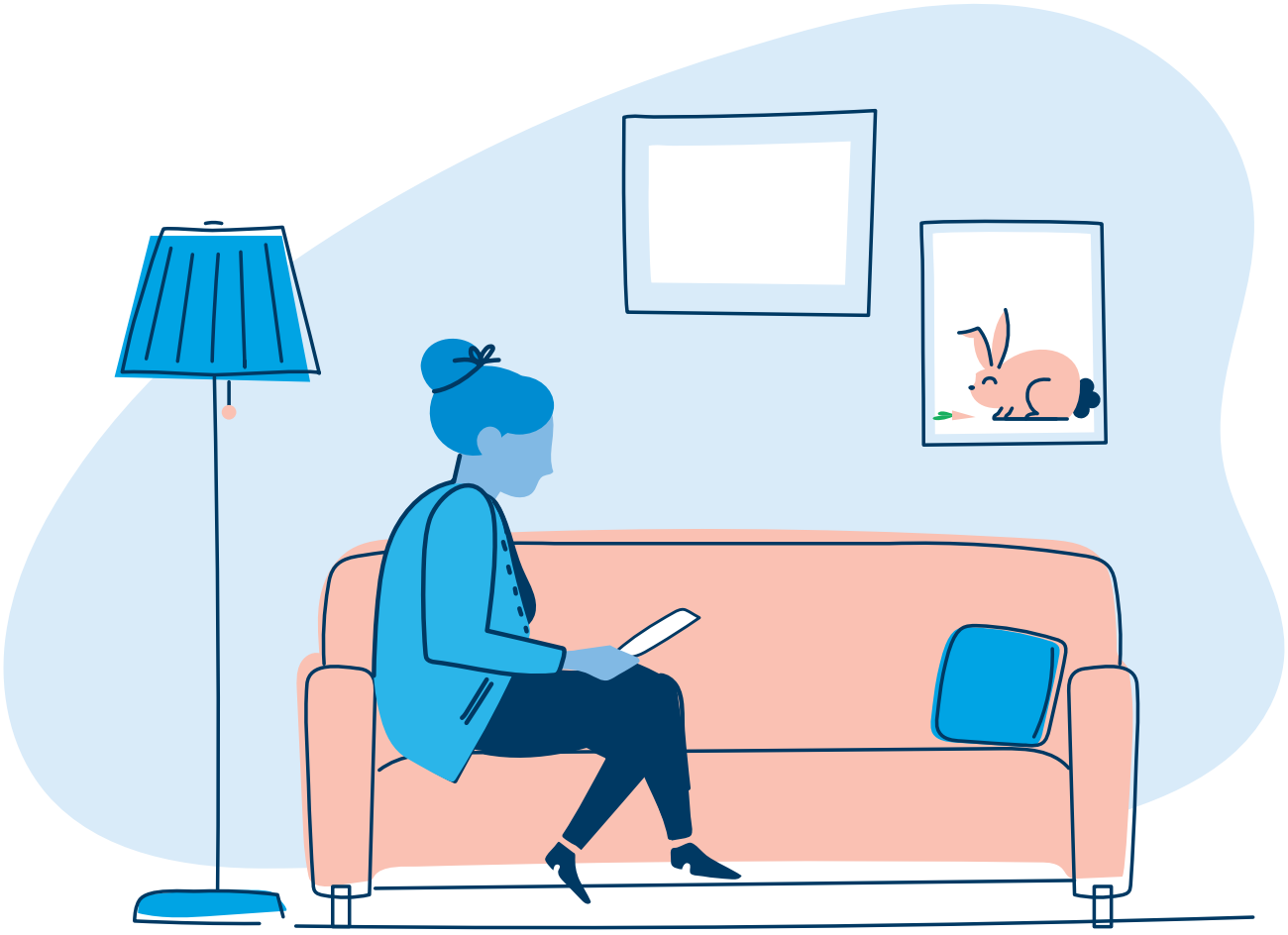
HIGHMARK
NORTHEASTERN NEW YORK

Medicare Employer Group



2023 CASHIC - Cobleskill CSD Medicare

Forever Blue PPO 799 Plan CF38 TRx (PPO)

Y0037_22_6461_M

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Welcome to the Benefit of BlueShield

We know that understanding Medicare and choosing a health plan are not always easy. Everyone is different, and BlueShield of Northeastern New York is here to help guide you to the plan that works best for you.

Robust local network

BlueShield Medicare Advantage plans connect you to the doctors and hospitals you trust the most. When you choose Blue, you carry the security of a card accepted at all Capital Region hospitals and the region's leading health systems and medical practices, including:

- Albany Medical Center
- CapitalCare Medical Group
- Community Care Physicians P.C.
- Ellis Hospital
- Glens Falls Hospital
- Hudson Headwaters Health Network
- Irongate Family Practice
- Samaritan Hospital
- Saratoga Hospital
- St. Peter's Health Partners

Security of a card accepted worldwide

When you travel, feel safe knowing BlueShield is your direct link to emergency care anywhere. Just show your member ID card at any hospital in the world and you'll receive care.

BLUE CONCIERGE

Ring the bell for Blue Concierge

Our exclusive Blue Concierge service connects you with a dedicated, knowledgeable team ready to help you get the most from your Medicare coverage. Our Blue Concierge team can help you understand your benefits and how they work, find providers, and even assist in scheduling appointments with doctors and specialists.

We're here to help

Please call us if you have any questions regarding your plan options.
1-855-215-9239 (TTY 711)

We're available:
Monday – Friday, 8 a.m. – 5 p.m.

HIGHMARK. NORTHEASTERN NEW YORK

Medicare Sales: 1-855-215-9239 (TTY 711)

Monday-Friday: 8 a.m. - 5 p.m.

GROUP NAME:

GROUP NUMBER:

PLAN NAME: Forever Blue PPO 799 Plan CF38 TRx (PPO) (2023)

Physician and other health professional services	In-Network	Out-of-Network
Primary doctor	$15	$20
Specialist	$15	$20
Radiation therapy	Covered in full	Covered in full
Emergency room (waived if admitted)	Covered in full	Covered in full
Urgent care (waived if admitted)	Covered in full	Covered in full
Ambulance	Covered in full	Covered in full
Telemedicine	Covered in full	Covered in full
More than 20 preventive services	In-Network	Out-of-Network
Flu shots – Part B	Covered in full	Covered in full
Immunizations – Part B (hepatitis/pneumonia)	Covered in full	Covered in full
All other preventive screenings and tests	Covered in full	Covered in full
Hospital, home health care, and skilled services	In-Network	Out-of-Network
Hospital (inpatient)	Covered in full	Covered in full
Observation	Covered in full	Covered in full
Outpatient surgery – hospital	Covered in full	Covered in full
Outpatient surgery – ambulatory center	Covered in full	Covered in full
Home health care	Covered in full	Covered in full
Skilled nursing facility (100 days per benefit period)	Covered in full	Covered in full
Dialysis	Covered in full	Inside service area: 20% for non-participating providers. Outside service area: $0 for non-participating providers.
Mental health / chemical dependence services	In-Network	Out-of-Network
Mental health (inpatient, 190-day lifetime limit)	Covered in full	Covered in full
Mental health (outpatient)	Covered in full	Covered in full
Mental health (with psychiatrist)	Covered in full	Covered in full
Alcohol substance abuse (inpatient)	Covered in full	Covered in full
Alcohol substance abuse (outpatient)	Covered in full	Covered in full

Laboratory and X-ray services	In-Network	Out-of-Network
Laboratory testing	Covered in full	Covered in full
X-rays	Covered in full	Covered in full
Advanced radiology – MRI, MRA, PET, and CT	Covered in full	Covered in full

Rehabilitation services	In-Network	Out-of-Network
Physical, occupational, and speech therapy	Covered in full	Covered in full
Chiropractor includes 12 routine visits	$15	$20
Acupuncture & Massage Therapy	$500 combined annual allowance	
Cardiac rehab	$15	$20

Vision	In-Network	Out-of-Network
Routine vision exam	$15	Covered in full
Medical vision exam	$15	$20
Allowance (lenses and frames)	$200 annual allowance	

Hearing	In-Network	Out-of-Network
Routine hearing exam – TruHearing™	$45	$45
Diagnostic hearing exam	$15	$20
Hearing aid benefit – TruHearing™	$699/$999	

Dental	In-Network	Out-of-Network
Dental	$200 annual allowance	

Supplies, equipment, and devices	In-Network	Out-of-Network
Durable medical equipment	$0 compression stockings; 20% all other items	20%
Prosthetics	$0 diabetic shoes/inserts; 20% all other items	20%
Diabetic supplies – Part B	Covered in full	20%

Fitness program	In-Network	Out-of-Network
SilverSneakers (“Steps” program included)®	Covered in full	

Prescription drugs – Part B	In-Network	Out-of-Network
Immunosuppressive drugs	Covered in full	Covered in full
Oral chemotherapy drugs	Covered in full	Covered in full
Physician administered injectables	Covered in full	Covered in full
Nebulizer inhalation solution	Covered in full	Covered in full
Part B drugs (other)	Covered in full	Covered in full

Prescription drugs – Part D	In-Network	Out-of-Network
Prescription drug (Rx)	Preferred pharmacies: $0/$5/$5/$10/$10 Standard pharmacies: $5/$10/$10/$15/$15	
Mail order	Tier 1: $0 copay for a 90 day supply; Tier 2 - Tier 4: 2 copays for a 90 day supply	
Shingles vaccine	Preferred pharmacies: $0 Standard pharmacies: $5	
Coverage gap/donut hole	No coverage gap	

General product information	In-Network	Out-of-Network
In-network out-of-pocket maximum	N/A	N/A
Combined out-of-pocket maximum	$4,500 Combined	
Prescription deductible	N/A	

Highmark Blue Shield of Northeastern New York (Highmark BSNENY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark BSNENY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark Blue Shield of Northeastern New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Onduo is an independent company that provides a diabetes management program on behalf of Highmark. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing aid benefit. SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit. American Well is an independent company that provides telemedicine services. American Well does not provide Blue Cross and/or Blue Shield products or services and it is solely responsible for its telemedicine services. Other pharmacies/physicians/providers are available in our network. Out-of-network/noncontracted providers are under no obligation to treat Highmark BSNENY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).
请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

Forever Blue PPO

Flexibility and freedom of choice

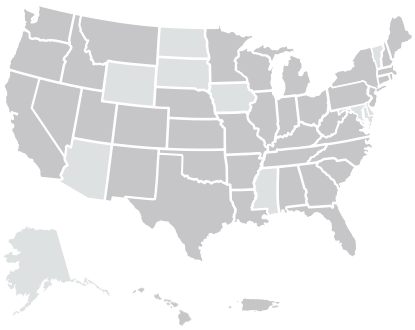
- Access to in-network and out-of-network doctors
- Comprehensive coverage when you travel throughout the nation

With a PPO (Preferred Provider Organization) plan, you can receive care within a network of doctors and hospitals, including our network and the BlueCard® network sharing program. You can also use out-of-network doctors and hospitals that accept Medicare for your covered services. If you see an out-of-network provider, your costs may be more than if you used an in-network provider.

If you travel often, enjoy the flexibility of BlueCard network sharing. BlueCard links all BlueCross and/or BlueShield plans — when you travel, you receive the same great care you're used to getting at home and pay the same as you would in-network for all plan-covered services.

In order for your services to be considered in-network while outside the service area:

- The provider must participate with the local BlueCard network sharing program in the service area.
- Both you and the provider must be located in the same service area when you receive care.



AL, AR, AZ, CA, CO, CT, FL, GA, HI, ID, IL, IN, KS, KY, LA, ME, MA, MI, MN, MO, MT, NE, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, TN, TX, UT, VA, VT, WA, WI, WV, PR.

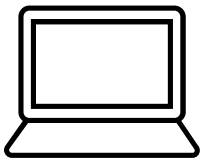
Outside the U.S. you can receive emergency and urgent care. You may be asked to pay 100% of the cost at the time of your service. You would then submit a claim to us to be reimbursed for your portion of the cost.

Ways to find out if a doctor or facility participates in the BlueCard network sharing program:

Call 1-800-810-BLUE (2583) (TTY 711), option 2

Visit **bsneny.com/medicare**

Access your benefits wherever you go

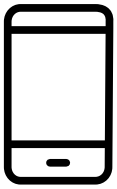


Manage your plan online

As a Highmark Blue Shield of Northeastern New York member, you have a personalized member homepage.* Here you can access key resources to help manage your plan online, 24/7.

Visit **medicare.highmark.com** to get started. You can:

- View plan benefits.
- Access recent claims.
- Find a nearby doctor, hospital, or pharmacy.
- Compare treatment options and estimate health care and pharmacy costs.
- Review your doctor.
- View and order replacement member ID cards.



Mobile app

With our user-friendly mobile app, you can view plan information, search for providers, and view the status of your claims. Download the app by searching for Highmark Blue Shield of Northeastern New York in the App Store (Apple devices) or Google Play (Android devices).

Away From Home Care®

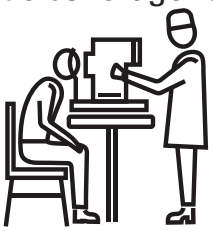
Spend up to 12 months each year out of your local service area and remain covered through that locality's Blue Cross and/or Blue Shield health plan. Perfect for retirees who enjoy traveling.

*The personal information you enter is secure and protected.

Vision Benefits

All of our Medicare Advantage plans include coverage for:

- Annual routine eye exam*
- Glasses or contacts after cataract surgery*



- Glaucoma screening
- Diagnostic eye exam
- Diabetic retinal eye exam

With BlueShield of Northeastern New York, you can find the right optometrists, ophthalmologists, and other medical providers to meet your health care needs. Visit **bsneny.com/medicare** to see if your provider participates with our plan. Our website includes both a provider directory in PDF format and an easy provider search tool.

Vision allowance*

If you're enrolled in a plan that offers a vision allowance, you can use those dollars to purchase:

- Contacts (conventional or disposable)
- Frames
- Lenses (single vision, bifocal, trifocal, lenticular)
- Lens enhancements (antireflective coating, tint, scratch-resistance)

Use your vision dollars to purchase from our Davis Vision providers.

America's Best Contacts & Eyeglasses

Visionworks

Walmart Retail Locations

*You must see a Davis Vision provider in order for coverage to be considered in-network.

Dental Allowance

Dental care is important to your overall health. That's why most of our plans provide you with a dental allowance to help cover some of your dental care costs.

It's simple — there's no dental network, so you can see any dentist you choose. You pay up front for your dental care, complete the dental reimbursement form, attach your itemized bill and paid receipt, and mail these materials to us.

Your annual dental allowance can be used for:

- Cleanings
- Periodontal cleanings
- Crowns
- Fillings

You can also use your dental allowance for any other dental services you may need throughout the year, and copays or coinsurance to reimburse yourself if you already have dental coverage.

Reimbursement

Please allow 4–6 weeks for processing and reimbursement once we receive your request.

If you have any questions, need help completing the reimbursement form, or need extra copies, please call us.

1-800-329-2792 (TTY 711)
October 1 – March 31, 8 a.m. – 8 p.m., 7 days a week
April 1 – September 30, 8 a.m. – 8 p.m., Monday – Friday

Better Hearing, Better Health

Good hearing is important to your overall health. That's why BlueShield of Northeastern New York offers a hearing-aid benefit through TruHearing®. Our benefit covers up to two hearing aids per year (one per ear) and makes payments more affordable at $999 per hearing aid or less.

