Dear Valued Member:

This Select Drug Program® Formulary Guide is intended to help you understand prescription drug coverage under the Independence Blue Cross Select Formulary. We are committed to providing you with comprehensive prescription drug coverage. To achieve this, we include a formulary feature in your prescription drug benefit. A formulary is a list of selected drugs. The drugs are approved by the U.S. Food and Drug Administration (FDA). They are also reviewed by our Pharmacy and Therapeutics Committee, a group of doctors and pharmacists from the area. These prescription drugs have been added to the Select Formulary for their reported medical effectiveness, safety, and value.

FutureScripts®, an independent company, is our pharmacy benefits manager. They monitor all drugs to ensure they are safe and effective drugs. They also make sure drugs are prescribed properly. They do so by using procedures such as prior authorization and safety edits. Safety edits are guidelines. They include, for example, age limits, quantity limits, and morphine milligram equivalent limits.

These guidelines are designed to help you get the most out of your prescription drug benefits. They are based on FDA guidelines and are approved by our Pharmacy and Therapeutics Committee.

You can find more about our safe prescribing guidelines at the end of the formulary list.

Please note: Because prescription drug benefits vary by group, your plan may not cover every drug listed in the formulary. Drug coverage is based on medical necessity. This formulary guide was current at the time of printing and is subject to change. Please call Customer Service at the number listed on the back of your ID card if you have any questions about your prescription drug benefits. Please discuss any questions or concerns about your drug therapy with your provider or pharmacist.

Sincerely,

Independence Blue Cross
Select Formulary Tier Structure
Each drug on the formulary is in a tier. The non-preferred tier will usually cost more than the preferred brand tier or generic tier. Below is a summary of tiers in the general order from lowest to highest level of cost-share. Benefits vary by group, the inclusion of a drug in this formulary does not guarantee coverage. All cost-share tiers may not be available on all plans.

- Low-Cost Generic (availability varies by benefit)
- Generic
- Preferred Brand
- Non-Preferred Drug
- Specialty (availability varies by benefit)

• Generally, when a brand drug has a generic equivalent, the brand version is covered at the non-preferred level of cost-sharing. The generic equivalent is covered at the generic level of cost-sharing. For example: Cipro® is a brand drug. It is covered at the non-preferred level of cost-sharing. Its generic equivalent, ciprofloxacin, is available at the generic level of cost-sharing.

• Sometimes brand-name drugs without generic equivalents, authorized generic drugs, and generic drugs are also covered at the non-preferred level of cost-sharing. This is because there are other more cost-effective options covered on the formulary to treat the same condition.

Covered generic drugs not listed in the formulary guide are available at the generic level of cost-sharing; covered brand drugs not listed in the formulary guide are available at the non-preferred level of cost-sharing.

The Low-Cost Generic [LCG] Tier offers copays lower than the cost-share for the generic tier, when possible. This applies to certain generic drugs that are typically used to treat chronic conditions such as high blood pressure, high cholesterol, diabetes, heart failure, and depression. Benefits may vary. Not all plans provide this incentive. The drug list is subject to change. When this incentive is not available on a plan, these drugs will be covered at the generic cost-share level.

Specialty Drugs [SP] meet certain criteria, including, but not limited to drugs used to treat rare, complex, or chronic diseases, drugs that have complex storage and/or shipping requirements, and drugs that require comprehensive patient monitoring and/or education. Specialty drugs covered under the pharmacy benefit may be managed by the FutureScripts® Specialty Pharmacy Program. Benefits may vary, and many plans cover specialty drugs on a specialty tier with higher cost-sharing. For cost-sharing purposes, drugs on the specialty tier are not eligible for tier lowering.

Authorized Generics [AG] are brand-name drugs that are marketed without the brand name on its label. An authorized generic may be marketed by the brand-name drug company, or another company with the brand company’s permission. These drugs are approved by the FDA. But they are not approved through the abbreviated new drug application (ANDA) process like a standard generic drug. For cost-sharing purposes, authorized generics are treated as brand-name drugs and are not eligible for coverage on the generic tier(s). For example, oxycodone ER tablet, an authorized generic of brand OxyContin®, is listed as non-preferred and is available at the non-preferred level of cost-sharing.
**Affordable Care Act Preventive Medications [ACA]**

Certain preventive medications, as described in the Patient Protection and Affordable Care Act (PPACA) and detailed by the U.S. Preventive Services Task Force, are covered without cost-sharing with a prescription when provided by a participating retail or mail-order pharmacy.

This formulary was current at the time of printing and is subject to change. Please understand that this formulary is not intended as a substitute for a provider’s independent, professional judgment. Rather, it is offered as a tool to help Plan members and providers recognize formulary drugs to facilitate the appropriate drug therapy.

The following categories of drugs may be available at no member cost-share with a prescription. Please note that individual benefits may vary. Always refer to your benefits to determine your coverage. This list is subject to change. Refer to the searchable drug lookup tool on your health insurance plan’s website to check the status of a specific drug.

