	1	MO
MYSOLINE	3	MO
NAYZILAM	2	PA; MO; QL (10 per 30 days)
NEURONTIN ORAL CAPSULE 100 MG, 400 MG	3	MO; QL (270 per 30 days)
NEURONTIN ORAL CAPSULE 300 MG	3	MO; QL (360 per 30 days)
NEURONTIN ORAL SOLUTION	3	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
NEURONTIN ORAL TABLET 600 MG	3	MO; QL (180 per 30 days)
NEURONTIN ORAL TABLET 800 MG	3	MO; QL (120 per 30 days)
ONFI ORAL SUSPENSION	3	PA; MO; QL (480 per 30 days)
ONFI ORAL TABLET	3	PA; MO; QL (60 per 30 days)
<i>oxcarbazepine</i>	1	MO
OXTELLAR XR	3	MO
<i>phenobarbital oral elixir</i>	1	PA; MO
<i>phenobarbital oral tablet 100 mg, 15 mg, 30 mg, 60 mg</i>	1	PA
<i>phenobarbital oral tablet 16.2 mg, 32.4 mg, 64.8 mg, 97.2 mg</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>pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg</i>	1	MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>pregabalin oral capsule 225 mg, 300 mg</i>	1	MO; QL (60 per 30 days)
<i>pregabalin oral solution</i>	1	MO; QL (900 per 30 days)
<i>pregabalin oral tablet extended release 24 hr 165 mg, 82.5 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>pregabalin oral tablet extended release 24 hr 330 mg</i>	1	PA; MO; QL (60 per 30 days)
PRIMIDONE ORAL TABLET 125 MG	3	MO
<i>primidone oral tablet 250 mg, 50 mg</i>	1	MO
QUDEXY XR	3	PA; MO
<i>roweepra oral tablet 500 mg</i>	1	MO
<i>rufinamide</i>	1	PA; MO
SABRIL	3	PA; MO; LA
SPRITAM	3	MO
<i>subvenite</i>	1	MO
<i>subvenite starter (blue) kit</i>	1	MO
<i>subvenite starter (green) kit</i>	1	MO
<i>subvenite starter (orange) kit</i>	1	MO
SYMPAZAN	3	PA; MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TEGRETOL ORAL SUSPENSION	3	MO
TEGRETOL ORAL TABLET	3	MO
TEGRETOL XR	3	MO
<i>tiagabine</i>	1	MO
TOPAMAX	3	PA; MO
<i>topiramate</i>	1	PA; MO
TRILEPTAL	3	MO
TROKENDI XR	3	PA; MO
<i>valproic acid</i>	1	MO
<i>valproic acid (as sodium salt) oral solution 250 mg/5 ml</i>	1	MO
VALTOCO	2	PA; MO; QL (10 per 30 days)
<i>vigabatrin</i>	1	PA; MO; LA
<i>vigadrone oral powder in packet</i>	1	PA; LA
VIMPAT ORAL SOLUTION	3	MO; QL (1200 per 30 days)
VIMPAT ORAL TABLET 100 MG, 150 MG, 200 MG	3	MO; QL (60 per 30 days)
VIMPAT ORAL TABLET 50 MG	3	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
XCOPRI MAINTENANCE PACK ORAL TABLET 250MG/DAY(150 MG X1-100MG X1), 350 MG/DAY (200 MG X1-150MG X1)	3	MO; QL (56 per 28 days)
XCOPRI ORAL TABLET 100 MG	3	MO; QL (120 per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	3	MO; QL (60 per 30 days)
XCOPRI ORAL TABLET 50 MG	3	MO; QL (240 per 30 days)
XCOPRI TITRATION PACK	3	MO; QL (28 per 180 days)
ZARONTIN	3	MO
ZONEGRAN ORAL CAPSULE 100 MG, 25 MG	3	PA; MO
ZONISADE	3	PA; MO
<i>zonisamide</i>	1	PA; MO
ZTALMY	3	PA; LA; QL (1080 per 30 days)
ANTIPARKINSONISM AGENTS		
APOKYN	3	PA; MO; LA; 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>apomorphine</i>	1	PA; QL (90 per 30 days)
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
DHIVY	3	MO
DUOPA	3	PA; MO
<i>entacapone</i>	1	MO
GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 137 MG	3	PA; QL (60 per 30 days)
GOCOVRI ORAL CAPSULE, EXTENDED RELEASE 24HR 68.5 MG	3	PA; QL (30 per 30 days)
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	3	PA; QL (300 per 30 days)
LODOSYN	3	MO
MIRAPEX ER	3	MO
NEUPRO	3	MO
NOURIANZ	3	PA; MO; LA; QL (30 per 30 days)
ONGENTYS	3	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
OSMOLEX ER ORAL TABLET, IR - ER, BIPHASIC 24HR 193 MG	3	PA; QL (30 per 30 days)
PARLODEL	3	MO
<i>pramipexole</i>	1	MO
<i>rasagiline</i>	1	MO
<i>ropinirole</i>	1	MO
RYTARY	3	MO
<i>selegiline hcl</i>	1	MO
SINEMET ORAL TABLET 10-100 MG, 25-100 MG	3	MO
STALEVO 100	3	MO
STALEVO 125	3	MO
STALEVO 150	3	MO
STALEVO 200	3	MO
STALEVO 75	3	MO
TASMAR ORAL TABLET 100 MG	3	PA; MO
<i>tolcapone</i>	1	PA
XADAGO	3	MO
ZELAPAR	3	PA; MO
MIGRAINE / CLUSTER HEADACHE THERAPY		
AIMOVIG AUTOINJECTOR	2	PA; MO; QL (1 per 30 days)
AJOVY AUTOINJECTOR	3	PA; MO; QL (1.5 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
AJOVY SYRINGE	3	PA; MO; QL (1.5 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)
<i>dihydroergotamine nasal</i>	1	QL (8 per 28 days)
<i>eletriptan</i>	1	MO; QL (18 per 28 days)
EMGALITY PEN	2	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 120 MG/ML	2	PA; MO; QL (2 per 30 days)
EMGALITY SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	3	PA; MO; QL (3 per 30 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)

Drug Name	Drug Tier	Requirements/Limits
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 SUBCUTANEOUS PEN INJECTOR 4 MG/0.5 ML	3	MO; QL (8 per 28 days)
IMITREX STATDOSE REFILL SUBCUTANEOUS CARTRIDGE 6 MG/0.5 ML	3	MO; QL (8 per 28 days)
MAXALT ORAL TABLET 10 MG	3	MO; QL (36 per 28 days)
MAXALT-MLT ORAL TABLET, DISINTEGRATING 10 MG	3	MO; QL (36 per 28 days)
<i>migergot</i>	1	MO
MIGRANAL	3	QL (8 per 28 days)
<i>naratriptan</i>	1	MO; QL (18 per 28 days)
NURTEC ODT	2	PA; QL (16 per 30 days)
ONZETRA XSAIL	3	MO; QL (32 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
QULIPTA	2	PA; MO; QL (30 per 30 days)
RELPAK	3	MO; QL (18 per 28 days)
REYVOW ORAL TABLET 100 MG	3	PA; QL (16 per 30 days)
REYVOW ORAL TABLET 50 MG	3	PA; QL (8 per 30 days)
<i>rizatriptan</i>	1	MO; QL (36 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 20 mg/lactuation</i>	1	MO; QL (18 per 28 days)
<i>sumatriptan nasal spray, non-aerosol 5 mg/lactuation</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)

Drug Name	Drug Tier	Requirements/Limits
TOSYMRA	3	MO; QL (24 per 28 days)
TREXIMET	3	MO; QL (18 per 28 days)
TRUDHESA	3	ST; QL (8 per 28 days)
UBRELVY	2	PA; QL (20 per 30 days)
ZEMBRACE SYMTOUCH	3	MO; QL (8 per 28 days)
<i>zolmitriptan nasal spray, non-aerosol 5 mg</i>	1	MO; QL (18 per 28 days)
<i>zolmitriptan oral</i>	1	MO; QL (18 per 28 days)
ZOMIG	3	MO; QL (18 per 28 days)

MISCELLANEOUS NEUROLOGICAL THERAPY

ADLARITY	3	MO
AMPYRA	3	PA; MO; LA; QL (60 per 30 days)
ARICEPT	3	MO
AUBAGIO	3	PA; MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
AUSTEDO ORAL TABLET 12 MG, 9 MG	3	PA; MO; LA; QL (120 per 30 days)
AUSTEDO ORAL TABLET 6 MG	3	PA; MO; LA; QL (60 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 12 MG	3	PA; MO; LA; QL (120 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 24 MG	3	PA; MO; LA; QL (60 per 30 days)
AUSTEDO XR ORAL TABLET EXTENDED RELEASE 24 HR 6 MG	3	PA; MO; LA; QL (240 per 30 days)
BAFIERTAM	3	PA; MO; QL (120 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 20 MG/ML	3	PA; MO; QL (30 per 30 days)
COPAXONE SUBCUTANEOUS SYRINGE 40 MG/ML	3	PA; MO; QL (12 per 28 days)
<i>dalfampridine</i>	1	PA; MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>dimethyl fumarate oral capsule, delayed release(drlec) 120 mg</i>	1	PA; MO; QL (14 per 30 days)
<i>dimethyl fumarate oral capsule, delayed release(drlec) 120 mg (14)- 240 mg (46)</i>	1	PA; MO; QL (120 per 180 days)
<i>dimethyl fumarate oral capsule, delayed release(drlec) 240 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>donepezil</i>	1	MO
EVRYSDI	3	PA; MO; LA; QL (240 per 30 days)
EXELON PATCH	3	MO
<i> fingolimod</i>	1	PA; MO; QL (30 per 30 days)
FIRDAPSE	2	PA; LA
<i>galantamine</i>	1	MO
GILENYA ORAL CAPSULE 0.25 MG	3	PA; QL (30 per 30 days)
GILENYA ORAL CAPSULE 0.5 MG	3	PA; MO; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 20 mg/ml</i>	1	PA; QL (30 per 30 days)
<i>glatiramer subcutaneous syringe 40 mg/ml</i>	1	PA; QL (12 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>glatopa subcutaneous syringe 20 mg/ml</i>	1	PA; MO; QL (30 per 30 days)
<i>glatopa subcutaneous syringe 40 mg/ml</i>	1	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	2	PA; LA; QL (30 per 30 days)
INGREZZA INITIATION PACK	2	PA; LA; QL (28 per 180 days)
KESIMPTA PEN	3	PA; MO; QL (1.6 per 28 days)
KEVEYIS	3	PA
MAVENCLAD (10 TABLET PACK)	3	PA; MO; LA; QL (40 per 720 days)
MAVENCLAD (4 TABLET PACK)	3	PA; MO; LA; QL (16 per 720 days)

Drug Name	Drug Tier	Requirements/Limits
MAVENCLAD (5 TABLET PACK)	3	PA; MO; LA; QL (20 per 720 days)
MAVENCLAD (6 TABLET PACK)	3	PA; MO; LA; QL (24 per 720 days)
MAVENCLAD (7 TABLET PACK)	3	PA; MO; LA; QL (28 per 720 days)
MAVENCLAD (8 TABLET PACK)	3	PA; MO; LA; QL (32 per 720 days)
MAVENCLAD (9 TABLET PACK)	3	PA; MO; LA; QL (36 per 720 days)
MAYZENT ORAL TABLET 0.25 MG	3	PA; MO; QL (120 per 30 days)
MAYZENT ORAL TABLET 1 MG, 2 MG	3	PA; MO; QL (30 per 30 days)
MAYZENT STARTER(FOR 1MG MAINT)	3	PA; MO; QL (7 per 180 days)
MAYZENT STARTER(FOR 2MG MAINT)	3	PA; MO; QL (12 per 180 days)
<i>memantine oral capsule, sprinkle, er 24hr</i>	1	PA; MO
<i>memantine oral solution</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>memantine oral tablet</i>	1	PA; MO
MEMANTINE ORAL TABLETS,DOSE PACK	3	PA; MO
NAMENDA ORAL TABLET	3	PA; MO
NAMENDA TITRATION PAK	3	PA; MO
NAMENDA XR ORAL CAPSULE,SPRINKLE,ER 24HR	3	PA; MO
NAMZARIC	2	PA; MO
NUEDEXTA	3	PA; MO
PONVORY	3	PA; MO; QL (30 per 30 days)
PONVORY 14-DAY STARTER PACK	3	PA; MO; QL (14 per 180 days)
RADICAVA ORS	2	PA; MO
RADICAVA ORS STARTER KIT SUSP	2	PA; MO
RELYVRIO	3	PA; MO
<i>rivastigmine</i>	1	MO
<i>rivastigmine tartrate</i>	1	MO
SKYCLARYS	3	PA; LA
TASCENSO ODT	3	MO

Drug Name	Drug Tier	Requirements/Limits
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG	3	PA; MO; LA; QL (14 per 30 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 120 MG (14)- 240 MG (46)	3	PA; MO; LA; QL (120 per 180 days)
TECFIDERA ORAL CAPSULE,DELAYED RELEASE(DR/EC) 240 MG	3	PA; MO; LA; QL (60 per 30 days)
TEGSEDI	3	PA; MO; LA
<i>teriflunomide</i>	1	PA; MO; QL (30 per 30 days)
<i>tetrabenazine oral tablet 12.5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>tetrabenazine oral tablet 25 mg</i>	1	PA; MO; QL (120 per 30 days)
VUMERITY	2	PA; MO; QL (120 per 30 days)
XENAZINE ORAL TABLET 12.5 MG	3	PA; MO; LA; QL (240 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
XENAZINE ORAL TABLET 25 MG	3	PA; MO; LA; QL (120 per 30 days)
ZEPOSIA	2	PA; MO; QL (30 per 30 days)
ZEPOSIA STARTER PACK (7-DAY)	2	PA; MO; QL (7 per 180 days)
MUSCLE RELAXANTS / ANTISPASMODIC THERAPY		
<i>baclofen oral suspension</i>	1	MO
<i>baclofen oral tablet</i>	1	MO
<i>cyclobenzaprine oral tablet</i>	1	PA; MO
DANTRIUM ORAL CAPSULE 25 MG	3	MO
<i>dantrolene oral</i>	1	MO
FEXMID	3	PA; MO
FLEQSUVY	3	MO
LYVISPAH	3	MO
MESTINON ORAL	3	MO
MESTINON TIMESPAN	3	MO
<i>pyridostigmine bromide oral syrup</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
PYRIDOSTIGMI NE BROMIDE ORAL TABLET 30 MG	3	MO
<i>pyridostigmine bromide oral tablet 60 mg</i>	1	MO
<i>pyridostigmine bromide oral tablet extended release</i>	1	MO
<i>tizanidine</i>	1	MO
ZANAFLEX	3	MO
NARCOTIC ANALGESICS		
<i>acetaminophen-caff- dihydrocod oral capsule</i>	1	MO; QL (300 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)
BELBUCA	2	PA; MO; QL (60 per 30 days)
<i>buprenorphine hcl sublingual</i>	1	MO
<i>buprenorphine transdermal patch</i>	1	PA; MO; QL (4 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
BUTRANS	3	PA; MO; QL (4 per 28 days)
<i>codeine sulfate</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)
<i>endocet</i>	1	MO; QL (360 per 30 days)
<i>fentanyl</i>	1	PA; MO; QL (10 per 30 days)
<i>fentanyl citrate buccal lozenge on a handle</i>	1	PA; MO; QL (120 per 30 days)
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT 100 MCG, 400 MCG, 600 MCG, 800 MCG	3	PA; QL (120 per 30 days)
FENTANYL CITRATE BUCCAL TABLET, EFFERVESCENT 200 MCG	3	PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FENTORA	3	PA; MO; QL (120 per 30 days)
<i>hydrocodone bitartrate, oral only, er 12hr</i>	1	PA; MO; QL (90 per 30 days)
<i>hydrocodone bitartrate, oral only, ext. rel. 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml</i>	1	MO; QL (5550 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	MO; QL (390 per 30 days)
<i>hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg</i>	1	MO; QL (360 per 30 days)
<i>hydrocodone-ibuprofen</i>	1	MO; QL (50 per 30 days)
<i>hydromorphone (pf) injection solution 10 (mg/ml) (5 ml)</i>	1	
<i>hydromorphone (pf) injection solution 10 mg/ml</i>	1	MO
<i>hydromorphone oral liquid</i>	1	MO; QL (2400 per 30 days)
<i>hydromorphone oral tablet</i>	1	MO; QL (180 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>hydromorphone oral tablet extended release 24 hr</i>	1	PA; MO; QL (60 per 30 days)
HYSINGLA ER	3	PA; MO; QL (60 per 30 days)
<i>levorphanol tartrate</i>	1	MO; QL (120 per 30 days)
<i>methadone oral solution 10 mg/5 ml</i>	1	PA; MO; QL (600 per 30 days)
<i>methadone oral solution 5 mg/5 ml</i>	1	PA; MO; QL (1200 per 30 days)
<i>methadone oral tablet 10 mg</i>	1	PA; MO; QL (120 per 30 days)
<i>methadone oral tablet 5 mg</i>	1	PA; MO; QL (240 per 30 days)
<i>morphine concentrate oral solution</i>	1	MO; QL (900 per 30 days)
<i>morphine oral capsule, er multiphase 24 hr</i>	1	PA; MO; QL (60 per 30 days)
<i>morphine oral capsule, extend. release pellets 10 mg, 100 mg, 20 mg, 30 mg, 50 mg, 60 mg, 80 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>morphine oral solution</i>	1	MO; QL (900 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>morphine oral tablet</i>	1	MO; QL (180 per 30 days)
<i>morphine oral tablet extended release</i>	1	PA; MO; QL (120 per 30 days)
MS CONTIN	3	PA; MO; QL (120 per 30 days)
NALOCET	3	MO; QL (390 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	3	PA; QL (90 per 30 days)
<i>oxycodone-acetaminophen oral solution 5-325 mg/5 ml</i>	1	QL (1860 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>oxycodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg</i>	1	QL (390 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)
OXYCONTIN, 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 ONLY, EXT.REL.12 HR 80 MG	2	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)
PERCOCET	3	MO; QL (360 per 30 days)
PROLATE ORAL SOLUTION	3	MO; QL (2000 per 30 days)
<i>prolate oral tablet</i>	1	MO; QL (390 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ROXICODONE ORAL TABLET 15 MG, 30 MG	3	MO; QL (180 per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 15 MG, 30 MG	3	QL (180 per 30 days)
ROXYBOND ORAL TABLET, ORAL ONLY 5 MG	3	QL (360 per 30 days)
SEGLENTIS	3	ST; MO; QL (120 per 30 days)
TREZIX	3	MO; QL (300 per 30 days)
XTAMPZA ER	3	PA; MO; QL (90 per 30 days)

NON-NARCOTIC ANALGESICS

ARTHROTEC 50	3	ST; MO
ARTHROTEC 75	3	ST; MO
<i>buprenorphine-naloxone sublingual film 12-3 mg</i>	1	MO; QL (60 per 30 days)
<i>buprenorphine-naloxone sublingual film 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg</i>	1	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>buprenorphine-naloxone sublingual tablet 2-0.5 mg</i>	1	MO; QL (360 per 30 days)
<i>buprenorphine-naloxone sublingual tablet 8-2 mg</i>	1	MO; QL (90 per 30 days)
<i>butorphanol nasal</i>	1	MO; QL (10 per 28 days)
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
DICLOFENAC EPOLAMINE	3	PA; QL (60 per 30 days)
<i>diclofenac potassium oral capsule</i>	1	MO
<i>diclofenac potassium oral powder in packet</i>	1	MO; QL (9 per 30 days)
<i>diclofenac potassium oral tablet</i>	1	MO
<i>diclofenac sodium oral</i>	1	MO
<i>diclofenac sodium topical drops</i>	1	MO; QL (300 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>diclofenac sodium topical gel 1 %</i>	1	MO; QL (1000 per 28 days)
<i>diclofenac sodium topical solution in metered-dose pump</i>	1	MO; QL (224 per 28 days)
<i>diclofenac-misoprostol</i>	1	MO
<i>diflunisal</i>	1	MO
DUEXIS	3	ST; MO
<i>etodolac</i>	1	MO
FELDENE	3	ST; MO
<i>fenoprofen oral capsule 400 mg</i>	1	MO
<i>fenoprofen oral tablet</i>	1	MO
FLECTOR	3	PA; MO; QL (60 per 30 days)
<i>flurbiprofen oral tablet 100 mg</i>	1	MO
<i>ibu oral tablet 600 mg, 800 mg</i>	1	MO
<i>ibuprofen oral suspension</i>	1	MO
<i>ibuprofen oral tablet 400 mg, 600 mg, 800 mg</i>	1	MO
<i>ibuprofen-famotidine</i>	1	
INDOCIN RECTAL	3	MO
<i>ketoprofen oral capsule 25 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>ketoprofen oral capsule 50 mg</i>	1	
<i>ketoprofen oral capsule, ext rel. pellets 24 hr 200 mg</i>	1	MO
KETOROLAC NASAL	3	ST
KLOXXADO	3	MO
LICART	3	PA; MO; QL (30 per 30 days)
LODINE ORAL TABLET	3	ST
<i>lofena</i>	1	MO
LUCEMYRA	3	PA; MO
<i>meclofenamate</i>	1	MO
<i>mefenamic acid</i>	1	MO
<i>meloxicam oral tablet</i>	1	MO; QL (30 per 30 days)
<i>meloxicam submicronized</i>	1	MO; QL (30 per 30 days)
<i>nabumetone</i>	1	MO
NALFON ORAL CAPSULE 400 MG	3	ST; MO
NALFON ORAL TABLET	3	ST; MO
<i>naloxone injection solution</i>	1	MO
<i>naloxone injection syringe</i>	1	MO
<i>naloxone nasal</i>	1	MO
<i>naltrexone</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
NAPRELAN CR	3	ST; MO
<i>naproxen oral suspension</i>	1	MO
<i>naproxen oral tablet</i>	1	MO
<i>naproxen oral tablet, delayed release (drlec) 375 mg</i>	1	MO
<i>naproxen oral tablet, delayed release (drlec) 500 mg</i>	1	
<i>naproxen sodium oral tablet 275 mg, 550 mg</i>	1	MO
<i>naproxen sodium oral tablet, er multiphase 24 hr</i>	1	MO
<i>naproxen-esomeprazole</i>	1	MO
NARCAN	3	MO
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)
NUCYNTA ORAL TABLET 75 MG	3	MO; QL (242 per 30 days)
<i>oxaprozin</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PENNSAID TOPICAL SOLUTION IN METERED-DOSE PUMP	3	ST; MO; QL (224 per 28 days)
<i>piroxicam</i>	1	MO
RELAFEN DS	3	ST; MO
SPRIX	3	ST
SUBOXONE SUBLINGUAL FILM 12-3 MG	3	MO; QL (60 per 30 days)
SUBOXONE SUBLINGUAL FILM 2-0.5 MG	3	MO; QL (360 per 30 days)
SUBOXONE SUBLINGUAL FILM 4-1 MG, 8-2 MG	3	MO; QL (90 per 30 days)
<i>sulindac</i>	1	MO
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 17-83	3	PA; MO; QL (30 per 30 days)
TRAMADOL ORAL CAPSULE,ER BIPHASE 24 HR 25-75 100 MG, 200 MG	3	PA; MO; QL (30 per 30 days)
TRAMADOL ORAL SOLUTION	3	QL (2400 per 30 days)
TRAMADOL ORAL TABLET 100 MG	3	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>tramadol oral tablet 50 mg</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)
VIMOVO	3	ST; MO
VIVITROL	2	MO
ZIMHI	3	
ZIPSOR	3	ST; MO
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 1.4-0.36 MG, 11.4-2.9 MG, 2.9- 0.71 MG, 5.7-1.4 MG	2	MO; QL (30 per 30 days)
ZUBSOLV SUBLINGUAL TABLET 8.6-2.1 MG	2	MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PSYCHOTHERAPEUTIC DRUGS		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING 720 MG/2.4 ML	2	MO; QL (2.4 per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION, EXTENDED RELEASE SYRING 960 MG/3.2 ML	2	MO; QL (3.2 per 56 days)
ABILIFY MAINTENA	2	MO; QL (1 per 28 days)
ABILIFY MYCITE MAINTENANCE KIT ORAL TABLET WITH SENSOR AND STRIP 15 MG, 20 MG, 30 MG, 5 MG	3	QL (30 per 30 days)
ABILIFY MYCITE STARTER KIT ORAL TABLET WITH SENSOR, STRIP, POD 10 MG	3	QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ABILIFY ORAL TABLET	3	MO; QL (30 per 30 days)
ADDERALL ORAL TABLET 20 MG, 5 MG, 7.5 MG	3	MO
ADDERALL XR	3	ST; MO
ADZENYS XR-ODT	3	ST; MO
AMBIEN	3	MO; QL (30 per 30 days)
AMBIEN CR	3	MO; QL (30 per 30 days)
<i>amitriptyline</i>	1	MO
<i>amoxapine</i>	1	MO
<i>amphetamine sulfate</i>	1	PA; MO
ANAFRANIL	3	MO
ALENZIN	3	MO; QL (30 per 30 days)
APTENSIO XR	3	ST; MO
<i>aripiprazole oral solution</i>	1	MO
<i>aripiprazole oral tablet</i>	1	MO; QL (30 per 30 days)
<i>aripiprazole oral tablet, disintegrating</i>	1	MO; QL (60 per 30 days)
ARISTADA INITIO	2	MO; QL (4.8 per 365 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 1,064 MG/3.9 ML	2	MO; QL (3.9 per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 441 MG/1.6 ML	2	MO; QL (1.6 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 662 MG/2.4 ML	2	MO; QL (2.4 per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION, EXTENDED REL SYRING 882 MG/3.2 ML	2	MO; QL (3.2 per 28 days)
<i>armodafinil</i>	1	PA; MO; QL (30 per 30 days)
<i>asenapine maleate</i>	1	MO; QL (60 per 30 days)
ATIVAN ORAL TABLET 0.5 MG, 1 MG	3	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ATIVAN ORAL TABLET 2 MG	3	PA; MO; QL (150 per 30 days)
<i>atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg</i>	1	MO; QL (60 per 30 days)
<i>atomoxetine oral capsule 100 mg, 60 mg, 80 mg</i>	1	MO; QL (30 per 30 days)
AUVELITY	3	ST; MO; QL (60 per 30 days)
AZSTARYS	3	ST; MO
BELSOMRA	3	PA; MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet</i>	1	MO
<i>bupropion hcl oral tablet extended release 24 hr 150 mg</i>	1	MO; QL (90 per 30 days)
<i>bupropion hcl oral tablet extended release 24 hr 300 mg</i>	1	MO; QL (30 per 30 days)
BUPROPION HCL ORAL TABLET EXTENDED RELEASE 24 HR 450 MG	3	MO; QL (30 per 30 days)
<i>bupropion hcl oral tablet sustained-release 12 hr</i>	1	MO; QL (60 per 30 days)
<i>bupirone</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
CAPLYTA	3	MO; QL (30 per 30 days)
CELEXA ORAL TABLET	3	MO; QL (30 per 30 days)
<i>chlorpromazine oral</i>	1	MO
CITALOPRAM ORAL CAPSULE	3	MO; QL (30 per 30 days)
<i>citalopram oral solution</i>	1	MO
<i>citalopram oral tablet</i>	1	MO; QL (30 per 30 days)
<i>clomipramine</i>	1	MO
<i>clonidine hcl oral tablet extended release 12 hr</i>	1	MO
<i>clorazepate dipotassium oral tablet 15 mg</i>	1	PA; MO; QL (180 per 30 days)
<i>clorazepate dipotassium oral tablet 3.75 mg</i>	1	PA; MO; QL (90 per 30 days)
<i>clorazepate dipotassium oral tablet 7.5 mg</i>	1	PA; MO; QL (360 per 30 days)
<i>clozapine</i>	1	
CLOZARIL	3	
CONCERTA	3	ST; MO
COTEMPLA XR-ODT	3	ST; MO
CYMBALTA	3	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
DAYTRANA	3	ST; MO
DAYVIGO	3	PA; MO; QL (30 per 30 days)
<i>desipramine</i>	1	MO
DESVENLAFAXINE ORAL TABLET EXTENDED RELEASE 24 HR 100 MG	3	MO; QL (120 per 30 days)
DESVENLAFAXINE 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 ORAL CAPSULE, EXTENDED RELEASE 10 MG, 15 MG	3	ST; MO
<i>dexmethylphenidate</i>	1	MO
<i>dextroamphetamine sulfate</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)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>diazepam oral tablet</i>	1	PA; MO; QL (120 per 30 days)
<i>doxepin oral capsule</i>	1	MO
<i>doxepin oral concentrate</i>	1	MO
<i>doxepin oral tablet</i>	1	MO; QL (30 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	3	MO; QL (60 per 30 days)
DRIZALMA ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	3	MO; QL (90 per 30 days)
<i>duloxetine oral capsule, delayed release(drlec) 20 mg, 30 mg, 60 mg</i>	1	MO; QL (60 per 30 days)
<i>duloxetine oral capsule, delayed release(drlec) 40 mg</i>	1	MO; QL (90 per 30 days)
DYANAVAL XR	3	ST; MO
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 150 MG, 37.5 MG	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
EFFEXOR XR ORAL CAPSULE,EXTENDED RELEASE 24HR 75 MG	3	MO; QL (90 per 30 days)
EMSAM	2	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	MO; QL (30 per 30 days)
EVEKEO	3	PA; MO
EVEKEO ODT	3	PA; MO
FANAPT ORAL TABLET	3	MO; QL (60 per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	3	MO; QL (8 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24HR DOSE PACK	2	MO; QL (28 per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	2	MO; QL (30 per 30 days)
<i>fluoxetine (pmdd) oral tablet 10 mg</i>	1	QL (240 per 30 days)
<i>fluoxetine (pmdd) oral tablet 20 mg</i>	1	QL (120 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>fluoxetine oral capsule 10 mg</i>	1	MO; QL (30 per 30 days)
<i>fluoxetine oral capsule 20 mg</i>	1	MO; QL (90 per 30 days)
<i>fluoxetine oral capsule 40 mg</i>	1	MO; QL (60 per 30 days)
<i>fluoxetine oral capsule, delayed release(drlec)</i>	1	MO; QL (4 per 28 days)
<i>fluoxetine oral solution</i>	1	MO
<i>fluoxetine oral tablet 10 mg</i>	1	MO; QL (240 per 30 days)
<i>fluoxetine oral tablet 20 mg</i>	1	MO; QL (120 per 30 days)
<i>fluoxetine oral tablet 60 mg</i>	1	MO; QL (30 per 30 days)
<i>fluphenazine decanoate</i>	1	MO
<i>fluphenazine hcl</i>	1	MO
<i>fluvoxamine oral capsule, extended release 24hr</i>	1	MO; QL (60 per 30 days)
<i>fluvoxamine oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>fluvoxamine oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>fluvoxamine oral tablet 50 mg</i>	1	MO; QL (60 per 30 days)
FOCALIN	3	MO
FOCALIN XR	3	ST; MO
FORFIVO XL	3	MO; QL (30 per 30 days)
GEODON INTRAMUSCULAR	3	MO
GEODON ORAL	3	MO; QL (60 per 30 days)
HALDOL DECANOATE	3	MO
<i>haloperidol</i>	1	MO
<i>haloperidol decanoate intramuscular solution 100 mg/ml (1 ml)</i>	1	
<i>haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml, 50 mg/ml(1ml)</i>	1	MO
<i>haloperidol lactate injection</i>	1	MO
<i>haloperidol lactate oral</i>	1	MO
HETLIOZ	3	PA; MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HETLIOZ LQ	3	PA; MO; QL (158 per 30 days)
<i>imipramine hcl</i>	1	MO
<i>imipramine pamoate</i>	1	MO
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	2	MO; QL (3.5 per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	2	MO; QL (5 per 180 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 1.5 MG, 3 MG, 9 MG	3	MO; QL (30 per 30 days)
INVEGA ORAL TABLET EXTENDED RELEASE 24HR 6 MG	3	MO; QL (60 per 30 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	2	MO; QL (0.75 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	2	MO; QL (1 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	2	MO; QL (1.5 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	2	MO; QL (0.25 per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	2	MO; QL (0.5 per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	2	MO; QL (0.88 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	2	MO; QL (1.32 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	2	MO; QL (1.75 per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	2	MO; QL (2.63 per 90 days)
JORNAY PM	3	ST; MO
KAPVAY	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	3	MO; QL (30 per 30 days)
LATUDA ORAL TABLET 80 MG	3	MO; QL (60 per 30 days)
LEXAPRO ORAL TABLET	3	MO; QL (30 per 30 days)
<i>lithium carbonate</i>	1	MO
LITHOBID	3	MO
<i>lorazepam intensol</i>	1	PA; 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)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 1 MG, 1.5 MG	3	PA; MO; QL (30 per 30 days)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 2 MG	3	PA; MO; QL (150 per 30 days)
LOREEV XR ORAL CAPSULE, EXTENDED RELEASE 24HR 3 MG	3	PA; MO; QL (90 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>loxapine succinate</i>	1	MO
LUNESTA	3	MO; QL (30 per 30 days)
<i>lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg</i>	1	MO; QL (30 per 30 days)
<i>lurasidone oral tablet 80 mg</i>	1	MO; QL (60 per 30 days)
LYBALVI	3	ST; MO; QL (30 per 30 days)
MARPLAN	3	MO
<i>methamphetamine</i>	1	PA; MO
METHYLIN ORAL SOLUTION	3	MO
<i>methylphenidate</i>	1	MO
<i>methylphenidate hcl oral cap, er sprinkle, biphasic 40-60</i>	1	MO
<i>methylphenidate hcl oral capsule, er biphasic 30-70</i>	1	MO
<i>methylphenidate hcl oral capsule, er biphasic 50-50</i>	1	MO
<i>methylphenidate hcl oral solution</i>	1	MO
<i>methylphenidate hcl oral tablet</i>	1	MO
<i>methylphenidate hcl oral tablet extended release</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>methylphenidate hcl oral tablet extended release 24hr 18 mg (bx rating), 27 mg (bx rating), 36 mg (bx rating), 54 mg (bx rating)</i>	1	
<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 45 MG, 63 MG, 72 MG	3	ST; MO
<i>methylphenidate hcl oral tablet, chewable</i>	1	MO
<i>mirtazapine</i>	1	MO
<i>modafinil oral tablet 100 mg</i>	1	PA; MO; QL (30 per 30 days)
<i>modafinil oral tablet 200 mg</i>	1	PA; MO; QL (60 per 30 days)
<i>molindone</i>	1	MO
MYDAYIS	3	ST; MO
NARDIL	3	MO
<i>nefazodone</i>	1	MO
NORPRAMIN ORAL TABLET 10 MG, 25 MG	3	MO
<i>nortriptyline</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
NUPLAZID	3	PA; MO; QL (30 per 30 days)
NUVIGIL	3	PA; MO; QL (30 per 30 days)
<i>olanzapine intramuscular</i>	1	MO
<i>olanzapine oral</i>	1	MO; QL (30 per 30 days)
<i>olanzapine-fluoxetine</i>	1	MO
<i>paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 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)
PAMELOR	3	MO
PARNATE	3	MO
<i>paroxetine hcl oral suspension</i>	1	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. sy m)</i>	1	MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PAXIL CR	3	MO; QL (60 per 30 days)
PAXIL ORAL SUSPENSION	3	MO
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
PERSERIS	2	MO; QL (1 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 ORAL TABLET 100 MG	3	PA; MO; QL (30 per 30 days)
PROVIGIL ORAL TABLET 200 MG	3	PA; MO; QL (60 per 30 days)
PROZAC ORAL CAPSULE 10 MG	3	MO; QL (30 per 30 days)
PROZAC ORAL CAPSULE 20 MG	3	MO; QL (90 per 30 days)
PROZAC ORAL CAPSULE 40 MG	3	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
QELBREE ORAL CAPSULE, EXTENDED RELEASE 24HR 100 MG, 150 MG	3	ST; MO; QL (30 per 30 days)
QELBREE ORAL CAPSULE, EXTENDED RELEASE 24HR 200 MG	3	ST; 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)
QUETIAPINE ORAL TABLET 150 MG	3	MO; QL (90 per 30 days)
<i>quetiapine oral tablet 300 mg, 400 mg</i>	1	MO; QL (60 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 150 mg, 200 mg</i>	1	MO; QL (30 per 30 days)
<i>quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg</i>	1	MO; QL (60 per 30 days)
QUILLICHEWER	3	ST; MO
QUILLIVANT XR	3	ST; MO
QUVIVIQ	3	PA; MO; QL (30 per 30 days)
<i>ramelteon</i>	1	MO; QL (30 per 30 days)
RELEXXII	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
REMERON ORAL TABLET 15 MG, 30 MG	3	MO
REMERON SOLTAB	3	MO
REXULTI	3	MO; QL (30 per 30 days)
RISPERDAL CONSTA	2	MO; QL (2 per 28 days)
RISPERDAL ORAL SOLUTION	3	MO
RISPERDAL ORAL TABLET 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
<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)