Our hearing benefit gives you:

- State of the art technology — natural, clear, lifelike sound in virtually all environments
- Personalized care — meet with a local provider for your hearing exam plus three follow-up visits for fittings and adjustments
- Peace of mind — all hearing aids come with a three-year warranty, 45-day trial period, 48 free batteries, and guides to get you started

TruHearing Advanced 32 channels | 6 programs	**TruHearing Premium*** 48 channels | 6 programs	**Routine Exam** In-Network[2]
Retail: **$2,445/aid**	Retail: **$3,125/aid**	
You pay: **$699** copay/aid	You pay: **$999** copay/aid	See your Evidence of Coverage for exam fee

*Rechargeable battery upgrade option on TruHearing Premium RIC Li for $50 per aid

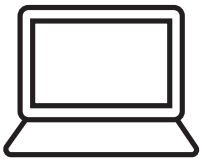
[1] Smartphone-compatible hearing aids connect directly to iPhone, iPad, and iPod Touch devices. Connectivity also available to many Android phones with use of an accessory.

[2] Must be performed by a TruHearing network provider.

Call TruHearing to learn more and schedule an appointment:
1-844-208-2470 (TTY 711)
Hours: 8 a.m. – 8 p.m., Monday – Friday
Visit: **truhearing.com/select**

Three follow-up visits must be used within one year after the date of initial purchase. Free battery offer is not applicable to the purchase of rechargeable hearing-aid models. Three-year warranty includes repairs and one-time loss-and-damage replacement. Hearing-aid repairs and replacements are subject to provider and manufacturer fees. For questions regarding fees, contact a TruHearing hearing consultant.

Access Your Benefits Wherever You Go



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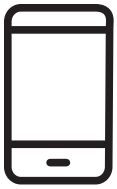
Visit **bsneny.com/register** to get started. You can:

- View plan benefits
- Access recent claims
- Find a nearby doctor, hospital, or pharmacy
- Compare treatment options and estimate health care and pharmacy costs
- Review your doctor
- View and order replacement member ID cards



Mobile app

With our user-friendly mobile app, you can view plan information, search for providers, and view the status of your claims. Download the app by searching for BlueShield of Northeastern New York in the App Store (Apple devices) or Google Play (Android devices).

Traveler benefit

Our BlueCard® network sharing program gives you the flexibility to receive care as if you were in-network while visiting or traveling throughout the country. You can remain out-of-network for the entire year and have the flexibility to select the participating provider of your choice. This benefit is available with our BlueShield Forever Blue PPO plan.

*The personal information you enter is secure and protected.

$0 Preventive Services

It's safer, easier, and more cost-effective to prevent health issues than to treat them. That's why we offer you more than 20 Medicare-covered preventive services at a $0 copay.* These services include:

- Abdominal aortic aneurysm screening
- Alcohol misuse screening and counseling
- Annual wellness visit
- Bone mass measurement (bone density test)
- Cardiovascular disease (behavioral therapy)
- Cardiovascular screenings (blood tests such as cholesterol, lipids, triglycerides)
- Cervical and vaginal cancer screenings
  - Pap smears and pelvic exams
- Colorectal cancer screenings
  - Barium enema
  - Colonoscopy
  - Fecal occult blood test
  - Flexible sigmoidoscopy
- CT screening for lung cancer
- Depression screening
- Diabetes screening tests
- Diabetes self-management training
- EKG as a result of the Welcome to Medicare initial preventive physical exam (IPPE)
- Flu (influenza) vaccine**
- Hepatitis B vaccine
- Hepatitis C virus screening (HCV)
- HIV screening
- Immunizations Part B (other)
- Mammogram (breast cancer screening)
- Medical nutrition therapy services
- Medicare Diabetes Prevention Program (MDPP)
- Obesity screening and counseling
- Pneumonia (pneumococcal) vaccine
- Prostate cancer screenings
- Sexually transmitted infections (STI) screening and counseling
- Tobacco-use cessation (counseling to stop smoking or tobacco use)
- Welcome to Medicare IPPE

* A $0 copay applies when using an in-network provider. To find an in-network provider near you, contact customer service.

** You have the option to go to your doctor or any in-network pharmacy to receive your flu vaccine. Pharmacies will bill us directly; there is no paperwork involved.

Health and wellness programs

Online health and wellness tools

A wide range of health and wellness tools are just a click away, 24 hours a day, seven days a week. Register as a member at **bsneny.com** to access these exclusive health tools.

MyHealth

MyHealth is a free online resource to help you and your family live healthier. With *MyHealth*, you can create a personalized dashboard to view your health data, track your progress with interactive tools, and engage in health and wellness programs that are just right for you.

With *MyHealth,* you can access:

- **Personal health itinerary** — follow a data-driven, personalized action plan based on your specific needs
- **Healthy living content** — view an ongoing calendar of wellness content, activities, and challenges
- **Tracking dashboard** — record your physical activity and measurements for blood pressure, weight, sleep, and more

Start with a health assessment

This quick, easy, and confidential online survey takes about 15 minutes to complete, and will help you build a personal health itinerary you can use to determine what health areas you may need or want to address.

Community wellness

We are committed to helping you take an active role in your health. We work with hospitals, nonprofit agencies, and community health educators to offer a variety of local classes, support groups, and workshops in the Capital Region.

- Alcohol and substance abuse
- Back care
- Diabetes
- Heart health
- Maternal and infant health
- Nutrition
- Physical activity and fitness
- Senior health
- Smoking cessation
- Stress management
- Weight management
- Women's health

Health coaching

Health coaches are trained professionals — registered nurses, nutritionists, health educators, and exercise physiologists. Our health coaches can educate, motivate, and support you with regard to health risks, guiding you to better health. Coaching takes place in person, over the telephone, or online. Our health coaches are focused on getting and keeping you healthy.

What our health coaches can do for you:

- Actively support, encourage, and educate
- Help develop goals and plans of action
- Identify barriers to better health
- Manage and control chronic conditions
- Promote safe and healthy lifestyles

To learn more about health coaching or our available health and wellness programs, visit **bsneny.com** or call us at the customer service number on the back of your member ID card.

$0 In-Home Care

Everyone hopes for a life of independence and quality as they age. We want to help make that happen. That's why we've partnered with Landmark Health to create **Care at Home**[SM].

The **Care at Home** team makes traditional house calls — just like in the old days. You receive the care and support you need without having to leave your home. Care is available 24/7 and is always coordinated with your primary doctor.

Care at Home does not replace your relationship with your primary care doctor. It is a complimentary, no-cost service to assist you and any family members or friends who may be involved in your care.

Care at Home is only available to our members with complex health needs, and is here to support you and your family if you ever need it down the road.

Visit **bsneny.com/careathome** for more information.

$0 Home Delivered Meals

Proper nutrition is essential to your health. We've partnered with **Mom's Meals** to offer nutritious and delicious meals after you're discharged from a hospital or skilled nursing facility.

Our care managers will coordinate a daily meal delivered right to your doorstep. Meals can be customized to your specific preferences and dietary needs.

Mom's Meals provides the support you need while you recuperate at home.

Health and wellness

Wellness rewards program

Preventive health is important to your overall well-being. With our rewards program, you'll receive a $20 Prepaid Card* after receiving each of these preventive services:

- Annual wellness visit
- Colorectal cancer screening**
- Breast cancer screening**

$0 fitness benefit

It's easy to stay active with our no-cost SilverSneakers® fitness program. After you receive your SilverSneakers ID number, you'll have access to:

- More than 16,000 fitness locations nationwide.
- Home exercise programs with walking, strength, and yoga workouts.
- Online resources to track your progress.

To learn more or to find the closest location, visit **silversneakers.com** or call 1-888-423-4632 (TTY 711), Monday – Friday, 8 a.m. – 8 p.m.

Chiropractor, acupuncture, and massage services

Professional massages, acupuncture, and chiropractic care contribute to your overall well-being, including:

- Easing muscle tension.
- Reducing stress.
- Lowering blood pressure.
- Improving sleep quality.

Your plan offers a $20 copay for chiropractic visits (see you Evidence of Coverage for details on the number of covered visits per year) and an annual allowance for reimbursement on massage and acupuncture care.

* One Prepaid Card per service, per member, per calendar year.

** Consult with your doctor to see if this service is right for you.

Prescription drug coverage gap

For Senior Blue 699 and Forever Blue 799 plans, you may need additional information on stages commonly referred to in Part D drug coverage. These phases in drug coverage, such as the coverage gap (or "donut hole") and the catastrophic drug phase, may change what you pay for your prescriptions.

You may not end up in the catastrophic drug phase, but you should be aware of how your drug plan works just in case.

Stage 1
Deductible

As you start filling prescriptions for the year

There is no deductible for these plans, so you begin in the next coverage phase.

Stage 2
Initial coverage

As you continue to fill prescriptions

You pay your regular tier copay or coinsurance for your prescriptions.

Stage 3
Coverage gap (donut hole)

Because there is no coverage gap for these plans, this payment stage would not apply to you

You will continue to pay your regular tier copay or coinsurance for your prescriptions.

Stage 4
Catastrophic coverage

After you go through the donut hole

Once your total out-of-pocket costs reach $7,400, your cost will not exceed your initial coverage level copay or coinsurance. You pay:

- Your initial coverage stage copay or coinsurance.
- 5% coinsurance of the cost of the drug.
- $4.15 for a generic drug or drug that is treated like a generic, and $10.35 for all other drugs.

$0 Tier 1 medications

If your plan offers $0 Tier 1 preferred generics, all of the medications listed below are available to you at a $0 copay under your Part D drug benefit. The medications listed are in Tier 1 in our list of covered drugs (or formulary).*

alendronate
allopurinol
amlodipine
amlodipine-benazepril
atenolol
atorvastatin
benazepril
bisoprolol-hydrochlorothiazide
carvedilol
chlorhexidine gluconate mouthwash
ciprofloxacin HCl
citalopram
clonidine HCl
clopidogrel
dexamethasone
doxazosin
enalapril maleate
enalapril-hydrochlorothiazide
famotidine
fluoxetine
fluticasone propionate-salmeterol inhalation aerosol powder breath-activated
fluticasone propionate-salmeterol blister with inhalation device
fosinopril
furosemide
gabapentin
gemfibrozil
glimepiride
glipizide
glipizide er/xl
glipizide-metformin
hydrochlorothiazide
IBU
ibuprofen
indapamide
irbesartan
irbesartan-hydrochlorothiazide
Jantoven
latanoprost
levothyroxine
Levoxyl
lisinopril
lisinopril-hydrochlorothiazide
lithium carbonate
losartan
losartan-hydrochlorothiazide
lovastatin
meloxicam
metformin
metformin er
metoprolol tartrate
mirtazapine
moexipril
naproxen
olmesartan
olmesartan-hydrochlorothiazide
omeprazole
pantoprazole
paroxetine HCl
perindopril erbumine
Periogard mouthwash
pioglitazone
pravastatin
prednisone tablet B/D
quinapril
quinapril-hydrochlorothiazide
ramipril
rosuvastatin
sertraline
Shingrix (PF)

simvastatin
spironolactone
sulfamethoxazole-trimethoprim
tamsulosin
terazosin
timolol maleate
topiramate
trandolapril
trazodone
triamterene-hydrochlorothiazide
Unithroid
valsartan
valsartan-hydrochlorothiazide
warfarin
Wixela Inhub

* List of $0 Tier 1 medications updated 7/1/2021. Please refer to our formulary for a complete list of Tier 1 drugs, including dosage form and strength.

Understanding Your Prescription Drug Options

What is a formulary?

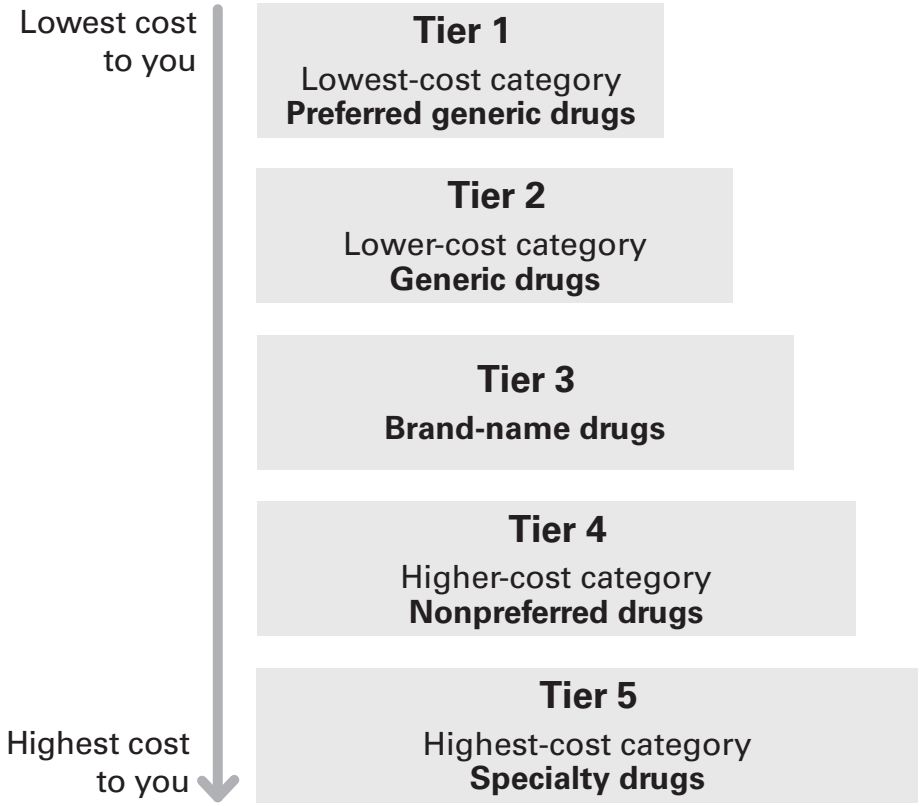
A formulary is a list of the medications that are covered under your Part D prescription drug benefit. A committee of doctors and pharmacists creates these lists by evaluating medications based on their cost, effectiveness, and availability. The formulary covers both generic and brand-name drugs.

Prescription drug tiers

The formulary will also tell you which of the five cost-sharing tiers the drug is in and whether there are any restrictions on your drug. To save money, your best option is to choose drugs that are on the first or second tier of your formulary.

How can I find out if my drug is on the formulary?

Visit **bcbswny.com/medicare** for more information. You can also search for a specific drug name or category of drug. Use the index in the back of the formulary to find drugs listed in alphabetical order. If you cannot find your drug, please contact us at 1-800-329-2792 (TTY 711).



Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO

2023 Medicare Part D: 5 Tier Fundamental Formulary

(List of Covered Plans)

Senior Blue HMO
Freedom Plus HMO
Freedom Value HMO
Forever Blue PPO
Freedom Nation PPO
Freedom Basic PPO
Senior Blue 699 HMO
Forever Blue 799 PPO

(List of Covered Drugs)

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

This formulary was updated on 9/1/2022.

Important message about what you pay for vaccines — Our plan covers most Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Call Member Service for more information.

Important message about what you pay for insulin — You won't pay more than $35 for a one-month supply of each Part D insulin product covered by our plan, no matter what cost-sharing tier it's on, even if you haven't paid your deductible (if applicable).

For more recent information or other questions, please contact:

Highmark Blue Shield of Northeastern New York Customer Service at 1-800-329-2792.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. EST, seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. EST, Monday – Friday.