<table>
<thead>
<tr>
<th>Category</th>
<th>Product(s) Available at $0 at the Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin products (OTC)</strong></td>
<td>aspirin 81mg (tab/chewable)</td>
</tr>
<tr>
<td>For adults age 50-59 to prevent cardiovascular disease and colorectal cancer; low dose (81mg) for women after 12 weeks’ gestation who are at high risk for preeclampsia</td>
<td></td>
</tr>
<tr>
<td><strong>Bowel Preparations</strong></td>
<td></td>
</tr>
<tr>
<td>Bowel preparation for colonoscopy needed for preventive colon cancer screening, for ages 50-75</td>
<td>generic bowel preparation products such as Gavilyte-CTM, Gavilyte-GTM, Gavilyte-NTM, Gavilyte-HTM with bisacodyl, polyethylene glycol (PEG) 3350 oral powder, Trilyte® w/packets</td>
</tr>
<tr>
<td><strong>Breast cancer chemo prevention</strong></td>
<td></td>
</tr>
<tr>
<td>For asymptomatic females age 35 years and older without a prior diagnosis of breast cancer, ductal carcinoma in situ, or lobular carcinoma in situ, who are at high risk for breast cancer and at low risk for adverse effects from breast cancer chemoprevention</td>
<td>tamoxifen 20mg</td>
</tr>
<tr>
<td><strong>Contraceptives</strong></td>
<td></td>
</tr>
<tr>
<td>Includes, but not limited to, oral, injectable, transdermal, diaphragms, cervical caps, intravaginal devices, female condoms, and contraceptive film and jelly (in accordance with the women’s preventive services provisions of the ACA). Note: IUDs and implantable products are covered under the medical benefit.</td>
<td>- Oral: all generics such as Amethia, Cryselle-28, Emoquette, Fayosim, Necon, Ocella, Sprintec, Trivora, Natazia - Injectable: all generics such as medroxyprogesterone injection - Transdermal: Xulane® patches - Diaphragms - Cervical Caps - Female condoms - Contraceptive film - Contraceptive gel/jelly/foam: such as VCF® foam 12.5%, 28%, Options Conceptrl® 4%, Options Gynol® 3% - Emergency: all generics such as levonorgestrel 1.5mg tab, My Way® 1.5mg tab - Intravaginal devices: etonogestrel-ethinyl estradiol vaginal ring</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Category</th>
<th>Product(s) Available at $0 at the Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fluoride</strong></td>
<td>sodium fluoride 1.1 (0.5f) mg/ml solution&lt;br&gt;sodium fluoride 0.55 (0.25f) mg chewable tab&lt;br&gt;Fluroritab 0.275 (0.125f) mg/drop solution&lt;br&gt;Fluroritab 1.1 (0.5f) mg chewable tab</td>
</tr>
<tr>
<td>For children ages 6 months to 16 years. Includes generics strengths <strong>up to 0.5mg</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Folic acid</strong></td>
<td>folic acid 400mcg tab&lt;br&gt;folic acid 800mcg tab&lt;br&gt;folic acid 0.8mg capsule (including generic prenatal vitamins with the above listed folic acid dose)</td>
</tr>
<tr>
<td>For women planning for or capable of pregnancy. Limited to 0.4 to 0.8mg of folic acid. For women younger than 51 years of age</td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco Cessation Medication</strong></td>
<td>Chantix®&lt;br&gt;bupropion SR (generic Zyban®) tablet&lt;br&gt;nicotine polacrilex lozenge&lt;br&gt;nicotine patch 24 hour transdermal&lt;br&gt;Nicotrol® Inhaler&lt;br&gt;Nicotrol® NS Solution</td>
</tr>
<tr>
<td>For adults ages 18+ years, who use tobacco products and want to quit</td>
<td></td>
</tr>
<tr>
<td><strong>Statins</strong></td>
<td>lovastatin 10mg&lt;br&gt;lovastatin 20mg&lt;br&gt;lovastatin 40mg</td>
</tr>
<tr>
<td>Low-to-moderate dose statin for prevention of cardiovascular disease, recommended for ages 40-75 years without a history of CVD when 1 or more CVD risk factors are present (e.g., dyslipidemia, diabetes, hypertension, or smoking) and a calculated 10-year risk of a cardiovascular event of 10% or greater</td>
<td></td>
</tr>
<tr>
<td><strong>HIV PrEP</strong></td>
<td>Truvada 200mg-300mg&lt;br&gt;Tenofovir 300mg</td>
</tr>
<tr>
<td>Preexposure prophylaxis (PrEP) with effective anti-retroviral therapy for persons who are at high risk of HIV acquisition</td>
<td></td>
</tr>
</tbody>
</table>
Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al número telefónico de Servicio al Cliente que figura en el reverso de su tarjeta de identificación.

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。请致电您ID卡背面的客户服务电话号码。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para telefone do Atendimento ao Cliente que está no verso do seu cartão de identificação.

Gujarati: સૂચના: જે તમે ગુજરાતી બોલતા હો, તો નિ:શુભ ભાષા સહાય સેવાઓને તમારા માત્ર ઉપલબ્ધ છે. કૃપા થાય તમારા આફ્થી કારની પાછળ આહ્ક સેવા નંબર પર કોલ કરો.


Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Позвоните в службу поддержки клиентов по номеру телефона, указанному на обратной стороне вашей идентификационной карты.


Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiami il numero dell’Assistenza clienti che troverà sul retro della sua tessera identificativa.

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالجانب. الرجاء الاتصال برقم "خدمة العملاء" الموجود على ظهر بطاقة هويليك.


French: ATTENTION: Si vous parlez français, des services d’aide linguistique-vous sont proposés gratuitement. Veuillez composer le numéro du service clientèle indiqué au dos de votre carte d’identité Médicale.


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया अपने आईडी कार्ड के पीछे दिए गए स्वाथ सेवा नंबर पर कॉल करें।


Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。ご自分のIDカードの裏面に記載されているカスタマーサービスの番号へお電話ください。

Persian (Farsi): توجه: اگر فارسی صحبت می‌کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می‌شود. لطفاً با شماره خدمات مشتریان که در پشت کارت شناسایی شما درج شده است تماس بگیرید.
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA, 19103; By phone: 1-888-377-3933 (TTY: 711), By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

## Antibiotics & Other Drugs Used for Infection

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>DRUG TIER</th>
<th>Requirements/Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>abacavir sulfate tab, soln</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>abacavir sulfate/lamivudine</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>abacavir/lamivudine/zidovudine</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Acticlate +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>acyclovir</td>
<td>G</td>
<td>QL</td>
</tr>
<tr>
<td>acyclovir 5% cream</td>
<td>G</td>
<td>QL</td>
</tr>
<tr>
<td>adefovir dipivoxil</td>
<td>G, SP</td>
<td></td>
</tr>
<tr>
<td>Aemcolo DR</td>
<td>NPD</td>
<td>QL</td>
</tr>
<tr>
<td>albendazole</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Altabax</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>amoxicillin</td>
<td>LCG</td>
<td></td>
</tr>
<tr>
<td>Amoxicillin 775mg</td>
<td>PB</td>
<td></td>
</tr>
<tr>
<td>amoxicillin/clavulanate</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>amoxicillin/clavulanate extended-release</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>ampicillin</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Amzeeq</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Ancobon</td>
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<tr>
<td>Arakoda</td>
<td>NPD</td>
<td></td>
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<tr>
<td>Arikayce</td>
<td>NPD, SP</td>
<td>PA</td>
</tr>
<tr>
<td>atazanavir</td>
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<td></td>
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<tr>
<td>atovaquone</td>
<td>G</td>
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<tr>
<td>atovaquone/proguanil</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Atripla</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Augmentin</td>
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<tr>
<td>Augmentin XR</td>
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<td></td>
</tr>
<tr>
<td>Avelox</td>
<td>NPD</td>
<td></td>
</tr>
<tr>
<td>avidoxy</td>
<td>G</td>
<td></td>
</tr>
</tbody>
</table>

**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug  
PA = Prior Authorization   QL = Quantity Limits Apply   SP = Specialty Drug   AL = Age Limit   LCG = Low Cost Generic   LDD = Limited Distribution Drug   SDS = Day Supply Limit   R = Requires Rider   + = PA for Selected NPD   NF = Non Formulary   G = Generic   Q/T = Quantity Over Time   PB = Preferred Brand   NPD = Non Preferred Drug   ACA = $0 Preventative Drug   MME = Morphine Milligram Equivalent
<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daklinza</td>
<td>NPD, SP</td>
<td>PA, QL, Q/T</td>
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<tr>
<td>dapsone tab</td>
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<tr>
<td>Daxbia</td>
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<tr>
<td>Delstrigo</td>
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<tr>
<td>demeclocycline</td>
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<td>dicloxacillin</td>
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<td>didanosine</td>
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<td>PA</td>
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<td>Doryx 50mg and 200mg DR tablet</td>
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<td>Dovato</td>
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<tr>
<td>E.E.S.</td>
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<td>Egaten 250mg tablet</td>
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<td>Emtriva</td>
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<td>PA, QL, Q/T</td>
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<td>erythromycin ethylsuccinate</td>
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<td>ethambutol</td>
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<td>Fuzeon</td>
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<td>griseofulvin microsize</td>
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<td>Harvoni</td>
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<td>Juluca</td>
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<td>Kalydeclo Tabs/ Pack</td>
<td>NPD, SP</td>
<td>PA, LDD</td>
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<tr>
<td>lamivudine</td>
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**Bold type** = Brand Name Drug  
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PA = Prior Authorization  
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LCG = Low Cost Generic  
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+ = PA for Selected NPD  
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**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug  
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**MME** = Morphine Milligram Equivalent
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**PAIN, NERVOUS SYSTEM, & PSYCH**