Drug Name	Drug Tier	Requirements/Limits
RITALIN	3	MO
RITALIN LA	3	ST; MO
ROZEREM	3	MO; QL (30 per 30 days)
SAPHRIS	3	MO; QL (60 per 30 days)
SECUADO	3	MO; QL (30 per 30 days)
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)
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)
SERTRALINE ORAL CAPSULE	3	MO; QL (30 per 30 days)
<i>sertraline oral concentrate</i>	1	MO
<i>sertraline oral tablet 100 mg, 50 mg</i>	1	MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>sertraline oral tablet 25 mg</i>	1	MO; QL (30 per 30 days)
SILENOR	3	MO; QL (30 per 30 days)
SODIUM OXYBATE	3	PA; LA; QL (540 per 30 days)
STRATTERA ORAL CAPSULE 10 MG, 18 MG, 25 MG, 40 MG	3	ST; MO; QL (60 per 30 days)
STRATTERA ORAL CAPSULE 100 MG, 60 MG, 80 MG	3	ST; MO; QL (30 per 30 days)
SUNOSI	3	PA; MO; QL (30 per 30 days)
SYMBYAX ORAL CAPSULE 3-25 MG, 6-25 MG	3	MO
<i>tasimelteon</i>	1	PA; QL (30 per 30 days)
<i>thioridazine</i>	1	MO
<i>thiothixene</i>	1	MO
<i>tranylcypromine</i>	1	MO
<i>trazodone</i>	1	MO
<i>trifluoperazine</i>	1	MO
<i>trimipramine</i>	1	MO
TRINTELLIX	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 100 MG/0.28 ML	2	MO; QL (0.28 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 125 MG/0.35 ML	2	MO; QL (0.35 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 150 MG/0.42 ML	2	MO; QL (0.42 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 200 MG/0.56 ML	2	MO; QL (0.56 per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 250 MG/0.7 ML	2	MO; QL (0.7 per 56 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 50 MG/0.14 ML	2	MO; QL (0.14 per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION, EXTENDED REL SYRING 75 MG/0.21 ML	2	MO; QL (0.21 per 28 days)
VALIUM	3	PA; MO; QL (120 per 30 days)
VENLAFAXINE BESYLATE	3	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 150 mg, 37.5 mg</i>	1	MO; QL (30 per 30 days)
<i>venlafaxine oral capsule, extended release 24hr 75 mg</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet</i>	1	MO; QL (90 per 30 days)
<i>venlafaxine oral tablet extended release 24hr</i>	1	MO; QL (30 per 30 days)
VERSACLOZ	2	
VIIBRYD ORAL TABLET	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
VIIBRYD ORAL TABLETS, DOSE PACK 10 MG (7)-20 MG (23)	2	MO; QL (30 per 180 days)
<i>vilazodone</i>	1	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE	3	MO; QL (30 per 30 days)
VRAYLAR ORAL CAPSULE, DOSE PACK	3	MO; QL (7 per 180 days)
VYVANSE	3	ST; MO
WAKIX	3	PA; MO; LA; QL (60 per 30 days)
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)
XELSTRYM	3	ST; MO
XYREM	3	PA; LA; QL (540 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
XYWAV	3	PA; LA; QL (540 per 30 days)
<i>zaleplon oral capsule 10 mg</i>	1	MO; QL (60 per 30 days)
<i>zaleplon oral capsule 5 mg</i>	1	MO; QL (30 per 30 days)
<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)
<i>ziprasidone mesylate</i>	1	MO
ZOLOFT ORAL CONCENTRATE	3	MO
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 tablet</i>	1	MO; QL (30 per 30 days)
<i>zolpidem oral tablet, ext release multiphase</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ZYPREXA INTRAMUSCULAR	3	MO
ZYPREXA ORAL	3	MO; QL (30 per 30 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	2	MO; QL (2 per 28 days)
ZYPREXA ZYDIS	3	MO; QL (30 per 30 days)

CARDIOVASCULAR, HYPERTENSION / LIPIDS

ANTIARRHYTHMIC AGENTS

<i>amiodarone oral tablet 100 mg, 200 mg</i>	1	MO
<i>amiodarone oral tablet 400 mg</i>	1	
BETAPACE AF	3	MO
<i>dofetilide</i>	1	MO
<i>flecainide</i>	1	MO
<i>mexiletine</i>	1	MO
MULTAQ	3	MO
<i>pacerone oral tablet 100 mg, 200 mg, 400 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<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</i>	1	
<i>sotalol oral</i>	1	MO
SOTYLIZE	3	MO
TIKOSYN	3	MO
ANTIHYPERTENSIVE THERAPY		
<i>acebutolol</i>	1	MO
ALDACTAZIDE ORAL TABLET 25-25 MG	3	MO
ALDACTONE	3	MO
<i>aliskiren</i>	1	MO
ALTACE	3	MO
<i>amiloride</i>	1	MO
<i>amiloride-hydrochlorothiazide</i>	1	MO
<i>amlodipine</i>	1	MO
<i>amlodipine-benazepril</i>	1	MO
<i>amlodipine-olmesartan</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<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	3	MO; QL (180 per 30 days)
<i>bisoprolol fumarate</i>	1	MO
<i>bisoprolol-hydrochlorothiazide</i>	1	MO
<i>bumetanide</i>	1	MO
BYSTOLIC	3	MO
<i>candesartan</i>	1	MO
<i>candesartan-hydrochlorothiazid</i>	1	MO
<i>captopril</i>	1	MO
CARDIZEM CD	3	MO
CARDIZEM 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
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)
CAROSPIR	3	MO
<i>cartia xt</i>	1	MO
<i>carvedilol</i>	1	MO
<i>carvedilol phosphate</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
CONJUPRI	3	MO
COREG CR	3	MO
CORGARD ORAL TABLET 20 MG, 40 MG	3	MO
COZAAR	3	ST; MO
DEMSER	3	PA; MO
DIBENZYLINE	3	PA; MO
<i>diltiazem hcl oral capsule, extended release 12 hr</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>diltiazem hcl oral capsule, extended release 24 hr 360 mg, 420 mg</i>	1	MO
<i>diltiazem hcl oral capsule, extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg</i>	1	MO
<i>diltiazem hcl oral tablet</i>	1	MO
<i>diltiazem hcl oral tablet extended release 24 hr 120 mg</i>	1	MO
<i>diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg, 420 mg</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)
DYRENIUM	3	MO
EDARBI	2	MO
EDARBYCLOR	2	MO
EDECIN	3	MO
<i>enalapril maleate</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>enalapril-hydrochlorothiazide</i>	1	MO
<i>eplerenone</i>	1	MO
<i>ethacrynic acid</i>	1	MO
EXFORGE	3	ST; MO
EXFORGE HCT	3	ST; MO
<i>felodipine</i>	1	MO
<i>fosinopril</i>	1	MO
<i>fosinopril-hydrochlorothiazide</i>	1	MO
FUROSCIX	3	ST
<i>furosemide injection solution</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>isosorbide-hydralazine</i>	1	MO; QL (180 per 30 days)
<i>isradipine</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
KAPSPARGO SPRINKLE	3	MO
KATERZIA	3	MO
KERENDIA	2	PA; QL (30 per 30 days)
<i>labetalol oral</i>	1	MO
LASIX	3	MO
LEVAMLODIPINE	3	MO
<i>lisinopril</i>	1	MO
<i>lisinopril-hydrochlorothiazide</i>	1	MO
LOPRESSOR ORAL	3	MO
<i>losartan</i>	1	MO
<i>losartan-hydrochlorothiazide</i>	1	MO
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
<i>metolazone</i>	1	MO
<i>metoprolol succinate</i>	1	MO
<i>metoprolol ta-hydrochlorothiaz</i>	1	MO
<i>metoprolol tartrate oral</i>	1	MO
<i>metyrosine</i>	1	PA; MO
MICARDIS	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
MICARDIS HCT	3	ST; MO
MINIPRESS	3	MO
<i>minoxidil oral</i>	1	MO
<i>moexipril</i>	1	MO
<i>nadolol</i>	1	MO
<i>nebivolol</i>	1	MO
<i>nicardipine oral</i>	1	MO
<i>nifedipine oral tablet extended release</i>	1	MO
<i>nifedipine oral tablet extended release 24hr</i>	1	MO
<i>nimodipine</i>	1	MO
<i>nisoldipine</i>	1	MO
NORLIQVA	3	MO
NORVASC	3	MO
NYMALIZE ORAL SYRINGE 60 MG/10 ML	3	
<i>olmesartan</i>	1	MO
<i>olmesartan-amlodipin-hcthiazyd</i>	1	MO
<i>olmesartan-hydrochlorothiazide</i>	1	MO
ORENITRAM	3	PA; MO
ORENITRAM MONTH 1 TITRATION KT	3	PA; MO
ORENITRAM MONTH 2 TITRATION KT	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
ORENITRAM MONTH 3 TITRATION KT	3	PA; MO
<i>perindopril erbumine</i>	1	MO
<i>phenoxybenzamine</i>	1	PA; MO
<i>pindolol</i>	1	MO
<i>prazosin</i>	1	MO
PROCARDIA XL	3	MO
<i>propranolol oral</i>	1	MO
QBRELIS	3	MO
<i>quinapril</i>	1	MO
<i>ramipril</i>	1	MO
SOANZ	3	ST; 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
<i>taztia xt</i>	1	MO
TEKTURNA	3	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
TENORMIN	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<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)
THALITONE	3	MO
<i>tiadylt er</i>	1	MO
TIAZAC	3	MO
<i>timolol maleate oral</i>	1	MO
TOPROL XL	3	MO
<i>torse mide oral</i>	1	MO
<i>trandolapril</i>	1	MO
<i>trandolapril-verapamil</i>	1	MO
<i>treprostinil sodium</i>	1	PA; MO; LA
<i>triamterene</i>	1	MO
<i>triamterene-hydrochlorothiazid</i>	1	MO
TRIBENZOR	3	ST; MO
UPTRAVI ORAL	2	PA; MO; LA
VALSARTAN ORAL SOLUTION	3	ST; MO
<i>valsartan oral tablet</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

Drug Name	Drug Tier	Requirements/Limits
ZESTORETIC	3	MO
ZESTRIL	3	MO
ZIAC	3	MO
COAGULATION THERAPY		
ARIXTRA	3	MO
<i>aspirin-dipyridamole</i>	1	MO
BRILINTA	2	MO
CABLIVI INJECTION KIT	2	PA; LA
<i>cilostazol</i>	1	MO
<i>clopidogrel oral tablet 75 mg</i>	1	MO; QL (30 per 30 days)
<i>dabigatran etexilate</i>	1	MO
<i>dipyridamole oral</i>	1	MO
DOPTELET (10 TAB PACK)	2	PA; MO; LA
DOPTELET (15 TAB PACK)	2	PA; MO; LA
DOPTELET (30 TAB PACK)	2	PA; MO; LA
EFFIENT	3	MO
ELIQUIS	2	MO
ELIQUIS DVT-PE TREAT 30D START	2	MO
<i>enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml</i>	1	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml</i>	1	MO; QL (22.4 per 28 days)
<i>enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml</i>	1	MO; QL (16.8 per 28 days)
<i>enoxaparin subcutaneous syringe 40 mg/0.4 ml</i>	1	MO; QL (11.2 per 28 days)
<i>fondaparinux</i>	1	MO
FRAGMIN SUBCUTANEOUS SOLUTION 25,000 ANTI-XA UNIT/ML	3	MO
FRAGMIN SUBCUTANEOUS SYRINGE	3	MO
<i>heparin (porcine) injection solution</i>	1	MO
<i>jantoven</i>	1	MO
LOVENOX SUBCUTANEOUS SYRINGE 100 MG/ML, 150 MG/ML	3	MO; QL (28 per 28 days)
LOVENOX SUBCUTANEOUS SYRINGE 120 MG/0.8 ML, 80 MG/0.8 ML	3	MO; QL (22.4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
LOVENOX SUBCUTANEOUS SYRINGE 30 MG/0.3 ML, 60 MG/0.6 ML	3	MO; QL (16.8 per 28 days)
LOVENOX SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	3	MO; QL (11.2 per 28 days)
MULPLETA	3	PA; MO
<i>pentoxifylline</i>	1	MO
PLAVIX ORAL TABLET 75 MG	3	MO; QL (30 per 30 days)
PRADAXA ORAL CAPSULE	3	PA; MO
PRADAXA ORAL PELLETS IN PACKET	3	PA
<i>prasugrel</i>	1	MO
PROMACTA	3	PA; MO; LA
SAVAYSA	3	PA; MO
TAVALISSE	3	PA; LA; QL (60 per 30 days)
<i>warfarin</i>	1	MO
XARELTO	2	MO
XARELTO DVT-PE TREAT 30D START	2	MO
ZONTIVITY	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
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 90 MG	3	MO
<i>atorvastatin</i>	1	MO; QL (30 per 30 days)
CADUET	3	ST; MO; QL (30 per 30 days)
<i>cholestyramine (with sugar) oral powder in packet</i>	1	MO
<i>cholestyramine light oral powder in packet</i>	1	
<i>colesevelam</i>	1	MO
COLESTID ORAL PACKET	3	MO
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)

Drug Name	Drug Tier	Requirements/Limits
EZALLOR SPRINKLE	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 oral capsule 130 mg, 134 mg, 200 mg, 43 mg, 67 mg</i>	1	MO
FENOFIBRATE MICRONIZED ORAL CAPSULE 90 MG	3	MO
<i>fenofibrate nanocrystallized</i>	1	MO
FENOFIBRATE ORAL CAPSULE	3	MO
<i>fenofibrate oral tablet</i>	1	MO
<i>fenofibric acid (choline)</i>	1	MO
FENOGLIDE	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)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>fluvastatin oral tablet extended release 24 hr</i>	1	MO; QL (30 per 30 days)
<i>gemfibrozil</i>	1	MO
<i>icosapent ethyl</i>	1	MO
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	2	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	3	ST; 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
NEXLETOL	2	PA; MO
NEXLIZET	2	PA; MO
<i>niacin oral tablet 500 mg</i>	1	MO
<i>niacin oral tablet extended release 24 hr</i>	1	MO
NIACOR	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>omega-3 acid ethyl esters</i>	1	MO
PRALUENT PEN	3	PA; QL (2 per 28 days)
<i>pravastatin</i>	1	MO; QL (30 per 30 days)
<i>prevalite oral powder in packet</i>	1	MO
QUESTRAN LIGHT	3	MO
QUESTRAN ORAL POWDER	3	MO
REPATHA	2	PA; QL (6 per 28 days)
REPATHA PUSHTRONEX	2	PA; QL (7 per 28 days)
REPATHA SURECLICK	2	PA; QL (6 per 28 days)
<i>rosuvastatin</i>	1	MO; QL (30 per 30 days)
ROSZET	3	ST; MO; QL (30 per 30 days)
<i>simvastatin</i>	1	MO; QL (30 per 30 days)
TRICOR	3	MO
TRILIPIX	3	MO
VASCEPA	3	ST; MO
VYTORIN 10-10	3	ST; MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
VYTORIN 10-20	3	ST; MO; QL (30 per 30 days)
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 ORAL TABLET 10 MG, 20 MG, 40 MG	3	ST; MO; QL (30 per 30 days)
ZYPITAMAG	3	ST; MO; QL (30 per 30 days)
MISCELLANEOUS CARDIOVASCULAR AGENTS		
ASPRUZYO SPRINKLE	3	MO
CAMZYOS	3	PA; MO; QL (30 per 30 days)
CORLANOR ORAL SOLUTION	2	QL (450 per 30 days)
CORLANOR ORAL TABLET	2	MO; QL (60 per 30 days)
<i>digoxin oral</i>	1	MO
ENTRESTO	2	MO; QL (60 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FILSPARI	3	PA; MO; QL (30 per 30 days)
LANOXIN ORAL	3	MO
<i>ranolazine</i>	1	MO
VECAMYL	3	
VERQUVO	2	MO; QL (30 per 30 days)
VYNDAMAX	3	PA; MO
VYNDAQEL	3	PA; MO
NITRATES		
ISORDIL	3	MO
ISORDIL TITRADOSE ORAL TABLET 5 MG	3	MO
<i>isosorbide dinitrate oral tablet</i>	1	MO
<i>isosorbide mononitrate</i>	1	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</i>	1	MO
NITROLINGUAL	3	MO
NITROSTAT	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
DERMATOLOGICAL/TOPICAL THERAPY		
ANTIPSORIATIC / ANTISEBORRHOIC		
<i>acitretin</i>	1	MO
<i>calcipotriene scalp</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene topical cream</i>	1	MO; QL (120 per 30 days)
CALCIPOTRIENE TOPICAL FOAM	3	QL (120 per 30 days)
<i>calcipotriene topical ointment</i>	1	MO; QL (120 per 30 days)
<i>calcipotriene-betamethasone</i>	1	MO; QL (400 per 30 days)
<i>calcitriol topical</i>	1	
COSENTYX (2 SYRINGES)	3	PA; MO; QL (10 per 28 days)
COSENTYX PEN (2 PENS)	3	PA; MO; QL (10 per 28 days)
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	3	PA; MO; QL (2.5 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ENSTILAR	3	MO; QL (400 per 30 days)
ILUMYA	3	PA; MO; QL (2 per 28 days)
<i>selenium sulfide topical lotion</i>	1	MO
SILIQ	3	PA; MO; QL (6 per 28 days)
SKYRIZI SUBCUTANEOUS PEN INJECTOR	2	PA; MO; QL (2 per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	2	PA; MO; QL (2 per 28 days)
SORILUX	3	MO; QL (120 per 30 days)
SOTYKTU	3	PA; MO
STELARA INTRAVENOUS	2	PA; MO; QL (104 per 180 days)
STELARA SUBCUTANEOUS SOLUTION	2	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	2	PA; MO; QL (0.5 per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	2	PA; MO; QL (1 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TACLONEX	3	MO; QL (400 per 30 days)
TALTZ AUTOINJECTOR	2	PA; MO; QL (1 per 28 days)
TALTZ SYRINGE	2	PA; MO; QL (1 per 28 days)
TREMFYA	3	PA; MO; QL (2 per 28 days)
VECTICAL	3	
VTAMA	3	PA; MO
ZORYVE	3	PA; MO
MISCELLANEOUS DERMATOLOGICALS		
ADBRY	2	PA; MO; QL (6 per 28 days)
<i>ammonium lactate</i>	1	MO
CARAC	3	MO
CIBINQO	2	PA; MO; QL (30 per 30 days)
CONDYLOX TOPICAL GEL	3	MO
<i>diclofenac sodium topical gel 3 %</i>	1	PA; MO; QL (100 per 28 days)
<i>doxepin topical</i>	1	MO; QL (45 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
DUPIXENT SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	2	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	2	PA; MO; QL (8 per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	2	PA; MO; QL (1.34 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	2	PA; MO; QL (4.56 per 28 days)
DUPIXENT SUBCUTANEOUS SYRINGE 300 MG/2 ML	2	PA; MO; QL (8 per 28 days)
EFUDEX TOPICAL CREAM	3	MO
ELIDEL	3	PA; MO; QL (100 per 30 days)
EUCRISA	3	PA; MO; QL (120 per 30 days)
FLUOROURACIL TOPICAL CREAM 0.5 %	3	MO
<i>fluorouracil topical cream 5 %</i>	1	MO
<i>fluorouracil topical solution</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HYFTOR	3	PA
<i>imiquimod topical cream in metered-dose pump</i>	1	MO
<i>imiquimod topical cream in packet 5%</i>	1	MO
<i>lidocaine hcl mucous membrane solution 4% (40 mg/ml)</i>	1	MO
<i>lidocaine topical adhesive patch, medicated 5%</i>	1	PA; MO; QL (90 per 30 days)
<i>lidocaine topical ointment</i>	1	MO; QL (36 per 30 days)
<i>lidocaine viscous</i>	1	MO
<i>lidocaine-prilocaine topical cream</i>	1	MO; QL (30 per 30 days)
LIDODERM	3	PA; MO; QL (90 per 30 days)
<i>methoxsalen</i>	1	MO
OPZELURA	3	PA; MO; QL (240 per 28 days)
PANRETIN	2	PA; MO
<i>pimecrolimus</i>	1	PA; MO; QL (100 per 30 days)
PLIAGLIS	3	PA; QL (30 per 30 days)
<i>podofilox</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>prudoxin</i>	1	MO; QL (45 per 30 days)
REGRANEX	2	MO; QL (15 per 30 days)
SANTYL	2	MO; QL (180 per 30 days)
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)
VALCHLOR	2	PA; MO
ZONALON	3	MO; QL (45 per 30 days)
ZTLIDO	3	PA; MO; QL (90 per 30 days)
ZYCLARA TOPICAL CREAM IN METERED-DOSE PUMP	3	MO
THERAPY FOR ACNE		
ABSORICA	3	
ABSORICA LD	3	
ACANYA TOPICAL GEL WITH PUMP	3	MO
<i>accutane</i>	1	

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ACZONE	3	MO
<i>adapalene topical cream</i>	1	PA; MO
<i>adapalene topical gel 0.3 %</i>	1	PA; MO
<i>adapalene topical swab</i>	1	PA
<i>adapalene-benzoyl peroxide</i>	1	PA; MO
AKLIEF	3	PA; MO
ALTRENO	3	PA; MO
<i>amnestem</i>	1	
AMZEEQ	3	MO
ARAZLO	3	PA; MO
ATRALIN	3	PA; MO
<i>avita topical cream</i>	1	PA; MO
<i>azelaic acid</i>	1	MO
AZELEX	3	MO
BENZAMYCIN	3	MO
<i>brimonidine topical</i>	1	PA; MO
<i>claravis</i>	1	
CLEOCIN T TOPICAL LOTION	3	MO; QL (120 per 30 days)
<i>clindacin</i>	1	QL (100 per 30 days)
<i>clindacin etz topical swab</i>	1	MO; QL (69 per 30 days)
CLINDAGEL	3	MO; QL (150 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clindamycin phosphate topical foam</i>	1	QL (100 per 30 days)
<i>clindamycin phosphate topical gel</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical lotion</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical solution</i>	1	MO; QL (120 per 30 days)
<i>clindamycin phosphate topical swab</i>	1	MO; QL (60 per 30 days)
<i>clindamycin-benzoyl peroxide topical gel</i>	1	MO
<i>clindamycin-benzoyl peroxide topical gel with pump 1.2-2.5 %</i>	1	MO
<i>clindamycin-tretinoin</i>	1	PA; MO
<i>dapsone topical</i>	1	MO
DIFFERIN TOPICAL CREAM	3	PA; MO
DIFFERIN TOPICAL GEL WITH PUMP	3	PA; MO
DIFFERIN TOPICAL LOTION	3	PA; MO
EPIDUO FORTE	3	PA; MO
EPIDUO TOPICAL GEL WITH PUMP	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EPSOLAY	3	ST; 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
FABIOR	3	PA; MO
FINACEA	3	ST; MO
<i>isotretinoin</i>	1	
<i>ivermectin topical cream</i>	1	MO; QL (60 per 30 days)
METROCREAM	3	ST; MO
METROGEL TOPICAL GEL 1 %	3	ST; MO
METROLOTION	3	ST
<i>metronidazole topical cream</i>	1	MO
<i>metronidazole topical gel</i>	1	MO
<i>metronidazole topical lotion</i>	1	MO
MIRVASO	3	PA; MO
<i>neuac</i>	1	MO
NORITATE	3	ST; MO
ONEXTON TOPICAL GEL WITH PUMP	3	MO
RETIN-A	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
RETIN-A MICRO TOPICAL GEL 0.04 %, 0.1 %	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; QL (60 per 30 days)
<i>tazarotene topical cream</i>	1	PA; MO
TAZAROTENE TOPICAL FOAM	3	PA
<i>tazarotene topical gel</i>	1	PA; MO
TAZORAC	3	PA; MO
<i>tretinoin microspheres topical gel</i>	1	PA; MO
<i>tretinoin topical</i>	1	PA; MO
TWYNEO	3	PA; MO
VELTIN	3	PA
WINLEVI	3	PA; MO
<i>zenatane</i>	1	
ZIANA	3	PA
ZILXI	3	ST; MO
TOPICAL ANTIBACTERIALS		
ALTABAX	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>gentamicin topical</i>	1	MO; QL (60 per 30 days)
KLARON	3	MO
<i>mafenide acetate</i>	1	MO
<i>mupirocin</i>	1	MO; QL (44 per 30 days)
<i>mupirocin calcium</i>	1	MO; QL (30 per 30 days)
NEO-SYNALAR	3	MO
<i>sulfacetamide sodium (acne)</i>	1	MO
SULFAMYLON TOPICAL CREAM	3	MO
TOPICAL ANTIFUNGALS		
<i>ciclopirox topical cream</i>	1	MO; QL (90 per 28 days)
<i>ciclopirox topical gel</i>	1	MO; QL (100 per 28 days)
<i>ciclopirox topical shampoo</i>	1	MO; QL (120 per 28 days)
<i>ciclopirox topical solution</i>	1	MO; QL (6.6 per 28 days)
<i>ciclopirox topical suspension</i>	1	MO; QL (60 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clotrimazole topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole topical solution</i>	1	MO; QL (30 per 28 days)
<i>clotrimazole-betamethasone topical cream</i>	1	MO; QL (45 per 28 days)
<i>clotrimazole-betamethasone topical lotion</i>	1	MO; QL (60 per 28 days)
<i>econazole</i>	1	MO; QL (85 per 28 days)
ERTACZO	3	MO; QL (60 per 28 days)
EXELDERM	3	MO; QL (60 per 28 days)
JUBLIA	3	MO; QL (8 per 30 days)
KERYDIN	3	MO; QL (10 per 30 days)
<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)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>ketodan</i>	1	MO; QL (100 per 28 days)
LOPROX TOPICAL SHAMPOO	3	MO; QL (120 per 28 days)
LULICONAZOLE	3	MO; QL (60 per 28 days)
LUZU	3	MO; QL (60 per 28 days)
<i>naftifine topical cream</i>	1	MO; QL (60 per 28 days)
<i>naftifine topical gel 2%</i>	1	MO; QL (60 per 28 days)
NAFTIN TOPICAL GEL	3	MO; QL (60 per 28 days)
<i>nyamyc</i>	1	MO; QL (180 per 30 days)
<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	QL (180 per 30 days)
<i>nystatin-triamcinolone</i>	1	MO; QL (60 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>nystop</i>	1	MO; QL (180 per 30 days)
<i>oxiconazole</i>	1	MO; QL (90 per 28 days)
OXISTAT TOPICAL CREAM	3	QL (90 per 28 days)
OXISTAT TOPICAL LOTION	3	MO; QL (60 per 28 days)
<i>tavaborole</i>	1	MO; QL (10 per 30 days)

TOPICAL ANTIVIRALS

<i>acyclovir topical cream</i>	1	PA; MO; QL (5 per 30 days)
<i>acyclovir topical ointment</i>	1	PA; MO; QL (30 per 30 days)
DENAVIR	3	MO; QL (5 per 30 days)
<i>penciclovir</i>	1	MO; QL (5 per 30 days)
XERESE	3	MO
ZOVIRAX TOPICAL CREAM	3	PA; MO; QL (5 per 30 days)
ZOVIRAX TOPICAL OINTMENT	3	PA; MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TOPICAL CORTICOSTEROIDS		
<i>ala-cort topical cream 1 %</i>	1	MO
<i>ala-cort topical cream 2.5 %</i>	1	
ALA-SCALP	3	MO
<i>alclometasone</i>	1	MO
<i>amcinonide topical lotion</i>	1	MO
<i>apexicon e</i>	1	MO; QL (120 per 30 days)
<i>betamethasone dipropionate</i>	1	MO
<i>betamethasone valerate</i>	1	MO
<i>betamethasone, augmented</i>	1	MO
BRYHALI	3	MO
CAPEX	3	MO
<i>clobetasol scalp</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical cream</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical foam</i>	1	MO; QL (100 per 28 days)
<i>clobetasol topical gel</i>	1	MO; QL (120 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
<i>clobetasol topical lotion</i>	1	MO; QL (118 per 28 days)
<i>clobetasol topical ointment</i>	1	MO; QL (120 per 28 days)
<i>clobetasol topical shampoo</i>	1	MO; QL (236 per 28 days)
<i>clobetasol topical spray, non-aerosol</i>	1	MO; QL (125 per 28 days)
<i>clobetasol-emollient topical cream</i>	1	MO; QL (120 per 28 days)
<i>clobetasol-emollient topical foam</i>	1	MO; QL (100 per 28 days)
CLOBEX TOPICAL LOTION	3	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>clocortolone pivalate</i>	1	MO
<i>clodan</i>	1	MO; QL (236 per 28 days)
CLODERM	3	MO
CORDRAN TAPE LARGE ROLL	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
CORDRAN TOPICAL CREAM 0.05 %	3	MO; QL (120 per 30 days)
CORDRAN TOPICAL LOTION	3	MO; QL (120 per 30 days)
DERMA-SMOOTHIE/FS SCALP OIL	3	MO
<i>desonide</i>	1	MO
DESOWEN TOPICAL CREAM	3	
<i>desoximetasone</i>	1	MO
<i>desrx</i>	1	MO
<i>diflorasone</i>	1	MO; QL (120 per 30 days)
DIPROLENE (AUGMENTED) TOPICAL OINTMENT	3	MO
DUOBRII	3	MO; QL (200 per 30 days)
<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</i>	1	MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>fluocinonide-emollient</i>	1	MO; QL (120 per 30 days)
<i>flurandrenolide topical cream</i>	1	MO; QL (120 per 30 days)
<i>flurandrenolide topical lotion</i>	1	MO; QL (120 per 30 days)
<i>fluticasone propionate topical</i>	1	MO
<i>halcinonide</i>	1	MO
<i>halobetasol propionate topical cream</i>	1	MO
HALOBETASOL PROPIONATE TOPICAL FOAM	3	MO
<i>halobetasol propionate topical ointment</i>	1	MO
HALOG	3	MO
<i>hydrocortisone butyrate topical cream</i>	1	MO; QL (120 per 30 days)
<i>hydrocortisone butyrate topical lotion</i>	1	MO; QL (118 per 30 days)
<i>hydrocortisone butyrate topical ointment</i>	1	MO; QL (120 per 30 days)
<i>hydrocortisone butyrate topical solution</i>	1	MO; QL (120 per 30 days)
<i>hydrocortisone topical cream 1 %</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<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
IMPEKLO	3	MO; QL (136 per 28 days)
KENALOG TOPICAL	3	MO; QL (126 per 28 days)
LEXETTE	3	MO
LOCOID LIPOCREAM	3	MO; QL (120 per 30 days)
LOCOID TOPICAL LOTION	3	MO; QL (118 per 30 days)
<i>mometasone topical</i>	1	MO
OLUX-E	3	MO; QL (100 per 28 days)
PANDEL	3	MO
SYNALAR TOPICAL CREAM	3	MO
SYNALAR TOPICAL SOLUTION	3	MO
TEXACORT	3	MO
TOPICORT TOPICAL CREAM	3	MO