Visit **medicare.highmark.com**.

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HIGHMARK NORTHEASTERN NEW YORK

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to “we,” “us,” or “our,” it means Highmark Blue Shield of Northeastern New York.

When it refers to “plan” or “our plan,” it means 2023 Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO.

This document includes a list of the drugs (formulary) for our plan, which is current as of Jan. 1, 2023. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on Jan. 1, 2024, and from time to time during the year.

What is the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?

A formulary is a list of covered drugs selected by our plans 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. Our plans will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at one of our plan’s network pharmacies, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary (drug list) change?

Most changes in drug coverage happen on Jan. 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. We must follow Medicare rules in making these changes.

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

- **New generic drugs.** We may immediately remove a brand name drug on our Drug List 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 Drug List, 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 find information in the section below entitled “How do I request an exception to the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?”

    - **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug’s manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand name drug currently on the formulary, or add new restrictions to the brand name drug or move it to a different cost-sharing tier, or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, add prior authorization, quantity limits and/or step therapy restrictions on a drug, or move a drug to a higher cost-sharing tier, 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 31-day supply of the drug.

    - 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 Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?”

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2023 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2023 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 Jan. 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.

The enclosed formulary is current as of Jan. 1, 2023. To get updated information about the drugs covered by our plans, please contact us. Our contact information appears on the front and back cover pages. In the event of mid-year non-maintenance formulary changes, members will be notified by mail and prospective members will receive an update with this formulary. The most up-to-date formulary is available on our website at **medicare.highmark.com**.

How do I use the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?

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

Medical Condition

The formulary begins on page 9. 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.” If you know what your drug is used for, look for the category name in the list that begins on page 9. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins at the end of this document. 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 first column of the list.

What are generic drugs?

Our plans cover both brand name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient 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:** Our plans require you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plans before you fill your prescriptions. If you don't get approval, our plans may not cover the drug.

- **Quantity Limits:** For certain drugs, our plans limit the amount of the drug that is covered. For example, our plans provide 31 tablets, per 31 days, per prescription of 100mg losartan. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, our plans require you 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, our plans may not cover Drug B unless you try Drug A first. If Drug A does not work for you, our plans will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 9. You can also get more information about the restrictions applied to specific covered drugs by visiting our website. We have posted online document(s) that explain(s) our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plans to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO?" on page 6 for information about how to request an exception.

What if my drug is not on the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?

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

If you learn that our plan does not cover your drug, you have two options:

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

How do I request an exception to the Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary?

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

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would 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 this drug is not on the specialty tier. If approved, this would lower the amount you must pay for your drug.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plans limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary, the lower cost-sharing drug or additional utilization restrictions, would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary or utilization restriction 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 believe 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.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or, you may be taking a drug that is on our formulary 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 a formulary 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, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary or if your ability to get your drugs is limited, we will cover a temporary 31-day supply. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 31-day supply of medication. After your first 31-day supply, we will not pay for these drugs, even if you have been a member of the plan 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 drugs is limited but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

The above transition process will be implemented to accommodate you if you have an immediate need for a non-formulary drug or a drug that requires prior authorization due to a change in your level of care while you are waiting for an exception request to be processed.

For more information

For more detailed information about your plan's prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about your plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

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, seven days a week. TTY users should call 1-877-486-2048, or visit **medicare.gov**.

Senior Blue HMO, Freedom HMO, Forever Blue PPO, Freedom PPO, and Freedom Nation PPO Formulary

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

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., ABELCET) and generic drugs are listed in lowercase italics (e.g., *abacavir*).

The information in the Requirements/Limits column tells you if your plan has any special requirements for coverage of your drug.

The following is a Formulary Format Example Only:

Drug Name	Fundamental Drug Tier	Requirements/ Limits
Anti-Infectives		
XYZ DRUG	NF	QL-28

Table of Contents

List of Abbreviations

T1: Cost-Sharing Tier 1 includes preferred generic drugs. This is the lowest cost-sharing tier.

T2: Cost-Sharing Tier 2 includes generic drugs.

T3: Cost-Sharing Tier 3 includes preferred brand name drugs and may include some single-sourced drugs (those generic drugs made by a single manufacturer).

T4: Cost-Sharing Tier 4 includes non-preferred brand name drugs and may include some single-sourced generic drugs (those generic drugs made by a single manufacturer).

T5: Cost-Sharing Tier 5 includes specialty drugs. This is the highest cost-sharing tier.

LA: Limited access

PA: Prior authorization required

PA-BvD: This drug may be covered under Medicare part B or D depending on the circumstance. Information may need to be submitted describing the use and setting of the drug to make the determination.

PA-NS: Prior authorization required for new starts only

QL: Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

QL: Quantity limit applies. The quantity limit is noted for each drug. For example, if the quantity limit is QL (90 EA per 180 days), the quantity limit would be 90 units per 180-day supply.

SI: Select Insulin Drug under the Part D Senior Savings Model. For complete coverage details on these preferred select insulins see Chapter 6 of your Evidence of Coverage.

ST: Step therapy applies

ST-NS: Step therapy applies to new starts only

Below is a list of drug name formatting patterns that may appear in the following pages.

List of Patterns

lowercase italics: Generic drugs

UPPERCASE BOLD: Brand name drugs

Drug Name	Drug Tier	Requirements/Limits
Anti - Infectives		
abacavir	T2	
abacavir-lamivudine	T2	
ABELCET	T4	PA-BvD
acyclovir oral capsule	T2	
acyclovir oral suspension 200 mg/5 ml	T2	
acyclovir oral tablet	T2	
acyclovir sodium intravenous solution	T4	PA-BvD
adefovir	T4	
albendazole	T5	
amantadine hcl oral capsule	T2	QL (124 EA per 31 days)
amantadine hcl oral solution	T2	
amantadine hcl oral tablet	T2	
AMBISOME	T5	PA-BvD
amikacin injection solution 500 mg/2 ml	T4	
amoxicillin oral capsule	T2	
amoxicillin oral suspension for reconstitution	T2	
amoxicillin oral tablet	T2	
amoxicillin oral tablet,chewable 125 mg, 250 mg	T2	
amoxicillin-pot clavulanate oral suspension for reconstitution	T2	
amoxicillin-pot clavulanate oral tablet	T2	
amoxicillin-pot clavulanate oral tablet,chewable	T2	
amphotericin b	T4	PA-BvD
ampicillin oral capsule 500 mg	T2	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	T4	
ampicillin-sulbactam injection	T4	
APTIVUS	T5	
ARIKAYCE	T5	PA
atazanavir	T4	
atovaquone	T5	
atovaquone-proguanil	T2	
azithromycin intravenous	T4	
azithromycin oral packet	T2	
azithromycin oral tablet	T2	
aztreonam	T4	
BICILLIN C-R	T3	
BICILLIN L-A	T4	

Drug Name	Drug Tier	Requirements/Limits
BIKTARVY	T5	QL (31 EA per 31 days)
caspofungin intravenous recon soln 50 mg	T5	
caspofungin intravenous recon soln 70 mg	T4	
CAYSTON	T5	PA
cefaclor oral capsule 500 mg	T2	
cefadroxil oral capsule	T2	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	T2	
cefadroxil oral tablet	T2	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	T4	
cefdinir oral capsule	T2	
cefepime injection	T4	
cefixime oral capsule	T4	
cefoxitin	T4	
cefpodoxime	T2	
cefprozil	T2	
ceftazidime	T4	
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	T2	
cefuroxime axetil oral tablet	T2	
cefuroxime sodium injection recon soln 750 mg	T4	
cefuroxime sodium intravenous recon soln 1.5 gram	T4	
cephalexin oral capsule 250 mg, 500 mg	T2	
cephalexin oral suspension for reconstitution	T2	
chloroquine phosphate oral tablet 250 mg	T2	PA; QL (50 EA per 30 days)
chloroquine phosphate oral tablet 500 mg	T2	PA; QL (25 EA per 30 days)
CIMDUO	T5	QL (31 EA per 31 days)
CIPRO ORAL SUSPENSION,MICROCAPSULE RECON	T4	
ciprofloxacin hcl oral tablet 100 mg, 750 mg	T2	
ciprofloxacin hcl oral tablet 250 mg, 500 mg	T1	
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	T4	
clarithromycin	T2	
clindamycin hcl	T2	
clindamycin in 5 % dextrose	T4	
CLINDAMYCIN PEDIATRIC	T2	
clindamycin phosphate injection	T4	

Drug Name	Drug Tier	Requirements/Limits
clindamycin phosphate intravenous solution 600 mg/4 ml	T4	
clotrimazole mucous membrane	T2	
COARTEM	T4	
colistin (colistimethate na)	T4	
COMPLERA	T5	
CRESEMBA ORAL	T5	
dapsone oral	T2	
daptomycin intravenous recon soln 350 mg	T5	
daptomycin intravenous recon soln 500 mg	T4	
DELSTRIGO	T5	QL (31 EA per 31 days)
DESCOVY ORAL TABLET 200-25 MG	T5	QL (31 EA per 31 days)
dicloxacillin	T2	
DIFICID ORAL TABLET	T5	QL (20 EA per 10 days)
DOVATO	T5	QL (31 EA per 31 days)
DOXY-100	T4	
doxycycline hyclate oral capsule	T2	
doxycycline hyclate oral tablet 100 mg	T2	
doxycycline hyclate oral tablet,delayed release (dr/ec) 100 mg	T4	
doxycycline monohydrate oral capsule 100 mg, 50 mg	T2	
doxycycline monohydrate oral suspension for reconstitution	T4	
doxycycline monohydrate oral tablet	T2	
E.E.S. 400 ORAL TABLET	T4	
EDURANT	T5	
efavirenz oral capsule 200 mg	T4	
efavirenz oral capsule 50 mg	T2	
efavirenz oral tablet	T4	
efavirenz-emtricitabin-tenofov	T5	
efavirenz-lamivu-tenofov disop	T5	QL (31 EA per 31 days)
emtricitabine	T2	
emtricitabine-tenofovir (tdf) oral tablet 100-150 mg, 133-200 mg, 167-250 mg	T5	
emtricitabine-tenofovir (tdf) oral tablet 200-300 mg	T4	
EMTRIVA ORAL SOLUTION	T3	
EMVERM	T5	
entecavir	T4	

Drug Name	Drug Tier	Requirements/Limits
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	T5	PA; QL (28 EA per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	T5	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET	T5	PA; QL (28 EA per 28 days)
EPIVIR HBV ORAL SOLUTION	T4	
ertapenem	T4	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	T4	
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	T4	
ERYTHROCIN INTRAVENOUS RECON SOLN 500 MG	T4	
erythromycin ethylsuccinate oral tablet	T4	
erythromycin oral tablet	T4	
ethambutol	T2	
etravirine	T5	
EVOTAZ	T5	
famciclovir	T2	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	T4	
fluconazole oral suspension for reconstitution	T3	
fluconazole oral tablet	T2	
flucytosine	T5	
fosamprenavir	T5	
FUZEON SUBCUTANEOUS RECON SOLN	T5	
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	T4	
gentamicin injection solution 40 mg/ml	T4	
GENVOYA	T5	
griseofulvin microsize	T4	
griseofulvin ultramicrosize	T4	
HARVONI ORAL PELLETS IN PACKET	T5	PA; QL (28 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	T5	PA; QL (28 EA per 28 days)
hydroxychloroquine oral tablet 200 mg	T2	QL (93 EA per 31 days)
imipenem-cilastatin	T4	
IMPAVIDO	T5	
INTELENCE ORAL TABLET 25 MG	T4	
ISENTRESS HD	T5	

Drug Name	Drug Tier	Requirements/Limits
ISENTRESS ORAL POWDER IN PACKET	T5	
ISENTRESS ORAL TABLET	T5	
ISENTRESS ORAL TABLET,CHEWABLE 100 MG	T5	
ISENTRESS ORAL TABLET,CHEWABLE 25 MG	T3	
isoniazid oral	T2	
itraconazole	T4	PA
ivermectin oral	T2	PA
JULUCA	T5	
ketoconazole oral	T2	
lamivudine	T3	
lamivudine-zidovudine	T3	
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	T3	
levofloxacin intravenous	T4	
levofloxacin oral	T2	
LEXIVA ORAL SUSPENSION	T4	
linezolid in dextrose 5%	T4	
linezolid oral suspension for reconstitution	T5	
linezolid oral tablet	T4	
lopinavir-ritonavir oral solution	T4	
lopinavir-ritonavir oral tablet 100-25 mg	T3	
lopinavir-ritonavir oral tablet 200-50 mg	T5	
maraviroc	T5	
mefloquine	T2	
meropenem	T4	
methenamine hippurate	T2	
metronidazole in nacl (iso-os)	T4	
metronidazole oral tablet	T2	
micafungin	T5	
minocycline oral capsule	T2	
minocycline oral tablet	T4	
moxifloxacin oral	T2	
nafcillin injection recon soln 1 gram, 2 gram	T4	
nafcillin injection recon soln 10 gram	T5	
neomycin	T2	
nevirapine oral suspension	T4	
nevirapine oral tablet	T3	

Drug Name	Drug Tier	Requirements/Limits
nevirapine oral tablet extended release 24 hr	T4	
nitazoxanide	T5	
nitrofurantoin	T5	QL (1800 ML per 365 days)
nitrofurantoin macrocrystal oral capsule 100 mg	T2	QL (90 EA per 365 days)
nitrofurantoin macrocrystal oral capsule 50 mg	T2	QL (180 EA per 365 days)
nitrofurantoin monohyd/m-cryst	T2	QL (90 EA per 365 days)
NORVIR ORAL POWDER IN PACKET	T4	
NORVIR ORAL SOLUTION	T4	
nystatin oral	T2	
ODEFSEY	T5	QL (31 EA per 31 days)
ofloxacin oral tablet 300 mg, 400 mg	T4	
ORACEA	T4	
oseltamivir oral capsule 30 mg	T2	QL (170 EA per 365 days)
oseltamivir oral capsule 45 mg, 75 mg	T2	QL (90 EA per 365 days)
oseltamivir oral suspension for reconstitution	T3	QL (1080 ML per 365 days)
oxacillin in dextrose(iso-osm) intravenous piggyback 1 gram/50 ml	T4	
oxacillin injection recon soln 1 gram, 2 gram	T4	
paromomycin	T4	
PASER	T3	
penicillin g pot in dextrose intravenous piggyback 2 million unit/50 ml, 3 million unit/50 ml	T4	
penicillin g potassium injection recon soln 20 million unit	T4	
penicillin g procaine intramuscular syringe 1.2 million unit/2 ml	T4	
penicillin v potassium	T2	
pentamidine inhalation	T4	PA-BvD; QL (1 EA per 28 days)
pentamidine injection	T4	
PIFELTRO	T5	QL (62 EA per 31 days)
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	T4	
posaconazole oral tablet,delayed release (dr/ec)	T5	
praziquantel	T4	
PREVYMIS ORAL	T5	QL (31 EA per 31 days)
PREZCOBIX	T5	
PREZISTA ORAL SUSPENSION	T5	
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	T5	
PRIFTIN	T3	