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**DRUG NAME**

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**Bold type** = Brand Name Drug   **Lower case italic** = Generic drug
PA = Prior Authorization   QL = Quantity Limits Apply   SP = Specialty Drug   AL = Age Limit   LCG = Low Cost Generic   LDD = Limited Distribution Drug   5DS = Day Supply Limit   R = Requires Rider   + = PA for Selected NPD   NF = Non Formulary   G = Generic   Q/T = Quantity Over Time   PB = Preferred Brand   NPD = Non Preferred Drug   ACA = $0 Preventative Drug   MME = Morphine Milligram Equivalent
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<th>DRUG NAME</th>
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**HEART, BLOOD PRESSURE, & CHOLESTEROL**

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Bold type = Brand Name Drug  Lower case italic = Generic drug
PA = Prior Authorization  QL = Quantity Limits Apply  SP = Specialty Drug  AL = Age Limit  LCG = Low Cost Generic
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MME = Morphine Milligram Equivalent
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</table>

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**SKIN MEDICATIONS**

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MME = Morphine Milligram Equivalent
<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>doxepin cream 5%</td>
<td>G</td>
<td>QL</td>
</tr>
<tr>
<td>Duac +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Duobrii Lotion +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Dupixent</td>
<td>PB, SP</td>
<td>PA</td>
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<tr>
<td>econazole</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Ecoza +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Efudex cream</td>
<td>NPD, SP</td>
<td></td>
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<tr>
<td>Elidel</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Elimite</td>
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</tr>
<tr>
<td>Elocon</td>
<td>NPD</td>
<td></td>
</tr>
<tr>
<td>Enstilar +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Epiduo</td>
<td>NPD</td>
<td>AL</td>
</tr>
<tr>
<td>Epiduo Forte gel</td>
<td>PB</td>
<td>AL</td>
</tr>
<tr>
<td>Effalcozo +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Erygel</td>
<td>NPD</td>
<td></td>
</tr>
<tr>
<td>erythromycin gel, soln, swabs</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Eucrisa</td>
<td>PB</td>
<td>PA</td>
</tr>
<tr>
<td>Eurax Lotion</td>
<td>NPD</td>
<td></td>
</tr>
<tr>
<td>Evoclin +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Exelderm +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Extina +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Fabior</td>
<td>NPD</td>
<td>AL</td>
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<tr>
<td>Fasenra</td>
<td>PB, SP</td>
<td>PA</td>
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<tr>
<td>Finacea</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>fluocinolone acetonide cream, sol, oil</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>fluocinonide gel, ointment</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Fluorouracil cream 0.5%</td>
<td>PB</td>
<td></td>
</tr>
<tr>
<td>fluorouracil solution 2%</td>
<td>G, SP</td>
<td></td>
</tr>
<tr>
<td>flurandrenolide cream, lotn, oint</td>
<td>NPD</td>
<td>PA</td>
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</table>

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
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</thead>
<tbody>
<tr>
<td>fluticasone propionate</td>
<td>G</td>
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<tr>
<td>gentamicin topical cream, ointment</td>
<td>G</td>
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</tr>
<tr>
<td>halcinonide cream 0.1%</td>
<td>G</td>
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</tr>
<tr>
<td>halobetasol propionate</td>
<td>G</td>
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</tr>
<tr>
<td>halobetasol propionate foam 0.05%</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Halog +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>hydrocortisone 2.5%</td>
<td>LCG</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone butyrate 0.1%</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone lot 0.1%</td>
<td>LCG</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone butyrate/emoll</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone supp</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>hydrocortisone valerate 0.2%</td>
<td>G</td>
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</tr>
<tr>
<td>hydrocortisone/ lidocaine HCl</td>
<td>G</td>
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<tr>
<td>imiquimod cream</td>
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<tr>
<td>Imiquimod Cream 3.75% Pump</td>
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<tr>
<td>Impoz Cream 0.025%</td>
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<tr>
<td>isotretinoin</td>
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<tr>
<td>Jublia</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Kenalog Spray +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Kerydin</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>ketoconazole cream</td>
<td>G</td>
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</tbody>
</table>