Drug Name	Drug Tier	Requirements/Limits
TOPICORT TOPICAL GEL	3	MO
TOPICORT TOPICAL OINTMENT 0.05 %	3	MO
TOPICORT TOPICAL SPRAY, NON-AEROSOL	3	MO
<i>tovet emollient</i>	1	MO; QL (100 per 28 days)
<i>triamcinolone acetonide topical aerosol</i>	1	MO; QL (126 per 28 days)
<i>triamcinolone acetonide topical cream</i>	1	MO
<i>triamcinolone acetonide topical lotion</i>	1	MO
<i>triamcinolone acetonide topical ointment</i>	1	MO
<i>trianex</i>	1	
<i>triderm topical cream</i>	1	MO
<i>tritocin</i>	1	
ULTRAVATE TOPICAL LOTION	3	MO
VANOS	3	MO; QL (120 per 30 days)
VERDESO	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TOPICAL SCABICIDES / PEDICULICIDES		
<i>crotan</i>	1	MO
<i>malathion</i>	1	MO
NATROBA	3	MO
OVIDE	3	MO
<i>permethrin</i>	1	MO; QL (60 per 30 days)
<i>spinosad</i>	1	MO
DIAGNOSTIC S / MISCELLANEOUS AGENTS		
MISCELLANEOUS AGENTS		
<i>acamprosate</i>	1	MO
AGRYLIN	3	MO
<i>anagrelide</i>	1	MO
ARALAST NP INTRAVENOUS RECON SOLN 1,000 MG	3	PA; MO; LA
AURYXIA	3	PA; MO
BUPHENYL	3	PA
CARBAGLU	3	PA; MO; LA
<i>carglumic acid</i>	1	PA
CARNITOR ORAL	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>cevimeline</i>	1	MO
CHEMET	2	PA
CLINIMIX 4.25%/D5W SULFIT FREE	3	PA
CLINIMIX E 2.75%/D5W SULF FREE	3	PA
CUVRIOR	3	PA; LA
<i>d10 %-0.45 % sodium chloride</i>	1	MO
<i>d2.5 %-0.45 % sodium chloride</i>	1	
<i>d5 % and 0.9 % sodium chloride</i>	1	MO
<i>d5 %-0.45 % sodium chloride</i>	1	MO
<i>deferasirox</i>	1	PA; MO
<i>deferiprone</i>	1	PA; MO
<i>dextrose 10 % and 0.2 % nacl</i>	1	
<i>dextrose 10 % in water (d10w)</i>	1	
<i>dextrose 5 % in water (d5w) intravenous piggyback</i>	1	MO
<i>dextrose 5%-0.2 % sod chloride</i>	1	
<i>disulfiram oral tablet 250 mg</i>	1	MO
<i>disulfiram oral tablet 500 mg</i>	1	
<i>droxidopa</i>	1	PA; MO
ENDARI	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EVOXAC	3	MO
EXJADE	3	PA; MO; LA
EXSERVAN	3	PA
FERRIPROX (2 TIMES A DAY)	3	PA
FERRIPROX ORAL SOLUTION	3	PA
FERRIPROX ORAL TABLET 500 MG	3	PA
FOSRENOL ORAL POWDER IN PACKET 1,000 MG	3	MO; QL (135 per 30 days)
FOSRENOL ORAL POWDER IN PACKET 750 MG	3	MO; QL (180 per 30 days)
FOSRENOL ORAL TABLET,CHEWA BLE 1,000 MG	3	MO; QL (135 per 30 days)
FOSRENOL ORAL TABLET,CHEWA BLE 500 MG	3	MO; QL (270 per 30 days)
FOSRENOL ORAL TABLET,CHEWA BLE 750 MG	3	MO; QL (180 per 30 days)
GLASSIA	3	PA; MO; LA
INCRELEX	2	MO; LA
JADENU	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
JADENU SPRINKLE	3	PA; MO
<i>lanthanum oral tablet,chewable 1,000 mg</i>	1	MO; QL (135 per 30 days)
<i>lanthanum oral tablet,chewable 500 mg</i>	1	MO; QL (270 per 30 days)
<i>lanthanum oral tablet,chewable 750 mg</i>	1	MO; QL (180 per 30 days)
<i>levocarnitine (with sugar)</i>	1	MO
<i>levocarnitine oral tablet</i>	1	MO
LITHOSTAT	3	
LOKELMA	2	MO
<i>midodrine</i>	1	MO
<i>nitisinone</i>	1	PA; MO
NITYR	3	PA; MO; LA
NORTHERA	3	PA; MO
ORFADIN	3	PA; LA
OXBRYTA ORAL TABLET 300 MG	3	PA; MO; LA; QL (150 per 30 days)
OXBRYTA ORAL TABLET 500 MG	3	PA; MO; LA; QL (90 per 30 days)
OXBRYTA ORAL TABLET FOR SUSPENSION	3	PA; MO; LA; QL (150 per 30 days)
PHEBURANE	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>pilocarpine hcl oral</i>	1	MO
PROLASTIN-C	2	PA; LA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	3	PA; LA; QL (56 per 28 days)
PYRUKYND ORAL TABLET 5 MG	3	PA; LA; QL (7 per 180 days)
PYRUKYND ORAL TABLETS, DOSE PACK	3	PA; LA; QL (14 per 180 days)
RAVICTI	3	PA; MO
RENAGEL ORAL TABLET 800 MG	3	MO
REVELA ORAL POWDER IN PACKET 0.8 GRAM	3	MO; QL (180 per 30 days)
REVELA ORAL POWDER IN PACKET 2.4 GRAM	3	MO; QL (90 per 30 days)
REVELA ORAL TABLET	3	MO; QL (270 per 30 days)
REVCIVI	2	PA; LA
RILUTEK	3	PA; MO
<i>riluzole</i>	1	PA; MO
<i>risedronate oral tablet 30 mg</i>	1	MO; QL (30 per 30 days)
SALAGEN (PILOCARPINE)	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>sevelamer carbonate oral powder in packet 0.8 gram</i>	1	MO; QL (180 per 30 days)
<i>sevelamer carbonate oral powder in packet 2.4 gram</i>	1	MO; QL (90 per 30 days)
<i>sevelamer carbonate oral tablet</i>	1	MO; QL (270 per 30 days)
<i>sevelamer hcl</i>	1	MO
<i>sodium chloride 0.9 % intravenous piggyback</i>	1	MO
<i>sodium chloride irrigation</i>	1	MO
<i>sodium phenylbutyrate oral powder</i>	1	PA; MO
<i>sodium phenylbutyrate oral tablet</i>	1	PA
<i>sodium polystyrene sulfonate oral powder</i>	1	MO
<i>sps (with sorbitol) oral</i>	1	MO
SYPRINE	3	PA; MO
TAVNEOS	3	PA; LA; QL (180 per 30 days)
THIOLA	3	PA
THIOLA EC	3	PA
TIGLUTIK	3	PA
<i>tiopronin</i>	1	PA; MO
<i>trientine</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
VELPHORO	2	MO; QL (180 per 30 days)
VELTASSA	2	MO
XURIDEN	3	PA
ZEMAIRA	3	PA; MO; LA
ZOKINVY	3	PA; LA; QL (120 per 30 days)

SMOKING DETERRENTS

<i>bupropion hcl (smoking deter)</i>	1	MO
NICOTROL	3	MO
NICOTROL NS	3	MO
<i>varenicline</i>	1	MO

EAR, NOSE / THROAT MEDICATIONS

MISCELLANEOUS AGENTS

<i>azelastine nasal aerosol, spray</i>	1	MO; QL (60 per 30 days)
<i>chlorhexidine gluconate mucous membrane</i>	1	MO
<i>ipratropium bromide nasal</i>	1	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<i>olopatadine nasal</i>	1	MO; QL (30.5 per 30 days)
<i>periogard</i>	1	MO
<i>triamcinolone acetonide dental</i>	1	MO

MISCELLANEOUS US OTIC PREPARATIONS

<i>acetic acid otic (ear)</i>	1	MO
<i>ciprofloxacin hcl otic (ear)</i>	1	MO
DERMOTIC OIL	3	MO
<i>flac otic oil</i>	1	MO
<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	3	MO; QL (7.5 per 7 days)
<i>ciprofloxacin-dexamethasone</i>	1	MO; QL (7.5 per 7 days)
CIPROFLOXACIN-FLUOCINOLONE	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>neomycin-polymyxin-hc otic (ear)</i>	1	MO
OTOVEL	3	MO
ENDOCRINE/ DIABETES		
ADRENAL HORMONES		
ACTHAR	3	PA; MO
ALKINDI SPRINKLE	3	
CORTEF	3	MO
CORTROPHIN GEL	3	PA; MO
<i>dexabliss</i>	1	
<i>dexamethasone oral solution</i>	1	MO
<i>dexamethasone oral tablet</i>	1	MO
<i>dexamethasone oral tablets,dose pack</i>	1	MO
EMFLAZA	3	PA; MO; LA
<i>fludrocortisone</i>	1	MO
HEMADY	3	MO
<i>hydrocortisone oral</i>	1	MO
MEDROL (PAK)	3	MO
MEDROL ORAL TABLET 16 MG, 2 MG, 4 MG, 8 MG	3	PA; MO
<i>methylprednisolone oral tablet</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>methylprednisolone oral tablets,dose pack</i>	1	MO
<i>millipred oral tablet</i>	1	PA; MO
ORAPRED ODT	3	PA; MO
<i>prednisolone oral solution</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
<i>prednisone intensol</i>	1	MO
<i>prednisone oral solution</i>	1	MO
<i>prednisone oral tablet</i>	1	MO
<i>prednisone oral tablets,dose pack 10 mg (48 pack), 5 mg (48 pack)</i>	1	
<i>prednisone oral tablets,dose pack 10 mg, 5 mg</i>	1	MO
RAYOS	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (21 TABS), 1.5 MG (49 TABS)	3	MO
TAPERDEX ORAL TABLETS,DOSE PACK 1.5 MG (27 TABS)	3	
TARPEYO	3	PA; QL (120 per 30 days)
ANTITHYROID AGENTS		
<i>methimazole oral tablet 10 mg, 5 mg</i>	1	MO
<i>propylthiouracil</i>	1	MO
DIABETES THERAPY		
<i>acarbose oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>acarbose oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>acarbose oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
ACTOPLUS MET ORAL TABLET 15-850 MG	3	MO; QL (90 per 30 days)
ACTOS	3	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ADMELOG SOLOSTAR U-100 INSULIN	3	ST; MO
ADMELOG U-100 INSULIN LISPRO	3	PA; MO
AFREZZA	3	MO
<i>alcohol pads</i>	1	
ALOGLIPTIN	3	ST; MO; QL (30 per 30 days)
ALOGLIPTIN- METFORMIN	3	ST; MO; QL (60 per 30 days)
ALOGLIPTIN- PIOGLITAZONE ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 MG	3	MO; QL (30 per 30 days)
APIDRA SOLOSTAR U-100 INSULIN	3	ST; MO
APIDRA U-100 INSULIN	3	PA; MO
BAQSIMI	2	MO
BASAGLAR KWIKPEN U-100 INSULIN	3	ST; MO
BASAGLAR TEMPO PEN(U- 100)INSLN	3	ST; MO
BYDUREON BCISE	2	PA; MO; QL (4 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	2	PA; MO; QL (2.4 per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	2	PA; MO; QL (1.2 per 30 days)
CYCLOSET	3	MO; QL (180 per 30 days)
<i>diazoxide</i>	1	MO
DROPSAFE ALCOHOL PREP PADS	2	MO
DUETACT	3	MO; QL (30 per 30 days)
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 PENFILL U-100 INSULIN	3	ST; MO
FIASP U-100 INSULIN	3	PA; MO
<i>glimepiride oral tablet 1 mg</i>	1	MO; QL (240 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
<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)
<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	3	ST; MO
GLUCAGON EMERGENCY KIT (HUMAN)	3	ST; MO
GLUCOTROL XL ORAL TABLET EXTENDED RELEASE 24HR 10 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
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 1,000 MG	3	ST; MO; QL (60 per 30 days)
GLUMETZA ORAL TABLET, ER GAST. RETENTION 24 HR 500 MG	3	ST; MO; QL (120 per 30 days)
GLYXAMBI	2	MO; QL (30 per 30 days)
GVOKE	2	MO
GVOKE HYOPEN 2-PACK	2	MO
GVOKE PFS 1-PACK SYRINGE	2	MO
HUMALOG JUNIOR KWIKPEN U-100	2	MO
HUMALOG KWIKPEN INSULIN	2	MO

Drug Name	Drug Tier	Requirements/Limits
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 TEMPO PEN(U-100)INSULN	3	ST; MO
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE	2	MO
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION	2	PA; 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

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HUMULIN R U-500 (CONC) INSULIN	2	MO
HUMULIN R U-500 (CONC) KWIKPEN	2	MO
INSULIN ASP PRT-INSULIN ASPART	3	ST; MO
INSULIN ASPART U-100 SUBCUTANEOUS CARTRIDGE	3	ST; MO
INSULIN ASPART U-100 SUBCUTANEOUS INSULIN PEN	3	ST; MO
INSULIN ASPART U-100 SUBCUTANEOUS SOLUTION	3	PA; MO
INSULIN DEGLUDEC	3	ST; MO
INSULIN GLARGINE	2	MO
INSULIN GLARGINE-YFGN	3	ST; MO
INSULIN LISPRO PROTAMIN-LISPRO	3	ST; MO
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
INSULIN LISPRO SUBCUTANEOUS INSULIN PEN, HALF-UNIT	3	ST; MO
INSULIN LISPRO SUBCUTANEOUS SOLUTION	2	PA; MO
INVOKAMET	3	ST; MO; QL (60 per 30 days)
INVOKAMET XR	3	ST; MO; QL (60 per 30 days)
INVOKANA	3	ST; 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	2	MO; QL (30 per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	2	MO; QL (60 per 30 days)
JANUVIA	2	MO; QL (30 per 30 days)
JARDIANCE	2	MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

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

Drug Name	Drug Tier	Requirements/Limits
LYUMJEV KWIKPEN U-100 INSULIN	2	MO
LYUMJEV KWIKPEN U-200 INSULIN	2	MO
LYUMJEV TEMPO PEN(U-100)INSULIN	3	ST; MO
LYUMJEV U-100 INSULIN	2	PA; MO
<i>metformin oral solution</i>	1	MO; QL (765 per 30 days)
<i>metformin oral tablet 1,000 mg</i>	1	MO; QL (75 per 30 days)
<i>metformin oral tablet 500 mg</i>	1	MO; QL (150 per 30 days)
METFORMIN ORAL TABLET 625 MG	3	QL (120 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 (60 per 30 days)
<i>metformin oral tablet extended release (osm) 24 hr 1,000 mg</i>	1	ST; MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>metformin oral tablet extended release (osm) 24 hr 500 mg</i>	1	ST; MO; QL (150 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 1,000 mg</i>	1	ST; MO; QL (60 per 30 days)
<i>metformin oral tablet,er gast.retention 24 hr 500 mg</i>	1	ST; MO; QL (120 per 30 days)
<i>miglitol oral tablet 100 mg</i>	1	MO; QL (90 per 30 days)
<i>miglitol oral tablet 25 mg</i>	1	MO; QL (360 per 30 days)
<i>miglitol oral tablet 50 mg</i>	1	MO; QL (180 per 30 days)
MOUNJARO	2	PA; MO; QL (2 per 28 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)
NESINA	3	ST; MO; QL (30 per 30 days)
NOVOLIN 70/30 U-100 INSULIN	3	ST; MO
NOVOLIN 70-30 FLEXPEN U-100	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
NOVOLIN N FLEXPEN	3	ST; MO
NOVOLIN N NPH U-100 INSULIN	3	ST; MO
NOVOLIN R FLEXPEN	3	ST; MO
NOVOLIN R REGULAR U100 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	PA; MO
ONGLYZA	3	ST; MO; QL (30 per 30 days)
OSENI ORAL TABLET 12.5-30 MG, 25-15 MG, 25-30 MG, 25-45 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG (2 MG/3 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 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)
PROGLYCEM	3	MO
QTERN	2	MO; QL (30 per 30 days)
<i>repaglinide oral tablet 0.5 mg</i>	1	MO; QL (960 per 30 days)
<i>repaglinide oral tablet 1 mg</i>	1	MO; QL (480 per 30 days)
<i>repaglinide oral tablet 2 mg</i>	1	MO; QL (240 per 30 days)
REZVOGLAR KWIKPEN	3	ST; MO
RYBELSUS	2	PA; MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
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)
SEMGLEE(INSULIN GLARGINE-YFGN)	3	ST; MO
SEMGLEE(INSULIN GLARG-YFGN)PEN	3	ST; MO
SOLIQUA 100/33	2	MO; QL (90 per 30 days)
STEGLATRO	2	MO; QL (30 per 30 days)
STEGLUJAN	3	ST; MO; QL (30 per 30 days)
SYMLINPEN 120	2	PA; MO; QL (10.8 per 30 days)
SYMLINPEN 60	2	PA; MO; QL (6 per 30 days)
SYNJARDY	2	MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	2	MO; QL (30 per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	2	MO; QL (60 per 30 days)
TOUJEO MAX U-300 SOLOSTAR	2	MO
TOUJEO SOLOSTAR U-300 INSULIN	2	MO
TRADJENTA	2	MO; QL (30 per 30 days)
TRESIBA FLEXTOUCH U-100	3	ST; MO
TRESIBA FLEXTOUCH U-200	3	ST; MO
TRESIBA U-100 INSULIN	3	ST; MO
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	2	MO; QL (30 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-2.5-1,000 MG, 5-2.5-1,000 MG	2	MO; QL (60 per 30 days)
TRULICITY	2	PA; MO; QL (2 per 28 days)
VICTOZA 3-PAK	3	PA; MO; QL (9 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	2	MO; QL (30 per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	2	MO; QL (60 per 30 days)
XULTOPHY 100/3.6	3	ST; MO; QL (15 per 30 days)
ZEGALOGUE AUTOINJECTOR	2	MO
ZEGALOGUE SYRINGE	2	MO
MISCELLANEOUS HORMONES		
ANDRODERM	3	PA; MO; QL (30 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ANDROGEL TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; MO; QL (150 per 30 days)
AVEED	3	PA; LA
<i>cabergoline</i>	1	MO
<i>calcitonin (salmon) nasal</i>	1	MO
<i>calcitriol oral capsule</i>	1	MO
<i>calcitriol oral solution</i>	1	
CERDELGA	3	PA; MO
<i>cinacalcet</i>	1	PA; MO
<i>danazol</i>	1	MO
DDAVP ORAL	3	MO
DEPO- TESTOSTERONE	3	PA; MO
<i>desmopressin nasal spray with pump</i>	1	MO
<i>desmopressin oral</i>	1	MO
<i>doxercalciferol oral</i>	1	MO
FORTESTA	3	PA; MO; QL (120 per 30 days)
GALAFOLD	3	PA; MO; LA; QL (15 per 30 days)
ISTURISA ORAL TABLET 1 MG	3	PA; LA; QL (240 per 30 days)
ISTURISA ORAL TABLET 10 MG	3	PA; LA; QL (180 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ISTURISA ORAL TABLET 5 MG	3	PA; LA; QL (60 per 30 days)
JATENZO ORAL CAPSULE 158 MG, 198 MG	3	PA; MO; QL (120 per 30 days)
JATENZO ORAL CAPSULE 237 MG	3	PA; MO; QL (60 per 30 days)
<i>javygtor</i>	1	PA; MO
JYNARQUE	3	PA; LA
KORLYM	3	PA
KUVAN	3	PA; MO
METHITEST	3	MO
<i>methyltestosterone oral capsule</i>	1	MO
<i>miglustat</i>	1	PA; MO; LA
MYALEPT	2	PA; MO; LA
NATESTO	3	PA; MO; QL (21.96 per 30 days)
NATPARA	2	PA; LA
NOCDURNA (MEN)	3	PA; MO; QL (30 per 30 days)
NOCDURNA (WOMEN)	3	PA; MO; QL (30 per 30 days)
ORILISSA	3	MO
PALYNZIQ SUBCUTANEOU S SYRINGE 10 MG/0.5 ML	3	PA; MO; LA; QL (15 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	3	PA; MO; LA; QL (4 per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	3	PA; MO; LA; QL (60 per 30 days)
<i>paricalcitol oral</i>	1	MO
RAYALDEE	3	MO
RECORLEV	3	PA
ROCALTROL ORAL CAPSULE	3	MO
ROCALTROL ORAL SOLUTION	3	
SAMSCA	3	PA; MO
<i>sapropterin</i>	1	PA; MO
SENSIPAR	3	PA; MO
SOMAVERT	3	PA; MO
SYNAREL	3	PA; MO
TESTIM	3	PA; MO; QL (300 per 30 days)
<i>testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml</i>	1	PA; MO
<i>testosterone cypionate intramuscular oil 200 mg/ml (1 ml)</i>	1	PA
<i>testosterone enanthate</i>	1	PA; MO

Drug Name	Drug Tier	Requirements/Limits
<i>testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram lactuation</i>	1	PA; MO; QL (120 per 30 days)
TESTOSTERONE TRANSDERMAL GEL IN METERED-DOSE PUMP 12.5 MG/1.25 GRAM (1 %)	3	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal gel in packet 1 % (25 mg/2.5 gram), 1 % (50 mg/5 gram)</i>	1	PA; MO; QL (300 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)</i>	1	PA; MO; QL (37.5 per 30 days)
<i>testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)</i>	1	PA; MO; QL (150 per 30 days)
<i>testosterone transdermal solution in metered pump w/lapp</i>	1	PA; MO; QL (180 per 30 days)
TLANDO	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>tolvaptan</i>	1	PA; MO
VOGELXO TRANSDERMAL GEL	3	PA; MO; QL (300 per 30 days)
VOGELXO TRANSDERMAL GEL IN METERED-DOSE PUMP	3	PA; MO; QL (300 per 30 days)
VOXZOGO	3	PA; MO
XYOSTED	3	PA; MO; QL (2 per 28 days)
ZAVESCA	3	PA; MO; LA
ZEMPLAR ORAL CAPSULE 1 MCG, 2 MCG	3	MO
THYROID HORMONES		
CYTOMEL	3	MO
ERMEZA	3	MO
<i>euthyrox</i>	1	MO
LEVOTHYROXINE ORAL CAPSULE	3	MO
<i>levothyroxine oral tablet</i>	1	
<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

Drug Name	Drug Tier	Requirements/Limits
<i>liothyronine oral</i>	1	MO
SYNTHROID	3	ST; MO
THYQUIDITY	3	MO
TIROSINT	3	MO
TIROSINT-SOL	3	MO
<i>unithroid</i>	1	MO
GASTROENTEROLOGY		
ANTIDIARRHEALS / ANTISPASMODICS		
CUVPOSA	3	MO
DARTISLA	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
GLYCATE	3	MO
<i>glycopyrrolate oral solution</i>	1	MO
<i>glycopyrrolate oral tablet 1 mg, 2 mg</i>	1	MO
<i>glycopyrrolate oral tablet 1.5 mg</i>	1	
LOMOTIL	3	MO
<i>loperamide oral capsule</i>	1	MO
<i>methscopolamine</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
MOTOFEN	3	MO
MYTESI	3	MO
ROBINUL FORTE	3	MO
ROBINUL ORAL	3	MO
MISCELLANEOUS GASTROINTESTINAL AGENTS		
<i>alosetron</i>	1	PA; MO
AMITIZA	3	ST; MO; QL (60 per 30 days)
ANTIVERT ORAL TABLET 50 MG	3	MO
ANTIVERT ORAL TABLET, CHEWABLE	3	MO
ANUSOL-HC TOPICAL	3	MO
ANZEMET ORAL TABLET 50 MG	3	PA; MO
<i>aprepitant</i>	1	PA; MO
APRISO	3	MO
AZULFIDINE	3	MO
AZULFIDINE EN-TABS	3	MO
<i>balsalazide</i>	1	MO
<i>betaine</i>	1	MO
BONJESTA	3	MO
<i>budesonide oral</i>	1	MO
<i>budesonide rectal</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
BYLVAY	3	PA; MO; LA
CANASA	3	MO
CHENODAL	2	PA; LA
CHOLBAM ORAL CAPSULE 250 MG	2	PA
CHOLBAM ORAL CAPSULE 50 MG	2	PA; QL (120 per 30 days)
CIMZIA	3	PA; MO; QL (2 per 28 days)
CIMZIA POWDER FOR RECONST	3	PA; MO; QL (2 per 28 days)
CLENPIQ	3	ST; MO
COLAZAL	3	MO
<i>compro</i>	1	MO
<i>constulose</i>	1	MO
CORTIFOAM	2	MO
CREON	2	MO
<i>cromolyn oral</i>	1	MO
CYSTADANE	3	
DELZICOL	3	MO
DICLEGIS	3	MO
DIPENTUM	3	MO
<i>doxylamine-pyridoxine (vit b6)</i>	1	MO
<i>dronabinol</i>	1	PA; MO
EMEND ORAL CAPSULE 80 MG	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EMEND ORAL CAPSULE,DOSE PACK	3	PA; MO
EMEND ORAL SUSPENSION FOR RECONSTITUTION	3	PA
<i>enulose</i>	1	MO
GASTROCROM	3	MO
GATTEX 30-VIAL	3	PA; MO
<i>gavilyte-c</i>	1	MO
<i>gavilyte-g</i>	1	MO
<i>generlac</i>	1	MO
GIMOTI	3	
GOLYTELY	3	ST; MO
<i>granisetron hcl oral</i>	1	PA; MO
<i>hydrocortisone rectal</i>	1	MO
<i>hydrocortisone topical cream with perineal applicator 2.5 %</i>	1	MO
<i>hydrocortisone-pramoxine rectal cream 1-1 %</i>	1	MO
IBSRELA	3	ST; MO; QL (60 per 30 days)
INFLECTRA	3	PA; MO; QL (20 per 28 days)
KRISTALOSE	3	MO
<i>lactulose oral packet</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>lactulose oral solution 10 gram/15 ml</i>	1	MO
LIALDA	3	MO
LINZESS	2	MO; QL (30 per 30 days)
LIVMARLI	3	PA; LA
LOTRONEX	3	PA; MO
<i>lubiprostone</i>	1	MO; QL (60 per 30 days)
MARINOL	3	PA; MO
<i>meclizine oral tablet 12.5 mg, 25 mg</i>	1	MO
<i>mesalamine oral capsule (with del rel tablets)</i>	1	MO
<i>mesalamine oral capsule, extended release</i>	1	
<i>mesalamine oral capsule,extended release 24hr</i>	1	MO
<i>mesalamine oral tablet,delayed release (drlec)</i>	1	MO
<i>mesalamine rectal</i>	1	MO
<i>metoclopramide hcl oral solution</i>	1	MO
<i>metoclopramide hcl oral tablet</i>	1	MO
<i>metoclopramide hcl oral tablet,disintegrating 5 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
MOTEGRITY	3	ST; MO; QL (30 per 30 days)
MOVANTIK	2	MO; QL (30 per 30 days)
MOVIPREP	3	ST; MO
OCALIVA	3	PA; MO; LA; QL (30 per 30 days)
<i>ondansetron</i>	1	PA; MO
<i>ondansetron hcl oral solution</i>	1	PA; MO
<i>ondansetron hcl oral tablet 4 mg, 8 mg</i>	1	PA; MO
OSMOPREP	3	ST; MO
PANCREAZE ORAL CAPSULE, DELAYED RELEASE(DR/EC) 10,500-35,500-61,500 UNIT, 16,800-56,800-98,400 UNIT, 2,600-8,800- 15,200 UNIT, 21,000-54,700- 83,900 UNIT, 37,000-97,300- 149,900 UNIT, 4,200-14,200- 24,600 UNIT	3	ST; MO
<i>peg 3350-electrolytes</i>	1	MO
<i>peg3350-sod sul-nacl-kcl-asb-c</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>peg-electrolyte</i>	1	MO
PENTASA	3	MO
PERTZYE	3	ST; MO
PLENVU	3	ST; MO
<i>prochlorperazine</i>	1	MO
<i>prochlorperazine maleate oral</i>	1	MO
<i>procto-med hc</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	3	MO; QL (90 per 30 days)
RELISTOR SUBCUTANEOUS SOLUTION	3	MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	3	MO; QL (18 per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	3	MO; QL (12 per 30 days)
RELTONE	3	
REMICADE	2	PA; MO; QL (20 per 28 days)
RENFLEXIS	3	PA; MO; QL (20 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ROWASA RECTAL ENEMA KIT	3	MO
SANCUSO	2	MO
<i>scopolamine base</i>	1	MO
SKYRIZI SUBCUTANEOU S WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	2	PA; MO; QL (1.2 per 56 days)
SKYRIZI SUBCUTANEOU S WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	2	PA; MO; QL (2.4 per 56 days)
<i>sodium,potassium,m ag sulfates</i>	1	MO
SUCRAID	2	PA
<i>sulfasalazine</i>	1	MO
SUPREP BOWEL PREP KIT	3	ST; MO
SUTAB	3	ST; MO
SYMPROIC	3	MO; QL (30 per 30 days)
SYNDROS	3	PA; MO
TRANSDERM- SCOP	3	MO
TRULANCE	2	MO; QL (30 per 30 days)
UCERIS	3	MO
URSO 250	3	MO

Drug Name	Drug Tier	Requirements/Limits
URSO FORTE	3	MO
<i>ursodiol oral capsule 200 mg, 400 mg</i>	1	
<i>ursodiol oral capsule 300 mg</i>	1	MO
<i>ursodiol oral tablet</i>	1	MO
VARUBI	2	PA
VIBERZI	2	MO; QL (60 per 30 days)
VIOKACE	2	MO
ZENPEP ORAL CAPSULE,DELA YED RELEASE(DR/EC) 10,000-32,000 - 42,000 UNIT, 15,000-47,000 - 63,000 UNIT, 20,000-63,000- 84,000 UNIT, 25,000-79,000- 105,000 UNIT, 3,000-10,000 - 14,000-UNIT, 40,000-126,000- 168,000 UNIT, 5,000-17,000- 24,000 UNIT	2	MO
ULCER THERAPY		
ACIPHEX	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>amoxicil-clarithromy-lansopraz</i>	1	MO; QL (112 per 180 days)
<i>bismuth subcit k-metronidz-ten</i>	1	MO; QL (120 per 180 days)
CARAFATE	3	MO
<i>cimetidine</i>	1	MO
CYTOTEC	3	MO
DEXILANT	3	MO; QL (30 per 30 days)
<i>dexlansoprazole</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule, delayed release(drlec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral capsule, delayed release(drlec) 40 mg</i>	1	MO; QL (60 per 30 days)
<i>esomeprazole magnesium oral granules dr for susp in packet 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>esomeprazole magnesium oral granules dr for susp in packet 40 mg</i>	1	MO; QL (60 per 30 days)
<i>famotidine oral suspension</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>famotidine oral tablet 20 mg, 40 mg</i>	1	MO
KONVOMEPEP	3	QL (600 per 30 days)
<i>lansoprazole oral capsule, delayed release(drlec) 15 mg</i>	1	MO; QL (30 per 30 days)
<i>lansoprazole oral capsule, delayed release(drlec) 30 mg</i>	1	MO; QL (60 per 30 days)
<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; QL (60 per 30 days)
<i>misoprostol</i>	1	MO
NEXIUM ORAL CAPSULE, DELAYED RELEASE(DR/EC) 20 MG	3	MO; QL (30 per 30 days)
NEXIUM ORAL CAPSULE, DELAYED RELEASE(DR/EC) 40 MG	3	MO; QL (60 per 30 days)
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 10 MG, 2.5 MG, 20 MG, 5 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
NEXIUM ORAL GRANULES DR FOR SUSP IN PACKET 40 MG	3	MO; QL (60 per 30 days)
<i>nizatidine oral capsule</i>	1	MO
OMECLAMOX-PAK	3	MO; QL (80 per 180 days)
<i>omeprazole oral capsule, delayed release(drlec) 10 mg, 20 mg</i>	1	MO; QL (30 per 30 days)
<i>omeprazole oral capsule, delayed release(drlec) 40 mg</i>	1	MO; QL (60 per 30 days)
<i>omeprazole-sodium bicarbonate</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral granules dr for susp in packet</i>	1	MO; QL (60 per 30 days)
<i>pantoprazole oral tablet, delayed release (drlec) 20 mg</i>	1	MO; QL (30 per 30 days)
<i>pantoprazole oral tablet, delayed release (drlec) 40 mg</i>	1	MO; QL (60 per 30 days)
PEPCID ORAL TABLET	3	MO

Drug Name	Drug Tier	Requirements/Limits
PREVACID ORAL CAPSULE, DELAYED RELEASE(DR/EC) 30 MG	3	MO; QL (60 per 30 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAYED REL 15 MG	3	MO; QL (30 per 30 days)
PREVACID SOLUTAB ORAL TABLET, DISINTEGRAT, DELAYED REL 30 MG	3	MO; QL (60 per 30 days)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 10 MG	3	MO; QL (120 per 30 days)
PRILOSEC ORAL SUSP, DELAYED RELEASE FOR RECON 2.5 MG	3	MO; QL (480 per 30 days)
PROTONIX ORAL GRANULES DR FOR SUSP IN PACKET	3	MO; QL (60 per 30 days)
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC) 20 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PROTONIX ORAL TABLET, DELAYED RELEASE (DR/EC) 40 MG	3	MO; QL (60 per 30 days)
PYLERA	3	MO; QL (120 per 180 days)
<i>rabeprazole oral tablet, delayed release (dr/ec)</i>	1	MO; QL (60 per 30 days)
<i>sucralfate</i>	1	MO
TALICIA	3	MO; QL (168 per 180 days)
ZEGERID	3	MO; QL (30 per 30 days)