Drug Name	Drug Tier	Requirements/Limits
primaquine	T3	
pyrazinamide	T4	
pyrimethamine	T5	PA
quinine sulfate	T4	PA; QL (42 EA per 28 days)
RELENZA DISKHALER	T4	
REYATAZ ORAL POWDER IN PACKET	T5	
ribavirin oral capsule	T3	
ribavirin oral tablet 200 mg	T3	
rifabutin	T4	
rifampin intravenous	T4	
rifampin oral	T3	
rimantadine	T2	
ritonavir	T3	
RUKOBIA	T5	QL (62 EA per 31 days)
SELZENTRY ORAL SOLUTION	T5	
SELZENTRY ORAL TABLET 25 MG	T4	
SELZENTRY ORAL TABLET 75 MG	T5	
SIRTURO	T5	
streptomycin	T5	
STRIBILD	T5	
sulfadiazine	T4	
sulfamethoxazole-trimethoprim oral suspension	T2	
sulfamethoxazole-trimethoprim oral tablet	T1	
SUPRAX ORAL SUSPENSION FOR RECONSTITUTION 500 MG/5 ML	T4	
SYMTUZA	T5	QL (31 EA per 31 days)
TEFLARO	T5	
tenofovir disoproxil fumarate	T3	
terbinafine hcl oral	T2	QL (90 EA per 180 days)
tetracycline	T4	
tigecycline	T5	
TIVICAY ORAL TABLET 10 MG	T4	
TIVICAY ORAL TABLET 25 MG, 50 MG	T5	
TIVICAY PD	T5	
TOBI PODHALER INHALATION CAPSULE, W/INHALATION DEVICE	T5	PA; QL (224 EA per 56 days)
tobramycin in 0.225 % nacl	T5	PA
tobramycin inhalation	T5	PA
tobramycin sulfate injection solution 10 mg/ml	T4	

Drug Name	Drug Tier	Requirements/Limits
tobramycin sulfate injection solution 40 mg/ml	T2	
TRECATOR	T4	
trimethoprim	T2	
TRIUMEQ	T5	
TRIUMEQ PD	T5	QL (186 EA per 31 days)
TRIZIVIR	T5	
valacyclovir	T2	
valganciclovir oral recon soln	T5	
valganciclovir oral tablet	T3	
vancomycin intravenous recon soln 1,000 mg, 10 gram, 500 mg, 750 mg	T4	
vancomycin oral capsule 125 mg	T4	PA; QL (124 EA per 31 days)
vancomycin oral capsule 250 mg	T4	PA; QL (248 EA per 31 days)
VEMLIDY	T5	QL (31 EA per 31 days)
VIRACEPT ORAL TABLET	T5	
VIREAD ORAL POWDER	T5	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	T5	
voriconazole intravenous	T5	PA
voriconazole oral suspension for reconstitution	T5	
voriconazole oral tablet	T4	
VOSEVI	T5	PA; QL (28 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	T5	QL (27 EA per 365 days)
XIFAXAN ORAL TABLET 550 MG	T5	PA; QL (62 EA per 31 days)
XOFLUZA ORAL TABLET 40 MG, 80 MG	T3	QL (9 EA per 365 days)
zidovudine	T2	
Antineoplastic / Immunosuppressant Drugs		
abiraterone oral tablet 250 mg	T5	PA-NS; QL (124 EA per 31 days)
abiraterone oral tablet 500 mg	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 2 MG, 5 MG	T5	PA-NS; QL (62 EA per 31 days)
AFINITOR DISPERZ ORAL TABLET FOR SUSPENSION 3 MG	T5	PA-NS; QL (93 EA per 31 days)
AFINITOR ORAL TABLET 10 MG	T5	PA-NS; QL (31 EA per 31 days)
ALECENSA	T5	PA-NS; QL (248 EA per 31 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	T5	PA-NS; QL (31 EA per 31 days)
ALUNBRIG ORAL TABLET 30 MG	T5	PA-NS; QL (186 EA per 31 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	T5	PA-NS; QL (60 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
anastrozole	T2	
AYVAKIT	T5	PA-NS; QL (31 EA per 31 days)
azathioprine oral tablet 50 mg	T2	PA-BvD
BALVERSA	T5	PA-NS
bexarotene oral	T5	PA-NS
bexarotene topical	T5	PA-NS; QL (60 GM per 28 days)
bicalutamide	T2	
BOSULIF ORAL TABLET 100 MG	T5	PA-NS; QL (93 EA per 31 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	T5	PA-NS; QL (31 EA per 31 days)
BRAFTOVI ORAL CAPSULE 75 MG	T5	PA-NS; QL (186 EA per 31 days)
BRUKINSA	T5	PA-NS; QL (124 EA per 31 days)
CABOMETYX	T5	PA-NS; QL (31 EA per 31 days)
CALQUENCE	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 100 MG	T5	PA-NS; QL (62 EA per 31 days)
CAPRELSA ORAL TABLET 300 MG	T5	PA-NS; QL (31 EA per 31 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	T5	PA-NS; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	T5	PA-NS; QL (84 EA per 28 days)
COPIKTRA	T5	PA-NS; QL (62 EA per 31 days)
COTELLIC	T5	PA-NS; LA; QL (63 EA per 28 days)
cyclophosphamide oral capsule	T2	PA-BvD
cyclophosphamide oral tablet	T3	PA-BvD
cyclosporine modified	T2	PA-BvD
cyclosporine oral capsule	T2	PA-BvD
DAURISMO ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
DAURISMO ORAL TABLET 25 MG	T5	PA-NS; QL (62 EA per 31 days)
DROXIA	T3	
ELIGARD	T4	
ELIGARD (3 MONTH)	T4	
ELIGARD (4 MONTH)	T4	
ELIGARD (6 MONTH)	T4	
EMCYT	T5	
ENVARSUS XR	T4	PA-BvD
ERIVEDGE	T5	PA-NS; QL (31 EA per 31 days)
ERLEADA	T5	PA-NS; QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
erlotinib	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 10 mg, 2.5 mg, 7.5 mg	T5	PA-NS; QL (31 EA per 31 days)
everolimus (antineoplastic) oral tablet 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg, 5 mg	T5	PA-NS; QL (62 EA per 31 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	T5	PA-NS; QL (93 EA per 31 days)
everolimus (immunosuppressive)	T5	PA-BvD
exemestane	T4	
EXKIVITY	T5	PA-NS; QL (124 EA per 31 days)
FOTIVDA	T5	PA-NS; QL (21 EA per 28 days)
GAVRETO	T5	PA-NS; QL (124 EA per 31 days)
GENGRAF	T2	PA-BvD
GILOTRIF	T5	PA-NS; QL (31 EA per 31 days)
hydroxyurea	T2	
IBRANCE	T5	PA-NS; QL (21 EA per 28 days)
ICLUSIG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
IDHIFA ORAL TABLET 50 MG	T5	PA-NS; QL (62 EA per 31 days)
imatinib oral tablet 100 mg	T5	PA-NS; QL (93 EA per 31 days)
imatinib oral tablet 400 mg	T5	PA-NS; QL (62 EA per 31 days)
IMBRUVICA ORAL CAPSULE 140 MG	T5	PA-NS; QL (124 EA per 31 days)
IMBRUVICA ORAL CAPSULE 70 MG	T5	PA-NS; QL (31 EA per 31 days)
IMBRUVICA ORAL TABLET 280 MG, 420 MG, 560 MG	T5	PA-NS; QL (31 EA per 31 days)
INLYTA	T5	PA-NS; QL (124 EA per 31 days)
INQOVI	T5	PA-NS; QL (5 EA per 28 days)
INREBIC	T5	PA-NS; QL (124 EA per 31 days)
IRESSA	T5	PA-NS; QL (31 EA per 31 days)
JAKAFI	T5	PA-NS; QL (62 EA per 31 days)
KISQALI FEMARA CO-PACK ORAL TABLET 200 MG/DAY(200 MG X 1)-2.5 MG	T5	PA-NS; QL (49 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 400 MG/DAY(200 MG X 2)-2.5 MG	T5	PA-NS; QL (70 EA per 28 days)
KISQALI FEMARA CO-PACK ORAL TABLET 600 MG/DAY(200 MG X 3)-2.5 MG	T5	PA-NS; QL (91 EA per 28 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
lapatinib	T5	PA-NS; QL (186 EA per 31 days)
lenalidomide	T5	PA-NS; QL (21 EA per 28 days)
LENVIMA	T5	PA-NS
letrozole	T2	
leucovorin calcium oral	T3	
LEUKERAN	T5	
leuprolide subcutaneous kit	T5	
LONSURF	T5	PA-NS
LORBRENA ORAL TABLET 100 MG	T5	PA-NS; QL (31 EA per 31 days)
LORBRENA ORAL TABLET 25 MG	T5	PA-NS; QL (93 EA per 31 days)
LUMAKRAS	T5	PA-NS; QL (248 EA per 31 days)
LUPRON DEPOT	T5	ST
LUPRON DEPOT (3 MONTH)	T5	ST
LUPRON DEPOT (4 MONTH)	T5	ST
LUPRON DEPOT (6 MONTH)	T5	ST
LYNPARZA	T5	PA-NS; QL (124 EA per 31 days)
LYSODREN	T3	
MATULANE	T5	
megestrol oral suspension 400 mg/10 ml (40 mg/ml)	T3	PA
megestrol oral suspension 625 mg/5 ml (125 mg/ml)	T4	PA
megestrol oral tablet	T3	PA-NS
MEKINIST ORAL TABLET 0.5 MG	T5	PA-NS; QL (93 EA per 31 days)
MEKINIST ORAL TABLET 2 MG	T5	PA-NS; QL (31 EA per 31 days)
MEKTOVI	T5	PA-NS; QL (186 EA per 31 days)
mercaptopurine	T2	
MESNEX ORAL	T5	
methotrexate sodium	T2	PA-BvD
methotrexate sodium (pf) injection solution	T2	PA-BvD
mycophenolate mofetil oral capsule	T2	PA-BvD
mycophenolate mofetil oral suspension for reconstitution	T5	PA-BvD
mycophenolate mofetil oral tablet	T2	PA-BvD
mycophenolate sodium	T2	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
NERLYNX	T5	PA-NS; QL (186 EA per 31 days)
nilutamide	T5	
NINLARO	T5	PA-NS; QL (3 EA per 28 days)
NUBEQA	T5	PA-NS; QL (124 EA per 31 days)
octreotide acetate injection solution 1,000 mcg/ml, 500 mcg/ml	T5	PA
octreotide acetate injection solution 100 mcg/ml, 200 mcg/ml, 50 mcg/ml	T4	PA
ODOMZO	T5	PA-NS; LA; QL (31 EA per 31 days)
ONUREG	T5	PA-NS; QL (14 EA per 28 days)
ORGOVYX	T5	PA-NS; QL (31 EA per 31 days)
PEMAZYRE	T5	PA-NS; QL (14 EA per 21 days)
PIQRAY ORAL TABLET 200 MG/DAY (200 MG X 1)	T5	PA-NS; QL (28 EA per 28 days)
PIQRAY ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1), 300 MG/DAY (150 MG X 2)	T5	PA-NS; QL (56 EA per 28 days)
POMALYST	T5	PA-NS; QL (21 EA per 28 days)
PROGRAF ORAL GRANULES IN PACKET	T4	PA-BvD
PURIXAN	T5	
QINLOCK	T5	PA-NS; QL (93 EA per 31 days)
RETEVMO ORAL CAPSULE 40 MG	T5	PA-NS; QL (186 EA per 31 days)
RETEVMO ORAL CAPSULE 80 MG	T5	PA-NS; QL (124 EA per 31 days)
REVLIMID ORAL CAPSULE 2.5 MG, 20 MG	T5	PA-NS; QL (21 EA per 28 days)
ROZLYTREK ORAL CAPSULE 100 MG	T5	PA-NS; QL (155 EA per 31 days)
ROZLYTREK ORAL CAPSULE 200 MG	T5	PA-NS; QL (93 EA per 31 days)
RUBRACA	T5	PA-NS; QL (124 EA per 31 days)
RYDAPT	T5	PA-NS; QL (248 EA per 31 days)
SANDIMMUNE ORAL SOLUTION	T4	PA-BvD
SCEMBLIX ORAL TABLET 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SCEMBLIX ORAL TABLET 40 MG	T5	PA-NS; QL (310 EA per 31 days)
SIGNIFOR	T5	PA
sirolimus oral solution	T5	PA-BvD
sirolimus oral tablet	T4	PA-BvD
SOLTAMOX	T5	
sorafenib	T5	PA-NS; QL (124 EA per 31 days)
SPRYCEL	T5	PA-NS; QL (31 EA per 31 days)
STIVARGA	T5	PA-NS; QL (84 EA per 28 days)