**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug  
PA = Prior Authorization  QL = Quantity Limits Apply  SP = Specialty Drug  AL = Age Limit  LCG = Low Cost Generic  
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<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>ketoconazole shampoo</td>
<td>G</td>
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</tr>
<tr>
<td>Klaron</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Lexette Foam 0.05%</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>lidocaine patch 5%</td>
<td>G</td>
<td>PA</td>
</tr>
<tr>
<td>lidocaine solution, gel, ointment</td>
<td>G</td>
<td>PA</td>
</tr>
<tr>
<td>Lidoderm +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Locoid +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Locoid Lipocream +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Loprox +</td>
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<td>PA</td>
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<tr>
<td>Lotrisone</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Luxiq +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Luzu +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>malathion lotion</td>
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<td>methoxsalen</td>
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<tr>
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<td>MetroLotion</td>
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<td>metronidazole cream, lotion, gel</td>
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<td>miconazole-zinc ointment</td>
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<td>PA</td>
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<tr>
<td>Mirvaso</td>
<td>PB</td>
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<tr>
<td>mometasone cream, ointment, solution</td>
<td>LCG</td>
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<tr>
<td>mupirocin cream, ointment</td>
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<tr>
<td>naftifine cream, gel</td>
<td>G</td>
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<tr>
<td>Naftin</td>
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<tr>
<td>Natroba</td>
<td>NPD</td>
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</tr>
<tr>
<td>Nizoral shampoo</td>
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</tr>
<tr>
<td>Noritate</td>
<td>NPD</td>
<td>PA</td>
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<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>nystatin/triamcinolone cream, ointment</td>
<td>G</td>
<td>PA</td>
</tr>
<tr>
<td>Olux [E] +</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Onexton +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Oxide</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>oxiconazole nitrate +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Oxistat +</td>
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<td>PA</td>
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<tr>
<td>Oxsoralen Ultra</td>
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<td>PA</td>
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<tr>
<td>Pandel +</td>
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<td>PA</td>
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<tr>
<td>Penlac</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>permethrin</td>
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</tr>
<tr>
<td>pimecrolimus cre 1%</td>
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<tr>
<td>podofilox soln</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>prednicarb ointment</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>prilocaine/ lidocaine</td>
<td>G</td>
<td></td>
</tr>
<tr>
<td>Proctofoam HC</td>
<td>PB</td>
<td></td>
</tr>
<tr>
<td>Prudoxin cream 5%</td>
<td>NPD</td>
<td>QL</td>
</tr>
<tr>
<td>Qbrexza Pad 2.4%</td>
<td>NPD</td>
<td>PA, QL</td>
</tr>
<tr>
<td>Retin-A +</td>
<td>NPD</td>
<td>PA, AL</td>
</tr>
<tr>
<td>Retin-A Micro +</td>
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<td>PA, AL</td>
</tr>
<tr>
<td>Rhofade 1% cream</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Sernivo</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Silic</td>
<td>NPD, SP</td>
<td>PA</td>
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<tr>
<td>Silvadene</td>
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<tr>
<td>silver sulfadiazine</td>
<td>LCG</td>
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<tr>
<td>Skyrizi Inj</td>
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<td>PA</td>
</tr>
<tr>
<td>Solaraze</td>
<td>NPD</td>
<td>PA</td>
</tr>
</tbody>
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<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
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<tbody>
<tr>
<td>Soolantra</td>
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<tr>
<td>Soriatane</td>
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<tr>
<td>spinosad</td>
<td>G</td>
<td>PA</td>
</tr>
<tr>
<td>sulconazole cream/solution</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Sulamylon</td>
<td>NPD</td>
<td></td>
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<tr>
<td>Synalar +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Taclonex +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Taltz Autoinjector</td>
<td>NPD, SP</td>
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<td>Targretin gel</td>
<td>PB</td>
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<tr>
<td>tazarotene cream 0.1%</td>
<td>G</td>
<td>AL</td>
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<tr>
<td>Tazorac cream 0.1%</td>
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<td>AL</td>
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<tr>
<td>Temovate</td>
<td>NPD</td>
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<tr>
<td>Topicort +</td>
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<td>PA</td>
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<td>Tremfya</td>
<td>PB, SP</td>
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<tr>
<td>tretinoin gel, cream</td>
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<td>AL</td>
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<tr>
<td>tretinoin microspheres gel</td>
<td>NPD</td>
<td>AL</td>
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<tr>
<td>triamcinolone acetonide</td>
<td>LCG</td>
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<tr>
<td>triamcinolone oint 0.05%</td>
<td>NPD</td>
<td>PA</td>
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<td>Trianex</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>triderm cream</td>
<td>LCG</td>
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<tr>
<td>Ultravate +</td>
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<td>PA</td>
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<td>Vectical</td>
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<tr>
<td>Veltin +</td>
<td>NPD</td>
<td>PA, AL</td>
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<tr>
<td>Verdeso +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Vusion +</td>
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<td>PA</td>
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<td>Xolegel +</td>
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<td>PA</td>
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<td>Ziana</td>
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<td>PA, AL</td>
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<tr>
<td>Zonalon cream 5%</td>
<td>NPD</td>
<td>QL</td>
</tr>
</tbody>
</table>

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**EAR, NOSE, THROAT MEDICATIONS**

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
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<tbody>
<tr>
<td>Zovirax cream</td>
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<td>QL</td>
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<td>Zovirax oint</td>
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</tr>
<tr>
<td>Ztildo Patch</td>
<td>NPD</td>
<td>PA, QL</td>
</tr>
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- acetosol HC, acetic acid HC otic
- azelastine
- Bactroban nasal oint
- Cetrexal
- cevimeline hcl
- Ciprodex
- ciprofloxacin
- ciprofloxacin-fluocinolone PF otic soln
- cortane B otic drops
- Dermotic
- Evoxac
- fluocinolone acetonide oil
- mometasone furoate nasal spray
- Nasonex
- neomycin/polyoxin/hydrocortisone
- ofloxacin otic
- olopatadine
- Omninair
- Patanase
- pilocarpine HCl
- Qnasl
- ribavirin
- Salagen
- Virazole
<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG TIER</th>
<th>REQUIREMENTS/ LIMITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xhance</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Zetonna</td>
<td>NPD</td>
<td>PA</td>
</tr>
</tbody>
</table>

**DIABETES, THYROID, STEROIDS, & OTHER MISCELLANEOUS HORMONES**

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>TIER</th>
<th>Requirements/Limits</th>
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<tbody>
<tr>
<td>acarbose</td>
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<tr>
<td>Actos</td>
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<tr>
<td>Adlyxin +</td>
<td>NPD</td>
<td>PA</td>
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<tr>
<td>Admelog</td>
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<td>PA, QL</td>
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<tr>
<td>Afrezza</td>
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<td>PA</td>
</tr>
<tr>
<td>Alogliptin benz/metformin hcl</td>
<td>PB</td>
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</tr>
<tr>
<td>Alogliptin benz/pioglitazone</td>
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<td>Amaryl</td>
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<tr>
<td>Androderm patch</td>
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<tr>
<td>Androgel 1.62% Packet, Pump</td>
<td>NPD</td>
<td>PA</td>
</tr>
<tr>
<td>Androgel 1%</td>
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<tr>
<td>Apidra</td>
<td>NPD</td>
<td>PA, QL</td>
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<td>Aved Sohn</td>
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<td>PA</td>
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<td>Axiron</td>
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<td>PA</td>
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<td>Baqsimi</td>
<td>PB</td>
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<tr>
<td>Basaglar +</td>
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<tr>
<td>cinacalcet</td>
<td>PB</td>
<td>PA, QL</td>
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</tbody>
</table>

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**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug  
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MME = Morphine Milligram Equivalent
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**STOMACH, ULCER, & BOWEL MEDS**

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MME = Morphine Milligram Equivalent
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The Injectable Fertility Agents in this section are covered only under certain benefits programs. Please check your handbook to determine coverage.

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**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug
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**ALLERGY, COUGH & COLD, LUNG MEDS**

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<td>Advair HFA</td>
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**VITAMINS & ELECTROLYTES**

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**DIAGNOSTICS & MISCELLANEOUS AGENTS**

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**Bold type** = Brand Name Drug  **Lower case italic** = Generic drug
PA = Prior Authorization  QL = Quantity Limits Apply  SP = Specialty Drug  AL = Age Limit  LCG = Low Cost Generic  LDD = Limited Distribution Drug  SDS = Day Supply Limit  R = Requires Rider  + = PA for Selected NPD  NF = Non Formulary  G = Generic  Q/T = Quantity Over Time  PB = Preferred Brand  NPD = Non Preferred Drug  ACA = $0 Preventative Drug  MME = Morphine Milligram Equivalent
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PROCEDURES THAT SUPPORT SAFE PRESCRIBING

Independence Blue Cross utilizes an independent pharmacy benefits management (PBM) company, FutureScripts®, to manage the administration of its prescription drug programs. As our PBM, FutureScripts® is responsible for providing a network of participating pharmacies, administering pharmacy benefits, and providing customer service to our members and their providers. The effectiveness and safety of drugs and drug-prescribing patterns are monitored by FutureScripts®. Several procedures, such as prior authorization, age limits, and quantity limits, have been established to support safe prescribing patterns and to provide optimal clinical outcomes for members.

**Prior authorization**
Prior authorization is a requirement that your provider obtain approval from your health plan for coverage of, or payment for, prescription drugs. Independence requires prior authorization of certain covered drugs to confirm that the drug prescribed is medically necessary, clinically appropriate, and is being prescribed according to FDA approved labeled or medically accepted use. The approval criteria were developed and approved by the Pharmacy and Therapeutics Committee, a group of physicians and pharmacists from the area.