**IMMUNOLOGY,
VACCINES /
BIOTECHNOLOGY**

BIOTECHNOLOGY DRUGS

ACTIMMUNE	2	PA; MO
ARANESP (IN POLYSORBATE) INJECTION SOLUTION 100 MCG/ML, 200 MCG/ML, 25 MCG/ML, 40 MCG/ML, 60 MCG/ML	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
ARANESP (IN POLYSORBATE) INJECTION SYRINGE	3	PA; MO
ARCALYST	2	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	2	PA; MO; QL (1 per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	2	PA; MO; QL (1 per 28 days)
BESREMI	3	PA; LA
BETASERON SUBCUTANEOUS KIT	2	PA; MO; QL (14 per 28 days)
EGRIFTA SV	3	PA; MO
EPOGEN INJECTION SOLUTION 2,000 UNIT/ML, 20,000 UNIT/2 ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	3	PA; MO
EXTAVIA SUBCUTANEOUS KIT	3	PA; MO; QL (15 per 28 days)
FULPHILA	3	PA; MO
FYLNETRA	3	PA
GENOTROPIN	3	PA; MO
GENOTROPIN MINIQUICK	3	PA; MO
GRANIX	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HUMATROPE INJECTION CARTRIDGE	3	PA; MO
LEUKINE INJECTION RECON SOLN	2	PA; MO
NEULASTA	3	PA; MO
NEULASTA ONPRO	3	PA; MO
NEUPOGEN	3	PA; MO
NIVESTYM	2	PA; MO
NORDITROPIN FLEXPRO	3	PA; MO
NUTROPIN AQ NUSPIN	3	PA; MO
NYVEPRIA	2	PA; MO
OMNITROPE	2	PA; MO
PEGASYS SUBCUTANEOUS SOLUTION	2	MO; QL (4 per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	2	MO; QL (2 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	2	PA; MO; QL (1 per 28 days)
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 63 MCG/0.5 ML-94 MCG/0.5 ML	2	PA; MO; QL (1 per 180 days)
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	2	PA; MO; QL (1 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
SEROSTIM SUBCUTANEOUS RECON SOLN 4 MG, 5 MG, 6 MG	3	PA; MO
SKYTROFA	3	PA; MO
SOGROYA	3	PA; MO
UDENYCA	3	PA; MO
UDENYCA AUTOINJECTOR	3	PA; MO
ZARXIO	2	PA; MO
ZIEXTENZO	2	PA; MO
ZOMACTON	3	PA; MO
ZORBTIVE	3	PA; MO
VACCINES / MISCELLANEOUS IMMUNOLOGICALS		
ACTHIB (PF)	2	MO
ADACEL(TDAP ADOLESN/ADULT)(PF)	1	MO; V
BCG VACCINE, LIVE (PF)	1	MO; V
BEXSERO	1	MO; V
BIVIGAM	3	PA; MO
BOOSTRIX TDAP	1	MO; V
DAPTACEL (DTAP PEDIATRIC) (PF)	2	MO
DYSPORT	3	PA; MO
ENGERIX-B (PF)	1	PA; MO; V
ENGERIX-B PEDIATRIC (PF)	1	PA; MO; V

Drug Name	Drug Tier	Requirements/Limits
FLEBOGAMMA DIF INTRAVENOUS SOLUTION 10 %	3	PA
GAMMAGARD LIQUID	3	PA; MO
GAMMAGARD S-D (IGA < 1 MCG/ML)	3	PA; MO
GAMMAKED INJECTION SOLUTION 1 GRAM/10 ML (10 %)	3	PA; MO
GAMMAPLEX	3	PA; MO
GAMMAPLEX (WITH SORBITOL)	3	PA; MO
GAMUNEX-C INJECTION SOLUTION 1 GRAM/10 ML (10 %)	3	PA; MO
GARDASIL 9 (PF)	1	MO; V
GRASTEK	3	MO
HAVRIX (PF) INTRAMUSCULAR SYRINGE 1,440 ELISA UNIT/ML	1	MO; V
HAVRIX (PF) INTRAMUSCULAR SYRINGE 720 ELISA UNIT/0.5 ML	2	MO
HEPLISAV-B (PF)	1	PA; MO; V

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HIBERIX (PF)	2	MO
IMOVAX RABIES VACCINE (PF)	1	V
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	2	MO
IPOL	1	V
IXIARO (PF)	1	V
JYNNEOS (PF)(STOCKPILE)	1	PA; V
KINRIX (PF) INTRAMUSCULAR SYRINGE	2	MO
MENACTRA (PF) INTRAMUSCULAR SOLUTION	1	MO; V
MENQUADFI (PF)	1	MO; V
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1	MO; V
M-M-R II (PF)	1	MO; V
OCTAGAM	3	PA; MO
ODACTRA	3	PA; MO
ORALAIR SUBLINGUAL TABLET 300 INDX REACTIVITY	3	
PANZYGA INTRAVENOUS SOLUTION 10 %	3	PA; MO

Drug Name	Drug Tier	Requirements/Limits
PANZYGA INTRAVENOUS SOLUTION 10 % (100 ML), 10 % (200 ML), 10 % (25 ML), 10 % (300 ML), 10 % (50 ML)	3	PA
PEDIARIX (PF)	2	MO
PEDVAX HIB (PF)	2	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	2	
PREHEVBRIO (PF)	1	PA; MO; V
PRIORIX (PF)	1	V
PRIVIGEN	2	PA; MO
PROQUAD (PF)	2	
QUADRACEL (PF)	2	
RABAVERT (PF)	1	MO; V
RAGWITEK	3	MO
RECOMBIVAX HB (PF)	1	PA; MO; V
ROTARIX	2	
ROTATEQ VACCINE	2	MO
SHINGRIX (PF)	1	MO; V; QL (2 per 720 days)
TDVAX	1	MO; V
TENIVAC (PF)	1	MO; V

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TETANUS,DIPH THERIA TOX PED(PF)	2	MO
TICOVAC	2	MO
TRUMENBA	1	MO; V
TWINRIX (PF)	1	MO; V
TYPHIM VI INTRAMUSCUL AR SOLUTION	1	V
TYPHIM VI INTRAMUSCUL AR SYRINGE	1	MO; V
VAQTA (PF) INTRAMUSCUL AR SUSPENSION 25 UNIT/0.5 ML	2	MO
VAQTA (PF) INTRAMUSCUL AR SUSPENSION 50 UNIT/ML	1	MO; V
VAQTA (PF) INTRAMUSCUL AR SYRINGE 25 UNIT/0.5 ML	2	MO
VAQTA (PF) INTRAMUSCUL AR SYRINGE 50 UNIT/ML	1	MO; V
VARIVAX (PF)	1	V
YF-VAX (PF)	1	V

Drug Name	Drug Tier	Requirements/Limits
MISCELLANEOUS SUPPLIES		
MISCELLANEOUS SUPPLIES		
1ST TIER UNIFINE PENTIPS	3	ST
1ST TIER UNIFINE PENTIPS PLUS	3	ST
ABOUTTIME PEN NEEDLE NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 3/16", 32 GAUGE X 5/32"	3	ST
ABOUTTIME PEN NEEDLE NEEDLE 31 GAUGE X 5/16"	3	ST; MO
ADVOCATE PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 31 GAUGE X 5/16", 33 GAUGE X 5/32"	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ADVOCATE SYRINGES SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST; MO
ASSURE ID PEN NEEDLE	3	ST; MO
BD AUTOSHIELD DUO PEN NEEDLE	2	MO
BD ECLIPSE LUER-LOK SYRINGE 1 ML 30 GAUGE X 1/2"	2	MO
BD INSULIN SYRINGE (HALF UNIT)	2	MO
BD INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.5 ML 29 GAUGE X 1/2", 1 ML 27 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	2	
BD INSULIN SYRINGE U-500	2	MO

Drug Name	Drug Tier	Requirements/Limits
BD INSULIN ULTRA-FINE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2"	2	MO
BD LO-DOSE MICRO-FINE IV	2	MO
BD NANO 2ND GEN PEN NEEDLE	2	MO
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64"	2	MO
BD SAFETYGLIDE INSULIN SYRINGE SYRINGE 0.5 ML 29 GAUGE X 1/2"	2	

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
BD SAFETYGLIDE SYRINGE 1 ML 27 GAUGE X 5/8"	2	MO
BD ULTRA-FINE MICRO PEN NEEDLE	2	MO
BD ULTRA-FINE MINI PEN NEEDLE	2	MO
BD ULTRA-FINE NANO PEN NEEDLE	2	MO
BD ULTRA-FINE ORIG PEN NEEDLE	2	MO
BD ULTRA-FINE SHORT PEN NEEDLE	2	MO
BD VEO INSULIN SYR (HALF UNIT)	2	MO
BD VEO INSULIN SYRINGE UF	2	MO
CAREFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2"	3	ST

Drug Name	Drug Tier	Requirements/Limits
CAREFINE PEN NEEDLE NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/32"	3	ST; MO
CARETOUCH INSULIN SYRINGE	3	ST
CARETOUCH PEN NEEDLE NEEDLE 29 GAUGE X 1/2"	3	ST
CARETOUCH PEN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 3/16", 32 GAUGE X 5/32"	3	ST; MO
CEQR SIMPLICITY	2	MO
CEQR SIMPLICITY INSERTER	2	MO
CLICKFINE PEN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16"	3	ST
CLICKFINE PEN NEEDLE 32 GAUGE X 5/32"	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
COMFORT EZ INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	3	ST
COMFORT EZ INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST; MO
COMFORT EZ PEN NEEDLES	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
COMFORT TOUCH PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 31 GAUGE X 5/32", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32"	3	ST
COMFORT TOUCH PEN NEEDLE NEEDLE 32 GAUGE X 1/4"	3	ST; MO
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 15/64", 0.5ML 30 GAUGE X 15/64"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
DROPLET INSULIN SYR(HALF UNIT) SYRINGE 0.5 ML 31 GAUGE X 5/16"	3	ST; MO
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 15/64", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 15/64", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 15/64", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 15/64"	3	ST
DROPLET INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.3 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16	3	ST; MO
DROPLET MICRON PEN NEEDLE	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
DROPLET PEN NEEDLE 29 GAUGE X 1/2", 29 GAUGE X 3/8", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32"	3	ST; MO
DROPLET PEN NEEDLE 30 GAUGE X 5/16"	3	ST
DROPSAFE INSULIN SYRINGE	3	ST
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16"	3	ST; MO
DROPSAFE PEN NEEDLE NEEDLE 31 GAUGE X 3/16"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EASY COMFORT INSULIN SYRINGE SYRINGE 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1 ML 32 GAUGE X 5/16", 1/2 ML 32 GAUGE X 5/16"	3	ST
EASY COMFORT PEN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 5/32"	3	ST; MO
EASY COMFORT PEN NEEDLE 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32"	3	ST
EASY GLIDE INSULIN SYRINGE	3	ST
EASY GLIDE PEN NEEDLE	3	ST

Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16"	3	ST
EASY TOUCH FLIPLOCK INSULIN SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16"	3	ST; MO
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2"	3	ST
EASY TOUCH INSULIN SAFETY SYRINGE 0.5 ML 30 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2"	3	ST; MO
EASY TOUCH INSULIN SYRINGE SYRINGE 0.3 ML 30 GAUGE X 1/2", 1 ML 27 GAUGE X 5/8", 1/2 ML 27 GAUGE X 1/2"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1/2 ML 28 GAUGE X 1/2"	3	ST; MO
EASY TOUCH LUER LOCK INSULIN	3	ST; MO
EASY TOUCH NEEDLE	3	ST; MO
EASY TOUCH PEN NEEDLE	3	ST; MO
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 3/16"	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
EASY TOUCH SAFETY PEN NEEDLE 29 GAUGE X 5/16", 30 GAUGE X 1/4", 30 GAUGE X 3/16", 30 GAUGE X 5/16"	3	ST
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16"	3	ST
EASY TOUCH SHEATHLOCK INSULIN SYRINGE 1 ML 31 GAUGE X 5/16"	3	ST; MO
EASY TOUCH UNI-SLIP SYRINGE 1 ML	3	ST
EMBRACE PEN NEEDLE	3	ST
FREESTYLE PRECISION SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
FREESTYLE PRECISION SYRINGE 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST
GAUZE PADS 2 X 2	2	
HEALTHWISE INSULIN SYRINGE	3	ST
HEALTHWISE PEN NEEDLE	3	ST
HEALTHY ACCENTS UNIFINE PENTIP NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16"	3	ST
INCONTROL PEN NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 5/16", 32 GAUGE X 5/32"	3	ST; MO
INCONTROL PEN NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 3/16"	3	ST
INPEN (FOR HUMALOG) BLUE	3	

Drug Name	Drug Tier	Requirements/Limits
INPEN (FOR HUMALOG) GREY	3	
INPEN (FOR HUMALOG) PINK	3	
INPEN (NOVOLOG OR FIASP) BLUE	3	
INPEN (NOVOLOG OR FIASP) GREY	3	
INPEN (NOVOLOG OR FIASP) PINK	3	
INSULIN PEN NEEDLE	2	MO
INSULIN PEN NEEDLE 29 GAUGE X 15/32", 31 GAUGE X 13/64", 31 GAUGE X 15/64", 31 GAUGE X 5/32", 32 GAUGE X 1/4", 32 GAUGE X 3/16", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 1/4", 33 GAUGE X 3/16", 33 GAUGE X 5/32"	3	ST
INSULIN MICROFINE SYRINGE 1 ML 27 GAUGE X 5/8"	2	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.3 ML 29 GAUGE, 1 ML 30 GAUGE X 1/2", 1/2 ML 28 GAUGE	2	
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	3	ST; MO
INSULIN SYRINGE (DISP) U-100 1 ML	2	MO
INSULIN SYRINGE-NEEDLE U-100 SYRINGE 1/2 ML 27 GAUGE X 1/2"	3	ST
INSUPEN PEN NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16"	3	ST

Drug Name	Drug Tier	Requirements/Limits
INSUPEN PEN NEEDLE 30 GAUGE X 5/16", 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 32 GAUGE X 5/32", 33 GAUGE X 5/32"	3	ST; MO
LITE TOUCH INSULIN PEN NEEDLES	3	ST; MO
LITE TOUCH INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1 ML 28 GAUGE, 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE, 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 30 GAUGE X 7/16", 1/2 ML 28 GAUGE X 1/2"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
LITE TOUCH INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16", 1 ML 31 GAUGE X 5/16, 1/2 ML 28 GAUGE, 1/2 ML 29, 1/2 ML 30 GAUGE	3	ST; MO
MAGELLAN INSULIN SAFETY SYRNG	3	ST; MO
MAGELLAN SYRINGE 0.3 ML 30 X 5/16"	3	ST; MO
MAGELLAN SYRINGE 0.5 ML 30 GAUGE X 5/16"	3	ST
MAXICOMFORT II PEN NEEDLE	3	ST
MAXICOMFORT INSULIN SYRINGE	3	ST
MAXI-COMFORT INSULIN SYRINGE	3	ST; MO
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 3/16"	3	ST

Drug Name	Drug Tier	Requirements/Limits
MAXICOMFORT SAFETY PEN NEEDLE NEEDLE 29 GAUGE X 5/16"	3	ST; MO
MICRODOT INSULIN PEN NEEDLE	3	ST
MINI ULTRA-THIN II	3	ST; MO
MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 29 GAUGE X 1/2"	3	ST; MO
MONOJECT INSULIN SAFETY SYRINGE 0.3 ML 30 GAUGE X 5/16"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
MONOJECT INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 25 GAUGE X 5/8", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST; MO
MONOJECT INSULIN SYRINGE SYRINGE 1 ML , 1 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	3	ST
MONOJECT SYRINGE 1/2 ML 28 GAUGE	3	ST
MONOJECT ULTRA COMFORT INSULIN	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
NEEDLES, INSULIN DISP.,SAFETY SYRINGE 0.5 ML 29 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64"	3	ST
NEEDLES, INSULIN DISP.,SAFETY SYRINGE 0.5 ML 31 GAUGE X 15/64"	3	ST; MO
NEEDLES, INSULIN DISP.,SAFETY	2	MO
NOVOFINE 32	3	ST; MO
NOVOFINE AUTOCOVER	3	ST; MO
NOVOFINE PLUS	3	ST; MO
OMNIPOD 5 G6 INTRO KIT (GEN 5)	2	MO; QL (1 per 720 days)
OMNIPOD 5 G6 PODS (GEN 5)	2	MO
OMNIPOD CLASSIC PODS (GEN 3)	2	MO
OMNIPOD DASH INTRO KIT (GEN 4)	2	MO; QL (1 per 720 days)
OMNIPOD DASH PODS (GEN 4)	2	MO
PEN NEEDLE, DIABETIC, SAFETY	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PENTIPS	3	ST
PIP PEN NEEDLE	3	ST; MO
PREVENT DROPSAFE PEN NEEDLE	3	ST
PRO COMFORT INSULIN SYRINGE	3	ST
PRO COMFORT PEN NEEDLE	3	ST
PRODIGY INSULIN SYRINGE 0.3 ML 31 GAUGE X 5/16"	3	ST
PRODIGY INSULIN SYRINGE 0.5 ML 31 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2"	3	ST; MO
PURE COMFORT PEN NEEDLE	3	ST
PURE COMFORT SAFETY PEN NEEDLE	3	ST
SAFESNAP INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
SAFESNAP INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2"	3	ST
SAFETY PEN NEEDLE	3	ST
SECURESAFE INSULIN SYRINGE	3	ST
SECURESAFE PEN NEEDLE	3	ST
SKY SAFETY PEN NEEDLE	3	ST
SURE COMFORT INS. SYR. 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
SURE COMFORT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16, 1/2 ML 28 GAUGE X 1/2"	3	ST; MO
SURE COMFORT INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 1/4", 1/2 ML 31 GAUGE X 1/4"	3	ST
SURE COMFORT PEN NEEDLE	3	ST; MO
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 31 GAUGE X 1/4"	3	ST

Drug Name	Drug Tier	Requirements/Limits
SURE COMFORT SAFETY PEN NEEDLE NEEDLE 32 GAUGE X 5/32"	3	ST; MO
SURE-FINE PEN NEEDLES	3	ST; MO
SURE-JECT INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1/2 ML 28 GAUGE X 1/2"	3	ST
SURE-JECT INSULIN SYRINGE 1 ML 31 GAUGE X 5/16	3	ST; MO
TECHLITE INSULIN SYRINGE 1 ML 29 GAUGE X 1/2"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TECHLITE INSULIN SYRINGE SYRINGE 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 15/64", 1 ML 31 GAUGE X 5/16	3	ST; MO
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.5 ML 30 GAUGE X 5/16"	3	ST
TECHLITE INSULN SYR(HALF UNIT) SYRINGE 0.3 ML 31 GAUGE X 15/64", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 15/64", 0.5 ML 31 GAUGE X 5/16"	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
TECHLITE PEN NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/16", 32 GAUGE X 5/32"	3	ST; MO
TECHLITE PEN NEEDLE 29 GAUGE X 3/8"	3	ST
TERUMO INSULIN SYRINGE 0.3 ML 30 X 3/8", 1/2 ML 27 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8"	3	ST
TERUMO INSULIN SYRINGE 0.5 ML 29 GAUGE X 1/2", 1 ML 27 GAUGE X 1/2", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	3	ST; MO
<i>thinpro insulin syringe 0.3 ml 29 gauge x 1/2", 0.5 ml 29 gauge x 1/2", 1 ml 29 gauge x 1/2"</i>	1	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
THINPRO INSULIN SYRINGE 0.3 ML 30 X 3/8", 1 ML 30 GAUGE X 3/8", 1/2 ML 28 GAUGE X 1/2", 1/2 ML 30 X 3/8"	3	ST
THINPRO INSULIN SYRINGE 0.3 ML 31 X 3/8", 0.5 ML 31 X 3/8", 1 ML 28 GAUGE X 1/2", 1 ML 31 X 3/8"	3	ST; MO
TOPCARE CLICKFINE	3	ST
TOPCARE ULTRA COMFORT	3	ST
TRUE COMFORT INSULIN SYRINGE	3	ST
TRUE COMFORT PEN NEEDLE	3	ST
TRUE COMFORT PRO INS SYRINGE	3	ST
TRUE COMFORT SAFETY PEN NEEDLE	3	ST

Drug Name	Drug Tier	Requirements/Limits
TRUEPLUS INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 1/2 ML 28 GAUGE X 1/2"	3	ST
TRUEPLUS INSULIN SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 28 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST; MO
TRUEPLUS PEN NEEDLE	3	ST; MO
ULTICARE INSULIN SYRINGE 0.3 ML 31 GAUGE X 1/4", 1 ML 31 GAUGE X 1/4"	3	ST; MO
ULTICARE INSULIN SYRINGE 1/2 ML 31 GAUGE X 1/4"	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ULTICARE INSULN SYR(HALF UNIT)	3	ST; MO
ULTICARE PEN NEEDLE	3	ST; MO
ULTICARE SAFETY PEN NEEDLE	3	ST
ULTICARE SYRINGE 0.3 ML 30 GAUGE X 1/2", 0.5 ML 30 GAUGE X 1/2", 0.5 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 1/2", 1 ML 31 GAUGE X 5/16	3	ST; MO
ULTICARE SYRINGE 0.3 ML 31 GAUGE X 5/16"	3	ST
ULTIGUARD SAFEPACK-INSULIN SYR	3	ST
ULTIGUARD SAFEPACK-PEN NEEDLE	3	ST

Drug Name	Drug Tier	Requirements/Limits
ULTILET INSULIN SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2", 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16", 1 ML 29 GAUGE X 1/2", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST
ULTILET PEN NEEDLE 29 GAUGE	3	ST
ULTILET PEN NEEDLE 32 GAUGE X 5/32"	3	ST; MO
ULTRA CMFT INS SYR (HALF UNIT)	3	ST
ULTRA COMFORT INSULIN SYRINGE	3	ST
ULTRA FLO INSUL SYR(HALF UNIT)	3	ST

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 29 GAUGE X 1/2", 0.3 ML 30 GAUGE X 5/16", 0.5 ML 29 GAUGE X 1/2"	3	ST
ULTRA FLO INSULIN SYRINGE SYRINGE 0.3 ML 31 GAUGE X 5/16"	3	ST; MO
ULTRA FLO PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 5/16", 33 GAUGE X 5/32"	3	ST
ULTRA FLO PEN NEEDLE NEEDLE 31 GAUGE X 3/16", 32 GAUGE X 5/32"	3	ST; MO
ULTRA THIN PEN NEEDLE	3	ST
ULTRACARE INSULIN SYRINGE	3	ST
ULTRACARE PEN NEEDLE	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
ULTRA-THIN II (SHORT) INS SYRINGE 0.3 ML 30 GAUGE X 5/16", 0.3 ML 31 GAUGE X 5/16", 1 ML 30 GAUGE X 5/16, 1 ML 31 GAUGE X 5/16	3	ST; MO
ULTRA-THIN II (SHORT) INS SYRINGE 0.5 ML 30 GAUGE X 5/16", 0.5 ML 31 GAUGE X 5/16"	3	ST
ULTRA-THIN II (SHORT) PEN NDL	3	ST; MO
ULTRA-THIN II INS PEN NEEDLES	3	ST; MO
ULTRA-THIN II INSULIN SYRINGE	3	ST; MO
UNIFINE PENTIPS MAXFLOW	3	ST; MO
UNIFINE PENTIPS NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 1/4", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32", 33 GAUGE X 5/32"	3	ST; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
UNIFINE PENTIPS PLUS	3	ST; MO
UNIFINE PENTIPS PLUS MAXFLOW	3	ST
UNIFINE SAFECONTROL	3	ST
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 1/4", 31 GAUGE X 5/16", 32 GAUGE X 5/32"	3	ST
UNIFINE ULTRA PEN NEEDLE NEEDLE 31 GAUGE X 3/16"	3	ST; MO
VANISHPOINT INSULIN SYRINGE	3	ST
VANISHPOINT SYRINGE 0.5 ML 30 GAUGE X 1/2", 1 ML 29 GAUGE X 1/2"	3	ST; MO
VERIFINE INSULIN SYRINGE	3	ST

Drug Name	Drug Tier	Requirements/Limits
VERIFINE PEN NEEDLE NEEDLE 29 GAUGE X 1/2", 31 GAUGE X 3/16", 31 GAUGE X 5/16", 32 GAUGE X 1/4", 32 GAUGE X 5/32"	3	ST
V-GO 20	2	MO
V-GO 30	2	MO
V-GO 40	2	MO
MUSCULOSKELETAL / RHEUMATOLOGY		
GOUT THERAPY		
<i>allopurinol oral tablet 100 mg, 300 mg</i>	1	MO
ALLOPURINOL ORAL TABLET 200 MG	3	
COLCHICINE (GOUT) ORAL CAPSULE	3	ST; MO
<i>colchicine (gout) oral tablet</i>	1	MO
COLCRYS	3	ST; MO
<i>febuxostat</i>	1	MO
MITIGARE	3	ST; MO
<i>probenecid</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>probenecid-colchicine</i>	1	MO
ULORIC	3	MO
ZYLOPRIM	3	MO
OSTEOPOROSIS THERAPY		
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)
<i>alendronate oral solution</i>	1	MO; QL (300 per 28 days)
<i>alendronate oral tablet 10 mg</i>	1	MO; QL (30 per 30 days)
<i>alendronate oral tablet 35 mg, 70 mg</i>	1	MO; QL (4 per 28 days)
ATELVIA	3	ST; MO; QL (4 per 28 days)
BINOSTO	3	ST; MO; QL (4 per 28 days)
EVENITY SUBCUTANEOUS SYRINGE 210MG/2.34ML (105MG/1.17MLX2)	3	PA; MO; QL (2.34 per 30 days)
EVISTA	3	MO
FORTEO	3	PA; MO; QL (2.4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
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	3	PA; MO; QL (1 per 180 days)
<i>raloxifene</i>	1	MO
<i>risedronate oral tablet 150 mg</i>	1	MO; QL (1 per 30 days)
<i>risedronate oral tablet 35 mg, 35 mg (12 pack), 35 mg (4 pack)</i>	1	MO; QL (4 per 28 days)
<i>risedronate oral tablet 5 mg</i>	1	MO; QL (30 per 30 days)
<i>risedronate oral tablet, delayed release (drlec)</i>	1	MO; QL (4 per 28 days)
TERIPARATIDE	2	PA; MO; QL (2.48 per 28 days)
TYMLOS	3	PA; MO; QL (1.56 per 30 days)
OTHER RHEUMATOLOGICALS		
ACTEMRA ACTPEN	3	PA; MO; QL (3.6 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ACTEMRA SUBCUTANEOUS	3	PA; MO; QL (3.6 per 28 days)
ADALIMUMAB-FKJP SUBCUTANEOUS PEN INJECTOR KIT	3	PA; QL (6 per 28 days)
ADALIMUMAB-FKJP SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	3	PA; QL (2 per 28 days)
ADALIMUMAB-FKJP SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	3	PA; QL (6 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS AUTO-INJECTOR 40 MG/0.8 ML	3	PA; MO; QL (4.8 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 10 MG/0.2 ML	3	PA; MO; QL (0.4 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 20 MG/0.4 ML	3	PA; MO; QL (0.8 per 28 days)
AMJEVITA (PREFERRED NDCS STARTING WITH 55513) SUBCUTANEOUS SYRINGE 40 MG/0.8 ML	3	PA; MO; QL (4.8 per 28 days)
ARAVA	3	MO; QL (30 per 30 days)
BENLYSTA SUBCUTANEOUS	2	PA; MO
CUPRIMINE	3	PA; MO
CYLTEZO(CF) PEN	2	PA; MO; QL (4 per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	2	PA; QL (6 per 180 days)
CYLTEZO(CF) PEN PSORIASIS STRT	2	PA; QL (4 per 180 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	2	PA; MO; QL (2 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	2	PA; MO; QL (4 per 28 days)
DEPEN TITRATABS	3	PA; MO
ENBREL MINI	2	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	2	PA; MO; QL (8 per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	2	PA; MO; QL (8 per 28 days)
ENBREL SURECLICK	2	PA; MO; QL (8 per 28 days)
HADLIMA(CF)	3	PA; QL (2.4 per 28 days)
HADLIMA(CF) PUSH TOUCH	3	PA; QL (2.4 per 28 days)
HULIO(CF) PEN	3	PA; MO; QL (6 per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT 20 MG/0.4 ML	3	PA; MO; QL (2 per 28 days)
HULIO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	3	PA; MO; QL (6 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HUMIRA PEN	2	PA; MO; QL (4 per 28 days)
HUMIRA PEN CROHNS-UC-HS START	2	PA; MO; QL (6 per 180 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	2	PA; MO; QL (4 per 180 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	2	PA; MO; QL (4 per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	2	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	2	PA; MO; QL (2 per 180 days)
HUMIRA(CF) PEN CROHNS-UC-HS	2	PA; MO; QL (3 per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC	2	PA; MO; QL (4 per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	2	PA; MO; QL (3 per 180 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	2	PA; MO; QL (4 per 28 days)
HUMIRA(CF) SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	2	PA; MO; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	2	PA; MO; QL (2 per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	2	PA; MO; QL (4 per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	2	PA; MO; QL (2.4 per 180 days)
HYRIMOZ PEN PSORIASIS STARTER	2	PA; MO; QL (1.6 per 180 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML- 40 MG/0.4 ML	2	PA; MO; QL (1.2 per 180 days)
HYRIMOZ(CF) PEN	2	PA; MO; QL (1.6 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	2	PA; MO; QL (0.2 per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	2	PA; MO; QL (0.4 per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	2	PA; MO; QL (1.6 per 28 days)
KEVZARA	3	PA; MO; QL (2.28 per 28 days)
KINERET	3	PA; QL (20.1 per 30 days)
<i>leflunomide</i>	1	MO; QL (30 per 30 days)
OLUMIANT	3	PA; MO; QL (30 per 30 days)
ORENCIA CLICKJECT	2	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	2	PA; MO; QL (4 per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	2	PA; MO; QL (1.6 per 28 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	2	PA; MO; QL (2.8 per 28 days)
OTEZLA	2	PA; MO; QL (60 per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	2	PA; MO; QL (55 per 180 days)
OTREXUP (PF)	3	MO
<i>penicillamine</i>	1	PA; MO
RASUVO (PF)	3	MO
REDITREX (PF)	3	MO
RIDAURA	3	MO
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	2	PA; MO; QL (30 per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	2	PA; MO; QL (84 per 180 days)
SAVELLA ORAL TABLET	2	MO; QL (60 per 30 days)
SAVELLA ORAL TABLETS,DOSE PACK	2	MO; QL (55 per 180 days)

Drug Name	Drug Tier	Requirements/Limits
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	3	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	3	PA; MO; QL (0.5 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	3	PA; MO; QL (3 per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	3	PA; MO; QL (0.5 per 28 days)
XELJANZ ORAL SOLUTION	2	PA; MO; QL (300 per 30 days)
XELJANZ ORAL TABLET	2	PA; MO; QL (60 per 30 days)
XELJANZ XR	2	PA; MO; QL (30 per 30 days)
YUSIMRY(CF) PEN	3	PA; QL (4.8 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
OBSTETRICS / GYNECOLOGY		
ESTROGENS / PROGESTINS		
ACTIVELLA ORAL TABLET 1- 0.5 MG	3	PA; MO
<i>amabelz</i>	1	PA; MO
ANGELIQ	3	PA; MO
AYGESTIN	3	MO
BIJUVA	3	PA; 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 INTRAMUSCUL AR SUSPENSION 150 MG/ML	3	MO

Drug Name	Drug Tier	Requirements/Limits
DEPO-PROVERA INTRAMUSCUL AR SYRINGE	3	MO
DEPO-SUBQ PROVERA 104	3	MO
DIVIGEL TRANSDERMAL GEL IN PACKET 0.25 MG/0.25 GRAM (0.1 %), 0.5 MG/0.5 GRAM (0.1 %), 0.75 MG/0.75 GRAM (0.1%), 1 MG/GRAM (0.1 %)	3	PA; MO; QL (30 per 30 days)
DIVIGEL TRANSDERMAL GEL IN PACKET 1.25 MG/1.25 GRAM (0.1 %)	3	PA; MO; QL (37.5 per 30 days)
<i>dotti</i>	1	PA; MO; QL (8 per 28 days)
DUAVEE	2	MO
ELESTRIN	3	PA; MO; QL (70 per 30 days)
<i>errin</i>	1	MO
ESTRACE ORAL	3	PA; MO
ESTRACE VAGINAL	3	ST; MO
<i>estradiol oral</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>estradiol transdermal gel in packet 0.25 mg/0.25 gram (0.1%), 0.5 mg/0.5 gram (0.1%), 0.75 mg/0.75 gram (0.1%), 1 mg/gram (0.1%)</i>	1	PA; MO; QL (30 per 30 days)
<i>estradiol transdermal gel in packet 1.25 mg/1.25 gram (0.1%)</i>	1	PA; MO; QL (37.5 per 30 days)
<i>estradiol transdermal patch semiweekly</i>	1	PA; MO; QL (8 per 28 days)
<i>estradiol transdermal patch weekly 0.025 mg/24 hr, 0.0375 mg/24 hr, 0.06 mg/24 hr, 0.075 mg/24 hr</i>	1	PA; QL (4 per 28 days)
<i>estradiol transdermal patch weekly 0.05 mg/24 hr, 0.1 mg/24 hr</i>	1	PA; MO; QL (4 per 28 days)
<i>estradiol vaginal</i>	1	MO
<i>estradiol valerate</i>	1	MO
<i>estradiol-norethindrone acetate</i>	1	PA; MO
ESTRING	3	MO
ESTROGEL	3	MO; QL (50 per 30 days)
EVAMIST	3	PA; MO; QL (16.2 per 30 days)
FEMRING	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
<i>fyavolv</i>	1	PA; MO
IMVEXXY MAINTENANCE PACK	2	MO
IMVEXXY STARTER PACK	2	MO
<i>incassia</i>	1	MO
<i>jinteli</i>	1	PA; MO
<i>lyleq</i>	1	MO
<i>lyllana</i>	1	PA; MO; QL (8 per 28 days)
<i>lyza</i>	1	
<i>medroxyprogesterone</i>	1	MO
MENEST	2	PA; MO
MENOSTAR	3	PA; MO; QL (4 per 28 days)
<i>mimvey</i>	1	PA; MO
MINIVELLE	3	PA; MO; QL (8 per 28 days)
<i>nora-be</i>	1	MO
<i>norethindrone (contraceptive)</i>	1	
<i>norethindrone acetate</i>	1	MO
<i>norethindrone acetate estradiol oral tablet 0.5-2.5 mg-mcg</i>	1	PA
<i>norethindrone acetate estradiol oral tablet 1-5 mg-mcg</i>	1	PA; MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PREFEST	3	PA; MO
PREMARIN ORAL	2	MO
PREMARIN VAGINAL	2	MO
PREMPHASE	2	MO
PREMPRO	2	MO
<i>progesterone micronized</i>	1	MO
PROMETRIUM	3	MO
PROVERA	3	MO
<i>sharobel</i>	1	MO
VAGIFEM	3	ST; MO
VIVELLE-DOT	3	PA; MO; QL (8 per 28 days)
<i>yuvafem</i>	1	MO
MISCELLANEOUS OB/GYN		
ANNOVERA	3	MO
CLEOCIN VAGINAL	3	MO
<i>clindamycin phosphate vaginal</i>	1	MO
CLINDESSE	3	MO
<i>eluryng</i>	1	MO
<i>etonogestrel-ethinyl estradiol</i>	1	
GYNAZOLE-1	3	MO
INTRAROSA	3	MO
KYLEENA	3	
LILETTA	3	MO