Drug Name	Drug Tier	Requirements/Limits
sunitinib	T5	PA-NS; QL (31 EA per 31 days)
SYNRIBO	T5	
TABLOID	T4	
TABRECTA	T5	PA-NS; QL (124 EA per 31 days)
tacrolimus oral	T2	PA-BvD
TAFINLAR	T5	PA-NS; QL (124 EA per 31 days)
TAGRISSO	T5	PA-NS; LA; QL (31 EA per 31 days)
TALZENNA	T5	PA-NS; QL (31 EA per 31 days)
tamoxifen	T2	
TASIGNA	T5	PA-NS; QL (124 EA per 31 days)
TAZVERIK	T5	PA-NS; QL (248 EA per 31 days)
TEPMETKO	T5	PA-NS; QL (62 EA per 31 days)
THALOMID ORAL CAPSULE 100 MG, 150 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 200 MG	T5	PA-NS; QL (56 EA per 28 days)
TIBSOVO	T5	PA-NS; QL (62 EA per 31 days)
toremifene	T5	
TRELSTAR INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION	T5	ST
tretinoin (antineoplastic)	T5	
TRUSELTIQ ORAL CAPSULE 100 MG/DAY (100 MG X 1)	T5	PA-NS; QL (21 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 125 MG/DAY(100 MG X1-25MG X1), 50 MG/DAY (25 MG X 2)	T5	PA-NS; QL (42 EA per 28 days)
TRUSELTIQ ORAL CAPSULE 75 MG/DAY (25 MG X 3)	T5	PA-NS; QL (63 EA per 28 days)
TUKYSA ORAL TABLET 150 MG	T5	PA-NS; QL (124 EA per 31 days)
TUKYSA ORAL TABLET 50 MG	T5	PA-NS; QL (248 EA per 31 days)
TURALIO	T5	PA-NS; QL (124 EA per 31 days)
VENCLEXTA ORAL TABLET 10 MG	T3	PA-NS; QL (62 EA per 31 days)
VENCLEXTA ORAL TABLET 100 MG	T5	PA-NS; QL (186 EA per 31 days)
VENCLEXTA ORAL TABLET 50 MG	T5	PA-NS; QL (31 EA per 31 days)
VENCLEXTA STARTING PACK	T5	PA-NS; QL (84 EA per 365 days)
VERZENIO	T5	PA-NS; QL (62 EA per 31 days)
VIJOICE ORAL TABLET 125 MG, 50 MG	T5	PA-NS; QL (28 EA per 28 days)
VIJOICE ORAL TABLET 250 MG/DAY (200 MG X1-50 MG X1)	T5	PA-NS; QL (56 EA per 28 days)
VITRAKVI ORAL CAPSULE 100 MG	T5	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
VITRAKVI ORAL CAPSULE 25 MG	T5	PA-NS; QL (186 EA per 31 days)
VITRAKVI ORAL SOLUTION	T5	PA-NS; QL (310 ML per 31 days)
VIZIMPRO	T5	PA-NS; QL (31 EA per 31 days)
VONJO	T5	PA-NS; QL (124 EA per 31 days)
VOTRIENT	T5	PA-NS; QL (124 EA per 31 days)
WELIREG	T5	PA-NS; QL (93 EA per 31 days)
XALKORI	T5	PA-NS; QL (62 EA per 31 days)
XATMEP	T4	PA-BvD
XERMELO	T5	PA; QL (93 EA per 31 days)
XGEVA	T5	PA-NS
XOSPATA	T5	PA-NS; QL (124 EA per 31 days)
XPOVIO ORAL TABLET 100 MG/WEEK (50 MG X 2), 40MG TWICE WEEK (40 MG X 2), 80 MG/WEEK (40 MG X 2)	T5	PA-NS; QL (8 EA per 28 days)
XPOVIO ORAL TABLET 40 MG/WEEK (40 MG X 1), 60 MG/WEEK (60 MG X 1)	T5	PA-NS; QL (4 EA per 28 days)
XPOVIO ORAL TABLET 60MG TWICE WEEK (120 MG/WEEK)	T5	PA-NS; QL (24 EA per 28 days)
XPOVIO ORAL TABLET 80MG TWICE WEEK (160 MG/WEEK)	T5	PA-NS; QL (32 EA per 28 days)
XTANDI ORAL CAPSULE	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 40 MG	T5	PA-NS; QL (124 EA per 31 days)
XTANDI ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
YONSA	T5	PA-NS; QL (124 EA per 31 days)
ZEJULA	T5	PA-NS; QL (93 EA per 31 days)
ZELBORAF	T5	PA-NS; QL (248 EA per 31 days)
ZOLINZA	T5	PA-NS
ZORTRESS ORAL TABLET 1 MG	T5	PA-BvD
ZYDELIG	T5	PA-NS; QL (62 EA per 31 days)
ZYKADIA ORAL TABLET	T5	PA-NS; QL (93 EA per 31 days)
Autonomic / Cns Drugs, Neurology / Psych		
ABILIFY MAINTENA	T5	QL (1 EA per 28 days)
acetaminophen-codeine oral solution 120-12 mg/5 ml	T2	PA; QL (5167 ML per 31 days)
acetaminophen-codeine oral tablet	T2	PA; QL (403 EA per 31 days)
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 140 MG/ML	T3	PA; QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
AIMOVIG AUTOINJECTOR SUBCUTANEOUS AUTO-INJECTOR 70 MG/ML	T3	PA; QL (2 ML per 28 days)
AJOVY AUTOINJECTOR	T3	PA; QL (1.5 ML per 28 days)
AJOVY SYRINGE	T3	PA; QL (1.5 ML per 28 days)
alprazolam oral tablet 0.25 mg, 0.5 mg	T2	PA; QL (93 EA per 31 days)
alprazolam oral tablet 1 mg, 2 mg	T2	PA; QL (155 EA per 31 days)
amitriptyline	T2	PA-NS
amoxapine	T3	
APTIOM ORAL TABLET 200 MG	T5	QL (186 EA per 31 days)
APTIOM ORAL TABLET 400 MG	T5	QL (93 EA per 31 days)
APTIOM ORAL TABLET 600 MG, 800 MG	T5	QL (62 EA per 31 days)
aripiprazole oral solution	T4	PA-NS
aripiprazole oral tablet	T2	PA-NS
aripiprazole oral tablet,disintegrating	T5	PA-NS
armodafinil	T4	PA; QL (31 EA per 31 days)
asenapine maleate	T4	QL (62 EA per 31 days)
atomoxetine oral capsule 10 mg, 25 mg, 40 mg	T4	QL (62 EA per 31 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	T4	QL (31 EA per 31 days)
atomoxetine oral capsule 18 mg	T4	QL (124 EA per 31 days)
AUBAGIO	T5	PA; QL (31 EA per 31 days)
baclofen oral tablet	T2	
BAFIERTAM	T5	PA; QL (124 EA per 31 days)
benztropine oral	T1	PA
BRIVIACT ORAL SOLUTION	T5	QL (620 ML per 31 days)
BRIVIACT ORAL TABLET 10 MG, 100 MG, 25 MG, 75 MG	T5	QL (62 EA per 31 days)
BRIVIACT ORAL TABLET 50 MG	T4	QL (62 EA per 31 days)
bromocriptine	T4	
buprenorphine	T4	PA; QL (4 EA per 28 days)
buprenorphine hcl sublingual tablet 2 mg	T2	QL (93 EA per 31 days)
buprenorphine hcl sublingual tablet 8 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 12-3 mg, 4-1 mg, 8-2 mg	T2	QL (62 EA per 31 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet	T2	
bupropion hcl oral tablet extended release 24 hr 150 mg	T2	QL (93 EA per 31 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	T2	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
bupropion hcl oral tablet sustained-release 12 hr	T2	QL (62 EA per 31 days)
buspirone	T2	
butorphanol nasal	T2	QL (5 ML per 28 days)
CAPLYTA ORAL CAPSULE 42 MG	T5	PA-NS; QL (31 EA per 31 days)
carbamazepine oral capsule, er multiphase 12 hr	T2	
carbamazepine oral suspension 100 mg/5 ml	T2	
carbamazepine oral tablet	T2	
carbamazepine oral tablet extended release 12 hr	T2	
carbamazepine oral tablet,chewable	T2	
carbidopa-levodopa	T2	
carbidopa-levodopa-entacapone	T4	
celecoxib	T2	ST; QL (62 EA per 31 days)
CELONTIN ORAL CAPSULE 300 MG	T4	
chlorpromazine oral	T4	
citalopram oral solution	T3	
citalopram oral tablet	T1	
clobazam oral suspension	T4	PA-NS; QL (496 ML per 31 days)
clobazam oral tablet	T3	PA-NS; QL (62 EA per 31 days)
clomipramine	T4	PA-NS
clonazepam oral tablet 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet 2 mg	T2	QL (310 EA per 31 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg	T2	QL (93 EA per 31 days)
clonazepam oral tablet,disintegrating 1 mg	T2	QL (124 EA per 31 days)
clonazepam oral tablet,disintegrating 2 mg	T2	QL (310 EA per 31 days)
clonidine hcl oral tablet extended release 12 hr	T4	PA
clorazepate dipotassium oral tablet 15 mg	T2	QL (186 EA per 31 days)
clorazepate dipotassium oral tablet 3.75 mg, 7.5 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet 100 mg, 25 mg	T2	QL (279 EA per 31 days)
clozapine oral tablet 200 mg	T2	QL (124 EA per 31 days)
clozapine oral tablet 50 mg	T2	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 100 mg, 25 mg	T4	QL (279 EA per 31 days)
clozapine oral tablet,disintegrating 12.5 mg	T4	QL (93 EA per 31 days)
clozapine oral tablet,disintegrating 150 mg	T4	QL (186 EA per 31 days)
clozapine oral tablet,disintegrating 200 mg	T4	QL (124 EA per 31 days)
cyclobenzaprine oral tablet 10 mg	T2	PA; QL (93 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
cyclobenzaprine oral tablet 5 mg	T2	PA; QL (155 EA per 31 days)
dalfampridine	T5	PA; QL (62 EA per 31 days)
dantrolene oral	T2	
desipramine	T2	
desvenlafaxine succinate	T2	QL (31 EA per 31 days)
dexmethylphenidate oral capsule,er biphasic 50-50	T2	QL (31 EA per 31 days)
dexmethylphenidate oral tablet 10 mg	T2	QL (62 EA per 31 days)
dexmethylphenidate oral tablet 2.5 mg, 5 mg	T2	QL (93 EA per 31 days)
dextroamphetamine-amphetamine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 10 mg, 12.5 mg, 15 mg, 30 mg, 5 mg, 7.5 mg	T2	QL (62 EA per 31 days)
dextroamphetamine-amphetamine oral tablet 20 mg	T2	QL (93 EA per 31 days)
DIACOMIT ORAL CAPSULE 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL CAPSULE 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 250 MG	T5	PA-NS; QL (341 EA per 31 days)
DIACOMIT ORAL POWDER IN PACKET 500 MG	T5	PA-NS; QL (186 EA per 31 days)
DIAZEPAM INTENSOL	T2	QL (248 ML per 31 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	T2	QL (1500 ML per 31 days)
diazepam oral tablet	T2	QL (124 EA per 31 days)
diazepam rectal	T4	
diclofenac potassium oral tablet 50 mg	T2	
diclofenac sodium oral	T2	
diclofenac sodium topical gel 1 %	T2	QL (900 GM per 28 days)
diclofenac-misoprostol	T2	
diflunisal	T2	
dihydroergotamine nasal	T5	PA; QL (8 ML per 31 days)
DILANTIN	T3	
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	T5	PA; QL (120 EA per 365 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg, 240 mg	T5	PA; QL (62 EA per 31 days)
divalproex	T2	
donepezil oral tablet 10 mg, 5 mg	T1	
donepezil oral tablet 23 mg	T2	QL (31 EA per 31 days)
donepezil oral tablet,disintegrating	T2	

Drug Name	Drug Tier	Requirements/Limits
doxepin oral capsule	T2	PA-NS
doxepin oral concentrate	T2	PA-NS
doxepin oral tablet	T2	PA
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG	T4	PA-NS; QL (93 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 30 MG, 60 MG	T4	PA-NS; QL (62 EA per 31 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	T4	PA-NS; QL (31 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 60 mg	T2	QL (62 EA per 31 days)
duloxetine oral capsule,delayed release(dr/ec) 30 mg	T2	QL (31 EA per 31 days)
eletriptan oral tablet 20 mg	T4	QL (12 EA per 28 days)
eletriptan oral tablet 40 mg	T4	QL (6 EA per 28 days)
EMGALITY PEN	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	T3	PA; QL (1 ML per 28 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 300 MG/3 ML (100 MG/ML X 3)	T5	PA; QL (3 ML per 28 days)
EMSAM	T5	QL (30 EA per 30 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	T2	PA; QL (372 EA per 31 days)
entacapone	T3	
EPIDIOLEX	T5	PA-NS
EPITOL	T2	
EPRONTIA	T4	PA-NS; QL (496 ML per 31 days)
ergotamine-caffeine	T3	PA
escitalopram oxalate oral solution	T2	QL (620 ML per 31 days)
escitalopram oxalate oral tablet 10 mg	T1	QL (45 EA per 30 days)
escitalopram oxalate oral tablet 20 mg, 5 mg	T1	QL (30 EA per 30 days)
eszopiclone	T4	PA; QL (31 EA per 31 days)
ethosuximide	T2	
etodolac	T2	
FANAPT ORAL TABLET 1 MG	T4	QL (62 EA per 31 days)
FANAPT ORAL TABLET 10 MG, 12 MG, 2 MG, 4 MG, 6 MG, 8 MG	T5	QL (62 EA per 31 days)
FANAPT ORAL TABLETS,DOSE PACK	T4	QL (16 EA per 365 days)
felbamate oral suspension	T5	
felbamate oral tablet	T4	

Drug Name	Drug Tier	Requirements/Limits
fentanyl citrate buccal lozenge on a handle 1,200 mcg	T5	PA; QL (40 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 1,600 mcg	T5	PA; QL (30 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 200 mcg	T4	PA; QL (124 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 400 mcg	T5	PA; QL (119 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 600 mcg	T5	PA; QL (79 EA per 31 days)
fentanyl citrate buccal lozenge on a handle 800 mcg	T5	PA; QL (59 EA per 31 days)
fentanyl transdermal patch 72 hour 100 mcg/hr	T2	PA; QL (10 EA per 30 days)
fentanyl transdermal patch 72 hour 12 mcg/hr, 25 mcg/hr	T2	PA; QL (20 EA per 30 days)
fentanyl transdermal patch 72 hour 50 mcg/hr	T2	PA; QL (17 EA per 30 days)
fentanyl transdermal patch 72 hour 75 mcg/hr	T2	PA; QL (12 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK	T3	PA-NS; QL (56 EA per 365 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 120 MG, 40 MG, 80 MG	T3	PA-NS; QL (31 EA per 31 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR 20 MG	T3	PA-NS; QL (93 EA per 31 days)
FINTEPLA	T5	PA-NS; QL (360 ML per 30 days)
FIRDAPSE	T5	PA; QL (248 EA per 31 days)
fluoxetine oral capsule	T1	
fluoxetine oral solution	T2	
fluoxetine oral tablet 10 mg, 20 mg	T2	
fluphenazine decanoate	T2	
fluphenazine hcl injection	T4	
fluphenazine hcl oral concentrate	T4	
fluphenazine hcl oral tablet	T4	
flurbiprofen oral tablet 100 mg	T2	
fluvoxamine oral capsule,extended release 24hr	T4	
fluvoxamine oral tablet	T2	
FYCOMPA ORAL SUSPENSION	T5	QL (744 ML per 31 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 4 MG, 6 MG, 8 MG	T5	QL (31 EA per 31 days)
FYCOMPA ORAL TABLET 2 MG	T4	QL (31 EA per 31 days)
gabapentin oral capsule 100 mg, 400 mg	T1	PA-NS; QL (270 EA per 30 days)
gabapentin oral capsule 300 mg	T1	PA-NS; QL (360 EA per 30 days)

Drug Name	Drug Tier	Requirements/Limits
gabapentin oral solution 250 mg/5 ml	T2	PA-NS; QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	T1	PA-NS; QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	T1	PA-NS; QL (120 EA per 30 days)
galantamine oral capsule,ext rel. pellets 24 hr	T3	
galantamine oral solution	T2	
galantamine oral tablet 12 mg, 8 mg	T3	
galantamine oral tablet 4 mg	T2	
GILENYA ORAL CAPSULE 0.5 MG	T5	PA; QL (31 EA per 31 days)
glatiramer subcutaneous syringe 20 mg/ml	T5	QL (31 ML per 31 days)
glatiramer subcutaneous syringe 40 mg/ml	T5	QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	T5	QL (31 ML per 31 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	T5	QL (12 ML per 28 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 300 MG	T3	PA; QL (155 EA per 31 days)
GRALISE ORAL TABLET EXTENDED RELEASE 24 HR 600 MG	T5	PA; QL (93 EA per 31 days)
haloperidol	T2	
haloperidol decanoate	T2	
haloperidol lactate injection	T2	
haloperidol lactate oral	T2	
HETLIOZ	T5	PA; QL (31 EA per 31 days)
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	T2	PA; QL (5723 ML per 31 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	T2	PA; QL (403 EA per 31 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
hydrocodone-ibuprofen oral tablet 10-200 mg, 5-200 mg	T3	PA; QL (155 EA per 31 days)
hydromorphone oral liquid	T4	PA; QL (1550 ML per 31 days)
hydromorphone oral tablet	T2	PA; QL (186 EA per 31 days)
IBU ORAL TABLET 600 MG, 800 MG	T1	
ibuprofen oral suspension	T2	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	T1	
imipramine hcl	T4	PA-NS
indomethacin oral capsule	T2	
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	T5	QL (3.5 ML per 180 days)