Using these approved criteria, clinical pharmacists evaluate requests for these drugs based on clinical data, information submitted by the member’s provider, and the member’s available prescription drug therapy history. The clinical pharmacists’ evaluation may include a review of potential drug-drug interactions or contraindications, appropriate dosing and length of therapy, and utilization of other drug therapies, if necessary. Please note, coverage of certain drugs on the formulary (e.g., weight loss drugs, fertility drugs) requires a benefit rider. Please contact the health insurance plan for member eligibility information and benefit details.

**Prior Authorization Requirements for Selected Drugs**
Prior Authorization Requirements for Selected Drugs is in place for certain medications. This expedites the review process by using information available in the member’s pharmacy benefit claim history to determine coverage for the requested medication at the pharmacy. For example, Tirosint® is a medication that requires previous trial of generic levothyroxine. With the Prior Authorization Requirements for Selected Drugs, a member will be able to immediately receive coverage for Tirosint® if the claim history shows a previous paid claim for generic levothyroxine. A manual prior authorization request will not be needed. If the claim history does not show a previous use of either drug (e.g., if the prescriber provided a sample for the member to try) then a prior authorization request will be needed in accordance with the standard prior authorization process.

**Without prior authorization, the member’s prescription will not be covered at the retail or mail-order pharmacy.** The prior authorization process may take up to two business days once complete information from the provider has been received. Incomplete information may result in a delayed decision.

Prior authorization approvals for some drugs may have a limited timeframe, for example six to twelve months. If the prior authorization approval for a drug is limited to a certain time frame, an expiration date will be given at the time the approval is made. If the provider wants a member to continue the drug therapy as requested after the expiration date, a new prior authorization request will need to be submitted and approved for coverage to continue.

(continued)
96-Hour Temporary Supply Program

The 96-Hour Temporary Supply Program is available for certain drugs that require prior authorization. Under the 96-Hour Temporary Supply Program, the dispensing pharmacist has the option to release a 96-hour supply as follows:

1. The dispensing pharmacist may place an override to release a 96-hour supply of the drug to the member with either no out-of-pocket co-pay or the appropriate percentage cost-sharing as defined by the member’s benefit.

2. The next business day, FutureScripts®, will contact the member’s provider to request that he or she submit documentation of medical necessity or medical appropriateness for review.

3. Once the completed medical documentation is received by FutureScripts®, the review will be completed, and the request will either be approved or denied.

4. If approved, the remainder of the prescription may be filled, and the appropriate prescription drug out-of-pocket cost-sharing will be applied.

5. If denied, notification will be sent to both the provider and the member.

Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved. This program limits a one-time release of 96-hour supply per drug. Some drugs, such as branded medications with available generic equivalents, anti-infectives, specialty medications, medications that have risk mitigation evaluation strategies (REMS), products whose packaging cannot be broken (e.g., topical products, injectable kits), are not eligible for the 96-Hour Temporary Supply Program due to packaging or other limitations.
Prior authorization applies to all formulations of the following specific drugs, including but not limited to, tablet, capsule, and oral suspensions. *

Abilify®
Absorica™
Absorica LD™
Abstral®
Acanyia®
Aciplex®
Acetamino® SC
Acitratel™
Actiq®
Aczone®
adapalene pad
Adcirca™
Adderall®
Addyi®
Adempas®
Adhansia™ XR
Adipex P®
Adlyxin™
Advena
Aklief
Ajovy®
Aklief®
Alecensa®
Alphanate®
Alphanine® SD
Alprolix™
Altabax™
Alunbrig™
Alvesco®
Ambien®
Ambien CR®
Amerge®
Amitiza®
amphetamine ER susp
amphetamine
(generic Evekeo)
Amphora™
Amzene™
Anaprox® DS
Androderm®
Androgel®
Apidra®
Apidra® SoloSTAR®
AplenzinTM
Aptensio XR®
Aptiom®
ArazioTM lotion
armodafinil
ArmonAir™
RespiClick®
Arthrotec®
ArymoTM ER
Asacol® HD
Asmanex
Asmanex® HFA
Atacand® (HCT)
Ativan®
Atralin®
Aubagio®
AustedoTM
Auvi-Q®
Avapro®/Avalide®
Aveed®
Avita®
Axert®
AvironTM
AvyakitTM
azelastine/fluticasone
spray
Azelex®
Azor®
Banzel®
Basaglar®
Bebulin®
Beconase AQ®
BelbucaTM
Belsomra®
Belviq® [XR]
BenefIX®
Benica®
Benica HCT®
Benlysta®
Benzaclen®
Benzamycin®
Benzamycinpak®
benzphetamine
Berinert®
Bevespi AerosphereTM
bexarotene
Beyaz®
Bonjesta®
boventan
Bosulif®
Brand prenatal vitamins
Bravelle®
Breeze2 test strips/
glucometer
Briviact®
BrukinsaTM
budesonide-formoterol
butorbital-acetaminophen
50-300mg
Buphenyl®
buprenorphine patch
Butrans®
ByvalsonTM
CabometyxTM
calcipotriene-
betamethasone dp susp
Calquence®
Capex®
CaplytaTM
Caprelsa®
Carac®
Carbaglu®
Carbatrol®
Cardizem® CD
Caverject®
Cayston™
Celebrex®
CerdelgaTM
Cholbam®
Cialis®
Ciclodan®
Cimzia®
Cinryze®
Cleocin T®
Clindagel®
clindamycin/benzoyl
peroxide 1%/5%
clobazam
Clobex®
Cloderm®
Coagadex®
Colchicine
CometrixTM
Comtempa XR ODT™
Concerta®
Contour Glucometer
Contour Next Test Strips
Contour Test Strips
Contrans® ER®
ConzipTM
Cordran®
Corifact®
Corlanor®
CosentyxTM
CotellicTM
Cozaar®/Hyzaar®
Cresemba®
Crestor®
Cuprimine®
Cutivate®
cyclobenzaprine ER
CysstaranTM
DaklinzaTM
dapsone gel 7.5%
Daypro®
DaytranaTM
dayvigoTM
dDAVP®
deferasirox
Delatestryl®
Demerol®
Depo®-Testosterone
desonate®
desoxyn®
dexchlorpheniramine soln
dexedrine®
dexilantTM
dH.E. 45
diabetic test strips
dibenzylamine®
diclegis®
diclofenac gel 3%
diethylpropion HCL
Differin®
dihydroergotamine
Dilaudid®
Diovan® (HCT)
(continued)
Evoclin®
Doral®
Doryx® DR
doxepin tablet
doxycycline DR 40 mg
doxylamine-pyridoxine
Drizalma Sprinkle™
Duac®
Duaklir®
Dulera®
Duobrii™
Dupixent®
Duragesic®
Durlaza®
Duzallo®
Dylanavel XR™
Dymista®
EC-Naprosyn®
Ecoza™
Edarbi™
Edarbyclor™
Edex®
Embeda®
Emflaza™
Emgality®
Enbrel®
Endari™
Estinmar®
Entresto™
Epclusa®
Erivedge™
Erleada®
erlotinib
er taczo®
Esbriet®
esomeprazole
Esperoct®
eszopiclone 3mg
Eucrisa™
Evekeo™
everolimus (generic for Afinitor)
Evocin® foam
Evzio™
Exalgo™
Exelderm®
Exforge® (HCT)
Exjade®
Extavia®
Extina®
Ezzalor™ Sprinkle Cap
Factive®
Fanapt™
Farydak®
Fasenra®
febuxostat
Feiba®
Felbatol®
fentanyl citrate-OTFC
fentanyl citrate tablet
fentanyl transdermal
Fentora®
Ferriprox®
Fetzima™
Fioricet® with Codeine
Fiorinal® with Codeine
Firazy®
Flector® patch
Focalin® XR
Follistim® AQ
Fortamet®
Forteo™
Fortesta™
Freestyle test strips/
glucometer
Frova®
Fulyzaq™
Gattex®
Genotropin®
Gilenya®
Gilotrif™
Gleevec®
Gloperba®
Glucagen® Hypokit®
Gralise™
Grastek®
Haegarda®
Halcion®
Halog®
Harvan®
Helixate® FS
Hemlibra® Soln
Hemofil® M
Hetioz™
Horizant™
Humalog®
Humate-P®
Humatrope®
Humira®
Humulin®
Hyacam®
hydrocodone ER
hydromorphone ER
Hysingla™
Ibrance®
Ibudone®
icatibant inj
Iclusig™
Idelvion®
Idhifa®
imatinib mesylate
Imbruvica™
Imitrex®
Impavido®
Increlex®
Inferhal® LA
indomethacin 20mg
Ingrezza™
Inlynta®
Inrebic®
insulin aspart
insulin aspart protamin
insulin lispro
insulin lispro inj junior
insulin lispro inj protamin
Intermezzo®
Intuniv™
Invega™
Invokamed® [XR]
Invokana®
Isturisa®
Ixinity®
Jadenu™
Jakafi™
Jatenzo®
Jentadueto™
Jornay™ PM
Jublia®
Juxtapid™
Jynarque®
Kadian®
Kalydeco™
Kapvay®
Kateria™
Kazano®
Kenalog™
Keppra®
Kerydin™
Kevevis®
Kevzara®
Khedezla®
Kinere®
Kisqali™
Klonopin®
Koate-DVI
Kogenate® FS
Korlym™
Koselugo™
Kynamro®
Lamictal® (ODT)
Lansoprazole Solutab
Latuda®
Lazanda®
ledipasvir-sofosbuvir
Lenvima™
Letairis®
Levemir®
Levitra®
Lexapro®
Lidoderm®
Lipitor®
Livalo®
Locoid®
Locoid® lipocream
Lo Loestrin FE®
Lomaira™
Lonhala™ Magnair™
Lonsurf®
Lopro™
Lorzone®
Lotronex®
Lovaza®
Lunesta®
Luxiq®
Luzu®
Lynparza™
Lyrica®
Lyrica® CR
Mavyret™
Maxalt® (MLT)
Mekinist®
Menopur®
methadone
methotrexate sodium inj
methyltestosterone