Drug Name	Drug Tier	Requirements/Limits
<i>metronidazole vaginal</i>	1	MO
<i>miconazole-3 vaginal suppository</i>	1	MO
MIRENA	3	
MYFEMBREE	2	PA; MO
NEXPLANON	3	
NUVARING	3	MO
ORIAHNN	3	PA; MO
OSPHENA	3	MO
PHEXXI	3	MO
SKYLA	3	
<i>terconazole</i>	1	MO
<i>tranexamic acid oral</i>	1	MO
<i>vandazole</i>	1	MO
<i>xulane</i>	1	MO
<i>zafemy</i>	1	MO
ORAL CONTRACEPTIVES / RELATED AGENTS		
<i>altavera (28)</i>	1	MO
<i>alyacen 1/35 (28)</i>	1	MO
<i>amethia</i>	1	MO
<i>apri</i>	1	MO
<i>aranelle (28)</i>	1	MO
<i>ashlyna</i>	1	MO
<i>aubra eq</i>	1	MO
<i>aviane</i>	1	MO
BALCOLTRA	3	MO
<i>balziva (28)</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
BEYAZ	3	MO
<i>blisovi 24 fe</i>	1	MO
<i>blisovi fe 1.5/30 (28)</i>	1	MO
<i>briellyn</i>	1	MO
<i>camrese lo</i>	1	MO
<i>cryselle (28)</i>	1	MO
<i>cyred eq</i>	1	MO
<i>desog-e.estradiol.e.estradiol</i>	1	
<i>desogestrel-ethinyl estradiol</i>	1	
<i>dolishale</i>	1	MO
<i>drospirenone-e.estradiol-lm,fa oral tablet 3-0.02-0.451 mg (24) (4)</i>	1	
<i>drospirenone-ethinyl estradiol oral tablet 3-0.02 mg</i>	1	MO
<i>drospirenone-ethinyl estradiol oral tablet 3-0.03 mg</i>	1	
<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>finzala</i>	1	MO
<i>gemmily</i>	1	MO
<i>hailey 24 fe</i>	1	MO
<i>iclevia</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<i>introvale</i>	1	MO
<i>isibloom</i>	1	MO
<i>jasmiel (28)</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 (28)</i>	1	MO
<i>kurvelo (28)</i>	1	MO
<i>l norgestle.estradiol-e.estradiol oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7), 0.15 mg-30 mcg (84)/10 mcg (7)</i>	1	
<i>l norgestle.estradiol-e.estradiol oral tablets,dose pack,3 month 0.15 mg-20 mcg/ 0.15 mg-25 mcg</i>	1	MO
<i>larin 1.5/30 (21)</i>	1	MO
<i>larin 1/20 (21)</i>	1	MO
<i>larin fe 1.5/30 (28)</i>	1	MO
<i>larin fe 1/20 (28)</i>	1	MO
<i>layolis fe</i>	1	MO
<i>leena 28</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>lessina</i>	1	MO
<i>levonest (28)</i>	1	MO
<i>levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg</i>	1	MO
<i>levonorgestrel-ethinyl estrad oral tablet 0.15-0.03 mg, 90-20 mcg (28)</i>	1	
<i>levonorgestrel-ethinyl estrad oral tablets, dose pack, 3 month</i>	1	MO
<i>levonorg-eth estrad triphasic</i>	1	
<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
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>lutra (28)</i>	1	MO
<i>marlissa (28)</i>	1	MO
<i>merzee</i>	1	MO
<i>mibelas 24 fe</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>microgestin 1.5/30 (21)</i>	1	MO
<i>microgestin 1/20 (21)</i>	1	MO
<i>microgestin 24 fe</i>	1	MO
<i>microgestin fe 1.5/30 (28)</i>	1	MO
<i>microgestin fe 1/20 (28)</i>	1	MO
<i>mili</i>	1	MO
NATAZIA	3	MO
<i>necon 0.5/35 (28)</i>	1	MO
NEXTSTELLIS	3	MO
<i>nikki (28)</i>	1	MO
<i>noreth-ethinyl estradiol-iron</i>	1	
<i>norethindrone acetate estradiol oral tablet 1-20 mg-mcg</i>	1	MO
<i>norethindrone-e.estradiol-iron oral capsule</i>	1	
<i>norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7), 1-20(5)/1-30(7)/1mg-35mcg (9)</i>	1	
<i>norethindrone-e.estradiol-iron oral tablet, chewable</i>	1	
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-25 mcg, 0.25-35 mg-mcg</i>	1	

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>norgestimate-ethinyl estradiol oral tablet 0.18/0.215/0.25 mg-35 mcg (28)</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>nylia 1/35 (28)</i>	1	MO
<i>nylia 7/7/7 (28)</i>	1	MO
<i>nymyo</i>	1	MO
<i>ocella</i>	1	MO
<i>pimtreea (28)</i>	1	MO
<i>portia 28</i>	1	MO
QUARTETTE	3	MO
<i>reclipsen (28)</i>	1	MO
<i>rivelsa</i>	1	MO
SAFYRAL	3	MO
SEASONIQUE	3	MO
<i>setlakin</i>	1	MO
SLYND	3	MO
<i>sprintec (28)</i>	1	MO
<i>sronyx</i>	1	MO
<i>syeda</i>	1	MO
<i>tarina 24 fe</i>	1	MO
<i>tarina fe 1-20 eq (28)</i>	1	MO
<i>tilia fe</i>	1	MO
<i>tri-estarylla</i>	1	MO
<i>tri-legest fe</i>	1	MO
<i>tri-lo-estarylla</i>	1	MO
<i>tri-lo-sprintec</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>tri-mili</i>	1	MO
<i>tri-nymyo</i>	1	MO
<i>tri-sprintec (28)</i>	1	MO
<i>trivora (28)</i>	1	MO
<i>tri-vylibra</i>	1	MO
<i>tri-vylibra lo</i>	1	MO
TYBLUME	3	MO
<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	MO
<i>wymzya fe</i>	1	MO
YASMIN (28)	3	MO
YAZ (28)	3	MO
<i>zovia 1-35 (28)</i>	1	MO

OPHTHALMOLOGY

ANTIBIOTICS

AZASITE	2	MO
<i>bacitracin ophthalmic (eye)</i>	1	MO
<i>bacitracin-polymyxin b</i>	1	MO
BESIVANCE	2	MO
CILOXAN OPHTHALMIC (EYE) 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>ciprofloxacin hcl ophthalmic (eye)</i>	1	MO
<i>erythromycin ophthalmic (eye)</i>	1	MO; QL (3.5 per 14 days)
<i>gatifloxacin</i>	1	MO
<i>gentamicin ophthalmic (eye) drops</i>	1	MO; QL (70 per 30 days)
<i>levofloxacin ophthalmic (eye) drops 0.5 %</i>	1	MO
<i>moxifloxacin ophthalmic (eye) drops</i>	1	MO
NATACYN	3	
<i>neomycin-bacitracin-polymyxin</i>	1	MO
<i>neomycin-polymyxin-gramicidin</i>	1	MO
<i>neo-polycin</i>	1	MO
OCUFLOX	3	MO
<i>ofloxacin ophthalmic (eye)</i>	1	MO
<i>polycin</i>	1	MO
<i>polymyxin b sulf-trimethoprim</i>	1	MO
<i>tobramycin ophthalmic (eye)</i>	1	MO; QL (10 per 14 days)
TOBREX OPTHALMIC (EYE) OINTMENT	3	MO; QL (3.5 per 14 days)

Drug Name	Drug Tier	Requirements/Limits
VIGAMOX	3	MO
ZYMAXID	3	MO
ANTIVIRALS		
<i>trifluridine</i>	1	MO
ZIRGAN	3	MO
BETA-BLOCKERS		
<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>timolol maleate (pf)</i>	1	MO
<i>timolol maleate ophthalmic (eye)</i>	1	MO
TIMOPTIC OCUDOSE (PF)	3	MO
TIMOPTIC-XE	3	MO
MISCELLANEOUS OPTHALMOLOGICS		
ALOMIDE	3	MO
<i>atropine ophthalmic (eye) drops</i>	1	MO
<i>azelastine ophthalmic (eye)</i>	1	MO
<i>bepotastine besilate</i>	1	MO
BEPREVE	3	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
BYOOVIZ	3	PA; MO
CEQUA	3	MO; QL (60 per 30 days)
CIMERLI	2	PA; MO
<i>cromolyn ophthalmic (eye)</i>	1	MO
<i>cyclosporine ophthalmic (eye)</i>	1	MO; QL (60 per 30 days)
CYSTADROPS	3	PA
CYSTARAN	2	PA
<i>epinastine</i>	1	MO
LACRISERT	3	PA; MO
<i>olopatadine ophthalmic (eye) drops 0.1 %</i>	1	MO
OXERVATE	3	PA; MO
PHOSPHOLINE IODIDE	3	
<i>pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %</i>	1	MO
RESTASIS	3	MO; QL (60 per 30 days)
RESTASIS MULTIDOSE	3	MO; QL (5.5 per 30 days)
<i>sulfacetamide sodium ophthalmic (eye)</i>	1	MO
<i>sulfacetamide-prednisolone</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
TYRVAYA	3	MO; QL (8.4 per 30 days)
VERKAZIA	3	PA; MO; QL (120 per 30 days)
VUITY	3	PA; MO
XIIDRA	2	MO; QL (60 per 30 days)
ZERVIATE	3	MO
NON-STEROIDAL ANTI-INFLAMMATORY AGENTS		
ACULAR	3	ST; MO
ACULAR LS	3	ST; MO
ACUVAIL (PF)	3	ST; MO
<i>bromfenac</i>	1	MO
BROMSITE	2	MO
<i>diclofenac sodium ophthalmic (eye)</i>	1	MO
<i>flurbiprofen sodium</i>	1	MO
ILEVRO	3	ST; MO
<i>ketorolac ophthalmic (eye)</i>	1	MO
NEVANAC	3	ST; MO
PROLENSA	2	MO
ORAL DRUGS FOR GLAUCOMA		
<i>acetazolamide</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>methazolamide</i>	1	MO
OTHER GLAUCOMA DRUGS		
AZOPT	3	MO
<i>bimatoprost ophthalmic (eye)</i>	1	MO
<i>brimonidine-timolol</i>	1	MO
<i>brinzolamide</i>	1	MO
COMBIGAN	3	MO
COSOPT	3	MO
COSOPT (PF)	3	MO
<i>dorzolamide</i>	1	MO
<i>dorzolamide-timolol</i>	1	MO
<i>dorzolamide-timolol (pf) ophthalmic (eye) dropperette</i>	1	MO
<i>latanoprost</i>	1	MO
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	2	MO
RHOPRESSA	2	MO
ROCKLATAN	2	MO
SIMBRINZA	2	MO
<i>tafluprost (pf)</i>	1	MO
TRAVATAN Z	3	ST; MO
<i>travoprost</i>	1	MO
VYZULTA	3	ST; MO
XALATAN	3	ST; MO
XELPROS	3	ST
ZIOPTAN (PF)	3	ST; MO

Drug Name	Drug Tier	Requirements/Limits
STEROID-ANTIBIOTIC COMBINATIONS		
MAXITROL	3	MO
<i>neomycin-bacitracin-poly-hc</i>	1	MO
<i>neomycin-polymyxin b-dexameth</i>	1	MO
<i>neomycin-polymyxin-hc ophthalmic (eye)</i>	1	MO
<i>neo-polycin hc</i>	1	MO
TOBRADEX OPHTHALMIC (EYE) DROPS,SUSPENSION	3	MO; QL (10 per 14 days)
TOBRADEX OPHTHALMIC (EYE) OINTMENT	2	MO; QL (3.5 per 14 days)
TOBRADEX ST	3	MO
<i>tobramycin-dexamethasone</i>	1	MO; QL (10 per 14 days)
ZYLET	3	MO; QL (10 per 14 days)
STEROIDS		
ALREX	2	MO
<i>dexamethasone sodium phosphate 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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>difluprednate</i>	1	MO
DUREZOL	3	MO
EYSUVIS	3	PA; MO; QL (8.3 per 14 days)
FLAREX	3	MO
<i>fluorometholone</i>	1	MO
FML FORTE	3	MO
FML LIQUIFILM	3	MO
INVELTYS	2	MO
LOTEMAX	3	MO
LOTEMAX SM	3	MO
<i>loteprednol etabonate</i>	1	MO
MAXIDEX	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		
ALPHAGAN P	3	MO
<i>apraclonidine</i>	1	MO
<i>brimonidine ophthalmic (eye)</i>	1	MO
IOPIDINE OPTHALMIC (EYE) DROPPERETTE	3	MO

Drug Name	Drug Tier	Requirements/Limits
RESPIRATORY AND ALLERGY		
ANTI-HISTAMINE / ANTI-ALLERGIC AGENTS		
AUVI-Q	3	QL (2 per 30 days)
<i>cetirizine oral solution 1 mg/ml</i>	1	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	3	MO; QL (2 per 30 days)
<i>epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml (manufactured by mylan specialty)</i>	1	MO; QL (2 per 30 days)

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

This drug list was updated in August 2023.

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

Drug Name	Drug Tier	Requirements/Limits
ADVAIR HFA	2	MO; QL (12 per 30 days)
AIRDUO DIGIHALER	3	ST; MO; QL (1 per 30 days)
AIRDUO RESPICLICK	3	ST; MO; QL (1 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcglactuation</i>	1	MO; QL (17 per 30 days)
<i>albuterol sulfate inhalation hfa aerosol inhaler 90 mcglactuation package size 6.7 gm</i>	1	QL (13.4 per 30 days)
ALBUTEROL SULFATE INHALATION HFA AEROSOL INHALER 90 MCG/ACTUATION (NDA020983)	3	ST; QL (36 per 30 days)
<i>albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg/3 ml (0.083%), 2.5 mg/0.5 ml</i>	1	PA; MO
<i>albuterol sulfate oral syrup</i>	1	MO
<i>albuterol sulfate oral tablet</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
ALVESCO INHALATION HFA AEROSOL INHALER 160 MCG/ACTUATION	2	MO; QL (12.2 per 30 days)
ALVESCO INHALATION HFA AEROSOL INHALER 80 MCG/ACTUATION	2	MO; QL (6.1 per 30 days)
<i>alyq</i>	1	PA; QL (60 per 30 days)
<i>ambrisentan</i>	1	PA; MO; LA
ANORO ELLIPTA	3	ST; MO; QL (60 per 30 days)
<i>arformoterol</i>	1	PA; MO; QL (120 per 30 days)
ARMONAIR DIGIHALER	3	ST; MO; QL (1 per 30 days)
ARNUITY ELLIPTA	3	ST; MO; QL (30 per 30 days)
ASMANEX HFA	2	MO; QL (13 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	2	MO; QL (1 per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	2	MO; QL (2 per 30 days)
ATROVENT HFA	3	MO; QL (25.8 per 30 days)
<i>azelastine- fluticasone</i>	1	MO; QL (23 per 30 days)
BECONASE AQ	3	ST; MO; QL (50 per 30 days)
BERINERT INTRAVENOUS KIT	3	PA; MO
BEVESPI AEROSPHERE	2	MO; QL (10.7 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>bosentan</i>	1	PA; MO; LA
BREO ELLIPTA	2	MO; QL (60 per 30 days)
BREZTRI AEROSPHERE	2	MO; QL (10.7 per 30 days)
BRONCHITOL	3	PA; MO
BROVANA	3	PA; MO; QL (120 per 30 days)
<i>budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml</i>	1	PA; MO; QL (120 per 30 days)
<i>budesonide inhalation suspension for nebulization 1 mg/2 ml</i>	1	PA; MO; QL (60 per 30 days)
BUDESONIDE-FORMOTEROL	3	ST; MO; QL (10.2 per 30 days)
CINRYZE	2	PA; MO
COMBIVENT RESPIMAT	2	MO; QL (8 per 30 days)
<i>cromolyn inhalation</i>	1	PA; MO
DALIRESP	3	PA; MO; QL (30 per 30 days)
DUAKLIR PRESSAIR	3	ST; MO; QL (1 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
DULERA	2	MO; QL (13 per 30 days)
DYMISTA	3	MO; QL (23 per 30 days)
ESBRIET ORAL CAPSULE	3	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 267 MG	3	PA; MO; QL (270 per 30 days)
ESBRIET ORAL TABLET 801 MG	3	PA; MO; QL (90 per 30 days)
FASENRA	2	PA; MO; QL (1 per 28 days)
FASENRA PEN	2	PA; MO; QL (1 per 28 days)
FIRAZYR	3	PA; MO
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 100 MCG/ACTUATION, 50 MCG/ACTUATION	3	ST; MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
FLOVENT DISKUS INHALATION BLISTER WITH DEVICE 250 MCG/ACTUATION	3	ST; MO; QL (240 per 30 days)
FLOVENT HFA AEROSOL INHALER 110 MCG/ACTUATION	3	ST; MO; QL (12 per 30 days)
FLOVENT HFA AEROSOL INHALER 220 MCG/ACTUATION	3	ST; MO; QL (24 per 30 days)
FLOVENT HFA AEROSOL INHALER 44 MCG/ACTUATION	3	ST; MO; QL (10.6 per 30 days)
<i>flunisolide</i>	1	MO; QL (50 per 30 days)
FLUTICASONE FUROATE-VILANTEROL	3	ST; MO; QL (60 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	3	ST; MO; QL (12 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	3	ST; MO; QL (24 per 30 days)
FLUTICASONE PROPIONATE INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	3	ST; MO; QL (10.6 per 30 days)
<i>fluticasone propionate nasal</i>	1	MO; QL (16 per 30 days)
FLUTICASONE PROPION-SALMETEROL INHALATION AEROSOL POWDR BREATH ACTIVATED	3	ST; MO; QL (1 per 30 days)
<i>fluticasone propion-salmeterol inhalation blister with device</i>	1	MO; QL (60 per 30 days)
FLUTICASONE PROPION-SALMETEROL INHALATION HFA AEROSOL INHALER	3	ST; MO; QL (12 per 30 days)
<i>formoterol fumarate</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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
HAEGARDA	3	PA; MO; LA
<i>icatibant</i>	1	PA; MO
INCRUSE ELLIPTA	3	ST; MO; QL (30 per 30 days)
<i>ipratropium bromide inhalation</i>	1	PA; MO
<i>ipratropium-albuterol</i>	1	PA; MO
KALBITOR	3	PA; MO
KALYDECO ORAL GRANULES IN PACKET 13.4 MG, 25 MG, 50 MG, 75 MG	3	PA; MO; QL (56 per 28 days)
KALYDECO ORAL TABLET	3	PA; MO; QL (56 per 28 days)
LETAIRIS	3	PA; MO; LA
<i>levalbuterol hcl</i>	1	PA; MO
LEVALBUTEROL TARTRATE	3	ST; MO; QL (30 per 30 days)
<i>mometasone nasal</i>	1	MO; QL (34 per 30 days)
<i>montelukast</i>	1	MO
NUCALA SUBCUTANEOUS AUTO-INJECTOR	2	PA; MO; LA; QL (3 per 28 days)

Drug Name	Drug Tier	Requirements/Limits
NUCALA SUBCUTANEOUS RECON SOLN	2	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	2	PA; MO; LA; QL (3 per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	2	PA; MO; LA; QL (0.4 per 28 days)
OFEV	2	PA; MO; QL (60 per 30 days)
OMNARIS	3	ST; MO; QL (12.5 per 30 days)
OPSUMIT	2	PA; MO; LA
ORKAMBI ORAL GRANULES IN PACKET	3	PA; MO; QL (56 per 28 days)
ORKAMBI ORAL TABLET	3	PA; MO; QL (112 per 28 days)
ORLADEYO	3	PA; LA
PERFOROMIST	3	PA; MO; QL (120 per 30 days)
<i>pirfenidone oral capsule</i>	1	PA; MO; QL (270 per 30 days)
<i>pirfenidone oral tablet 267 mg</i>	1	PA; MO; QL (270 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
PIRFENIDONE ORAL TABLET 534 MG	3	PA; QL (90 per 30 days)
<i>pirfenidone oral tablet 801 mg</i>	1	PA; MO; QL (90 per 30 days)
PROAIR DIGIHALER	3	ST; MO; QL (2 per 30 days)
PROAIR RESPICLICK	3	ST; MO; QL (2 per 30 days)
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)
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 0.25 MG/2 ML, 0.5 MG/2 ML	3	PA; MO; QL (120 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
PULMICORT INHALATION SUSPENSION FOR NEBULIZATION 1 MG/2 ML	3	PA; MO; QL (60 per 30 days)
PULMOZYME	2	PA; MO
QNASL NASAL HFA AEROSOL INHALER 40 MCG/ACTUATION	3	ST; MO; QL (4.9 per 30 days)
QNASL NASAL HFA AEROSOL INHALER 80 MCG/ACTUATION	3	ST; MO; QL (8.7 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	3	PA; MO; QL (224 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
REVATIO ORAL TABLET	3	PA; MO; QL (90 per 30 days)
<i>roflumilast</i>	1	PA; MO; QL (30 per 30 days)
RUCONEST	3	PA; MO
RYALTRIS	3	ST; MO; QL (29 per 30 days)
<i>sajazir</i>	1	PA; MO
SEREVENT DISKUS	3	ST; MO; QL (60 per 30 days)
<i>sildenafil (pulmonary arterial hypertension) oral suspension for reconstitution 10 mg/ml</i>	1	PA; MO; QL (224 per 30 days)
<i>sildenafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; MO; QL (90 per 30 days)
SINGULAIR	3	MO
SPIRIVA RESPIMAT	2	MO; QL (4 per 30 days)
SPIRIVA WITH HANDIHALER	2	MO; QL (90 per 90 days)
STIOLTO RESPIMAT	2	MO; QL (4 per 30 days)
STRIVERDI RESPIMAT	2	MO; QL (4 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
SYMBICORT	3	ST; MO; QL (10.2 per 30 days)
SYMDEKO	3	PA; MO; QL (56 per 28 days)
<i>tadalafil (pulmonary arterial hypertension) oral tablet 20 mg</i>	1	PA; QL (60 per 30 days)
TADLIQ	3	PA; MO; QL (300 per 30 days)
TAKHZYRO	3	PA; MO; LA
<i>terbutaline oral</i>	1	MO
TEZSPIRE	3	PA; MO; QL (1.91 per 30 days)
THEO-24	2	MO
<i>theophylline oral solution</i>	1	
<i>theophylline oral tablet extended release 12 hr 300 mg, 450 mg</i>	1	MO
<i>theophylline oral tablet extended release 24 hr</i>	1	MO
TRACLEER	3	PA; MO; LA
TRELEGY ELLIPTA	2	MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	3	PA; MO; QL (56 per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	3	PA; MO; QL (84 per 28 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATIO N	3	ST; MO; QL (1 per 30 days)
TUDORZA PRESSAIR INHALATION AEROSOL POWDR BREATH ACTIVATED 400 MCG/ACTUATIO N (30 ACTUAT)	3	ST; QL (1 per 30 days)
TYVASO DPI	3	PA; MO
VENTAVIS	3	PA; MO
VENTOLIN HFA	3	ST; MO; QL (36 per 30 days)
<i>wixela inhub</i>	1	QL (60 per 30 days)
XHANCE	3	ST; MO; QL (32 per 30 days)

Drug Name	Drug Tier	Requirements/Limits
XOLAIR SUBCUTANEOU S RECON SOLN	3	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOU S SYRINGE 150 MG/ML	3	PA; MO; LA; QL (8 per 28 days)
XOLAIR SUBCUTANEOU S SYRINGE 75 MG/0.5 ML	3	PA; MO; LA; QL (1 per 28 days)
XOPENEX HFA	3	ST; MO; QL (30 per 30 days)
YUPELRI	3	PA; MO; QL (90 per 30 days)
<i>zafirlukast</i>	1	MO
ZETONNA	3	ST; MO; QL (6.1 per 30 days)
<i>zileuton</i>	1	MO
ZYFLO	3	MO
UROLOGICALS		
ANTICHOLINERGICS / ANTISPASMODICS		
<i>darifenacin</i>	1	MO
DETROL	3	MO
DETROL LA	3	MO
<i>fesoterodine</i>	1	MO
<i>flavoxate</i>	1	MO

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
GELNIQUE TRANSDERMAL GEL IN PACKET	3	MO; QL (30 per 30 days)
GEMTESA	3	ST; MO
MYRBETRIQ ORAL SUSPENSION, EXTENDED RELEASE RECON	2	
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	2	MO
<i>oxybutynin chloride oral syrup</i>	1	MO
<i>oxybutynin chloride oral tablet 5 mg</i>	1	MO
<i>oxybutynin chloride oral tablet extended release 24hr</i>	1	MO
OXYTROL	3	MO; QL (8 per 28 days)
<i>solifenacin</i>	1	MO
<i>tolterodine</i>	1	MO
TOVIAZ	3	MO
<i>trospium</i>	1	MO
VESICARE	3	MO
VESICARE LS	3	MO
BENIGN PROSTATIC HYPERPLASIA (BPH) THERAPY		
<i>alfuzosin</i>	1	MO
<i>dutasteride</i>	1	MO

Drug Name	Drug Tier	Requirements/Limits
<i>dutasteride-tamsulosin</i>	1	MO
ENTADFI	3	PA; MO; QL (30 per 30 days)
<i>finasteride oral tablet 5 mg</i>	1	MO
FLOMAX	3	ST; MO
PROSCAR	3	MO
RAPAFLO	3	ST; MO
<i>silodosin</i>	1	MO
<i>tamsulosin</i>	1	MO
UROXATRAL	3	ST; MO
MISCELLANEOUS UROLOGICALS		
<i>bethanechol chloride</i>	1	MO
CIALIS ORAL TABLET 2.5 MG	3	PA; MO; QL (60 per 30 days)
CIALIS ORAL TABLET 5 MG	3	PA; MO; QL (30 per 30 days)
CYSTAGON	3	PA; LA
ELMIRON	2	MO
<i>potassium citrate oral tablet extended release</i>	1	MO
PROCYSBI ORAL GRANULES DEL RELEASE IN PACKET	3	PA; MO
<i>tadalafil oral tablet 2.5 mg</i>	1	PA; MO; QL (60 per 30 days)

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>tadalafil oral tablet 5 mg</i>	1	PA; MO; QL (30 per 30 days)
UROCIT-K 10	3	MO
UROCIT-K 15	3	MO
UROCIT-K 5	3	MO

VITAMINS, HEMATINICS

/ ELECTROLYTES

ELECTROLYTES

<i>calcium acetate (phosphate bind)</i>	1	MO; QL (360 per 30 days)
<i>klor-con 10</i>	1	MO
<i>klor-con 8</i>	1	MO
<i>klor-con m10</i>	1	MO
<i>klor-con m15</i>	1	MO
<i>klor-con m20</i>	1	MO
<i>klor-con oral packet 20</i>	1	MO
<i>magnesium sulfate injection solution</i>	1	MO
<i>magnesium sulfate injection syringe</i>	1	
<i>potassium chloride-d5-0.45%nacl</i>	1	

Drug Name	Drug Tier	Requirements/Limits
<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</i>	1	
<i>potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml</i>	1	
<i>potassium chloride intravenous</i>	1	
<i>potassium chloride oral capsule, extended release</i>	1	MO
<i>potassium chloride oral liquid</i>	1	MO
<i>potassium chloride oral packet</i>	1	
<i>potassium chloride oral tablet extended release 10 meq, 8 meq</i>	1	MO
<i>potassium chloride oral tablet extended release 20 meq</i>	1	

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

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>potassium chloride oral tablet, er particles/crystals 10 meq</i>	1	MO
<i>potassium chloride oral tablet, er particles/crystals 15 meq, 20 meq</i>	1	
<i>potassium chloride-0.45 % nacl</i>	1	
<i>potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l</i>	1	
<i>potassium chloride-d5-0.9%nacl</i>	1	
<i>sodium chloride 0.45 % intravenous</i>	1	MO
<i>sodium chloride 3 % hypertonic</i>	1	
<i>sodium chloride 5 % hypertonic</i>	1	MO
TPN ELECTROLYTES	3	
MISCELLANEOUS NUTRITION PRODUCTS		
CLINIMIX 5%/D15W SULFITE FREE	3	PA
CLINIMIX 4.25%/D10W SULF FREE	3	PA

Drug Name	Drug Tier	Requirements/Limits
CLINIMIX 5%-D20W(SULFITE-FREE)	3	PA
CLINIMIX E 4.25%/D10W 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
CLINISOL SF 15 %	3	PA
DOJOLVI	3	PA; MO; LA
<i>intralipid intravenous emulsion 20 %</i>	1	PA
INTRALIPID INTRAVENOUS EMULSION 30 %	3	PA
ISOLYTE S PH 7.4	3	
ISOLYTE-P IN 5 % DEXTROSE	3	
NUTRILIPID	3	PA
PLASMA-LYTE 148	2	
PLASMA-LYTE A	2	
PLENAMINE	3	PA
<i>premasol 10 %</i>	1	PA
PROSOL 20 %	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 express-scripts.com.

This drug list was updated in August 2023.

Drug Name	Drug Tier	Requirements/Limits
<i>travasol 10 %</i>	1	PA
TROPHAMINE 10 %	3	PA
VITAMINS / HEMATINICS		
<i>fluoride (sodium) oral tablet</i>	1	
<i>prenatal vitamin oral tablet</i>	1	

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

This drug list was updated in August 2023.

Index

1ST TIER UNIFINE PENTIPS.....	100	ACULAR.....	130	<i>albendazole</i>	7
1ST TIER UNIFINE PENTIPS PLUS.....	100	ACULAR LS.....	130	<i>albuterol sulfate</i>	133
<i>abacavir</i>	2	ACUVAIL (PF).....	130	ALBUTEROL SULFATE..	133
<i>abacavir-lamivudine</i>	2	<i>acyclovir</i>	2, 70	<i>alclometasone</i>	71
ABELCET.....	1	<i>acyclovir sodium</i>	2	<i>alcohol pads</i>	79
ABILIFY.....	42	ACZONE.....	67	ALDACTAZIDE.....	55
ABILIFY ASIMTUFII.....	42	ADACEL(TDAP ADOLESN/ADULT)(PF)....	98	ALDACTONE.....	55
ABILIFY MAINTENA.....	42	ADALIMUMAB-FKJP.....	119	ALECENSA.....	14
ABILIFY MYCITE MAINTENANCE KIT.....	42	<i>adapalene</i>	67	<i>alendronate</i>	118
ABILIFY MYCITE STARTER KIT.....	42	<i>adapalene-benzoyl peroxide</i>	67	<i>alfuzosin</i>	141
<i>abiraterone</i>	14	ADBRY.....	65	<i>aliskiren</i>	55
ABOUTTIME PEN NEEDLE.....	100	ADCIRCA.....	133	ALKINDI SPRINKLE.....	78
ABSORICA.....	66	ADDERALL.....	42	ALLOPURINOL.....	117
ABSORICA LD.....	66	ADDERALL XR.....	42	<i>almotriptan malate</i>	30
<i>acamprosate</i>	74	<i>adefovir</i>	2	ALOGLIPTIN.....	79
ACANYA.....	66	ADEMPAS.....	133	ALOGLIPTIN- METFORMIN.....	79
<i>acarbose</i>	79	ADLARITY.....	31	ALOGLIPTIN- PIOGLITAZONE.....	79
ACCOLATE.....	133	ADMELOG SOLOSTAR U-100 INSULIN.....	79	ALOMIDE.....	129
<i>accutane</i>	66	ADMELOG U-100 INSULIN LISPRO.....	79	<i>alosectron</i>	90
<i>acebutolol</i>	55	ADVAIR DISKUS.....	133	ALPHAGAN P.....	132
<i>acetaminophen-caff- dihydrocod</i>	35	ADVAIR HFA.....	133	ALREX.....	131
<i>acetaminophen-codeine</i>	35	ADVOCATE PEN NEEDLE.....	100	ALTABAX.....	68
<i>acetazolamide</i>	130	ADVOCATE SYRINGES..	101	ALTACE.....	55
<i>acetic acid</i>	77	ADZENYS XR-ODT.....	42	<i>altavera (28)</i>	125
<i>acetylcysteine</i>	133	AEMCOLO.....	7	ALTOPREV.....	61
ACIPHEX.....	93	AFINITOR.....	14	ALTRENO.....	67
<i>acitretin</i>	64	AFINITOR DISPERZ.....	14	ALUNBRIG.....	14
ACTEMRA.....	119	AFREZZA.....	79	ALVESCO.....	134
ACTEMRA ACTPEN.....	118	AGRYLIN.....	74	<i>alyacen 1/35 (28)</i>	125
ACTHAR.....	78	AIMOVIG AUTOINJECTOR.....	29	ALYMSYS.....	14
ACTHIB (PF).....	98	AIRDUO DIGIHALER....	133	<i>alyq</i>	134
ACTIMMUNE.....	96	AIRDUO RESPICLICK....	133	<i>amabelz</i>	123
ACTIVELLA.....	123	AJOVY AUTOINJECTOR..	29	<i>amantadine hcl</i>	2
ACTONEL.....	118	AJOVY SYRINGE.....	30	AMBIEN.....	42
ACTOPLUS MET.....	79	AKLIEF.....	67	AMBIEN CR.....	42
ACTOS.....	79	<i>ala-cort</i>	71	AMBISOME.....	1
		ALA-SCALP.....	71	<i>ambrisentan</i>	134
				<i>amcinonide</i>	71
				<i>amethia</i>	125

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

This drug list was updated in August 2023.