Drug Name	Drug Tier	Requirements/Limits
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	T5	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	T5	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	T5	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	T5	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	T3	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	T5	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	T5	QL (0.88 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	T5	QL (1.32 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	T5	QL (1.75 ML per 84 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	T5	QL (2.63 ML per 84 days)
KLOXXADO	T3	
KYNMOBI SUBLINGUAL FILM 10 MG	T4	PA; QL (155 EA per 31 days)
KYNMOBI SUBLINGUAL FILM 15 MG, 20 MG, 25 MG, 30 MG	T5	PA; QL (155 EA per 31 days)
lacosamide oral	T4	
lamotrigine oral tablet	T1	
lamotrigine oral tablet disintegrating, dose pk 25 mg(14)-50 mg (14)-100 mg (7)	T4	
lamotrigine oral tablet extended release 24hr	T4	
lamotrigine oral tablet, chewable dispersible	T2	
LATUDA ORAL TABLET 120 MG, 20 MG, 40 MG, 60 MG	T5	PA-NS; QL (31 EA per 31 days)
LATUDA ORAL TABLET 80 MG	T5	PA-NS; QL (62 EA per 31 days)
levetiracetam oral solution 100 mg/ml	T2	
levetiracetam oral tablet	T2	
levetiracetam oral tablet extended release 24 hr	T2	
lithium carbonate oral capsule	T1	
lithium carbonate oral tablet	T1	
lithium carbonate oral tablet extended release	T2	
LORAZEPAM INTENSOL	T2	QL (155 ML per 31 days)
lorazepam oral tablet 0.5 mg	T2	QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
lorazepam oral tablet 1 mg	T2	QL (186 EA per 31 days)
lorazepam oral tablet 2 mg	T2	QL (155 EA per 31 days)
loxapine succinate	T2	
MARPLAN	T4	
meloxicam oral tablet	T1	
memantine oral capsule,sprinkle,er 24hr	T2	
memantine oral solution	T2	
memantine oral tablet	T2	
methadone oral solution 10 mg/5 ml	T2	PA; QL (1033 ML per 31 days)
methadone oral solution 5 mg/5 ml	T2	PA; QL (2066 ML per 31 days)
methadone oral tablet 10 mg	T2	PA; QL (206 EA per 31 days)
methadone oral tablet 5 mg	T2	PA; QL (248 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 10 mg	T4	QL (186 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 20 mg	T4	QL (93 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 30 mg, 40 mg	T4	QL (62 EA per 31 days)
methylphenidate hcl oral capsule,er biphasic 50-50 60 mg	T4	QL (31 EA per 31 days)
methylphenidate hcl oral tablet	T2	QL (93 EA per 31 days)
methylphenidate hcl oral tablet extended release 10 mg	T4	QL (186 EA per 31 days)
methylphenidate hcl oral tablet extended release 20 mg	T4	QL (93 EA per 31 days)
mirtazapine oral tablet	T1	
mirtazapine oral tablet,disintegrating	T2	
modafinil	T2	PA; QL (31 EA per 31 days)
molindone	T2	
morphine concentrate oral solution	T2	PA; QL (310 ML per 31 days)
morphine oral solution 10 mg/5 ml	T2	PA; QL (2800 ML per 31 days)
morphine oral solution 20 mg/5 ml (4 mg/ml)	T2	PA; QL (1400 ML per 31 days)
morphine oral tablet	T2	PA; QL (186 EA per 31 days)
morphine oral tablet extended release 100 mg	T2	PA; QL (62 EA per 31 days)
morphine oral tablet extended release 15 mg, 30 mg, 60 mg	T2	PA; QL (100 EA per 31 days)
morphine oral tablet extended release 200 mg	T2	PA; QL (31 EA per 31 days)
nabumetone	T2	
naloxone injection solution	T2	
naloxone injection syringe	T2	

Drug Name	Drug Tier	Requirements/Limits
naloxone nasal	T2	
naltrexone	T2	
NAMZARIC	T3	PA
naproxen oral suspension	T2	
naproxen oral tablet	T1	
naproxen oral tablet,delayed release (dr/ec) 375 mg	T2	
naproxen oral tablet,delayed release (dr/ec) 500 mg	T4	
naproxen sodium oral tablet 550 mg	T2	
naratriptan oral tablet 1 mg	T2	QL (20 EA per 28 days)
naratriptan oral tablet 2.5 mg	T2	QL (8 EA per 28 days)
NARCAN	T3	
NAYZILAM	T5	PA-NS; QL (10 EA per 30 days)
nefazodone	T2	
NEUPRO	T4	
nortriptyline	T2	
NUEDEXTA	T5	PA; QL (62 EA per 31 days)
NUPLAZID	T5	PA-NS; QL (31 EA per 31 days)
NURTEC ODT	T5	PA; QL (18 EA per 28 days)
olanzapine intramuscular	T4	
olanzapine oral	T2	QL (31 EA per 31 days)
oxaprozin	T4	
oxcarbazepine	T2	
oxycodone oral capsule	T2	PA; QL (186 EA per 31 days)
oxycodone oral concentrate	T4	PA; QL (180 ML per 31 days)
oxycodone oral solution	T2	PA; QL (4133 ML per 31 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 5 mg	T2	PA; QL (186 EA per 31 days)
oxycodone oral tablet 30 mg	T2	PA; QL (138 EA per 31 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	T2	PA; QL (372 EA per 31 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	T4	QL (31 EA per 31 days)
paliperidone oral tablet extended release 24hr 6 mg	T4	QL (62 EA per 31 days)
paroxetine hcl oral suspension	T4	
paroxetine hcl oral tablet	T1	
paroxetine hcl oral tablet extended release 24 hr	T4	
PAXIL ORAL SUSPENSION	T4	

Drug Name	Drug Tier	Requirements/Limits
perphenazine	T2	
PERSERIS	T5	QL (1 EA per 28 days)
phenelzine	T3	
phenobarbital	T2	PA-NS
phenytoin oral suspension 125 mg/5 ml	T2	
phenytoin oral tablet,chewable	T2	
phenytoin sodium extended	T2	
pimozide	T4	
piroxicam	T2	
pramipexole oral tablet	T2	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	T2	PA-NS; QL (93 EA per 31 days)
pregabalin oral capsule 225 mg, 300 mg	T2	PA-NS; QL (62 EA per 31 days)
pregabalin oral solution	T2	PA-NS; QL (930 ML per 31 days)
primidone	T2	
protriptyline	T4	
pyridostigmine bromide oral tablet 60 mg	T2	
pyridostigmine bromide oral tablet extended release	T3	
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 300 mg, 400 mg, 50 mg	T2	QL (62 EA per 31 days)
quetiapine oral tablet extended release 24 hr	T2	QL (62 EA per 31 days)
RADICAVA ORS STARTER KIT SUSP	T5	PA; QL (70 ML per 28 days)
ramelteon	T2	QL (31 EA per 31 days)
rasagiline	T4	
REXULTI	T5	PA-NS; QL (31 EA per 31 days)
REYVOW ORAL TABLET 100 MG	T4	QL (8 EA per 28 days)
REYVOW ORAL TABLET 50 MG	T4	QL (4 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 12.5 MG/2 ML, 25 MG/2 ML	T3	QL (2 EA per 28 days)
RISPERDAL CONSTA INTRAMUSCULAR SUSPENSION,EXTENDED REL RECON 37.5 MG/2 ML, 50 MG/2 ML	T5	QL (2 EA per 28 days)
risperidone oral solution	T2	QL (496 ML per 31 days)
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg	T1	QL (31 EA per 31 days)
risperidone oral tablet 3 mg	T1	QL (93 EA per 31 days)
risperidone oral tablet 4 mg	T1	QL (124 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg	T4	QL (31 EA per 31 days)
risperidone oral tablet,disintegrating 3 mg	T4	QL (93 EA per 31 days)
risperidone oral tablet,disintegrating 4 mg	T4	QL (124 EA per 31 days)
rivastigmine	T3	QL (30 EA per 30 days)
rivastigmine tartrate	T2	
rizatriptan oral tablet 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet 5 mg	T2	QL (24 EA per 28 days)
rizatriptan oral tablet,disintegrating 10 mg	T2	QL (12 EA per 28 days)
rizatriptan oral tablet,disintegrating 5 mg	T2	QL (24 EA per 28 days)
ropinirole oral tablet	T2	
ropinirole oral tablet extended release 24 hr	T4	
ROWEEPRA ORAL TABLET 500 MG	T2	
rufinamide oral suspension	T5	PA-NS
rufinamide oral tablet 200 mg	T4	PA-NS
rufinamide oral tablet 400 mg	T5	PA-NS
SECUADO	T5	QL (31 EA per 31 days)
selegiline hcl	T2	
sertraline oral concentrate	T2	
sertraline oral tablet	T1	
SPRITAM	T4	
sulindac	T2	
sumatriptan nasal spray,non-aerosol 20 mg/actuation	T4	QL (8 EA per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	T4	QL (32 EA per 28 days)
sumatriptan succinate oral tablet 100 mg	T2	QL (9 EA per 28 days)
sumatriptan succinate oral tablet 25 mg	T2	QL (36 EA per 28 days)
sumatriptan succinate oral tablet 50 mg	T2	QL (18 EA per 28 days)
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	T4	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 4 mg/0.5 ml	T4	QL (6 ML per 28 days)
sumatriptan succinate subcutaneous pen injector 6 mg/0.5 ml	T4	QL (4 ML per 28 days)
sumatriptan succinate subcutaneous solution	T4	QL (4 ML per 28 days)
SYMPAZAN ORAL FILM 10 MG, 20 MG	T5	PA-NS; QL (62 EA per 31 days)
SYMPAZAN ORAL FILM 5 MG	T4	PA-NS; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
tetrabenazine oral tablet 12.5 mg	T5	PA; QL (93 EA per 31 days)
tetrabenazine oral tablet 25 mg	T5	PA; QL (124 EA per 31 days)
thioridazine	T3	
thiothixene	T2	
tiagabine	T4	
tizanidine	T2	
topiramate oral capsule, sprinkle	T2	
topiramate oral tablet	T1	
tramadol oral tablet 50 mg	T2	PA; QL (240 EA per 30 days)
tramadol-acetaminophen	T2	PA; QL (372 EA per 31 days)
tranylcypromine	T4	
trazodone	T1	
trifluoperazine	T2	
trimipramine	T4	PA-NS
TRINTELLIX	T3	
TRUDHESA	T5	PA; QL (12 ML per 28 days)
UBRELVY ORAL TABLET 100 MG	T5	PA; QL (17 EA per 28 days)
UBRELVY ORAL TABLET 50 MG	T5	PA; QL (34 EA per 28 days)
valproic acid	T2	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	T2	
VALTOCO	T5	PA-NS; QL (10 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	T2	QL (31 EA per 31 days)
venlafaxine oral capsule,extended release 24hr 75 mg	T2	QL (93 EA per 31 days)
venlafaxine oral tablet	T2	
venlafaxine oral tablet extended release 24hr	T2	QL (31 EA per 31 days)
VERSACLOZ	T5	QL (558 ML per 31 days)
vigabatrin	T5	PA-NS
VIGADRONE	T5	PA-NS
VIIBRYD ORAL TABLETS,DOSE PACK 10 MG (7)- 20 MG (23)	T3	QL (60 EA per 365 days)
vilazodone	T3	QL (31 EA per 31 days)
VIVITROL	T5	
VRAYLAR ORAL CAPSULE	T5	PA-NS; QL (31 EA per 31 days)
VRAYLAR ORAL CAPSULE,DOSE PACK	T4	PA-NS; QL (14 EA per 365 days)
VUMERITY	T5	PA; QL (124 EA per 31 days)
XCOPRI	T5	PA-NS

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)	T5	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 12.5 MG (14)- 25 MG (14)	T4	PA-NS
XCOPRI TITRATION PACK ORAL TABLETS,DOSE PACK 150 MG (14)- 200 MG (14), 50 MG (14)- 100 MG (14)	T5	PA-NS
XYREM	T5	PA; QL (540 ML per 30 days)
zaleplon oral capsule 10 mg	T4	PA; QL (62 EA per 31 days)
zaleplon oral capsule 5 mg	T4	PA; QL (93 EA per 31 days)
ZEPOSIA	T5	PA; QL (31 EA per 31 days)
ZEPOSIA STARTER KIT	T5	PA; QL (74 EA per 365 days)
ZEPOSIA STARTER PACK	T5	PA; QL (14 EA per 365 days)
ziprasidone hcl	T2	QL (62 EA per 31 days)
ziprasidone mesylate	T4	
zolmitriptan oral tablet 2.5 mg	T4	QL (16 EA per 28 days)
zolmitriptan oral tablet 5 mg	T4	QL (8 EA per 28 days)
zolmitriptan oral tablet,disintegrating 2.5 mg	T4	QL (16 EA per 28 days)
zolmitriptan oral tablet,disintegrating 5 mg	T4	QL (8 EA per 28 days)
zolpidem oral tablet	T2	PA; QL (31 EA per 31 days)
zonisamide	T2	
ZUBSOLV SUBLINGUAL TABLET 0.7-0.18 MG, 2.9-0.71 MG, 8.6-2.1 MG	T3	QL (62 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG	T3	QL (93 EA per 31 days)
ZUBSOLV SUBLINGUAL TABLET 11.4-2.9 MG, 5.7-1.4 MG	T3	QL (31 EA per 31 days)
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	T5	QL (2 EA per 28 days)
Cardiovascular, Hypertension / Lipids		
acebutolol	T2	
aliskiren	T4	
amiloride	T2	
amiloride-hydrochlorothiazide	T2	
amiodarone oral	T2	
amlodipine	T1	
amlodipine-atorvastatin	T2	
amlodipine-benazepril	T1	

Drug Name	Drug Tier	Requirements/Limits
amlodipine-olmesartan	T2	QL (31 EA per 31 days)
amlodipine-valsartan	T1	
aspirin-dipyridamole	T4	
atenolol	T1	
atenolol-chlorthalidone	T2	
atorvastatin	T1	
benazepril	T1	
benazepril-hydrochlorothiazide	T1	
bisoprolol fumarate	T2	
bisoprolol-hydrochlorothiazide	T1	
BRILINTA	T3	
bumetanide oral	T2	
BYSTOLIC ORAL TABLET 10 MG, 2.5 MG	T3	QL (93 EA per 31 days)
BYSTOLIC ORAL TABLET 20 MG	T3	QL (62 EA per 31 days)
BYSTOLIC ORAL TABLET 5 MG	T3	QL (217 EA per 31 days)
CABLIVI INJECTION KIT	T5	PA; QL (31 EA per 31 days)
CAMZYOS	T5	PA; QL (31 EA per 31 days)
candesartan	T2	
candesartan-hydrochlorothiazid	T2	
captopril	T2	
CARTIA XT	T2	
carvedilol	T1	
chlorthalidone oral tablet 25 mg, 50 mg	T2	
cholestyramine (with sugar) oral powder in packet	T2	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	T2	
cilostazol	T2	
clonidine	T4	
clonidine hcl oral tablet	T1	
clopidogrel oral tablet 75 mg	T1	
colesevelam	T4	
colestipol oral packet	T2	
colestipol oral tablet	T2	
CORLANOR ORAL SOLUTION	T3	PA; QL (420 ML per 28 days)
CORLANOR ORAL TABLET 5 MG	T3	PA; QL (93 EA per 31 days)
CORLANOR ORAL TABLET 7.5 MG	T3	PA; QL (62 EA per 31 days)
DIGITEK ORAL TABLET 125 MCG (0.125 MG)	T2	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
DIGITEK ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
DIGOX ORAL TABLET 125 MCG (0.125 MG)	T2	QL (62 EA per 31 days)
DIGOX ORAL TABLET 250 MCG (0.25 MG)	T2	QL (31 EA per 31 days)
digoxin oral solution	T3	QL (155 ML per 31 days)
digoxin oral tablet 125 mcg (0.125 mg)	T2	QL (62 EA per 31 days)
digoxin oral tablet 250 mcg (0.25 mg)	T2	QL (31 EA per 31 days)
digoxin oral tablet 62.5 mcg (0.0625 mg)	T2	QL (124 EA per 31 days)
diltiazem hcl oral capsule,extended release 12 hr	T2	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	T2	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	T2	
diltiazem hcl oral tablet	T1	
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg	T2	
DILT-XR	T2	
dipyridamole oral	T4	
dofetilide	T4	
DOPTELET (10 TAB PACK)	T5	PA
DOPTELET (15 TAB PACK)	T5	PA
DOPTELET (30 TAB PACK)	T5	PA
doxazosin	T1	
EDARBI	T3	
EDARBYCLOR	T3	
ELIQUIS DVT-PE TREAT 30D START	T3	QL (74 EA per 30 days)
ELIQUIS ORAL TABLET 2.5 MG	T3	QL (60 EA per 30 days)
ELIQUIS ORAL TABLET 5 MG	T3	QL (74 EA per 30 days)
enalapril maleate oral tablet	T1	
enalapril-hydrochlorothiazide	T1	
enoxaparin subcutaneous syringe	T4	
ENTRESTO ORAL TABLET 24-26 MG	T3	QL (186 EA per 31 days)
ENTRESTO ORAL TABLET 49-51 MG	T3	QL (93 EA per 31 days)
ENTRESTO ORAL TABLET 97-103 MG	T3	QL (62 EA per 31 days)
eplerenone	T2	
ethacrynic acid	T4	
ezetimibe	T2	
ezetimibe-simvastatin	T2	