(continued)
Micardis® (HCT)  
miglustat  
Migranal®  
Minastrin® FE  
Minocin®  
minocycline ER cap  
Mitigare®  
Mobic®  
modafinil  
mometasone furoate  
Monoclate-P®  
Monodox®  
Mononine  
MorphaBond™ ER  
morphine ER  
Motegrity™  
Movantik®  
MS Contin®  
Muse®  
Myalept™  
Mydayis™  
Mytesi™  
Naprelan®  
Naprosyn®  
Nascobal®  
Nasonex®  
Natco®  
Nator®  
nitishine  
Noctiva™  
Non Preferred Diabetic Meters  
Norco®  
Norditropin®  
Northera™  
Nourianz™  
Novoeight®  
Novoseven® RT  
Noxafil®  
Nubeqa™  
Nucala® Soln  
Nucynta®  
Nucynta ER®  
NuedextraTM  
NupladizTM  
Nurtec™ chw ODT  
Nutropin® (AQ)  
Nuvigil®  
Nuwiq®  
Obizur  
OcalivaTM  
Odactra® SL  
Odomzo®  
Ofev®  
Olumiant®  
Olux®[E]  
Omnaris®  
Omnitrope®  
Onexton™  
Onfi®  
OnmelTM  
Onzeta XsailTM  
Pana®  
Pana ER®  
Opsumit®  
Oracea®  
Oralair®  
Orenicia® SQ  
OrenitramTM  
Orfadin®  
OrkambiTM  
Oseni®  
OtezlaTM  
OtrexupTM  
OxbrytaTM  
oxiconazole nitrate  
Oxistat®  
Oxtellar® XR  
oxycodone ER  
Oxycontin®  
oxymorphine ER  
Ozempic®  
OzobaxTM  
PalfoziaTM cap/powder  
PametorTM  
Pandel®  
PemazyreTM  
penicillamine capsule  
Penlac®  
Penna®d®  
Percocet®  
phendimetrazine tartrate  
Picato®  
Piqray®  
Pomalyst®  
Praluent®  
Precision Glucometer  
Precision XTRA Test Strips  
Pretonamid®  
Prevacid®  
Prilosec®  
PristiqTM  
ProAir®DigihalerTM  
Proctocort® Supp 30mg  
Procyso®  
Profiling®  
Prolact™  
Promacta™  
Protonix®  
Protopic®  
Proventil® HFA  
Provigil®  
Prozac®  
QnaslTM  
Qsymia® ER  
Qtern®  
Qualaquin®  
Quedxy® XR  
QuilliChew® ER®  
Quillivant® XR™  
quinine sulfate  
Qvar RediHaler®  
rabeprazole  
Ragwitek™  
Rasuvo™  
Ravicti™  
Rayaldee®  
Rayos®  
Rebif®  
Rebif® Rebido®  
Rebivyn®  
Recombinate™  
Regimen®  
Regranex®  
Relafine®  
ReliOn®  
Relistor®  
Relpax®  
Repatha™  
Rescula®  
Restori®  
Retin-A® (Micro)  
RevatioTM  
Revlimid®  
Rexulti®  
Reyvow™  
Rhopressa®  
Riaisto®  
RinoQ™  
Ritalin® LA  
RixubisTM  
Roxicodone®  
RozlytrekTM  
Rubraca®  
Ruconest®  
Ruzurgi®  
RycloraTM  
Rydapt®  
RytaryTM  
Sabril®  
Safyral®  
Saizen®  
SamscaTM  
Saphris®  
Saxenda®  
Secuado®  
Segluromet®  
SernivoTM  
Serostim®  
Signifor®  
sildenafil  
Silenor®  
SiliqTM  
SimponiTM  
SirturoTM  
SivextroTM  
Skelaxin®  
SkyriziTM  
sofosbuvir-velpatasvir  
Solaraze® Gel  
Soliqua™  
Solodyne®  
Sonata®  
SovaldiTM  
Sprycel®  
Staxyn™  
Stelara®  
(continued)
Compound products with total cost equal to or greater than $75 per prescription