<i>amikacin</i>	7	<i>apexicon e</i>	71	ASSURE ID PEN NEEDLE	101
<i>amiloride</i>	55	APIDRA SOLOSTAR U-			
<i>amiloride-hydrochlorothiazide</i>	55	100 INSULIN.....	79	ASTAGRAF XL.....	14
<i>amiodarone</i>	54	APIDRA U-100 INSULIN...	79	ATACAND.....	55
AMITIZA.....	90	ALENZIN.....	42	ATACAND HCT.....	55
<i>amitriptyline</i>	42	APOKYN.....	28	<i>atazanavir</i>	2
AMJEVITA (PREFERRED		<i>apomorphine</i>	29	ATELVIA.....	118
NDCS STARTING WITH		<i>apraclonidine</i>	132	<i>atenolol</i>	55
55513).....	119	<i>aprepitant</i>	90	<i>atenolol-chlorthalidone</i>	55
<i>amlodipine</i>	55	<i>apri</i>	125	ATIVAN.....	43
<i>amlodipine-atorvastatin</i>	61	APRISO.....	90	<i>atomoxetine</i>	43
<i>amlodipine-benazepril</i>	55	APTENSIO XR.....	42	<i>atorvastatin</i>	61
<i>amlodipine-olmesartan</i>	55	APTIOM.....	23, 24	<i>atovaquone</i>	7
<i>amlodipine-valsartan</i>	55	APTIVUS.....	2	<i>atovaquone-proguanil</i>	7
<i>amlodipine-valsartan-</i>		ARALAST NP.....	74	ATRALIN.....	67
<i>hcthiiazid</i>	55	<i>aranelle (28)</i>	125	<i>atropine</i>	129
<i>ammonium lactate</i>	65	ARANESP (IN		ATROVENT HFA.....	134
<i>amnesteem</i>	67	POLYSORBATE).....	96	AUBAGIO.....	31
<i>amoxapine</i>	42	ARAVA.....	119	<i>aubra eq</i>	125
<i>amoxicil-clarithromy-</i>		ARAZLO.....	67	AUGMENTIN.....	11
<i>lansopraz</i>	94	ARCALYST.....	96	AUGMENTIN ES-600.....	11
<i>amoxicillin</i>	10	<i>arformoterol</i>	134	AURYXIA.....	74
<i>amoxicillin-pot clavulanate</i>	10	ARICEPT.....	31	AUSTEDO.....	32
<i>amphetamine sulfate</i>	42	ARIKAYCE.....	7	AUSTEDO XR.....	32
<i>amphotericin b</i>	1	ARIMIDEX.....	14	AUVELITY.....	43
<i>ampicillin</i>	10	<i>aripiprazole</i>	42	AUVI-Q.....	132
<i>ampicillin sodium</i>	11	ARISTADA.....	43	AVALIDE.....	55
<i>ampicillin-sulbactam</i>	11	ARISTADA INITIO.....	42	AVAPRO.....	55
AMPYRA.....	31	ARIXTRA.....	59	AVEED.....	87
AMZEEQ.....	67	<i>armodafinil</i>	43	<i>aviane</i>	125
ANAFRANIL.....	42	ARMONAIR DIGIHALER		<i>avita</i>	67
<i>anagrelide</i>	74		134	AVONEX.....	96
<i>anastrozole</i>	14	ARNUITY ELLIPTA.....	134	AVYCAZ.....	5
ANCOBON.....	1	AROMASIN.....	14	AYGESTIN.....	123
ANDRODERM.....	86	ARTHROTEC 50.....	38	AYVAKIT.....	14
ANDROGEL.....	87	ARTHROTEC 75.....	38	AZACTAM.....	7
ANGELIQ.....	123	<i>asenapine maleate</i>	43	AZASAN.....	14
ANNOVERA.....	125	<i>ashlyna</i>	125	AZASITE.....	128
ANORO ELLIPTA.....	134	ASMANEX HFA.....	134	<i>azathioprine</i>	14
ANTARA.....	61	ASMANEX		<i>azelaic acid</i>	67
ANTIVERT.....	90	TWISTHALER.....	134	<i>azelastine</i>	77, 129
ANUSOL-HC.....	90	<i>aspirin-dipyridamole</i>	59	<i>azelastine-fluticasone</i>	134
ANZEMET.....	90	ASPRUZYO SPRINKLE.....	63	AZELEX.....	67

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

This drug list was updated in August 2023.

AZILECT.....	29	BD SAFETYGLIDE		BETOPTIC S.....	129
<i>azithromycin</i>	6	SYRINGE.....	102	BEVESPI AEROSPHERE..	134
AZOPT.....	131	BD ULTRA-FINE MICRO		<i>bexarotene</i>	14
AZOR.....	55	PEN NEEDLE.....	102	BEXSERO.....	98
AZSTARYS.....	43	BD ULTRA-FINE MINI		BEYAZ.....	126
<i>aztreonam</i>	7	PEN NEEDLE.....	102	<i>bicalutamide</i>	15
AZULFIDINE.....	90	BD ULTRA-FINE NANO		BICILLIN C-R.....	11
AZULFIDINE EN-TABS....	90	PEN NEEDLE.....	102	BICILLIN L-A.....	11
<i>bacitracin</i>	128	BD ULTRA-FINE ORIG		BIDIL.....	55
<i>bacitracin-polymyxin b</i>	128	PEN NEEDLE.....	102	BIJUVA.....	123
<i>baclofen</i>	35	BD ULTRA-FINE SHORT		BIKTARVY.....	2
BACTRIM.....	12	PEN NEEDLE.....	102	BILTRICIDE.....	7
BACTRIM DS.....	12	BD VEO INSULIN SYR		<i>bimatoprost</i>	131
BAFIERTAM.....	32	(HALF UNIT).....	102	BINOSTO.....	118
BALCOLTRA.....	125	BD VEO INSULIN		<i>bismuth subcit k-metronidz-</i>	
<i>balsalazide</i>	90	SYRINGE UF.....	102	<i>tcn</i>	94
BALVERSA.....	14	BECONASE AQ.....	134	<i>bisoprolol fumarate</i>	55
<i>balziva (28)</i>	125	BELBUCA.....	35	<i>bisoprolol-</i>	
BANZEL.....	24	BELSOMRA.....	43	<i>hydrochlorothiazide</i>	55
BAQSIMI.....	79	<i>benazepril</i>	55	BIVIGAM.....	98
BARACLUDGE.....	2	<i>benazepril-</i>		<i>blisovi 24 fe</i>	126
BASAGLAR KWIKPEN		<i>hydrochlorothiazide</i>	55	<i>blisovi fe 1.5/30 (28)</i>	126
U-100 INSULIN.....	79	BENICAR.....	55	BONJESTA.....	90
BASAGLAR TEMPO		BENICAR HCT.....	55	BOOSTRIX TDAP.....	98
PEN(U-100)INSLN.....	79	BENLYSTA.....	119	<i>bosentan</i>	135
BAXDELA.....	12	BENZAMYCIN.....	67	BOSULIF.....	15
BCG VACCINE, LIVE (PF).98		BENZNIDAZOLE.....	7	BRAFTOVI.....	15
BD AUTOSHIELD DUO		<i>benztropine</i>	29	BREO ELLIPTA.....	135
PEN NEEDLE.....	101	<i>bepotastine besilate</i>	129	BREZTRI AEROSPHERE.135	
BD ECLIPSE LUER-LOK.101		BEPREVE.....	129	<i>briellyn</i>	126
BD INSULIN SYRINGE...101		BERINERT.....	134	BRILINTA.....	59
BD INSULIN SYRINGE		BESIVANCE.....	128	<i>brimonidine</i>	67, 132
(HALF UNIT).....	101	BESREMI.....	96	<i>brimonidine-timolol</i>	131
BD INSULIN SYRINGE		<i>betaine</i>	90	<i>brinzolamide</i>	131
U-500.....	101	<i>betamethasone dipropionate</i>	71	BRIVIACT.....	24
BD INSULIN SYRINGE		<i>betamethasone valerate</i>	71	<i>bromfenac</i>	130
ULTRA-FINE.....	101	<i>betamethasone, augmented</i>	71	<i>bromocriptine</i>	29
BD LO-DOSE MICRO-		BETAPACE AF.....	54	BROMSITE.....	130
FINE IV.....	101	BETASERON.....	96	BRONCHITOL.....	135
BD NANO 2ND GEN PEN		<i>betaxolol</i>	55, 129	BROVANA.....	135
NEEDLE.....	101	<i>bethanechol chloride</i>	141	BRUKINSA.....	15
BD SAFETYGLIDE		BETHKIS.....	7	BRYHALI.....	71
INSULIN SYRINGE.....	101	BETIMOL.....	129	<i>budesonide</i>	90, 135

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

This drug list was updated in August 2023.

BUDESONIDE- FORMOTEROL.....	135	CAPEX.....	71	<i>ceftazidime</i>	5, 6
<i>bumetanide</i>	55	CAPLYTA.....	44	<i>ceftriaxone</i>	6
BUPHENYL.....	74	CAPRELSA.....	15	<i>cefuroxime axetil</i>	6
<i>buprenorphine hcl</i>	35	<i>captopril</i>	55	<i>cefuroxime sodium</i>	6
<i>buprenorphine transdermal patch</i>	35	CARAC.....	65	CELEBREX.....	39
<i>buprenorphine-naloxone</i>	38, 39	CARAFATE.....	94	<i>celecoxib</i>	39
<i>bupropion hcl</i>	43	CARBAGLU.....	74	CELEXA.....	44
BUPROPION HCL.....	43	<i>carbamazepine</i>	24	CELLCEPT.....	15
<i>bupropion hcl (smoking deter)</i>	77	CARBATROL.....	24	CELONTIN.....	24
<i>bupirone</i>	43	<i>carbidopa</i>	29	<i>cephalexin</i>	6
<i>butorphanol</i>	39	<i>carbidopa-levodopa</i>	29	CEQUA.....	130
BUTRANS.....	36	<i>carbidopa-levodopa- entacapone</i>	29	CEQUR SIMPLICITY.....	102
BYDUREON BCISE.....	79	CARDIZEM.....	56	INSERTER.....	102
BYETTA.....	80	CARDIZEM CD.....	55	CERDELGA.....	87
BYLVAY.....	90	CARDIZEM LA.....	55	<i>cetirizine</i>	132
BYOOVIZ.....	130	CARDURA.....	56	<i>cevimeline</i>	74
BYSTOLIC.....	55	CARDURA XL.....	56	CHEMET.....	74
<i>cabergoline</i>	87	CAREFINE PEN NEEDLE	102	CHENODAL.....	90
CABLIVI.....	59	CARETOUCH INSULIN SYRINGE.....	102	<i>chlorhexidine gluconate</i>	77
CABOMETYX.....	15	CARETOUCH PEN NEEDLE.....	102	<i>chloroquine phosphate</i>	7
CADUET.....	61	<i>carglumic acid</i>	74	<i>chlorpromazine</i>	44
<i>calcipotriene</i>	64	CARNITOR.....	74	<i>chlorthalidone</i>	56
CALCIPOTRIENE.....	64	CAROSPIR.....	56	CHOLBAM.....	90
<i>calcipotriene-betamethasone</i> ...	64	<i>carteolol</i>	129	<i>cholestyramine (with sugar)</i> ...	61
<i>calcitonin (salmon)</i>	87	<i>cartia xt</i>	56	<i>cholestyramine light</i>	61
<i>calcitriol</i>	64, 87	<i>carvedilol</i>	56	CIALIS.....	141
<i>calcium acetate(phosphat bind)</i>	142	<i>carvedilol phosphate</i>	56	CIBINQO.....	65
CALQUENCE.....	15	CASODEX.....	15	<i>ciclopirox</i>	69
CALQUENCE (ACALABRUTINIB MAL).	15	<i>caspofungin</i>	1	<i>cilostazol</i>	59
CAMBIA.....	39	CAYSTON.....	7	CILOXAN.....	128
<i>camila</i>	123	<i>cefaclor</i>	5	CIMDUO.....	2
<i>camrese lo</i>	126	<i>cefadroxil</i>	5	CIMERLI.....	130
CAMZYOS.....	63	<i>cefazolin</i>	5	<i>cimetidine</i>	94
CANASA.....	90	<i>cefdinir</i>	5	CIMZIA.....	90
CANCIDAS.....	1	<i>cefepime</i>	5	CIMZIA POWDER FOR RECONST.....	90
<i>candesartan</i>	55	<i>cefixime</i>	5	<i>cinacalcet</i>	87
<i>candesartan- hydrochlorothiazid</i>	55	<i>cefoxitin</i>	5	CINRYZE.....	135
		<i>cefpodoxime</i>	5	CIPRO.....	12
		<i>cefprozil</i>	5	CIPRO HC.....	77
				CIPRODEX.....	77
				<i>ciprofloxacin hcl</i>	12, 77, 129

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

This drug list was updated in August 2023.

<i>ciprofloxacin in 5 % dextrose</i> ..12	CLINIMIX E 5%/D15W	COMPLERA..... 2
<i>ciprofloxacin-dexamethasone</i> ..77	SULFIT FREE..... 143	<i>compro</i> 90
CIPROFLOXACIN- FLUOCINOLONE..... 77	CLINIMIX E 5%/D20W	COMTAN.....29
CITALOPRAM..... 44	SULFIT FREE..... 143	CONCERTA.....44
<i>citalopram</i> 44	CLINISOL SF 15 %..... 143	CONDYLOX.....65
<i>claravis</i>.....67	<i>clobazam</i> 24	CONJUPRI..... 56
CLARINEX..... 132	<i>clobetasol</i> 71	<i>constulose</i>.....90
CLARINEX-D 12 HOUR.. 132	<i>clobetasol-emollient</i> 71	CONZIP..... 39
<i>clarithromycin</i> 6	CLOBEX.....71	COPAXONE.....32
CLENPIQ..... 90	<i>clocortolone pivalate</i>.....71	COPIKTRA..... 15
CLEOCIN..... 125	<i>clodan</i> 71	CORDRAN.....72
CLEOCIN HCL.....7	CLODERM..... 71	CORDRAN TAPE LARGE ROLL.....71
CLEOCIN PEDIATRIC..... 7	<i>clomipramine</i>.....44	COREG CR..... 56
CLEOCIN T..... 67	<i>clonazepam</i> 24	CORGARD..... 56
CLICKFINE PEN NEEDLE.....102	<i>clonidine</i>.....56	CORLANOR..... 63
CLIMARA.....123	<i>clonidine hcl</i>.....44, 56	CORTEF.....78
CLIMARA PRO..... 123	<i>clopidogrel</i> 59	CORTIFOAM..... 90
<i>clindacin</i> 67	<i>clorazepate dipotassium</i>.....44	CORTROPHIN GEL..... 78
<i>clindacin etz</i> 67	<i>clotrimazole</i> 1, 69	COSENTYX..... 64
CLINDAGEL..... 67	<i>clotrimazole-betamethasone</i> ...69	COSENTYX (2 SYRINGES)..... 64
<i>clindamycin hcl</i>.....7	<i>clozapine</i> 44	COSENTYX PEN (2 PENS).64
<i>clindamycin in 5 % dextrose</i> 7	CLOZARIL..... 44	COSOPT..... 131
<i>clindamycin pediatric</i>.....8	COARTEM..... 8	COSOPT (PF)..... 131
<i>clindamycin phosphate</i> ..8, 67, 125	<i>codeine sulfate</i> 36	COTELLIC..... 15
<i>clindamycin-benzoyl peroxide</i> .. 67	COLAZAL.....90	COTEMPLA XR-ODT.....44
<i>clindamycin-tretinoin</i> 67	COLCHICINE (GOUT)..... 117	COZAAR..... 56
CLINDESSE..... 125	<i>colchicine (gout)</i> 117	CREON.....90
CLINIMIX 5%/D15W	COLCRYS..... 117	CRESEMBA..... 1
SULFITE FREE..... 143	<i>colesevelam</i> 61	CRESTOR..... 61
CLINIMIX 4.25%/D10W	COLESTID..... 61	CRINONE..... 123
SULF FREE..... 143	<i>colestipol</i> 61	<i>cromolyn</i> 90, 130, 135
CLINIMIX 4.25%/D5W	<i>colistin (colistimethate na)</i>.....8	<i>crotan</i>.....74
SULFIT FREE..... 74	COMBIGAN.....131	<i>cryselle (28)</i>.....126
CLINIMIX 5%- D20W(SULFITE-FREE).... 143	COMBIPATCH..... 123	CUBICIN RF..... 8
CLINIMIX E 2.75%/D5W	COMBIVENT RESPIMAT 135	CUPRIMINE..... 119
SULF FREE..... 74	COMBIVIR..... 2	CUVPOSA..... 89
CLINIMIX E 4.25%/D10W	COMETRIQ..... 15	CUVRIOR..... 74
SUL FREE.....143	COMFORT EZ INSULIN SYRINGE..... 103	<i>cyclobenzaprine</i> 35
CLINIMIX E 4.25%/D5W	COMFORT EZ PEN NEEDLES.....103	<i>cyclophosphamide</i>.....15
SULF FREE..... 143	COMFORT TOUCH PEN NEEDLE.....103	CYCLOPHOSPHAMIDE.... 15
		CYCLOSET..... 80

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

This drug list was updated in August 2023.

<i>cyclosporine</i>	15, 130	<i>deblitane</i>	123	<i>dextroamphetamine sulfate</i>	44
<i>cyclosporine modified</i>	15	<i>deferasirox</i>	74	<i>dextroamphetamine-</i>	
CYLTEZO(CF).....	119, 120	<i>deferiprone</i>	74	<i>amphetamine</i>	44
CYLTEZO(CF) PEN.....	119	DELESTROGEN.....	123	<i>dextrose 10 % and 0.2 % nacl.</i>	74
CYLTEZO(CF) PEN		DELSTRIGO.....	2	<i>dextrose 10 % in water</i>	
CROHN'S-UC-HS.....	119	DELZICOL.....	90	<i>(d10w)</i>	74
CYLTEZO(CF) PEN		<i>demeclocycline</i>	12	<i>dextrose 5 % in water (d5w)</i> ...	74
PSORIASIS STRT.....	119	DEMSEER.....	56	<i>dextrose 5%-0.2 % sod</i>	
CYMBALTA.....	44	DENAVIR.....	70	<i>chloride</i>	74
<i>cyred eq</i>	126	DEPAKOTE.....	24	DHIVY.....	29
CYSTADANE.....	90	DEPAKOTE ER.....	24	DIACOMIT.....	24
CYSTADROPS.....	130	DEPAKOTE SPRINKLES..	24	DIASTAT.....	24
CYSTAGON.....	141	DEPEN TITRATABS.....	120	DIASTAT ACUDIAL.....	24
CYSTARAN.....	130	DEPO-ESTRADIOL.....	123	<i>diazepam</i>	24, 44, 45
CYTOMEL.....	89	DEPO-PROVERA.....	123	<i>diazepam intensol</i>	44
CYTOTEC.....	94	DEPO-SUBQ PROVERA		<i>diazoxide</i>	80
<i>d10 %-0.45 % sodium chloride</i>	74	104.....	123	DIBENZYLINE.....	56
<i>d2.5 %-0.45 % sodium</i>		DEPO-TESTOSTERONE....	87	DICLEGIS.....	90
<i>chloride</i>	74	DERMA-SMOOTH/FS		DICLOFENAC	
<i>d5 % and 0.9 % sodium</i>		SCALP OIL.....	72	EPOLAMINE.....	39
<i>chloride</i>	74	DERMOTIC OIL.....	77	<i>diclofenac potassium</i>	39
<i>d5 %-0.45 % sodium chloride</i> ..	74	DESCOVY.....	2	<i>diclofenac sodium</i>	39, 65, 130
<i>dabigatran etexilate</i>	59	<i>desipramine</i>	44	<i>diclofenac-misoprostol</i>	39
<i>dalfampridine</i>	32	<i>desloratadine</i>	132	<i>dicloxacillin</i>	11
DALIRESP.....	135	<i>desmopressin</i>	87	<i>dicyclomine</i>	89
DALVANCE.....	8	<i>desog-e.estradiolle.estradiol</i> ..	126	DIFFERIN.....	67
<i>danazol</i>	87	<i>desogestrel-ethinyl estradiol</i> ..	126	DIFICID.....	6
DANTRIUM.....	35	<i>desonide</i>	72	<i>diflorasone</i>	72
<i>dantrolene</i>	35	DESOWEN.....	72	DIFLUCAN.....	1
<i>dapsone</i>	8, 67	<i>desoximetasone</i>	72	<i>diflunisal</i>	39
DAPTACEL (DTAP		<i>desrx</i>	72	<i>difluprednate</i>	132
PEDIATRIC) (PF).....	98	DESVENLAFAXINE.....	44	<i>digoxin</i>	63
DAPTOMYCIN.....	8	<i>desvenlafaxine succinate</i>	44	<i>dihydroergotamine</i>	30
<i>daptomycin</i>	8	DETROL.....	140	DILANTIN 30 MG.....	24
DARAPRIM.....	8	DETROL LA.....	140	DILANTIN EXTENDED	
<i>darifenacin</i>	140	<i>dexabliss</i>	78	100 MG.....	24
DARTISLA.....	89	<i>dexamethasone</i>	78	DILANTIN INFATABS 50	
<i>darunavir ethanolate</i>	2	<i>dexamethasone sodium</i>		MG.....	24
DAURISMO.....	15	<i>phosphate</i>	131	DILANTIN-125 125 MG/5	
DAYPRO.....	39	DEXEDRINE SPANSULE..	44	ML.....	24
DAYTRANA.....	44	DEXILANT.....	94	DILAUDID.....	36
DAYVIGO.....	44	<i>dexlansoprazole</i>	94	<i>diltiazem hcl</i>	56
DDAVP.....	87	<i>dexmethylphenidate</i>	44	<i>dilt-xr</i>	56

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

This drug list was updated in August 2023.

<i>dimethyl fumarate</i>	32	DROPLET INSULIN	EASY GLIDE PEN
DIOVAN.....	56	SYR(HALF UNIT).....	103, 104
DIOVAN HCT.....	56	DROPLET INSULIN	NEEDLE.....
DIPENTUM.....	90	SYRINGE.....	105
<i>diphenoxylate-atropine</i>	89	DROPLET MICRON PEN	EASY TOUCH.....
DIPROLENE		NEEDLE.....	106
(AUGMENTED).....	72	DROPLET PEN NEEDLE.	EASY TOUCH FLIPLOCK
<i>dipyridamole</i>	59	DROPSAFE ALCOHOL	INSULIN.....
<i>disulfiram</i>	74	PREP PADS.....	105
DIURIL.....	56	DROPSAFE INSULIN	EASY TOUCH INSULIN
<i>divalproex</i>	25	SYRINGE.....	105, 106
DIVIGEL.....	123	DROPSAFE PEN NEEDLE	EASY TOUCH LUER
<i>dofetilide</i>	54	.....	106
DOJOLVI.....	143	<i>drospirenone-e.estradiol-lm.fa</i>	LOCK INSULIN.....
<i>dolishale</i>	126	.....	EASY TOUCH PEN
<i>donepezil</i>	32	<i>drospirenone-ethinyl estradiol</i>	NEEDLE.....
DOPTELET (10 TAB		DROXIA.....	EASY TOUCH SAFETY
PACK).....	59	<i>droxidopa</i>	106
DOPTELET (15 TAB		DUAKLIR PRESSAIR.....	EASY TOUCH
PACK).....	59	DUAVEE.....	SHEATHLOCK INSULIN
DOPTELET (30 TAB		DUETACT.....	EASY TOUCH UNI-SLIP..
PACK).....	59	DUEXIS.....	106
DORYX.....	12	DULERA.....	<i>econazole</i>
DORYX MPC.....	12	<i>duloxetine</i>	69
<i>dorzolamide</i>	131	DUOBRII.....	EDARBI.....
<i>dorzolamide-timolol</i>	131	DUOPA.....	56
<i>dorzolamide-timolol (pf)</i>	131	DUPIXENT PEN.....	EDARBYCLOR.....
<i>dotti</i>	123	DUPIXENT SYRINGE.....	56
DOVATO.....	2	DUREZOL.....	EDECIN.....
<i>doxazosin</i>	56	<i>dutasteride</i>	EDURANT.....
<i>doxepin</i>	45, 65	<i>dutasteride-tamsulosin</i>	2
<i>doxercalciferol</i>	87	DYANAVEL XR.....	<i>efavirenz</i>
<i>doxy-100</i>	12	DYMISTA.....	2
<i>doxycycline hyclate</i>	12	DYRENIUM.....	<i>efavirenz-emtricitabin-tenofov..</i>
DOXYCYCLINE		DYSPORT.....	<i>efavirenz-lamivu-tenofov</i>
HYCLATE.....	12	<i>e.e.s. 400</i>	2
<i>doxycycline monohydrate</i>	13	E.E.S. GRANULES.....	EFFEXOR XR.....
DOXYCYCLINE		EASY COMFORT	EFFIENT.....
MONOHYDRATE.....	13	INSULIN SYRINGE.....	59
<i>doxylamine-pyridoxine (vit</i>		EASY COMFORT PEN	EFUDEX.....
<i>b6)</i>	90	NEEDLES.....	65
DRIZALMA SPRINKLE...	45	EASY GLIDE INSULIN	EGRIFTA SV.....
<i>dronabinol</i>	90	SYRINGE.....	96
			ELESTRIN.....
			<i>eletriptan</i>
			30
			ELIDEL.....
			65
			ELIGARD.....
			15
			ELIGARD (3 MONTH).....
			16
			ELIGARD (4 MONTH).....
			16
			ELIGARD (6 MONTH).....
			16
			ELIQUIS.....
			59
			ELIQUIS DVT-PE TREAT
			30D START.....
			59
			ELMIRON.....
			141
			<i>eluryng</i>
			125

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

This drug list was updated in August 2023.

EMBRACE PEN NEEDLE	106	<i>eplerenone</i>	57	<i>ethosuximide</i>	25
EMCYT	16	EPOGEN	96	<i>ethynodiol diac-eth estradiol</i>	126
EMEND	90, 91	EPRONTIA	25	<i>etodolac</i>	39
EMFLAZA	78	EPSOLAY	68	<i>etonogestrel-ethinyl estradiol</i>	125
EMGALITY PEN	30	EPZICOM	3	<i>etravirine</i>	3
EMGALITY SYRINGE	30	EQUETRO	25	EUCRISA	65
EMSAM	45	ERAXIS(WATER DILUENT)	1	<i>euthyrox</i>	89
<i>emtricitabine</i>	2	<i>ergoloid</i>	45	EVAMIST	124
<i>emtricitabine-tenofovir (tdf)</i>	2	<i>ergotamine-caffeine</i>	30	EVEKEO	45
EMTRIVA	2	ERIVEDGE	16	EVEKEO ODT	45
EMVERM	8	ERLEADA	16	EVENITY	118
<i>enalapril maleate</i>	56	<i>erlotinib</i>	16	<i>everolimus (antineoplastic)</i>	16
<i>enalapril-hydrochlorothiazide</i>	57	ERMEZA	89	<i>everolimus</i>	
ENBREL	120	<i>errin</i>	123	<i>(immunosuppressive)</i>	16
ENBREL MINI	120	ERTACZO	69	EVISTA	118
ENBREL SURECLICK	120	<i>ertapenem</i>	8	EVOTAZ	3
ENDARI	74	<i>ery pads</i>	68	EVOXAC	75
<i>endocet</i>	36	<i>erygel</i>	68	EVRYSOI	32
ENGERIX-B (PF)	98	ERYPED 200	6	EXELDERM	69
ENGERIX-B PEDIATRIC (PF)	98	ERYPED 400	6	EXELON PATCH	32
<i>enoxaparin</i>	59, 60	<i>ery-tab</i>	6	<i>exemestane</i>	16
<i>enpresse</i>	126	ERY-TAB	7	EXFORGE	57
<i>enskyce</i>	126	ERYTHROCIN	7	EXFORGE HCT	57
ENSPRYNG	16	<i>erythrocine (as stearate)</i>	7	EXJADE	75
ENSTILAR	64	<i>erythromycin</i>	7, 129	EXKIVITY	16
<i>entacapone</i>	29	<i>erythromycin ethylsuccinate</i>	7	EXSERVAN	75
ENTADFI	141	<i>erythromycin with ethanol</i>	68	EXTAVIA	96
<i>entecavir</i>	2	<i>erythromycin-benzoyl peroxide</i>	68	EYSUVIS	132
ENTRESTO	63	ESBRIET	135	EZALLOR SPRINKLE	61
<i>enulose</i>	91	<i>escitalopram oxalate</i>	45	<i>ezetimibe</i>	61
ENVARUS XR	16	<i>esomeprazole magnesium</i>	94	<i>ezetimibe-simvastatin</i>	61
EPCLUSA	2	<i>estarylla</i>	126	FABIOR	68
EPIDIOLEX	25	ESTRACE	123	<i>falmina (28)</i>	126
EPIDUO	67	<i>estradiol</i>	123, 124	<i>famciclovir</i>	3
EPIDUO FORTE	67	<i>estradiol valerate</i>	124	<i>famotidine</i>	94
<i>epinastine</i>	130	<i>estradiol-norethindrone acet.</i>	124	FANAPT	45
EPINEPHRINE	132, 133	ESTRING	124	FARESTON	16
<i>epinephrine</i>	132	ESTROGEL	124	FARXIGA	80
EPIPEN 2-PAK	133	<i>eszopiclone</i>	45	FASENRA	135
EPIPEN JR 2-PAK	133	<i>ethacrynic acid</i>	57	FASENRA PEN	135
<i>epitol</i>	25	<i>ethambutol</i>	8	<i>febuxostat</i>	117
EPIVIR	2			<i>felbamate</i>	25
				FELBATOL	25

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

This drug list was updated in August 2023.

FELDENE.....	39	FLEBOGAMMA DIF	98	FOCALIN.....	46
<i>felodipine</i>	57	<i>flecainide</i>	54	FOCALIN XR.....	46
FEMARA.....	16	FLECTOR.....	39	<i>fondaparinux</i>	60
FEMRING.....	124	FLEQSUVY.....	35	FORFIVO XL.....	46
FENOFIBRATE.....	61	FLOLIPID.....	61	<i>formoterol fumarate</i>	136
<i>fenofibrate</i>	61	FLOMAX.....	141	FORTEO.....	118
<i>fenofibrate micronized</i>	61	FLOVENT DISKUS... 135, 136		FORTESTA.....	87
FENOFIBRATE		FLOVENT HFA.....	136	FOSAMAX.....	118
MICRONIZED.....	61	<i>fluconazole</i>	1	FOSAMAX PLUS D.....	118
<i>fenofibrate nanocrystallized</i>	61	<i>fluconazole in nacl (iso-osm)</i>	1	<i>fosamprenavir</i>	3
<i>fenofibric acid (choline)</i>	61	<i>flucytosine</i>	1	<i>fosfomycin tromethamine</i>	13
FENOGLIDE.....	61	<i>fludrocortisone</i>	78	<i>fosinopril</i>	57
<i>fenoprofen</i>	39	<i>flunisolide</i>	136	<i>fosinopril-hydrochlorothiazide</i>	57
<i>fentanyl</i>	36	<i>fluocinolone</i>	72	FOSRENOL.....	75
<i>fentanyl citrate</i>	36	<i>fluocinolone acetonide oil</i>	77	FOTIVDA.....	16
FENTANYL CITRATE.....	36	<i>fluocinolone and shower cap</i>	72	FRAGMIN.....	60
FENTORA.....	36	<i>fluocinonide</i>	72	FREESTYLE PRECISION	
FERRIPROX.....	75	<i>fluocinonide-emollient</i>	72	.....	106, 107
FERRIPROX (2 TIMES A		<i>fluoride (sodium)</i>	144	FROVA.....	30
DAY).....	75	<i>fluorometholone</i>	132	<i>frovatriptan</i>	30
<i>fesoterodine</i>	140	FLUOROURACIL.....	65	FULPHILA.....	96
FETZIMA.....	45	<i>fluorouracil</i>	65	FUROSCIX.....	57
FEXMID.....	35	<i>fluoxetine</i>	46	<i>furosemide</i>	57
FIASP FLEXTOUCH U-		<i>fluoxetine (pmdd)</i>	45	FUZEON.....	3
100 INSULIN.....	80	<i>fluphenazine decanoate</i>	46	<i>fyavolv</i>	124
FIASP PENFILL U-100		<i>fluphenazine hcl</i>	46	FYCOMPA.....	25
INSULIN.....	80	<i>flurandrenolide</i>	72	FYLNETRA.....	96
FIASP U-100 INSULIN.....	80	<i>flurbiprofen</i>	39	<i>gabapentin</i>	25
FILSPARI.....	63	<i>flurbiprofen sodium</i>	130	GALAFOLD.....	87
FINACEA.....	68	FLUTICASONE		<i>galantamine</i>	32
<i>finasteride</i>	141	FUROATE-VILANTEROL		GAMMAGARD LIQUID... 98	
<i>fingolimod</i>	32	.....	136	GAMMAGARD S-D (IGA	
FINTEPLA.....	25	<i>fluticasone propionate</i>	72, 136	< 1 MCG/ML).....	98
<i>finzala</i>	126	FLUTICASONE		GAMMAKED.....	98
FIRAZYR.....	135	PROPIONATE.....	136	GAMMAPLEX.....	98
FIRDAPSE.....	32	FLUTICASONE		GAMMAPLEX (WITH	
FIRMAGON KIT W		PROPION-SALMETEROL	136	SORBITOL).....	98
DILUENT SYRINGE.....	16	<i>fluticasone propion-salmeterol</i>		GAMUNEX-C.....	98
FIRVANQ.....	8	.....	136	GARDASIL 9 (PF).....	98
<i>flac otic oil</i>	77	<i>fluvastatin</i>	61, 62	GASTROCROM.....	91
FLAGYL.....	8	<i>fluvoxamine</i>	46	<i>gatifloxacin</i>	129
FLAREX.....	132	FML FORTE.....	132	GATTEX 30-VIAL.....	91
<i>flavoxate</i>	140	FML LIQUIFILM.....	132	GAUZE PAD.....	107

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

This drug list was updated in August 2023.