Drug Name	Drug Tier	Requirements/Limits
felodipine	T2	
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	T2	
fenofibrate nanocrystallized	T2	
fenofibrate oral tablet 160 mg, 54 mg	T2	
fenofibric acid (choline)	T2	
flecainide	T2	
fluvastatin oral capsule	T4	
fondaparinux subcutaneous syringe 10 mg/0.8 ml, 5 mg/0.4 ml, 7.5 mg/0.6 ml	T5	
fondaparinux subcutaneous syringe 2.5 mg/0.5 ml	T4	
fosinopril	T1	
fosinopril-hydrochlorothiazide	T2	
furosemide injection	T2	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	T2	
furosemide oral tablet	T1	
gemfibrozil	T1	
heparin (porcine) injection solution	T3	
hydralazine oral	T2	
hydrochlorothiazide	T1	
icosapent ethyl	T2	QL (124 EA per 31 days)
indapamide	T1	
irbesartan	T1	QL (31 EA per 31 days)
irbesartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	T2	
isosorbide mononitrate oral tablet	T2	
isosorbide mononitrate oral tablet extended release 24 hr	T1	
isradipine	T2	
JANTOVEN	T1	
JUXTAPID ORAL CAPSULE 10 MG, 20 MG, 30 MG, 5 MG	T5	PA
KERENDIA	T4	PA; QL (31 EA per 31 days)
labetalol oral	T2	
lisinopril	T1	
lisinopril-hydrochlorothiazide	T1	
LIVALO	T3	
losartan oral tablet 100 mg	T1	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
losartan oral tablet 25 mg	T1	QL (93 EA per 31 days)
losartan oral tablet 50 mg	T1	QL (62 EA per 31 days)
losartan-hydrochlorothiazide	T1	
lovastatin	T1	
metolazone	T2	
metoprolol succinate	T1	
metoprolol ta-hydrochlorothiaz	T2	
metoprolol tartrate oral	T1	
metyrosine	T5	
mexiletine	T2	
minoxidil oral	T2	
moexipril	T1	
MULPLETA	T5	PA
MULTAQ	T4	
nadolol	T2	
nebivolol oral tablet 10 mg, 2.5 mg	T2	QL (93 EA per 31 days)
nebivolol oral tablet 20 mg	T2	QL (62 EA per 31 days)
nebivolol oral tablet 5 mg	T2	QL (217 EA per 31 days)
NEXLETOL	T3	PA; QL (31 EA per 31 days)
NEXLIZET	T3	PA; QL (31 EA per 31 days)
niacin oral tablet extended release 24 hr 1,000 mg, 750 mg	T2	
niacin oral tablet extended release 24 hr 500 mg	T2	QL (31 EA per 31 days)
nicardipine oral	T4	
nifedipine oral tablet extended release	T2	
nifedipine oral tablet extended release 24hr	T2	
nimodipine	T4	
NITRO-BID	T2	
nitroglycerin sublingual	T2	
nitroglycerin transdermal patch 24 hour	T2	
nitroglycerin translingual	T4	
olmesartan oral tablet 20 mg, 40 mg	T1	QL (31 EA per 31 days)
olmesartan oral tablet 5 mg	T1	QL (93 EA per 31 days)
olmesartan-amlodipin-hcthiazid	T3	
olmesartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
omega-3 acid ethyl esters	T2	QL (124 EA per 31 days)
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	T2	
pentoxifylline	T2	

Drug Name	Drug Tier	Requirements/Limits
perindopril erbumine	T1	
pindolol	T3	
prasugrel	T2	
pravastatin	T1	
prazosin	T2	
PREVALITE ORAL POWDER IN PACKET	T2	
PROMACTA ORAL POWDER IN PACKET 12.5 MG	T5	PA; QL (372 EA per 31 days)
PROMACTA ORAL POWDER IN PACKET 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 12.5 MG, 25 MG	T5	PA; QL (31 EA per 31 days)
PROMACTA ORAL TABLET 50 MG, 75 MG	T5	PA; QL (62 EA per 31 days)
propafenone oral capsule,extended release 12 hr	T4	
propafenone oral tablet	T2	
propranolol oral capsule,extended release 24 hr	T2	
propranolol oral solution	T2	
propranolol oral tablet	T1	
quinapril	T1	
quinapril-hydrochlorothiazide	T1	
quinidine sulfate oral tablet	T2	
ramipril	T1	
ranolazine	T2	QL (62 EA per 31 days)
REPATHA PUSHTRONEX	T3	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	T3	PA; QL (3 ML per 28 days)
REPATHA SYRINGE	T3	PA; QL (3 ML per 28 days)
rosuvastatin	T1	
simvastatin oral tablet	T1	
SORINE	T2	
SOTALOL AF	T2	
sotalol oral	T2	
spironolactone	T1	
spironolacton-hydrochlorothiaz	T2	
TAZTIA XT	T2	
telmisartan	T2	
telmisartan-amlodipine	T2	
telmisartan-hydrochlorothiazid	T2	
terazosin	T1	
TIADYLT ER	T2	

Drug Name	Drug Tier	Requirements/Limits
timolol maleate oral	T2	
torsemide oral	T2	
trandolapril	T1	
triamterene-hydrochlorothiazid oral capsule 37.5-25 mg	T1	
triamterene-hydrochlorothiazid oral tablet	T1	
UPTRAVI ORAL TABLET 1,000 MCG, 1,200 MCG, 1,400 MCG, 1,600 MCG, 400 MCG, 600 MCG, 800 MCG	T5	PA; QL (62 EA per 31 days)
UPTRAVI ORAL TABLET 200 MCG	T5	PA; QL (224 EA per 28 days)
UPTRAVI ORAL TABLETS,DOSE PACK	T5	PA; QL (400 EA per 365 days)
valsartan oral tablet 160 mg, 40 mg, 80 mg	T1	QL (62 EA per 31 days)
valsartan oral tablet 320 mg	T1	QL (31 EA per 31 days)
valsartan-hydrochlorothiazide	T1	QL (31 EA per 31 days)
VASCEPA ORAL CAPSULE 0.5 GRAM	T3	QL (248 EA per 31 days)
VASCEPA ORAL CAPSULE 1 GRAM	T3	QL (124 EA per 31 days)
verapamil oral capsule, 24 hr er pellet ct	T3	
verapamil oral capsule,ext rel. pellets 24 hr	T2	
verapamil oral tablet	T2	
verapamil oral tablet extended release	T2	
VERQUVO	T3	PA; QL (31 EA per 31 days)
VYNDAMAX	T5	PA; QL (31 EA per 31 days)
VYNDAQEL	T5	PA; QL (124 EA per 31 days)
warfarin	T1	
XARELTO DVT-PE TREAT 30D START	T3	QL (51 EA per 30 days)
XARELTO ORAL SUSPENSION FOR RECONSTITUTION	T3	QL (930 ML per 31 days)
XARELTO ORAL TABLET 10 MG, 20 MG	T3	QL (31 EA per 31 days)
XARELTO ORAL TABLET 15 MG	T3	QL (52 EA per 31 days)
XARELTO ORAL TABLET 2.5 MG	T3	QL (62 EA per 31 days)
Dermatologicals/Topical Therapy		
ACCUTANE	T4	
acitretin	T4	PA
acyclovir topical ointment	T4	QL (30 GM per 30 days)
ADBRY	T5	PA; QL (4 ML per 28 days)
ALA-CORT TOPICAL CREAM 1 %	T2	
ALA-CORT TOPICAL CREAM 2.5 %	T2	QL (30 GM per 28 days)
alclometasone	T2	
ammonium lactate	T2	

Drug Name	Drug Tier	Requirements/Limits
AMNESTEEM	T4	
AVITA TOPICAL CREAM	T2	PA; QL (45 GM per 28 days)
azelaic acid	T4	QL (50 GM per 28 days)
betamethasone dipropionate	T2	
betamethasone valerate topical cream	T2	
betamethasone valerate topical lotion	T2	
betamethasone valerate topical ointment	T2	
betamethasone, augmented	T2	
calcipotriene scalp	T3	QL (60 ML per 28 days)
calcipotriene topical cream	T4	QL (60 GM per 28 days)
calcipotriene topical ointment	T3	QL (60 GM per 28 days)
calcitriol topical	T4	ST
CIBINQO	T5	PA; QL (31 EA per 31 days)
ciclopirox topical cream	T2	QL (90 GM per 28 days)
ciclopirox topical gel	T2	QL (45 GM per 28 days)
ciclopirox topical shampoo	T2	QL (120 ML per 28 days)
ciclopirox topical solution	T2	
ciclopirox topical suspension	T2	QL (60 ML per 28 days)
CLARAVIS	T4	
clindamycin phosphate topical gel	T2	QL (75 GM per 28 days)
clindamycin phosphate topical lotion	T2	QL (60 ML per 28 days)
clindamycin phosphate topical solution	T2	QL (60 ML per 28 days)
clobetasol scalp	T2	QL (50 ML per 28 days)
clobetasol topical cream	T2	QL (60 GM per 28 days)
clobetasol topical foam	T2	QL (100 GM per 28 days)
clobetasol topical gel	T2	QL (60 GM per 28 days)
clobetasol topical lotion	T2	QL (118 ML per 28 days)
clobetasol topical ointment	T2	QL (60 GM per 28 days)
clobetasol topical shampoo	T2	QL (118 ML per 28 days)
clobetasol topical spray,non-aerosol	T2	QL (125 ML per 28 days)
clobetasol-emollient topical cream	T2	QL (60 GM per 28 days)
clotrimazole topical cream	T2	QL (45 GM per 28 days)
clotrimazole topical solution	T2	QL (30 ML per 28 days)
clotrimazole-betamethasone topical cream	T2	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	T2	QL (60 ML per 28 days)
COSENTYX (2 SYRINGES)	T5	PA; QL (2 ML per 28 days)
COSENTYX PEN (2 PENS)	T5	PA; QL (2 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
COSENTYX SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
CROTAN	T4	
DENAVIR	T4	QL (5 GM per 28 days)
desonide topical cream	T4	QL (60 GM per 28 days)
desonide topical gel	T4	QL (60 GM per 28 days)
desonide topical lotion	T4	QL (118 ML per 28 days)
desonide topical ointment	T4	QL (60 GM per 28 days)
desoximetasone topical cream	T4	QL (100 GM per 28 days)
desoximetasone topical gel	T4	QL (60 GM per 28 days)
desoximetasone topical spray,non-aerosol	T4	QL (100 ML per 28 days)
DESRX	T4	QL (60 GM per 28 days)
diclofenac sodium topical gel 3 %	T4	PA; QL (100 GM per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 100 MG/0.67 ML	T5	PA; QL (1.34 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	T5	PA; QL (2.28 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	T5	PA; QL (8 ML per 28 days)
econazole	T2	QL (85 GM per 28 days)
ERY PADS	T2	
erythromycin with ethanol topical solution	T2	QL (60 ML per 28 days)
fluocinolone and shower cap	T2	QL (118.28 ML per 28 days)
fluocinolone topical cream 0.01 %	T2	QL (60 GM per 28 days)
fluocinolone topical cream 0.025 %	T2	QL (120 GM per 28 days)
fluocinolone topical ointment	T2	QL (120 GM per 28 days)
fluocinolone topical solution	T2	QL (90 ML per 28 days)
fluocinonide topical cream 0.05 %	T2	QL (60 GM per 28 days)
fluocinonide topical gel	T3	QL (60 GM per 28 days)
fluocinonide topical ointment	T2	QL (60 GM per 28 days)
fluocinonide topical solution	T2	QL (60 ML per 28 days)
fluocinonide-emollient	T4	QL (60 GM per 28 days)
fluorouracil topical cream 5 %	T2	
fluorouracil topical solution	T2	
fluticasone propionate topical cream	T2	
gentamicin topical	T2	QL (60 GM per 28 days)

Drug Name	Drug Tier	Requirements/Limits
halobetasol propionate topical cream	T2	QL (50 GM per 28 days)
halobetasol propionate topical ointment	T2	QL (50 GM per 28 days)
hydrocortisone topical cream 1 %	T2	
hydrocortisone topical lotion 2.5 %	T2	QL (118 ML per 28 days)
hydrocortisone topical ointment 1 %, 2.5 %	T2	
imiquimod topical cream in packet 5 %	T2	
isotretinoin	T4	
ivermectin topical cream	T2	
ketoconazole topical cream	T2	QL (60 GM per 28 days)
ketoconazole topical shampoo	T2	QL (120 ML per 28 days)
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	T2	PA; QL (50 ML per 28 days)
lidocaine topical adhesive patch,medicated 5 %	T2	PA; QL (93 EA per 31 days)
lidocaine topical ointment	T4	PA; QL (50 GM per 28 days)
LIDOCAINE VISCOUS	T2	
lidocaine-prilocaine topical cream	T2	PA; QL (30 GM per 28 days)
malathion	T2	
metronidazole topical cream	T2	
metronidazole topical gel	T2	
metronidazole topical lotion	T2	
mometasone topical	T2	
mupirocin	T2	
MYORISAN	T4	
NYAMYC	T2	QL (60 GM per 28 days)
nystatin topical cream	T2	QL (30 GM per 28 days)
nystatin topical ointment	T2	QL (30 GM per 28 days)
nystatin topical powder	T2	QL (60 GM per 28 days)
nystatin-triamcinolone	T2	QL (60 GM per 28 days)
NYSTOP	T2	QL (60 GM per 28 days)
PANRETIN	T5	PA-NS
permethrin	T2	
pimecrolimus	T4	QL (100 GM per 28 days)
podofilox	T2	
REGRANEX	T5	PA
SANTYL	T3	QL (180 GM per 30 days)
selenium sulfide topical lotion	T2	
silver sulfadiazine	T2	
SKYRIZI SUBCUTANEOUS PEN INJECTOR	T5	PA; QL (1 ML per 84 days)