1 All brand prenatal vitamins require prior authorization
2 All diabetic test strips require prior authorization except for OneTouch®
*Compound products with total cost equal to or greater than $75 per prescription

Stendra™
Stivarga®
Strattera™
Stresnil™
Striant®
Subsys®
sulconazole
sumatriptan/naproxen
Sunosi™
Sutent®
Sylatron™
Symdeko®
Symlin®
Sympazan™ Film
Synalar®
Syprine®
Taclonex®
Tafinlar®
Tagrisso™
Taltz Autoinjector®
Tanzeum™
Tarceva®
Targadox™
Targetin®
Tasigna®
Tazverik™
Technivie™
Tegretol® [XR]
Tekturna® (HCT)
Temixys™
Temodar® Oral
temozolomide
Tenoretic®
Tenormin®
Teriparatide® inj
Testim®
testosterone cypionate solution
testosterone enanthate
testosterone topical
Thalomid®
Thiola®
Tirosint®
Tivorbex®
Topamax® Sprinkle
Topamax® tab
Topicort®
topiramate ER sprinkle
Tosymra™
Toviaz™
Tracleer®
Tradjenta™
Trelgy™ Ellipta®
Tremfya™
Tresiba®
Tretten®
Treximet™
triamicinolone 0.05%
ointment
TrianeX®
Tribenzor®
Trikafta™
Trintellix®
Trokendi®XR
Trulance™
Tudorza® Pressair®
Tukysa™
Turalio™
Twynsta®
Tykerb®
Tylenol® w/Codeine
Tymlos™
Tyvaso®
Ubrelyv™
Uloric®
Ultrace®
Ultram®
Ultravate®
Uptravi®
Utibron™ Neohaler
Valchlor™
Valium®
Valtoco®
Valtrex™
Vascepa®
Vasotec®
Vecamyl™
Veltin™
Vencllexa®
Ventavis®
Ventolin® HFA
Verdeso®
Verzenio™
Viagra®
Viberzi™
Vibramycin®
Viekira Pak™
Viibryd®
Vivlox™
Vogelxo®
Voltaren XR®
Vovirex®
Voxeo®
Waxi®
Wellbutrin® XL
Wilate®
Xadago™
Xalkori®
Xanax®
Xcopia® pak/tab
Xeljanz® [XR]
Xenazine™
Xenical®
XermeloTM
Xhance™ MIS 93mcg
Xiaflex®
Xigela®
Ximelagát®
Ximino ER™
Ximino™
Xofigo®
Xofigo™ Pak
Xtampza® XR
Xtandi®
Xultophy®
Xuriden™
Xyntha®
Xyrem®
Zavesca®
Zejula™
Zelboraf®
Zelnorm®
Zembrace Symtouch™
Zepatier™
Zestil®
Zetia®
Zetona™
Ziana®
Zioptan™
Zipact™
Zmax™
Zohydro® ER
Zolpidem 10mg
Zolpidem ER 12.5mg
Zolpidem SL 3.5mg
Zomacton™
Zomig® (ZMT)
Zomig Nasal Spray
Zonegran®
Zorbtive™
Zorvulex®
Zurampic®
Zydelig®
Zykadia™
Zypitamag™
Zyvox®

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Safety Edits

Safety edits are applied to prescription medications to ensure safe and appropriate use of drugs. They are designed to align with the clinical practice guideline and FDA approved use outlined in the manufacturer package insert. The FDA approves drugs through an extensive process called a New Drug Application (NDA) Review, which establishes specific guidelines that govern drug prescribing practices. These guidelines are designed to prevent potential harm to patients. There are safety edits that are based on the maximum daily dose approved by the FDA, the drug formulation and the availability of multiple strengths of the drug where a dose can be achieved with another available strength and/or standard dosing. Some of these safety edits will prompt member counseling at the point of sale (POS), while some will require prior authorization review. Examples of safety edits are age limits, quantity limits, morphine milligram equivalent (MME) limits and concurrent drug utilization review (cDUR).

Age Limits

Some drugs, such as zafirlukast, are approved by the FDA only for individuals age five and older. If the member’s prescription falls outside of the FDA guidelines, it may not be covered unless prior authorization is obtained. In addition, an age limit may be applied when certain drugs are more likely to be used in certain age groups. For example, drugs to treat Alzheimer’s disease may require prior authorization for use in young adults. The provider may request coverage for drugs outside of the age limit when medically necessary. The approval criteria for this review were developed and approved by the Pharmacy and Therapeutics Committee. The member should contact the provider to initiate the prior authorization process.

Quantity Limits

Quantity limits are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses, standard dosing, and/or length of therapy of a drug. Independence has several different types of quantity limits that are explained in detail below. The purpose of these limits is to ensure safe and appropriate utilization. If a member requires more than the limit, the member’s provider will need to submit a prior authorization request. Similar to other prior authorization requests, quantity limit override requests for certain drugs may have a limited approval timeframe.

- **Quantity Over Time:** This quantity limit is based on dosing guidelines over a rolling time period. For example, if a drug has a quantity limit over a 30-day time period and a member went to the pharmacy on January 1, 2020, for one of these medications, the plan would have looked back 30 days to December 2, 2019, to see how much medication was dispensed. The purpose of these limits is to prevent the dispensing of excessive quantities. Examples of quantity limits over time are:
  - Nuvaring® = 1 ring per 28 days
  - Ibandronate (Boniva®) 150mg = 1 tablet per 30 days
  - Sumatriptan (Imitrex®) 50mg = 18 tablets per 30 days
  - Diabetic supplies such as blood glucose test strips = 200 strips per 30 days
  - Sildenafil (Viagra®), tadalafil (Cialis®) 10mg, 20mg) = 8 tablets per 30 days

- **Maximum daily dose:** This quantity limit defines the maximum number of units of the drug allowed per day. Examples of maximum daily dose quantity limits are:
  - Zolpidem (Ambien®) = 1 tablet per day
  - Oxycodone/acetaminophen (Percocet®) 5/325mg = 12 tablets per day
  - Guanfacine Extended Release 24 Hour = 1 tablet per day

(continued)
• **Refill too soon:** This limit is in place to encourage appropriate utilization and minimize stockpiling of prescription medications. Based on this edit, a member can receive a refill of a prescription after 75% utilization. Additional refills will be covered once 75% of the supply has been consumed. The following examples illustrate how refill too soon limit works:

  - A 30 days’ supply of a prescription filled on 1/1/2020 will be refillable again on or after 1/24/2020
  - A 90 days’ supply of a prescription filled on 7/1/2020 will be refillable again on or after 9/7/2020

• **Day Supply Limit:** This limit is based on the day supply and not the quantity. However, quantity limits may apply as well. Day Supply Limits apply to some classes of drugs, such as opioids. If a quantity limit applies, the member will also be limited to the maximum daily dose for that drug. The following are examples of drugs that have a day supply and a quantity limit:

  - Short acting opioids, such as oxycodone/acetaminophen 5mg/325mg
    - Day supply limit = Two 5 days’ supplies limit per 60 days for adults, two 3 days’ supply limit for children under 18 years of age.