<i>gavilyte-c</i>	91	<i>griseofulvin microsize</i>	1	HUMALOG KWIKPEN	
<i>gavilyte-g</i>	91	<i>griseofulvin ultramicrosize</i>	1	INSULIN.....	81
GAVRETO.....	16	GVOKE.....	81	HUMALOG MIX 50-50	
<i>gefitinib</i>	16	GVOKE HYPOPEN 2-		INSULN U-100.....	81
GELNIQUE.....	141	PACK.....	81	HUMALOG MIX 50-50	
<i>gemfibrozil</i>	62	GVOKE PFS 1-PACK		KWIKPEN.....	81
<i>gemmily</i>	126	SYRINGE.....	81	HUMALOG MIX 75-25	
GEMTESA.....	141	GYNAZOLE-1.....	125	KWIKPEN.....	81
<i>generlac</i>	91	HADLIMA(CF).....	120	HUMALOG MIX 75-25(U-	
<i>gengraf</i>	16	HADLIMA(CF)		100)INSULN.....	81
GENOTROPIN.....	96	PUSHTOUCH.....	120	HUMALOG TEMPO	
GENOTROPIN		HAEGARDA.....	137	PEN(U-100)INSULN.....	81
MINIQUICK.....	96	<i>hailey 24 fe</i>	126	HUMALOG U-100	
<i>gentamicin</i>	8, 69, 129	<i>halcinonide</i>	72	INSULIN.....	81
<i>gentamicin in nacl (iso-osm)</i>	8	HALDOL DECANOATE... 46		HUMATIN.....	8
GENVOYA.....	3	<i>halobetasol propionate</i>	72	HUMATROPE.....	97
GEODON.....	46	HALOBETASOL		HUMIRA.....	120
GILENYA.....	32	PROPIONATE.....	72	HUMIRA PEN.....	120
GILOTRIF.....	16	HALOG.....	72	HUMIRA PEN CROHNS-	
GIMOTI.....	91	<i>haloperidol</i>	46	UC-HS START.....	120
GLASSIA.....	75	<i>haloperidol decanoate</i>	46	HUMIRA PEN PSOR-	
<i>glatiramer</i>	32	<i>haloperidol lactate</i>	46	UVEITS-ADOL HS.....	120
<i>glatopa</i>	33	HARVONI.....	3	HUMIRA(CF).....	121
GLEEEVEC.....	16	HAVRIX (PF).....	98	HUMIRA(CF) PEDI	
GLEOSTINE.....	17	HEALTHWISE INSULIN		CROHNS STARTER.....	120
<i>glimepiride</i>	80	SYRINGE.....	107	HUMIRA(CF) PEN.....	121
<i>glipizide</i>	80	HEALTHWISE PEN		HUMIRA(CF) PEN	
<i>glipizide-metformin</i>	80	NEEDLE.....	107	CROHNS-UC-HS.....	120
GLUCAGEN HYPOKIT.....	80	HEALTHY ACCENTS		HUMIRA(CF) PEN	
GLUCAGON		UNIFINE PENTIP.....	107	PEDIATRIC UC.....	120
EMERGENCY KIT		HEMADY.....	78	HUMIRA(CF) PEN PSOR-	
(HUMAN).....	80	<i>heparin (porcine)</i>	60	UV-ADOL HS.....	120
GLUCOTROL XL.....	80, 81	HEPLISAV-B (PF).....	98	HUMULIN 70/30 U-100	
GLUMETZA.....	81	HETLIOZ.....	46	INSULIN.....	81
GLYCATE.....	89	HETLIOZ LQ.....	47	HUMULIN 70/30 U-100	
<i>glycopyrrolate</i>	89	HIBERIX (PF).....	99	KWIKPEN.....	81
GLYXAMBI.....	81	HIPREX.....	13	HUMULIN N NPH	
GOCOVRI.....	29	HORIZANT.....	33	INSULIN KWIKPEN.....	81
GOLYTELY.....	91	HULIO(CF).....	120	HUMULIN N NPH U-100	
GRALISE.....	25	HULIO(CF) PEN.....	120	INSULIN.....	81
<i>granisetron hcl</i>	91	HUMALOG JUNIOR		HUMULIN R REGULAR	
GRANIX.....	96	KWIKPEN U-100.....	81	U-100 INSULN.....	81
GRASTEK.....	98				

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

This drug list was updated in August 2023.

HUMULIN R U-500 (CONC) INSULIN.....	82	ILUMYA.....	64	INPEN (NOVOLOG OR FIASP) BLUE.....	107
HUMULIN R U-500 (CONC) KWIKPEN.....	82	<i>imatinib</i>	17	INPEN (NOVOLOG OR FIASP) GREY.....	107
<i>hydralazine</i>	57	IMBRUVICA.....	17	INPEN (NOVOLOG OR FIASP) PINK.....	107
HYDREA.....	17	<i>imipenem-cilastatin</i>	8	INQOVI.....	17
<i>hydrochlorothiazide</i>	57	<i>imipramine hcl</i>	47	INREBIC.....	17
<i>hydrocodone bitartrate</i>	36	<i>imipramine pamoate</i>	47	INSPIRA.....	57
<i>hydrocodone-acetaminophen</i> ...	36	<i>imiquimod</i>	66	INSULIN ASP PRT- INSULIN ASPART.....	82
<i>hydrocodone-ibuprofen</i>	36	IMITREX.....	30	INSULIN ASPART U-100...	82
<i>hydrocortisone</i>	72, 73, 78, 91	IMITREX STATDOSE PEN.....	30	INSULIN DEGLUDEC.....	82
<i>hydrocortisone butyrate</i>	72	IMITREX STATDOSE REFILL.....	30	INSULIN GLARGINE.....	82
<i>hydrocortisone valerate</i>	73	IMOVA RABIES VACCINE (PF).....	99	INSULIN GLARGINE- YFGN.....	82
<i>hydrocortisone-acetic acid</i>	77	IMPAVIDO.....	8	INSULIN LISPRO.....	82
<i>hydrocortisone-pramoxine</i>	91	IMPEKLO.....	73	INSULIN LISPRO PROTAMIN-LISPRO.....	82
<i>hydromorphone</i>	36, 37	IMURAN.....	17	INSULIN PEN NEEDLE...107	
<i>hydromorphone (pf)</i>	36	IMVEXXY MAINTENANCE PACK...124		INSULIN SYRINGE MICROFINE.....	107
<i>hydroxychloroquine</i>	8	IMVEXXY STARTER PACK.....	124	INSULIN SYRINGE- NEEDLE U-100.....	108
<i>hydroxyurea</i>	17	INBRIJA.....	29	INSUPEN PEN NEEDLE..108	
<i>hydroxyzine hcl</i>	133	<i>incassia</i>	124	INTELENCE.....	3
HYFTOR.....	66	INCONTROL PEN NEEDLE.....	107	<i>intralipid</i>	143
HYRIMOZ PEN CROHN'S-UC STARTER..121		INCRELEX.....	75	INTRALIPID.....	143
HYRIMOZ PEN PSORIASIS STARTER.....	121	INCRUSE ELLIPTA.....	137	INTRAROSA.....	125
HYRIMOZ(CF).....	121	<i>indapamide</i>	57	<i>introvale</i>	126
HYRIMOZ(CF) PEDI CROHN STARTER.....	121	INDERAL LA.....	57	INVANZ.....	8
HYRIMOZ(CF) PEN.....	121	INDOCIN.....	39	INVEGA.....	47
HYSINGLA ER.....	37	INFANRIX (DTAP) (PF)....	99	INVEGA HAFYERA.....	47
HYZAAR.....	57	INFLECTRA.....	91	INVEGA SUSTENNA.....	47
<i>ibandronate</i>	118	INGREZZA.....	33	INVEGA TRINZA.....	47
IBRANCE.....	17	INGREZZA INITIATION PACK.....	33	INVELTYS.....	132
IBSRELA.....	91	INLYTA.....	17	INVOKAMET.....	82
<i>ibu</i>	39	INNOPRAN XL.....	57	INVOKAMET XR.....	82
<i>ibuprofen</i>	39	INPEN (FOR HUMALOG) BLUE.....	107	INVOKANA.....	82
<i>ibuprofen-famotidine</i>	39	INPEN (FOR HUMALOG) GREY.....	107	IOPIDINE.....	132
<i>icatibant</i>	137	INPEN (FOR HUMALOG) PINK.....	107	IPOL.....	99
<i>iclevia</i>	126			<i>ipratropium bromide</i>	77, 137
ICLUSIG.....	17			<i>ipratropium-albuterol</i>	137
<i>icosapent ethyl</i>	62				
IDHIFA.....	17				
ILEVRO.....	130				

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

This drug list was updated in August 2023.

<i>irbesartan</i>	57	<i>junel 1/20 (21)</i>	126	<i>klor-con 8</i>	142
<i>irbesartan-hydrochlorothiazide</i>	57	<i>junel fe 1.5/30 (28)</i>	126	<i>klor-con m10</i>	142
IRESSA.....	17	<i>junel fe 1/20 (28)</i>	126	<i>klor-con m15</i>	142
ISENTRESS.....	3	<i>junel fe 24</i>	126	<i>klor-con m20</i>	142
ISENTRESS HD.....	3	JUXTAPID.....	62	<i>klor-con oral packet 20</i>	142
<i>isibloom</i>	126	JYNARQUE.....	87	KLOXXADO.....	40
ISOLYTE S PH 7.4.....	143	JYNNEOS		KOMBIGLYZE XR.....	83
ISOLYTE-P IN 5 %		(PF)(STOCKPILE).....	99	KONVOMEPI.....	94
DEXTROSE.....	143	<i>kaitlib fe</i>	126	KORLYM.....	87
<i>isoniazid</i>	8	KALBITOR.....	137	KOSELUGO.....	18
ISORDIL.....	63	KALETRA.....	3	KRAZATI.....	18
ISORDIL TITRADOSE.....	63	KALYDECO.....	137	KRINTAFEL.....	8
<i>isosorbide dinitrate</i>	63	KANJINTI.....	17	KRISTALOSE.....	91
<i>isosorbide mononitrate</i>	63	KAPSPARGO SPRINKLE..	57	<i>kurvelo (28)</i>	126
<i>isosorbide-hydralazine</i>	57	KAPVAY.....	47	KUVAN.....	87
<i>isotretinoin</i>	68	<i>kariva (28)</i>	126	KYLEENA.....	125
<i>isradipine</i>	57	KATERZIA.....	57	<i>l norgestle.estradiol-e.estradiol</i>	126
ISTALOL.....	129	KAZANO.....	83	<i>labetalol</i>	57
ISTURISA.....	87	<i>kelnor 1/35 (28)</i>	126	<i>lacosamide</i>	25
<i>itraconazole</i>	1	<i>kelnor 1-50 (28)</i>	126	LACRISERT.....	130
<i>ivermectin</i>	8, 68	KENALOG.....	73	<i>lactulose</i>	91
IXIARO (PF).....	99	KEPPRA.....	25	LAMICTAL.....	26
JADENU.....	75	KEPPRA XR.....	25	LAMICTAL ODT.....	25
JADENU SPRINKLE.....	75	KERENDIA.....	57	LAMICTAL STARTER	
JAKAFI.....	17	KERYDIN.....	69	(BLUE) KIT.....	26
<i>jantoven</i>	60	KESIMPTA PEN.....	33	LAMICTAL STARTER	
JANUMET.....	82	<i>ketoconazole</i>	1, 69	(GREEN) KIT.....	26
JANUMET XR.....	82	<i>ketodan</i>	70	LAMICTAL STARTER	
JANUVIA.....	82	<i>ketoprofen</i>	39, 40	(ORANGE) KIT.....	26
JARDIANCE.....	82	KETOROLAC.....	40	LAMICTAL XR.....	26
<i>jasmiel (28)</i>	126	<i>ketorolac</i>	130	LAMICTAL XR STARTER	
JATENZO.....	87	KEVEYIS.....	33	(BLUE).....	26
<i>javygtor</i>	87	KEVZARA.....	121	LAMICTAL XR STARTER	
JAYPIRCA.....	17	KINERET.....	121	(GREEN).....	26
JENTADUETO.....	83	KINRIX (PF).....	99	LAMICTAL XR STARTER	
JENTADUETO XR.....	83	KISQALI.....	18	(ORANGE).....	26
<i>jinteli</i>	124	KISQALI FEMARA CO-		<i>lamivudine</i>	3
JORNAY PM.....	47	PACK.....	17, 18	<i>lamivudine-zidovudine</i>	3
JUBLIA.....	69	KITABIS PAK.....	8	<i>lamotrigine</i>	26
<i>juleber</i>	126	KLARON.....	69	LAMPIT.....	8
JULUCA.....	3	KLISYRI.....	18	LANOXIN.....	63
<i>junel 1.5/30 (21)</i>	126	KLONOPIN.....	25	<i>lansoprazole</i>	94
		<i>klor-con 10</i>	142	<i>lanthanum</i>	75

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

This drug list was updated in August 2023.

LANTUS SOLOSTAR U-100 INSULIN.....	83	<i>levonorg-eth estrad triphasic</i>	127	LOESTRIN FE 1.5/30 (28-DAY).....	127
LANTUS U-100 INSULIN..	83	<i>levora-28</i>	127	LOESTRIN FE 1/20 (28-DAY).....	127
<i>lapatinib</i>	18	<i>levorphanol tartrate</i>	37	<i>lofena</i>	40
<i>larin 1.5/30 (21)</i>	126	LEVOTHYROXINE.....	89	LOKELMA.....	75
<i>larin 1/20 (21)</i>	126	<i>levothyroxine</i>	89	LOMOTIL.....	89
<i>larin fe 1.5/30 (28)</i>	126	<i>levoxyl</i>	89	LONSURF.....	18
<i>larin fe 1/20 (28)</i>	126	LEXAPRO.....	48	<i>loperamide</i>	89
LASIX.....	57	LEXETTE.....	73	LOPID.....	62
<i>latanoprost</i>	131	LEXIVA.....	3	<i>lopinavir-ritonavir</i>	3
LATUDA.....	48	LIALDA.....	91	LOPRESSOR.....	57
<i>layolis fe</i>	126	LICART.....	40	LOPROX.....	70
LEDIPASVIR- SOFOSBUVIR.....	3	<i>lidocaine</i>	66	<i>lorazepam</i>	48
<i>leena 28</i>	126	<i>lidocaine hcl</i>	66	<i>lorazepam intensol</i>	48
<i>leflunomide</i>	121	<i>lidocaine viscous</i>	66	LORBRENA.....	18
<i>lenalidomide</i>	18	<i>lidocaine-prilocaine</i>	66	LOREEV XR.....	48
LENVIMA.....	18	LIDODERM.....	66	<i>loryna (28)</i>	127
LESCOL XL.....	62	LILETTA.....	125	<i>losartan</i>	57
<i>lessina</i>	127	<i>linezolid</i>	8	<i>losartan-hydrochlorothiazide</i> ..	57
LETAIRIS.....	137	<i>linezolid in dextrose 5%</i>	8	LOSEASONIQUE.....	127
<i>letrozole</i>	18	LINZESS.....	91	LOTEMAX.....	132
<i>leucovorin calcium</i>	14	<i>liothyronine</i>	89	LOTEMAX SM.....	132
LEUKERAN.....	18	LIPITOR.....	62	LOTENSIN.....	57
LEUKINE.....	97	LIPOFEN.....	62	<i>loteprednol etabonate</i>	132
<i>leuprolide</i>	18	<i>lisinopril</i>	57	LOTREL.....	57
LEUPROLIDE (3 MONTH).....	18	<i>lisinopril-hydrochlorothiazide</i> ..	57	LOTRONEX.....	91
<i>levalbuterol hcl</i>	137	LITE TOUCH INSULIN PEN NEEDLES.....	108	<i>lovastatin</i>	62
LEVALBUTEROL TARTRATE.....	137	LITE TOUCH INSULIN SYRINGE.....	108, 109	LOVAZA.....	62
LEVAMLODIPINE.....	57	<i>lithium carbonate</i>	48	LOVENOX.....	60
LEVEMIR FLEXPEN.....	83	LITHOBID.....	48	<i>low-ogestrel (28)</i>	127
LEVEMIR U-100 INSULIN	83	LITHOSTAT.....	75	<i>loxapine succinate</i>	48
<i>levetiracetam</i>	26	LIVALO.....	62	<i>lubiprostone</i>	91
<i>levobunolol</i>	129	LIVMARLI.....	91	LUCEMYRA.....	40
<i>levocarnitine</i>	75	LIVTENCITY.....	3	LULICONAZOLE.....	70
<i>levocarnitine (with sugar)</i>	75	LO LOESTRIN FE.....	127	LUMAKRAS.....	18
<i>levocetirizine</i>	133	LOCOID.....	73	LUMIGAN.....	131
<i>levofloxacin</i>	12, 129	LOCOID LIPOCREAM.....	73	LUNESTA.....	48
<i>levofloxacin in d5w</i>	12	LODINE.....	40	LUPKYNIS.....	18
<i>levonest (28)</i>	127	LODOSYN.....	29	LUPRON DEPOT.....	18
<i>levonorgestrel-ethinyl estrad</i> ..	127	LOESTRIN 1.5/30 (21).....	127	LUPRON DEPOT (3 MONTH).....	18
		LOESTRIN 1/20 (21).....	127		

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

This drug list was updated in August 2023.

LUPRON DEPOT (4 MONTH).....	19	<i>matzim la</i>	57	MEKINIST.....	19
LUPRON DEPOT (6 MONTH).....	19	MAVENCLAD (10 TABLET PACK).....	33	MEKTOVI.....	19
LUPRON DEPOT-PED.....	19	MAVENCLAD (4 TABLET PACK).....	33	<i>meloxicam</i>	40
LUPRON DEPOT-PED (3 MONTH).....	19	MAVENCLAD (5 TABLET PACK).....	33	<i>meloxicam submicronized</i>	40
<i>lurasidone</i>	48	MAVENCLAD (6 TABLET PACK).....	33	<i>memantine</i>	33, 34
<i>luteira (28)</i>	127	MAVENCLAD (7 TABLET PACK).....	33	MEMANTINE.....	34
LUZU.....	70	MAVENCLAD (8 TABLET PACK).....	33	MENACTRA (PF).....	99
LYBALVI.....	48	MAVENCLAD (9 TABLET PACK).....	33	MENEST.....	124
<i>lyleq</i>	124	MAVENCLAD (10 TABLET PACK).....	33	MENOSTAR.....	124
<i>lyllana</i>	124	MAVYRET.....	3	MENQUADFI (PF).....	99
LYNPARZA.....	19	MAXALT.....	30	MENVEO A-C-Y-W-135-DIP (PF).....	99
LYRICA.....	26	MAXALT-MLT.....	30	MEPRON.....	9
LYRICA CR.....	26	MAXICOMFORT II PEN NEEDLE.....	109	<i>mercaptopurine</i>	19
LYSODREN.....	19	MAXICOMFORT INSULIN SYRINGE.....	109	<i>meropenem</i>	9
LYTGOBI.....	19	MAXI-COMFORT INSULIN SYRINGE.....	109	<i>merzee</i>	127
LYUMJEV KWIKPEN U-100 INSULIN.....	83	MAXICOMFORT SAFETY PEN NEEDLE....	109	<i>mesalamine</i>	91
LYUMJEV KWIKPEN U-200 INSULIN.....	83	MAXIDEX.....	132	MESNEX.....	14
LYUMJEV TEMPO PEN(U-100)INSULN.....	83	MAXITROL.....	131	MESTINON.....	35
LYUMJEV U-100 INSULIN.....	83	MAYZENT.....	33	MESTINON TIMESPAN....	35
LYVISPAH.....	35	MAYZENT STARTER(FOR 1MG MAINT).....	33	<i>metformin</i>	83, 84
<i>lyza</i>	124	MAYZENT STARTER(FOR 2MG MAINT).....	33	METFORMIN.....	83
MACROBID.....	13	<i>meclizine</i>	91	<i>methadone</i>	37
MACRODANTIN.....	13	<i>meclofenamate</i>	40	<i>methamphetamine</i>	48
<i>mafenide acetate</i>	69	MEDROL.....	78	<i>methazolamide</i>	131
MAGELLAN INSULIN SAFETY SYRNG.....	109	MEDROL (PAK).....	78	<i>methenamine hippurate</i>	13
MAGELLAN SYRINGE... ..	109	<i>medroxyprogesterone</i>	124	<i>methimazole</i>	79
<i>magnesium sulfate</i>	142	<i>mefenamic acid</i>	40	METHITEST.....	87
MALARONE.....	8	<i>mefloquine</i>	9	<i>methotrexate sodium</i>	19
MALARONE PEDIATRIC... ..	9	<i>megestrol</i>	19	<i>methotrexate sodium (pf)</i>	19
<i>malathion</i>	74			<i>methoxsalen</i>	66
<i>maraviroc</i>	3			<i>methscopolamine</i>	89
MARINOL.....	91			<i>methsuximide</i>	26
<i>marlissa (28)</i>	127			METHYLIN.....	48
MARPLAN.....	48			<i>methylphenidate</i>	48
MATULANE.....	19			<i>methylphenidate hcl</i>	48, 49

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

This drug list was updated in August 2023.

<i>metoprolol ta-</i>	<i>modafinil</i>	49	<i>naftifine</i>	70
<i>hydrochlorothiaz</i>	<i>moexipril</i>	58	NAFTIN.....	70
<i>metoprolol tartrate</i>	<i>molindone</i>	49	NALFON.....	40
METROCREAM.....	<i>mometasone</i>	73, 137	NALOCET.....	37
METROGEL.....	MONOJECT INSULIN		<i>naloxone</i>	40
METROLOTION.....	SAFETY SYRING.....	109	<i>naltrexone</i>	40
<i>metronidazole</i>	MONOJECT INSULIN		NAMENDA.....	34
<i>metronidazole in nacl (iso-os)</i> ..	SYRINGE.....	110	NAMENDA TITRATION	
<i>metyrosine</i>	MONOJECT SYRINGE....	110	PAK.....	34
<i>mexiletine</i>	MONOJECT ULTRA		NAMENDA XR.....	34
<i>mibelas 24 fe</i>	COMFORT INSULIN.....	110	NAMZARIC.....	34
<i>micafungin</i>	<i>montelukast</i>	137	NAPRELAN CR.....	40
MICARDIS.....	<i>morphine</i>	37	<i>naproxen</i>	40
MICARDIS HCT.....	<i>morphine concentrate</i>	37	<i>naproxen sodium</i>	40
<i>miconazole-3</i>	MOTEGRITY.....	92	<i>naproxen-esomeprazole</i>	40
MICRODOT INSULIN	MOTOFEN.....	90	<i>naratriptan</i>	30
PEN NEEDLE.....	MOUNJARO.....	84	NARCAN.....	40
<i>microgestin 1.5/30 (21)</i>	MOVANTIK.....	92	NARDIL.....	49
<i>microgestin 1/20 (21)</i>	MOVIPREP.....	92	NATACYN.....	129
<i>microgestin 24 fe</i>	<i>moxifloxacin</i>	12, 129	NATAZIA.....	127
<i>microgestin fe 1.5/30 (28)</i>	<i>moxifloxacin-</i>		<i>nateglinide</i>	84
<i>microgestin fe 1/20 (28)</i>	<i>sod.chloride (iso)</i>	12	NATESTO.....	87
<i>midodrine</i>	MS CONTIN.....	37	NATPARA.....	87
<i>migergot</i>	MULPLETA.....	60	NATROBA.....	74
<i>miglitol</i>	MULTAQ.....	54	NAYZILAM.....	26
<i>miglustat</i>	<i>mupirocin</i>	69	<i>neбиволол</i>	58
MIGRANAL.....	<i>mupirocin calcium</i>	69	NEBUPENT.....	9
<i>mili</i>	MVASI.....	19	<i>necon 0.5/35 (28)</i>	127
<i>millipred</i>	MYALEPT.....	87	NEEDLES, INSULIN	
<i>mimvey</i>	MYAMBUTOL.....	9	DISP.,SAFETY.....	110
MINI ULTRA-THIN II....	MYCAPSSA.....	19	<i>nefazodone</i>	49
MINIPRESS.....	MYCOBUTIN.....	9	<i>neomycin</i>	9
MINIVELLE.....	<i>mycophenolate mofetil</i>	19	<i>neomycin-bacitracin-poly-hc</i> ..	131
<i>minocycline</i>	<i>mycophenolate sodium</i>	19	<i>neomycin-bacitracin-</i>	
MINOLIRA ER.....	MYDAYIS.....	49	<i>polymyxin</i>	129
<i>minoxidil</i>	MYFEMBREE.....	125	<i>neomycin-polymyxin b-</i>	
MIRAPEX ER.....	MYFORTIC.....	19	<i>dexameth</i>	131
MIRENA.....	MYRBETRIQ.....	141	<i>neomycin-polymyxin-</i>	
<i>mirtazapine</i>	MYSOLINE.....	26	<i>gramicidin</i>	129
MIRVASO.....	MYTESI.....	90	<i>neomycin-polymyxin-hc</i> ..	78, 131
<i>misoprostol</i>	<i>nabumetone</i>	40	<i>neo-polycin</i>	129
MITIGARE.....	<i>nadolol</i>	58	<i>neo-polycin hc</i>	131
M-M-R II (PF).....	<i>nafacillin</i>	11	NEORAL.....	19

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

This drug list was updated in August 2023.

NEO-SYNALAR.....	69	<i>nizatidine</i>	95	NOVOLOG FLEXPEN U-	
NERLYNX.....	19	NOCDURNA (MEN).....	87	100 INSULIN.....	84
NESINA.....	84	NOCDURNA (WOMEN)....	87	NOVOLOG MIX 70-30 U-	
<i>neuac</i>	68	<i>nora-be</i>	124	100 INSULN.....	84
NEULASTA.....	97	NORDITROPIN		NOVOLOG MIX 70-	
NEULASTA ONPRO.....	97	FLEXPRO.....	97	30FLEXPEN U-100.....	84
NEUPOGEN.....	97	<i>noreth-ethinyl estradiol-iron</i> ..	127	NOVOLOG PENFILL U-	
NEUPRO.....	29	<i>norethindrone (contraceptive)</i>		100 INSULIN.....	84
NEURONTIN.....	26, 27	.....	124	NOVOLOG U-100	
NEVANAC.....	130	<i>norethindrone acetate</i>	124	INSULIN ASPART.....	84
<i>nevirapine</i>	3	<i>norethindrone ac-eth estradiol</i>		NOXAFIL.....	1
NEXAVAR.....	19	.....	124, 127	NUBEQA.....	20
NEXIUM.....	94	<i>norethindrone-e.estradiol-iron</i>		NUCALA.....	137
NEXIUM PACKET.....	94, 95	.....	127	NUCYNTA.....	40
NEXLETOL.....	62	<i>norgestimate-ethinyl estradiol</i>		NUCYNTA ER.....	40
NEXLIZET.....	62	.....	127, 128	NUEDEXTA.....	34
NEXPLANON.....	125	NORITATE.....	68	NUPLAZID.....	49
NEXTSTELLIS.....	127	NORLIQVA.....	58	NURTEC ODT.....	30
<i>niacin</i>	62	NORPRAMIN.....	49	NUTRILIPID.....	143
NIACOR.....	62	NORTHERA.....	75	NUTROPIN AQ NUSPIN..	97
<i>nicardipine</i>	58	<i>nortrel 0.5/35 (28)</i>	128	NUVARING.....	125
NICOTROL.....	77	<i>nortrel 1/35 (21)</i>	128	NUVIGIL.....	49
NICOTROL NS.....	77	<i>nortrel 1/35 (28)</i>	128	NUZYRA.....	13
<i>nifedipine</i>	58	<i>nortrel 7/7/7 (28)</i>	128	<i>nyamyc</i>	70
<i>nikki (28)</i>	127	<i>nortriptyline</i>	49	<i>nylia 1/35 (28)</i>	128
NILANDRON.....	19	NORVASC.....	58	<i>nylia 7/7/7 (28)</i>	128
<i>nilutamide</i>	19	NORVIR.....	3	NYMALIZE.....	58
<i>nimodipine</i>	58	NOURIANZ.....	29	<i>nymyo</i>	128
NINLARO.....	19	NOVOFINE 32.....	110	<i>nystatin</i>	1, 70
<i>nisoldipine</i>	58	NOVOFINE		<i>nystatin-triamcinolone</i>	70
<i>nitazoxanide</i>	9	AUTOCOVER.....	110	<i>nystop</i>	70
<i>nitisinone</i>	75	NOVOFINE PLUS.....	110	NYVEPRIA.....	97
<i>nitro-bid</i>	63	NOVOLIN 70/30 U-100		OICALIVA.....	92
NITRO-DUR.....	63	INSULIN.....	84	<i>ocella</i>	128
<i>nitrofurantoin</i>	13	NOVOLIN 70-30		OCTAGAM.....	99
<i>nitrofurantoin macrocrystal</i>	13	FLEXPEN U-100.....	84	<i>octreotide acetate</i>	20
<i>nitrofurantoin monohydlm-</i>		NOVOLIN N FLEXPEN....	84	OCUFLOX.....	129
<i>cryst</i>	13	NOVOLIN N NPH U-100		ODACTRA.....	99
<i>nitroglycerin</i>	63	INSULIN.....	84	ODEFSEY.....	3
NITROLINGUAL.....	63	NOVOLIN R FLEXPEN....	84	ODOMZO.....	20
NITROSTAT.....	63	NOVOLIN R REGULAR		OFEV.....	137
NITYR.....	75	U100 INSULIN.....	84	<i>ofloxacin</i>	12, 77, 129
NIVESTYM.....	97			<i>olanzapine</i>	49

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

This drug list was updated in August 2023.

<i>olanzapine-fluoxetine</i>	49	ORENITRAM MONTH 1	PAMELOR.....	49
<i>olmesartan</i>	58	TITRATION KT.....	PANCREAZE.....	92
<i>olmesartan-amlodipin-</i>		ORENITRAM MONTH 2	PANDEL.....	73
<i>hcthiiazid</i>	58	TITRATION KT.....	PANRETIN.....	66
<i>olmesartan-</i>		ORENITRAM MONTH 3	<i>pantoprazole</i>	95
<i>hydrochlorothiazide</i>	58	TITRATION KT.....	PANZYGA.....	99
<i>olopatadine</i>	77, 130	ORFADIN.....	<i>paricalcitol</i>	88
OLUMIANT.....	121	ORGOVYX.....	PARLODEL.....	29
OLUX-E.....	73	ORIAHNN.....	PARNATE.....	49
OMECLAMOX-PAK.....	95	ORILISSA.....	<i>paromomycin</i>	9
<i>omega-3 acid ethyl esters</i>	62	ORKAMBI.....	<i>paroxetine hcl</i>	49
<i>omeprazole</i>	95	ORLADEYO.....	<i>paroxetine</i>	
<i>omeprazole-sodium</i>		ORSERDU.....	<i>mesylate (menop.sym)</i>	49
<i>bicarbonate</i>	95	<i>oseltamivir</i>	PAXIL.....	50
OMNARIS.....	137	OSENI.....	PAXIL CR.....	50
OMNIPOD 5 G6 INTRO		OSMOLEX ER.....	PEDIARIX (PF).....	99
KIT (GEN 5).....	110	OSMOPREP.....	PEDVAX HIB (PF).....	99
OMNIPOD 5 G6 PODS		OSPHENA.....	<i>peg 3350-electrolytes</i>	92
(GEN 5).....	110	OTEZLA.....	<i>peg3350-sod sul-nacl-kcl-asb-</i>	
OMNIPOD CLASSIC		OTEZLA STARTER.....	<i>c</i>	92
PODS (GEN 3).....	110	OTOVEL.....	PEGASYS.....	97
OMNIPOD DASH INTRO		OTREXUP (PF).....	<i>peg-electrolyte</i>	92
KIT (GEN 4).....	110	OVIDE.....	PEMAZYRE.....	20
OMNIPOD DASH PODS		<i>oxacillin</i>	PEN NEEDLE, DIABETIC,	
(GEN 4).....	110	<i>oxacillin in dextrose (iso-osm)</i>	SAFETY.....	110
OMNITROPE.....	97	<i>oxaprozin</i>	<i>penciclovir</i>	70
<i>ondansetron</i>	92	OXBRYTA.....	<i>penicillamine</i>	122
<i>ondansetron hcl</i>	92	<i>oxcarbazepine</i>	PENICILLIN G POT IN	
ONEXTON.....	68	OXERVATE.....	DEXTROSE.....	11
ONFI.....	27	<i>oxiconazole</i>	<i>penicillin g potassium</i>	11
ONGENTYS.....	29	OXISTAT.....	<i>penicillin g procaine</i>	11
ONGLYZA.....	84	OXTELLAR XR.....	<i>penicillin g sodium</i>	11
ONTRUZANT.....	20	<i>oxybutynin chloride</i>	<i>penicillin v potassium</i>	11
ONUREG.....	20	<i>oxycodone</i>	PENNSAID.....	41
ONZETRA XSAIL.....	30	OXYCODONE.....	PENTACEL (PF).....	99
OPSUMIT.....	137	<i>oxycodone-acetaminophen</i>	PENTAM.....	9
OPZELURA.....	66	OXYCONTIN.....	<i>pentamidine</i>	9
ORACEA.....	13	<i>oxymorphone</i>	PENTASA.....	92
ORALAIR.....	99	OXYTROL.....	PENTIPS.....	111
ORAPRED ODT.....	78	OZEMPIC.....	<i>pentoxifylline</i>	60
ORENCIA.....	121, 122	<i>pacerone</i>	PEPCID.....	95
ORENCIA CLICKJECT....	121	<i>paliperidone</i>	PERCOCET.....	38
ORENITRAM.....	58	PALYNZIQ.....	PERFOROMIST.....	137

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

This drug list was updated in August 2023.

<i>perindopril erbumine</i>	58	POMALYST.....	20	<i>prenatal vitamin oral tablet</i> ...	144
<i>periogard</i>	77	PONVORY.....	34	PRETOMANID.....	9
<i>permethrin</i>	74	PONVORY 14-DAY		PREVACID.....	95
<i>perphenazine</i>	50	STARTER PACK.....	34	PREVACID SOLUTAB.....	95
PERSERIS.....	50	<i>portia 28</i>	128	<i>prevalite</i>	62
PERTZYE.....	92	<i>posaconazole</i>	1	PREVENT DROPSAFE	
PHEBURANE.....	75	<i>potassium chlorid-d5-</i>		PEN NEEDLE.....	111
<i>phenelzine</i>	50	<i>0.45%nacl</i>	142	PREVYMIS.....	3
<i>phenobarbital</i>	27	<i>potassium chloride</i>	142, 143	PREZCOBIX.....	3
<i>phenoxybenzamine</i>	58	<i>potassium chloride in</i>		PREZISTA.....	3
PHENYTEK.....	27	<i>0.9%nacl</i>	142	PRIFTIN.....	9
<i>phenytoin</i>	27	<i>potassium chloride in 5 % dex</i>	142	PRILOSEC.....	95
<i>phenytoin sodium extended</i>	27	<i>potassium chloride in lr-d5</i>	142	PRIMAQUINE.....	9
PHEXXI.....	125	<i>potassium chloride in water</i> ...	142	PRIMAXIN IV.....	9
PHOSPHOLINE IODIDE..	130	<i>potassium chloride-0.45 %</i>		PRIMIDONE.....	27
PIFELTRO.....	3	<i>nacl</i>	143	<i>primidone</i>	27
<i>pilocarpine hcl</i>	76, 130	<i>potassium chloride-d5-</i>		PRIORIX (PF).....	99
<i>pimecrolimus</i>	66	<i>0.2%nacl</i>	143	PRISTIQ.....	50
<i>pimozide</i>	50	<i>potassium chloride-d5-</i>		PRIVIGEN.....	99
<i>pimtree (28)</i>	128	<i>0.9%nacl</i>	143	PRO COMFORT INSULIN	
<i>pindolol</i>	58	<i>potassium citrate</i>	141	SYRINGE.....	111
<i>pioglitazone</i>	85	PRADAXA.....	60	PRO COMFORT PEN	
<i>pioglitazone-glimepiride</i>	85	PRALUENT PEN.....	62	NEEDLE.....	111
<i>pioglitazone-metformin</i>	85	<i>pramipexole</i>	29	PROAIR DIGIHALER.....	138
PIP PEN NEEDLE.....	111	<i>prasugrel</i>	60	PROAIR RESPICLICK.....	138
<i>piperacillin-tazobactam</i>	11	<i>pravastatin</i>	62	<i>probenecid</i>	117
PIQRAY.....	20	<i>praziquantel</i>	9	<i>probenecid-colchicine</i>	118
<i>pirfenidone</i>	137, 138	<i>prazosin</i>	58	PROCARDIA XL.....	58
PIRFENIDONE.....	138	PRED FORTE.....	132	<i>procentra</i>	50
<i>piroxicam</i>	41	PRED MILD.....	132	<i>prochlorperazine</i>	92
PLAQUENIL.....	9	<i>prednisolone</i>	78	<i>prochlorperazine maleate oral</i> .	92
PLASMA-LYTE 148.....	143	<i>prednisolone acetate</i>	132	PROCRT.....	97
PLASMA-LYTE A.....	143	<i>prednisolone sodium</i>		<i>procto-med hc</i>	92
PLAVIX.....	60	<i>phosphate</i>	78, 132	<i>proctosol hc</i>	92
PLEGRIDY.....	97	<i>prednisone</i>	78	<i>proctozone-hc</i>	92
PLENAMINE.....	143	<i>prednisone intensol</i>	78	PROCYSBI.....	141
PLENVU.....	92	PREFEST.....	125	PRODIGY INSULIN	
PLIAGLIS.....	66	<i>pregabalin</i>	27	SYRINGE.....	111
<i>podofilox</i>	66	PREHEVBRIO (PF).....	99	<i>progesterone micronized</i>	125
<i>polycin</i>	129	PREMARIN.....	125	PROGLYCEM.....	85
<i>polymyxin b sulfate</i>	9	<i>premasol 10 %</i>	143	PROGRAF.....	20
<i>polymyxin b sulf-</i>		PREMPHASE.....	125	PROLASTIN-C.....	76
<i>trimethoprim</i>	129	PREMPRO.....	125	PROLATE.....	38

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

This drug list was updated in August 2023.

<i>prolactin</i>	38	QUESTRAN.....	62	RELEXXII.....	50
PROLENSA.....	130	QUESTRAN LIGHT.....	62	RELISTOR.....	92
PROLIA.....	118	<i>quetiapine</i>	50	RELPAX.....	31
PROMACTA.....	60	QUETIAPINE.....	50	RELTONE.....	92
<i>promethazine</i>	133	QUILLICHEW ER.....	50	RELYVRIO.....	34
PROMETRIUM.....	125	QUILLIVANT XR.....	50	REMERON.....	51
<i>propafenone</i>	55	<i>quinapril</i>	58	REMERON SOLTAB.....	51
<i>propranolol</i>	58	<i>quinidine gluconate</i>	55	REMICADE.....	92
<i>propylthiouracil</i>	79	<i>quinidine sulfate</i>	55	RENAGEL.....	76
PROQUAD (PF).....	99	<i>quinine sulfate</i>	9	RENFLEXIS.....	92
PROSCAR.....	141	QULIPTA.....	31	REVELA.....	76
PROSOL 20 %.....	143	QUVIVIQ.....	50	<i>repaglinide</i>	85
PROTONIX.....	95, 96	QVAR REDIHALER.....	138	REPATHA.....	62
<i>protriptyline</i>	50	RABAVERT (PF).....	99	REPATHA	
PROVERA.....	125	<i>rabeprazole</i>	96	PUSHTRONEX.....	62
PROVIGIL.....	50	RADICAVA ORS.....	34	REPATHA SURECLICK....	62
PROZAC.....	50	RADICAVA ORS		RESTASIS.....	130
<i>prudoxin</i>	66	STARTER KIT SUSP.....	34	RESTASIS MULTIDOSE..	130
PULMICORT.....	138	RAGWITEK.....	99	RETACRIT.....	97
PULMICORT		<i>raloxifene</i>	118	RETEVMO.....	20
FLEXHALER.....	138	<i>ramelteon</i>	50	RETIN-A.....	68
PULMOZYME.....	138	<i>ramipril</i>	58	RETIN-A MICRO.....	68
PURE COMFORT PEN		<i>ranolazine</i>	63	RETROVIR.....	4
NEEDLE.....	111	RAPAFLO.....	141	REVATIO.....	138, 139
PURE COMFORT		RAPAMUNE.....	20	REVCОВI.....	76
SAFETY PEN NEEDLE....	111	<i>rasagiline</i>	29	REVLIMID.....	20
PURIXAN.....	20	RASUVO (PF).....	122	REXULTI.....	51
PYLERA.....	96	RAVICTI.....	76	REYATAZ.....	4
<i>pyrazinamide</i>	9	RAYALDEE.....	88	REYVOW.....	31
<i>pyridostigmine bromide</i>	35	RAYOS.....	78	REZLIDHIA.....	20
PYRIDOSTIGMINE		REBIF (WITH ALBUMIN)..	97	REZUROCK.....	20
BROMIDE.....	35	REBIF REBIDOSE.....	97	REZVOGLAR KWIKPEN..	85
<i>pyrimethamine</i>	9	REBIF TITRATION PACK	97	RHOFADE.....	68
PYRUKYND.....	76	<i>reclipsen (28)</i>	128	RHOPRESSA.....	131
QBRELIS.....	58	RECOMBIVAX HB (PF)....	99	RIABNI.....	20
QELBREE.....	50	RECORLEV.....	88	<i>ribavirin</i>	4
QINLOCK.....	20	RECTIV.....	92	RIDAURA.....	122
QNASL.....	138	REDITREX (PF).....	122	<i>rifabutin</i>	9
QTERN.....	85	REGLAN.....	92	<i>rifampin</i>	9
QUADRACEL (PF).....	99	REGRANEX.....	66	RILUTEK.....	76
QUALAQUIN.....	9	RELAFEN DS.....	41	<i>riluzole</i>	76
QUARTETTE.....	128	RELENZA DISKHALER.....	4	<i>rimantadine</i>	4
QUDEXY XR.....	27	RELEUKO.....	97	RINVOQ.....	122

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

This drug list was updated in August 2023.

<i>risedronate</i>	76, 118	<i>sajazir</i>	139	SIKLOS.....	21
RISPERDAL.....	51	SALAGEN		<i>sildenafil (pulmonary arterial</i>	
RISPERDAL CONSTA.....	51	(PILOCARPINE).....	76	<i>hypertension)</i>	139
<i>risperidone</i>	51	SAMSCA.....	88	SILENOR.....	52
RITALIN.....	51	SANCUSO.....	93	SILIQ.....	64
RITALIN LA.....	51	SANDIMMUNE.....	20	<i>silodosin</i>	141
<i>ritonavir</i>	4	SANDOSTATIN.....	21	SILVADENE.....	66
<i>rivastigmine</i>	34	SANTYL.....	66	<i>silver sulfadiazine</i>	66
<i>rivastigmine tartrate</i>	34	SAPHRIS.....	51	SIMBRINZA.....	131
<i>rivelsa</i>	128	<i>sapropterin</i>	88	SIMPONI.....	122
<i>rizatRIPTAN</i>	31	SAVAYSA.....	60	<i>simvastatin</i>	62
ROBINUL.....	90	SAVELLA.....	122	SINEMET.....	29
ROBINUL FORTE.....	90	SCSEMBLIX.....	21	SINGULAIR.....	139
ROCALTROL.....	88	<i>scopolamine base</i>	93	<i>sirolimus</i>	21
ROCKLATAN.....	131	SEASONIQUE.....	128	SIRTURO.....	9
<i>roflumilast</i>	139	SECUADO.....	51	SITAVIG.....	4
<i>ropinirole</i>	29	SECURESAFE INSULIN		SIVEXTRO.....	9
<i>rosuvastatin</i>	62	SYRINGE.....	111	SKY SAFETY PEN	
ROSZET.....	62	SECURESAFE PEN		NEEDLE.....	111
ROTARIX.....	99	NEEDLE.....	111	SKYCLARYS.....	34
ROTATEQ VACCINE.....	99	SEGLENTIS.....	38	SKYLA.....	125
ROWASA.....	93	SEGLUROMET.....	85	SKYRIZI.....	64, 93
<i>roweepira</i>	27	<i>selegiline hcl</i>	29	SKYTROFA.....	98
ROXICODONE.....	38	<i>selenium sulfide</i>	64	SLYND.....	128
ROXYBOND.....	38	SELZENTRY.....	4	SOAANZ.....	58
ROZEREM.....	51	SEMGLEE(INSULIN		<i>sodium chloride</i>	76
ROZLYTREK.....	20	GLARGINE-YFGN).....	85	<i>sodium chloride 0.45 %</i>	143
RUBRACA.....	20	SEMGLEE(INSULIN		<i>sodium chloride 0.9 %</i>	76
RUCONEST.....	139	GLARG-YFGN)PEN.....	85	<i>sodium chloride 3 %</i>	
<i>rufinamide</i>	27	SENSIPAR.....	88	<i>hypertonic</i>	143
RUKOBIA.....	4	SEREVENT DISKUS.....	139	<i>sodium chloride 5 %</i>	
RUXIENCE.....	20	SEROQUEL.....	51	<i>hypertonic</i>	143
RYALTRIS.....	139	SEROQUEL XR.....	51	SODIUM OXYBATE.....	52
RYBELSUS.....	85	SEROSTIM.....	98	<i>sodium phenylbutyrate</i>	76
RYDAPT.....	20	SERTRALINE.....	51	<i>sodium polystyrene sulfonate</i> ..	76
RYTARY.....	29	<i>sertraline</i>	51, 52	<i>sodium,potassium,mag</i>	
RYTHMOL SR.....	55	<i>setlakin</i>	128	<i>sulfates</i>	93
SABRIL.....	27	<i>sevelamer carbonate</i>	76	SOFOSBUVIR-	
SAFESNAP INSULIN		<i>sevelamer hcl</i>	76	VELPATASVIR.....	4
SYRINGE.....	111	SEYSARA.....	13	SOGROYA.....	98
SAFETY PEN NEEDLE....	111	<i>sharobel</i>	125	<i>solifenacin</i>	141
SAFYRAL.....	128	SHINGRIX (PF).....	99	SOLIQUA 100/33.....	85
SAIZEN.....	97	SIGNIFOR.....	21	SOLODYN.....	13

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

This drug list was updated in August 2023.

SOLOSEC.....	9	SUBOXONE.....	41	SYMDEKO.....	139
SOLTAMOX.....	21	<i>subvenite</i>	27	SYMFI.....	4
SOMATULINE DEPOT.....	21	<i>subvenite starter (blue) kit</i>	27	SYMFI LO.....	4
SOMAVERT.....	88	<i>subvenite starter (green) kit</i> ...	27	SYMJEPI.....	133
SOOLANTRA.....	68	<i>subvenite starter (orange) kit</i> ..	27	SYMLINPEN 120.....	85
<i>sorafenib</i>	21	SUCRAID.....	93	SYMLINPEN 60.....	85
SORILUX.....	64	<i>sucralfate</i>	96	SYMPAZAN.....	27
<i>sorine</i>	55	SULAR.....	58	SYMPROIC.....	93
<i>sotalol</i>	55	<i>sulfacetamide sodium</i>	130	SYMTUZA.....	4
<i>sotalol af</i>	55	<i>sulfacetamide sodium (acne)</i> ..	69	SYNALAR.....	73
SOTYKTU.....	64	<i>sulfacetamide-prednisolone</i> ...	130	SYNAREL.....	88
SOTYLIZE.....	55	<i>sulfadiazine</i>	12	SYNDROS.....	93
SOVALDI.....	4	<i>sulfamethoxazole-</i>		SYNJARDY.....	85
<i>spinosad</i>	74	<i>trimethoprim</i>	12	SYNJARDY XR.....	86
SPIRIVA RESPIMAT.....	139	SULFAMYLLON.....	69	SYNRIBO.....	21
SPIRIVA WITH		<i>sulfasalazine</i>	93	SYNTHROID.....	89
HANDIHALER.....	139	<i>sulindac</i>	41	SYPRINE.....	76
<i>spironolactone</i>	58	<i>sumatriptan</i>	31	TABLOID.....	21
<i>spironolacton-</i>		<i>sumatriptan succinate</i>	31	TABRECTA.....	21
<i>hydrochlorothiaz</i>	58	<i>sumatriptan-naproxen</i>	31	TACLONEX.....	65
SPORANOX.....	2	<i>sunitinib malate</i>	21	<i>tacrolimus</i>	21, 66
<i>sprintec (28)</i>	128	SUNLENCA.....	4	<i>tadalafil</i>	141, 142
SPRITAM.....	27	SUNOSI.....	52	<i>tadalafil (pulmonary arterial</i>	
SPRIX.....	41	SUPRAX.....	6	<i>hypertension) oral tablet 20</i>	
SPRYCEL.....	21	SUPREP BOWEL PREP		<i>mg</i>	139
<i>sps (with sorbitol)</i>	76	KIT.....	93	TADLIQ.....	139
<i>sronyx</i>	128	SURE COMFORT INS.		TAFINLAR.....	21
<i>ssd</i>	66	SYR. U-100.....	111	<i>tafluprost (pf)</i>	131
STALEVO 100.....	29	SURE COMFORT		TAGRISO.....	21
STALEVO 125.....	29	INSULIN SYRINGE.....	112	TAKHZYRO.....	139
STALEVO 150.....	29	SURE COMFORT PEN		TALICIA.....	96
STALEVO 200.....	29	NEEDLE.....	112	TALTZ AUTOINJECTOR..	65
STALEVO 75.....	29	SURE COMFORT		TALTZ SYRINGE.....	65
STEGLATRO.....	85	SAFETY PEN NEEDLE....	112	TALZENNA.....	21
STEGLUJAN.....	85	SURE-FINE PEN		TAMIFLU.....	4
STELARA.....	64	NEEDLES.....	112	<i>tamoxifen</i>	21
STIOLTO RESPIMAT.....	139	SURE-JECT INSULIN		<i>tamsulosin</i>	141
STIVARGA.....	21	SYRINGE.....	112	TAPERDEX.....	79
STRATTERA.....	52	SUTAB.....	93	TARGADOX.....	13
STREPTOMYCIN.....	9	SUTENT.....	21	TARGRETIN.....	21
STRIBILD.....	4	<i>syeda</i>	128	<i>tarina 24 fe</i>	128
STRIVERDI RESPIMAT..	139	SYMBICORT.....	139	<i>tarina fe 1-20 eq (28)</i>	128
STROMECTOL.....	9	SYMBYAX.....	52	TARPEYO.....	79

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

This drug list was updated in August 2023.

TASCENSO ODT.....	34	TESTIM.....	88	<i>tizanidine</i>	35
TASIGNA.....	21	<i>testosterone</i>	88	TLANDO.....	88
<i>tasimelteon</i>	52	TESTOSTERONE.....	88	TOBI.....	9
TASMAR.....	29	<i>testosterone cypionate</i>	88	TOBI PODHALER.....	9
<i>tavaborole</i>	70	<i>testosterone enanthate</i>	88	TOBRADEX.....	131
TAVALISSE.....	60	TETANUS,DIPHThERIA		TOBRADEX ST.....	131
TAVNEOS.....	76	TOX PED(PF).....	100	<i>tobramycin</i>	10, 129
<i>tazarotene</i>	68	<i>tetrabenazine</i>	34	<i>tobramycin in 0.225 % nacl</i>	9
TAZAROTENE.....	68	<i>tetracycline</i>	13	<i>tobramycin sulfate</i>	10
<i>tazicef</i>	6	TEXACORT.....	73	<i>tobramycin-dexamethasone</i> ..	131
TAZORAC.....	68	TEZSPIRE.....	139	TOBREX.....	129
<i>taztia xt</i>	58	THALITONE.....	59	<i>tolcapone</i>	29
TAZVERIK.....	21	THALOMID.....	21, 22	TOLSURA.....	2
TDVAX.....	99	THEO-24.....	139	<i>tolterodine</i>	141
TECFIDERA.....	34	<i>theophylline</i>	139	<i>tolvaptan</i>	89
TECHLITE INSULIN		<i>thinpro insulin syringe</i>	113	TOPAMAX.....	28
SYRINGE.....	112, 113	THINPRO INSULIN		TOPCARE CLICKFINE....	114
TECHLITE INSULN		SYRINGE.....	114	TOPCARE ULTRA	
SYR(HALF UNIT).....	113	THIOLA.....	76	COMFORT.....	114
TECHLITE PEN NEEDLE	113	THIOLA EC.....	76	TOPICORT.....	73
TEFLARO.....	6	<i>thioridazine</i>	52	<i>topiramate</i>	28
TEGRETOL.....	28	<i>thiothixene</i>	52	TOPROL XL.....	59
TEGRETOL XR.....	28	THYQUIDITY.....	89	<i>toremifene</i>	22
TEGSEDI.....	34	<i>tiadylt er</i>	59	<i>torseamide</i>	59
TEKTRUNA.....	58	<i>tiagabine</i>	28	TOSYMRA.....	31
<i>telmisartan</i>	58	TIAZAC.....	59	TOUJEO MAX U-300	
<i>telmisartan-amlodipine</i>	58	TIBSOVO.....	22	SOLOSTAR.....	86
<i>telmisartan-</i>		TICOVAC.....	100	TOUJEO SOLOSTAR U-	
<i>hydrochlorothiazid</i>	58	<i>tigecycline</i>	9	300 INSULIN.....	86
TENIVAC (PF).....	99	TIGLUTIK.....	76	<i>tovet emollient</i>	73
<i>tenofovir disoproxil fumarate</i>	4	TIKOSYN.....	55	TOVIAZ.....	141
TENORETIC 100.....	58	<i>tilia fe</i>	128	TPN ELECTROLYTES....	143
TENORETIC 50.....	58	<i>timolol maleate</i>	59, 129	TRACLEER.....	139
TENORMIN.....	58	<i>timolol maleate (pf)</i>	129	TRADJENTA.....	86
TEPMETKO.....	21	TIMOPTIC OCUDOSE		TRAMADOL.....	41
<i>terazosin</i>	59	(PF).....	129	<i>tramadol</i>	41
<i>terbinafine hcl</i>	2	TIMOPTIC-XE.....	129	<i>tramadol-acetaminophen</i>	41
<i>terbutaline</i>	139	<i>tinidazole</i>	9	<i>trandolapril</i>	59
<i>terconazole</i>	125	<i>tiopronin</i>	76	<i>trandolapril-verapamil</i>	59
<i>teriflunomide</i>	34	TIROSINT.....	89	<i>tranexamic acid</i>	125
TERIPARATIDE.....	118	TIROSINT-SOL.....	89	TRANSDERM-SCOP.....	93
TERUMO INSULIN		TIVICAY.....	4	<i>tranylcypromine</i>	52
SYRINGE.....	113	TIVICAY PD.....	4	<i>travasol 10 %</i>	144

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

This drug list was updated in August 2023.

TRAVATAN Z.....	131	<i>tri-nymyo</i>	128	UCERIS.....	93
<i>travoprost</i>	131	<i>tri-sprintec (28)</i>	128	UDENYCA.....	98
TRAZIMERA.....	22	<i>tritocin</i>	73	UDENYCA	
<i>trazodone</i>	52	TRIUMEQ.....	4	AUTOINJECTOR.....	98
TRECTOR.....	10	TRIUMEQ PD.....	4	ULORIC.....	118
TRELEGY ELLIPTA.....	139	<i>trivora (28)</i>	128	ULTICARE.....	115
TRELSTAR.....	22	<i>tri-vylibra</i>	128	ULTICARE INSULIN	
TREMFYA.....	65	<i>tri-vylibra lo</i>	128	SYRINGE.....	114
<i>treprostinil sodium</i>	59	TRIZIVIR.....	4	ULTICARE INSULN	
TRESIBA FLEXTOUCH		TROKENDI XR.....	28	SYR(HALF UNIT).....	115
U-100.....	86	TROPHAMINE 10 %.....	144	ULTICARE PEN NEEDLE	
TRESIBA FLEXTOUCH		<i>trosipium</i>	141	.....	115
U-200.....	86	TRUDHESA.....	31	ULTICARE SAFETY PEN	
TRESIBA U-100 INSULIN..	86	TRUE COMFORT		NEEDLE.....	115
<i>tretinoin (antineoplastic)</i>	22	INSULIN SYRINGE.....	114	ULTIGUARD	
<i>tretinoin microspheres</i>	68	TRUE COMFORT PEN		SAFEPACK-INSULIN	
<i>tretinoin topical</i>	68	NEEDLE.....	114	SYR.....	115
TREXALL.....	22	TRUE COMFORT PRO		ULTIGUARD	
TREXIMET.....	31	INS SYRINGE.....	114	SAFEPACK-PEN	
TREZIX.....	38	TRUE COMFORT		NEEDLE.....	115
<i>triamcinolone acetonide</i>	73, 77	SAFETY PEN NEEDLE....	114	ULTILET INSULIN	
<i>triamterene</i>	59	TRUEPLUS INSULIN.....	114	SYRINGE.....	115
<i>triamterene-</i>		TRUEPLUS PEN NEEDLE		ULTILET PEN NEEDLE..	115
<i>hydrochlorothiazid</i>	59	.....	114	ULTRA CMFT INS SYR	
<i>trianex</i>	73	TRULANCE.....	93	(HALF UNIT).....	115
TRIBENZOR.....	59	TRULICITY.....	86	ULTRA COMFORT	
TRICOR.....	62	TRUMENBA.....	100	INSULIN SYRINGE.....	115
<i>triderm</i>	73	TRUVADA.....	4	ULTRA FLO INSUL	
<i>trientine</i>	76	TUDORZA PRESSAIR....	140	SYR(HALF UNIT).....	115
<i>tri-estarylla</i>	128	TUKYSA.....	22	ULTRA FLO INSULIN	
<i>trifluoperazine</i>	52	TURALIO.....	22	SYRINGE.....	116
<i>trifluridine</i>	129	TWINRIX (PF).....	100	ULTRA FLO PEN	
TRIJARDY XR.....	86	TWYNEO.....	68	NEEDLE.....	116
TRIKAFTA.....	140	TYBLUME.....	128	ULTRA THIN PEN	
<i>tri-legest fe</i>	128	TYBOST.....	4	NEEDLE.....	116
TRILEPTAL.....	28	<i>tydemy</i>	128	ULTRACARE INSULIN	
TRILIPIX.....	62	TYGACIL.....	10	SYRINGE.....	116
<i>tri-lo-estarylla</i>	128	TYKERB.....	22	ULTRACARE PEN	
<i>tri-lo-sprintec</i>	128	TYMLOS.....	118	NEEDLE.....	116
<i>trimethoprim</i>	13	TYPHIM VI.....	100	ULTRA-THIN II (SHORT)	
<i>tri-mili</i>	128	TYRVAYA.....	130	INS SYR.....	116
<i>trimipramine</i>	52	TYVASO DPI.....	140	ULTRA-THIN II (SHORT)	
TRINTELLIX.....	52	UBRELVY.....	31	PEN NDL.....	116

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

This drug list was updated in August 2023.

ULTRA-THIN II INS PEN	<i>vandazole</i>	125	VFEND IV.....	2
NEEDLES.....	VANISHPOINT INSULIN		V-GO 20.....	117
116	SYRINGE.....	117	V-GO 30.....	117
ULTRA-THIN II INSULIN	VANISHPOINT SYRINGE		V-GO 40.....	117
SYRINGE.....	.....	117	VIBERZI.....	93
116	VANOS.....	73	VIBRAMYCIN.....	13
ULTRAVATE.....	VAQTA (PF).....	100	VIBRAMYCIN	
73	<i>varenicline</i>	77	(CALCIUM).....	13
UNASYN.....	VARIVAX (PF).....	100	VIBRAMYCIN (MONO).....	13
11, 12	VARUBI.....	93	VICTOZA 3-PAK.....	86
UNIFINE PENTIPS.....	VASCEPA.....	62	<i>vienna</i>	128
116	VASERETIC.....	59	<i>vigabatrin</i>	28
UNIFINE PENTIPS	VASOTEC.....	59	<i>vigadrone</i>	28
MAXFLOW.....	VECAMEYL.....	63	VIGAMOX.....	129
116	VECTICAL.....	65	VIIBRYD.....	53
UNIFINE PENTIPS PLUS	<i>velivet triphasic regimen (28)</i>	128	VIJOICE.....	22
117	VELPHORO.....	77	<i>vilazodone</i>	53
UNIFINE PENTIPS PLUS	VELTASSA.....	77	VIMOVO.....	41
MAXFLOW.....	VELTIN.....	68	VIMPAT.....	28
117	VEMLIDY.....	5	VIOKACE.....	93
UNIFINE	VENCLEXTA.....	22	VIRACEPT.....	5
SAFECONTROL.....	VENCLEXTA STARTING		VIREAD.....	5
117	PACK.....	22	VITRAKVI.....	22
UNIFINE ULTRA PEN	<i>venlafaxine</i>	53	VIVELLE-DOT.....	125
NEEDLE.....	VENLAFAXINE		VIVITROL.....	41
117	BESYLATE.....	53	VIVJOA.....	2
<i>unithroid</i>	VENTAVIS.....	140	VIZIMPRO.....	22
89	VENTOLIN HFA.....	140	VOGELXO.....	89
UPTRAVI.....	<i>verapamil</i>	59	VONJO.....	22
59	VERDESO.....	73	<i>voriconazole</i>	2
UROCIT-K 10.....	VERELAN.....	59	VOSEVI.....	5
142	VERELAN PM.....	59	VOTRIENT.....	22
UROCIT-K 15.....	VERIFINE INSULIN		VOXZOGO.....	89
142	SYRINGE.....	117	VRAYLAR.....	53
UROCIT-K 5.....	VERIFINE PEN NEEDLE	117	VTAMA.....	65
142	VERKAZIA.....	130	VUITY.....	130
UROXATRAL.....	VERQUVO.....	63	VUMERITY.....	34
141	VERSACLOZ.....	53	<i>vyfemla (28)</i>	128
URSO 250.....	VERZENIO.....	22	<i>vylibra</i>	128
93	VESICARE.....	141	VYNDAMAX.....	63
URSO FORTE.....	VESICARE LS.....	141	VYNDAQEL.....	63
93	<i>vestura (28)</i>	128	VYTORIN 10-10.....	62
<i>ursodiol</i>	VFEND.....	2	VYTORIN 10-20.....	63
93				
UZEDY.....				
52, 53				
VABOMERE.....				
10				
VAGIFEM.....				
125				
<i>valacyclovir</i>				
4				
VALCHLOR.....				
66				
VALCYTE.....				
5				
<i>valganciclovir</i>				
5				
VALIUM.....				
53				
<i>valproic acid</i>				
28				
<i>valproic acid (as sodium salt)</i>				
28				
VALSARTAN.....				
59				
<i>valsartan</i>				
59				
<i>valsartan-hydrochlorothiazide</i>				
59				
VALTOCO.....				
28				
VALTREX.....				
5				
VANOCOCIN.....				
10				
<i>vancomycin</i>				
10				
VANCOMYCIN.....				
10				

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

This drug list was updated in August 2023.

VYTORIN 10-40.....	63	XPOVIO.....	23	ZERVIATE.....	130
VYTORIN 10-80.....	63	XTAMPZA ER.....	38	ZESTORETIC.....	59
VYVANSE.....	53	XTANDI.....	23	ZESTRIL.....	59
VYZULTA.....	131	<i>xulane</i>	125	ZETIA.....	63
WAKIX.....	53	XULTOPHY 100/3.6.....	86	ZETONNA.....	140
<i>warfarin</i>	60	XURIDEN.....	77	ZIAC.....	59
WELCHOL.....	63	XYOSTED.....	89	ZIAGEN.....	5
WELIREG.....	23	XYREM.....	53	ZIANA.....	68
WELLBUTRIN SR.....	53	XYWAV.....	54	<i>zidovudine</i>	5
WELLBUTRIN XL.....	53	YASMIN (28).....	128	ZIEXTENZO.....	98
WINLEVI.....	68	YAZ (28).....	128	<i>zileuton</i>	140
<i>wixela inhub</i>	140	YF-VAX (PF).....	100	ZILXI.....	68
<i>wymzya fe</i>	128	YONSA.....	23	ZIMHI.....	41
XADAGO.....	29	YUPELRI.....	140	ZIOPTAN (PF).....	131
XALATAN.....	131	YUSIMRY(CF) PEN.....	122	<i>ziprasidone hcl</i>	54
XALKORI.....	23	<i>yuvafem</i>	125	<i>ziprasidone mesylate</i>	54
XARELTO.....	60	<i>zafemy</i>	125	ZIPSOR.....	41
XARELTO DVT-PE		<i>zafirlukast</i>	140	ZIRABEV.....	23
TREAT 30D START.....	60	<i>zaleplon</i>	54	ZIRGAN.....	129
XATMEP.....	23	ZANAFLEX.....	35	ZITHROMAX.....	7
XCOPRI.....	28	ZARONTIN.....	28	ZITHROMAX TRI-PAK.....	7
XCOPRI MAINTENANCE		ZARXIO.....	98	ZITHROMAX Z-PAK.....	7
PACK.....	28	ZAVESCA.....	89	ZOCOR.....	63
XCOPRI TITRATION		ZEGALOGUE		ZOKINVY.....	77
PACK.....	28	AUTOINJECTOR.....	86	ZOLINZA.....	23
XELJANZ.....	122	ZEGALOGUE SYRINGE...	86	<i>zolmitriptan</i>	31
XELJANZ XR.....	122	ZEGERID.....	96	ZOLOFT.....	54
XELPROS.....	131	ZEJULA.....	23	<i>zolpidem</i>	54
XELSTRYM.....	53	ZELAPAR.....	29	ZOMACTON.....	98
XENAZINE.....	34, 35	ZELBORAF.....	23	ZOMIG.....	31
XENLETA.....	10	ZEMAIRA.....	77	ZONALON.....	66
XERESE.....	70	ZEMBRACE SYMTOUCH.	31	ZONEGRAN.....	28
XERMELO.....	23	ZEMDRI.....	10	ZONISADE.....	28
XGEVA.....	14	ZEMPLAR.....	89	<i>zonisamide</i>	28
XHANCE.....	140	<i>zenatane</i>	68	ZONTIVITY.....	60
XIFAXAN.....	10	ZENPEP.....	93	ZORBTIVE.....	98
XIGDUO XR.....	86	<i>zenzedi</i>	54	ZORTRESS.....	23
XIIDRA.....	130	ZENZEDI.....	54	ZORYVE.....	65
XIMINO.....	13	ZEPATIER.....	5	ZOSYN IN DEXTROSE	
XOFLUZA.....	5	ZEPOSIA.....	35	(ISO-OSM).....	12
XOLAIR.....	140	ZEPOSIA STARTER		<i>zovia 1-35 (28)</i>	128
XOPENEX HFA.....	140	PACK (7-DAY).....	35	ZOVIRAX.....	70
XOSPATA.....	23	ZERBAXA.....	6	ZTALMY.....	28

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

This drug list was updated in August 2023.

ZTLIDO.....	66
ZUBSOLV.....	41
ZYCLARA.....	66
ZYDELIG.....	23
ZYFLO.....	140
ZYKADIA.....	23
ZYLET.....	131
ZYLOPRIM.....	118
ZYMAXID.....	129
ZYPITAMAG.....	63
ZYPREXA.....	54
ZYPREXA RELPREVV.....	54
ZYPREXA ZYDIS.....	54
ZYTIGA.....	23
ZYVOX.....	10

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

This drug list was updated in August 2023.

This page intentionally left blank

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

This formulary was updated on 08/22/2023. For more recent information or to price a medication, you can visit us on the Web at [express-scripts.com](https://www.express-scripts.com). Or you can contact **Express Scripts Medicare**[®] (PDP) Customer Service at the numbers located on the back of your member ID card. Customer Service is available 24 hours a day, 7 days a week.

© 2023 Express Scripts. All Rights Reserved.

F0PA3T4A

This drug list was updated in August 2023.