  - Butalbital containing headache agents, such as butalbital/aspirin
    - Day supply limit = 5-day supply per 30 days
    - Quantity Limit = 6 tablets per 1 day
    - Maximum quantity allowed without prior authorization = 30 tablets (6 tablets per day for 5 days)

  - Opioid containing cough and cold products, such as hydrocodone/homatropine
    - Day supply limit = Two 5 days’ supplies limit per 60 days for adults, two 3 days’ supply limit for children under 18 years of age.
    - Quantity Limit = 30 ml per 1 day
    - Maximum quantity allowed without prior authorization = 150 ml (30 ml per day for 5 days)

**Morphine Milligram Equivalent (MME) Limit**

Independence applies additional safety measures to opioid products by limiting the total daily dose. This limit accounts for various opioid products through a measurement called the Morphine Milligram Equivalent (MME) dose. The MME is a number that is used to determine and compare the potency of opioid medications. It helps to identify when additional caution is needed. The daily limit is calculated based on the number of opioid drugs, their potencies and the total daily usage. Prior authorization is required for an opioid dose that exceeds 90 MME per day. MME Limit applies to the opioid products containing the active ingredients listed below:

<table>
<thead>
<tr>
<th>Active Ingredient</th>
<th>codeine</th>
<th>dihydrocodeine</th>
<th>fentanyl</th>
<th>hydrocodone</th>
</tr>
</thead>
<tbody>
<tr>
<td>hydromorphone</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>levorphanol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>morphine</td>
<td></td>
<td></td>
<td>oxycodone</td>
<td>oxymorphone</td>
</tr>
<tr>
<td>morphine</td>
<td>Opium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tapentadol</td>
<td>Tramadol</td>
<td></td>
<td></td>
<td>benzhydrocodone</td>
</tr>
</tbody>
</table>

*(continued)*
Cumulative Stimulant Limit
CNS stimulants such as amphetamine and methylphenidate, when used in high doses, are associated with increased risk for cardiac related adverse events such as hypertension and new or worsening psychosis including manic behavior. Cumulative stimulant limit is a safety measure designed to ensure the provider has assessed the members for alternative medication and advised the members about the risks associated with stimulant use. The cumulative stimulant limit works by calculating the total daily stimulant dose by the drug’s active ingredient. Stimulant claims that exceed the limit outlined below would require prior authorization.

<table>
<thead>
<tr>
<th>Active ingredient</th>
<th>Medications impacted (brands and generics)</th>
<th>High cumulative daily dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amphetamine</td>
<td>Adzenys ER[ODT], Dyanavel, Evekeo [ODT]</td>
<td>60mg/day</td>
</tr>
<tr>
<td>Amphetamine-Dextroamphetamine</td>
<td>Adderall [IR/XR], Mydayis</td>
<td>60mg/day</td>
</tr>
<tr>
<td>Dextroamphetamine</td>
<td>Dexedrine, Zenzedi, ProCentra</td>
<td>60mg/day</td>
</tr>
<tr>
<td>Lisdexamfetamine</td>
<td>Vyvanse</td>
<td>70mg/day</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>Desoxyn</td>
<td>60mg/day</td>
</tr>
<tr>
<td>Dexamethylphenidate</td>
<td>Focalin [IR/XR]</td>
<td>40mg/day</td>
</tr>
<tr>
<td>Methylphenidate</td>
<td>Ritalin [IR/LA], Daytrana, Cotemp-</td>
<td>72mg/day</td>
</tr>
<tr>
<td></td>
<td>pla, Metadate [ER/CD], Methylin,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quillivant XR, Concerta, Aptensio</td>
<td></td>
</tr>
<tr>
<td></td>
<td>XR, QuilliChew ER, Jornay PM, Adhansi</td>
<td></td>
</tr>
</tbody>
</table>

*Prior authorization and other safety edits including quantity limit and age limit continue to apply.

Concurrent Drug Utilization Review (cDUR)
CDURs are built into the pharmacy claim adjudication system to review a member’s prescription history for possible drug related problems including drug-drug interactions and drug therapy duplications. Drugs may reject at the Point-of-Sale (POS) and/or generate a message to the dispensing pharmacist when there is a safety concern. The dispensing pharmacist can review the issue with the provider and override the rejection if appropriate for most edits. Examples of cDURs are:

- Drug-drug interaction: sildenafil (Viagra®/Revatio®) and nitroglycerin in combination may lead to potentially fatal hypotension.
- Drug therapy duplication: Simvastatin and atorvastatin in combination will trigger a message in the claim adjudication system to alert the dispensing pharmacist there is a duplication of statin therapy.

To determine if a covered prescription drug prescribed for you has a prior authorization requirement, an age limit, a quantity limit, or a morphine milligram equivalent (MME) limit, see the plan website at https://www.ibx.com/rx or call FutureScripts® at the phone number on the back of your ID card.
How to submit a Prior Authorization

The process for requesting a prior authorization/preapproval or override is as follows:

- The provider prescribing the drug can access electronic prior authorization (ePA) platforms such as CoverMyMeds® and SureScripts™ to submit a prior authorization request. Alternatively, the provider can complete a prior authorization fax form or write a letter of medical necessity and submit it to FutureScripts® by fax at 1-888-671-5285. The forms are available online at: https://www.futurescripts.com/prior-authorization1.html.

- FutureScripts® will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review the document.

- A decision is made regarding the request.

- If approved, the provider will be notified of the approval via fax and/or telephone, and the pharmacy claim adjudication system will be coded with the approval. Note: ePA approval can occur in real time, this means the member can be approved for the drug prior to leaving the provider’s office with a prescription. The member may call the Customer Service phone number on his or her ID card to determine if the request is approved.

- If denied, the prescribing provider will be notified via letter, fax, or telephone. The member is also notified via letter. The appeals process is detailed within the denial letters sent to the member and provider.

Formulary Exception Requests

Tier exceptions: Providers may request consideration for preferred coverage of a non-preferred drug when there has been a trial of, or contraindication to, at least three formulary alternatives when applicable.

- Requests for a generic medication that is located on the non-preferred drug tier to be lowered to the generic tier will be approved if the exception criteria are met.

- Requests for a brand medication or an authorized generic that is located on the non-preferred drug tier to be lowered to the preferred brand tier will be approved if the exception criteria are met.

Please note, restrictions apply to formulary exception requests. Drugs on the generic tier, the preferred brand tier and the specialty tier are not eligible for tier exceptions. Tier exceptions are not available under some plans; please refer to the member benefit booklet for details.

When requesting an exception, the provider should complete the formulary exception request form, providing detail to support the request, and fax the request to 1-888-671-5285. If the formulary exception request is approved for a non-preferred drug, the drug will pay at the appropriate preferred brand or generic level of cost-sharing. If the request is denied, the member and provider will receive a denial letter with the appropriate appeals language. The forms are available online at: https://www.futurescripts.com/prior-authorization1.html.

Appealing a decision

If a request for prior authorization or exception results in a denial, the member, or the provider on the member’s behalf (with the member’s consent), may file an appeal. Both the member and his or her provider will receive written notification of a denial, which will include the appropriate telephone number and address to direct an appeal. To assist in the appeals process, it is recommended that the provider be involved to provide any additional information on the basis of the appeal.
Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.