Drug Name	Drug Tier	Requirements/Limits
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	T5	PA; QL (1 ML per 84 days)
SKYRIZI SUBCUTANEOUS SYRINGE KIT	T5	PA; QL (1 EA per 84 days)
SSD	T4	
STELARA SUBCUTANEOUS SOLUTION	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	T5	PA; QL (0.5 ML per 84 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	T5	PA; QL (1 ML per 56 days)
sulfacetamide sodium (acne)	T2	
SULFAMYLON TOPICAL CREAM	T3	
tacrolimus topical	T2	QL (100 GM per 28 days)
TALTZ AUTOINJECTOR	T5	PA; QL (1 ML per 28 days)
TALTZ SYRINGE	T5	PA; QL (1 ML per 28 days)
tavaborole	T4	
tazarotene topical cream	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL CREAM 0.05 %	T4	PA; QL (60 GM per 28 days)
TAZORAC TOPICAL GEL	T4	PA; QL (100 GM per 28 days)
tretinoin topical cream	T2	PA; QL (45 GM per 28 days)
tretinoin topical gel	T3	PA; QL (45 GM per 28 days)
triamcinolone acetonide topical cream	T2	
triamcinolone acetonide topical lotion	T2	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	T2	
TRIDERM TOPICAL CREAM	T2	
VALCHLOR	T5	PA-NS
ZENATANE	T4	
Diagnostics / Miscellaneous Agents		
acamprosate	T4	
anagrelide	T2	
bupropion hcl (smoking deter)	T2	QL (62 EA per 31 days)
CARBAGLU	T5	PA
carglumic acid	T5	PA
cevimeline	T2	
CHEMET	T4	
CLINIMIX 4.25%/D5W SULFIT FREE	T4	PA-BvD
d10 %-0.45 % sodium chloride	T2	
d2.5 %-0.45 % sodium chloride	T2	
d5 % and 0.9 % sodium chloride	T2	

Drug Name	Drug Tier	Requirements/Limits
d5 %-0.45 % sodium chloride	T2	
deferasirox oral granules in packet	T5	PA
deferasirox oral tablet 180 mg, 360 mg	T5	PA
deferasirox oral tablet 90 mg	T4	PA
deferasirox oral tablet, dispersible	T5	PA
deferiprone	T5	PA
dextrose 10 % in water (d10w)	T2	
dextrose 5 % in water (d5w) intravenous piggyback	T2	
disulfiram	T2	
droxidopa oral capsule 100 mg	T5	PA; QL (465 EA per 31 days)
droxidopa oral capsule 200 mg, 300 mg	T5	PA; QL (186 EA per 31 days)
FERRIPROX ORAL TABLET 500 MG	T5	PA
INCRELEX	T5	PA
levocarnitine (with sugar)	T2	PA-BvD
levocarnitine oral tablet	T2	PA-BvD
LOKELMA	T3	PA; QL (93 EA per 31 days)
midodrine	T2	
NICOTROL	T4	
NICOTROL NS	T4	
nitisinone	T5	
pilocarpine hcl oral	T3	
PROLASTIN-C INTRAVENOUS RECON SOLN	T5	PA
PYRUKYND ORAL TABLET 20 MG, 5 MG (4-WEEK PACK), 50 MG	T5	PA; QL (56 EA per 28 days)
RAVICTI	T5	PA
REVCOVI	T5	
riluzole	T3	
risedronate oral tablet 30 mg	T2	
sevelamer carbonate oral tablet	T3	
sodium chloride 0.9 % intravenous piggyback	T2	
sodium chloride irrigation	T2	
sodium phenylbutyrate	T5	PA
sodium polystyrene sulfonate oral powder	T2	
SPS (WITH SORBITOL) ORAL	T2	
trientine	T5	QL (248 EA per 31 days)
varenicline oral tablet	T4	QL (60 EA per 30 days)
varenicline oral tablets,dose pack	T4	QL (106 EA per 365 days)

Drug Name	Drug Tier	Requirements/Limits
VELTASSA	T5	PA; QL (30 EA per 30 days)
XURIDEN	T5	PA; QL (124 EA per 31 days)
Ear, Nose / Throat Medications		
acetic acid otic (ear)	T2	
azelastine nasal	T2	QL (30 ML per 25 days)
chlorhexidine gluconate mucous membrane	T1	
ciprofloxacin-dexamethasone	T3	
fluocinolone acetonide oil	T2	
hydrocortisone-acetic acid	T2	
ipratropium bromide nasal spray,non-aerosol 21 mcg (0.03 %)	T2	QL (30 ML per 28 days)
ipratropium bromide nasal spray,non-aerosol 42 mcg (0.06 %)	T2	QL (15 ML per 28 days)
neomycin-polymyxin-hc otic (ear)	T2	
ofloxacin otic (ear)	T2	
olopatadine nasal	T2	QL (30.5 GM per 30 days)
PERIOGARD	T1	
triamcinolone acetonide dental	T2	
Endocrine/Diabetes		
acarbose	T2	QL (93 EA per 31 days)
ALCOHOL PADS	T3	
ANDRODERM	T3	PA; QL (31 EA per 31 days)
BAQSIMI	T3	
cabergoline	T2	
calcitonin (salmon) nasal	T2	PA-BvD
calcitriol oral	T2	PA-BvD
CERDELGA	T5	PA; QL (62 EA per 31 days)
cinacalcet oral tablet 30 mg, 60 mg	T4	PA-BvD; QL (62 EA per 31 days)
cinacalcet oral tablet 90 mg	T4	PA-BvD; QL (124 EA per 31 days)
danazol	T4	
desmopressin nasal spray with pump	T2	
desmopressin oral	T2	
dexamethasone oral solution	T2	
dexamethasone oral tablet	T1	
diazoxide	T4	
doxercalciferol oral	T4	PA-BvD
EUTHYROX	T3	
fludrocortisone	T1	

Drug Name	Drug Tier	Requirements/Limits
glimepiride	T1	PA
glipizide	T1	
glipizide-metformin	T1	
GLUCAGON EMERGENCY KIT (HUMAN)	T3	
GLYXAMBI	T3	QL (31 EA per 31 days)
GVOKE	T3	
GVOKE HYPOPEN 2-PACK	T3	
GVOKE PFS 1-PACK SYRINGE	T3	
HUMALOG JUNIOR KWIKPEN U-100	T3	SI
HUMALOG KWIKPEN INSULIN	T3	SI
HUMALOG MIX 50-50 INSULN U-100	T3	SI
HUMALOG MIX 50-50 KWIKPEN	T3	SI
HUMALOG MIX 75-25 KWIKPEN	T3	SI
HUMALOG MIX 75-25(U-100)INSULN	T3	SI
HUMALOG U-100 INSULIN	T3	SI
HUMULIN 70/30 U-100 INSULIN	T3	SI
HUMULIN 70/30 U-100 KWIKPEN	T3	SI
HUMULIN N NPH INSULIN KWIKPEN	T3	SI
HUMULIN N NPH U-100 INSULIN	T3	SI
HUMULIN R REGULAR U-100 INSULN	T3	SI
HUMULIN R U-500 (CONC) INSULIN	T3	SI
HUMULIN R U-500 (CONC) KWIKPEN	T3	SI
hydrocortisone oral	T2	
INVOKAMET	T3	QL (62 EA per 31 days)
INVOKAMET XR	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 100 MG	T3	QL (62 EA per 31 days)
INVOKANA ORAL TABLET 300 MG	T3	QL (31 EA per 31 days)
JANUMET	T3	QL (62 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG, 50-500 MG	T3	QL (31 EA per 31 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG	T3	QL (62 EA per 31 days)
JANUVIA ORAL TABLET 100 MG, 50 MG	T3	QL (31 EA per 31 days)
JANUVIA ORAL TABLET 25 MG	T3	QL (93 EA per 31 days)
JARDIANCE ORAL TABLET 10 MG	T3	QL (62 EA per 31 days)
JARDIANCE ORAL TABLET 25 MG	T3	QL (31 EA per 31 days)
JENTADUETO	T3	QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG	T3	QL (62 EA per 31 days)
JENTADUETO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 5-1,000 MG	T3	QL (31 EA per 31 days)
KORLYM	T5	PA; QL (124 EA per 31 days)
LANTUS SOLOSTAR U-100 INSULIN	T3	SI
LANTUS U-100 INSULIN	T3	SI
levothyroxine oral tablet	T1	
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	T3	
liothyronine oral	T2	
LYUMJEV KWIKPEN U-100 INSULIN	T3	SI
LYUMJEV KWIKPEN U-200 INSULIN	T3	SI
LYUMJEV U-100 INSULIN	T3	SI
metformin oral tablet 1,000 mg, 500 mg, 850 mg	T1	
metformin oral tablet extended release 24 hr	T1	
metformin oral tablet extended release 24hr	NF	
metformin oral tablet,er gast.retention 24 hr	NF	
methimazole oral tablet 10 mg, 5 mg	T1	
methylprednisolone	T2	
miglustat	T5	PA; QL (93 EA per 31 days)
MOUNJARO	T3	PA; QL (2 ML per 28 days)
MYALEPT	T5	PA
nateglinide	T2	QL (93 EA per 31 days)
NATPARA	T5	PA; QL (31 EA per 31 days)
oxandrolone oral tablet 10 mg	T4	PA
oxandrolone oral tablet 2.5 mg	T3	PA
OZEMPIC SUBCUTANEOUS PEN INJECTOR 0.25 MG OR 0.5 MG(2 MG/1.5 ML), 1 MG/DOSE (4 MG/3 ML), 2 MG/DOSE (8 MG/3 ML)	T3	PA; QL (3 ML per 28 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 10 MG/0.5 ML	T5	PA; QL (15 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 2.5 MG/0.5 ML	T5	PA; QL (4 ML per 30 days)
PALYNZIQ SUBCUTANEOUS SYRINGE 20 MG/ML	T5	PA; QL (90 ML per 30 days)
paricalcitol oral	T4	PA-BvD
pioglitazone	T1	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
pioglitazone-metformin	T2	QL (93 EA per 31 days)
prednisolone oral solution	T2	
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	T2	
prednisone oral solution	T2	
prednisone oral tablet	T1	
prednisone oral tablets,dose pack	T2	
propylthiouracil	T2	
RECORLEV	T5	PA; QL (248 EA per 31 days)
repaglinide oral tablet 0.5 mg, 1 mg	T2	QL (124 EA per 31 days)
repaglinide oral tablet 2 mg	T2	QL (248 EA per 31 days)
RYBELSUS	T3	PA; QL (31 EA per 31 days)
sapropterin	T5	PA
SOLIQUA 100/33	T3	SI; QL (18 ML per 30 days)
SOMAVERT	T5	PA
SYMLINPEN 120	T5	QL (10.8 ML per 28 days)
SYMLINPEN 60	T5	QL (6 ML per 28 days)
SYNAREL	T5	PA
SYNJARDY	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 12.5-1,000 MG, 5-1,000 MG	T3	QL (62 EA per 31 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 25-1,000 MG	T3	QL (31 EA per 31 days)
SYNTHROID	T3	
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml, 200 mg/ml (1 ml)	T2	PA
testosterone enanthate	T3	PA
testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation, 20.25 mg/1.25 gram (1.62 %)	T2	PA
testosterone transdermal gel in packet	T2	PA
testosterone transdermal solution in metered pump w/app	T2	PA
tolvaptan	T5	PA
TOUJEO MAX U-300 SOLOSTAR	T3	SI
TOUJEO SOLOSTAR U-300 INSULIN	T3	SI
TRADJENTA	T3	QL (31 EA per 31 days)
TRIJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-5-1,000 MG, 25-5-1,000 MG	T3	QL (31 EA per 31 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	T3	QL (62 EA per 31 days)
TRULICITY	T3	PA; QL (2 ML per 28 days)
UNITHROID	T3	
VICTOZA 3-PAK	T3	PA; QL (9 ML per 30 days)
XULTOPHY 100/3.6	T3	SI; QL (15 ML per 30 days)
ZEGALOGUE AUTOINJECTOR	T3	
ZEGALOGUE SYRINGE	T3	
Gastroenterology		
alosetron oral tablet 0.5 mg	T5	PA; QL (93 EA per 31 days)
alosetron oral tablet 1 mg	T5	PA; QL (62 EA per 31 days)
AMITIZA	T3	QL (62 EA per 31 days)
aprepitant	T4	PA-BvD
balsalazide	T2	
betaine	T5	
budesonide oral capsule,delayed,extend.release	T4	
budesonide oral tablet,delayed and ext.release	T5	
CHOLBAM	T5	PA
cimetidine	T2	
CIMZIA	T5	PA; QL (2 EA per 28 days)
CIMZIA POWDER FOR RECONST	T5	PA; QL (2 EA per 28 days)
CLENPIQ	T4	
COMPRO	T3	
CONSTULOSE	T2	
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 12,000-38,000 -60,000 UNIT, 3,000-9,500- 15,000 UNIT, 6,000-19,000 -30,000 UNIT	T3	
CREON ORAL CAPSULE,DELAYED RELEASE(DR/EC) 24,000-76,000 -120,000 UNIT, 36,000-114,000- 180,000 UNIT	T5	
cromolyn oral	T4	
dicyclomine oral capsule	T2	
dicyclomine oral solution	T2	
dicyclomine oral tablet	T2	
diphenoxylate-atropine	T2	
dronabinol	T4	PA-BvD
ENULOSE	T2	

Drug Name	Drug Tier	Requirements/Limits
esomeprazole magnesium oral capsule,delayed release(dr/ec)	T2	QL (31 EA per 31 days)
famotidine oral suspension	T2	
famotidine oral tablet 20 mg, 40 mg	T1	
GATTEX 30-VIAL	T5	PA
GAVILYTE-C	T2	
GAVILYTE-G	T2	
GENERLAC	T2	
glycopyrrolate oral tablet 1 mg, 2 mg	T2	
granisetron hcl oral	T2	PA-BvD
hydrocortisone rectal	T4	
hydrocortisone topical cream with perineal applicator 2.5 %	T2	
IBSRELA	T5	PA; QL (62 EA per 31 days)
lactulose oral solution 10 gram/15 ml	T2	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	T2	QL (31 EA per 31 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	T2	QL (62 EA per 31 days)
LINZESS	T3	QL (31 EA per 31 days)
loperamide oral capsule	T2	
meclizine oral tablet 12.5 mg, 25 mg	T2	
mesalamine oral capsule (with del rel tablets)	T2	
mesalamine oral capsule,extended release 24hr	T2	
mesalamine oral tablet,delayed release (dr/ec)	T4	
mesalamine rectal enema	T4	
metoclopramide hcl oral solution	T2	
metoclopramide hcl oral tablet	T1	
misoprostol	T2	
MOVANTIK	T3	QL (31 EA per 31 days)
OCALIVA	T5	PA; QL (31 EA per 31 days)
omeprazole oral capsule,delayed release(dr/ec)	T1	
ondansetron	T2	PA-BvD
ondansetron hcl oral solution	T2	PA-BvD
ondansetron hcl oral tablet 4 mg, 8 mg	T2	PA-BvD
pantoprazole oral tablet,delayed release (dr/ec)	T1	
peg 3350-electrolytes oral recon soln 236-22.74-6.74 -5.86 gram	T2	
peg3350-sod sul-nacl-kcl-asb-c	T4	

Drug Name	Drug Tier	Requirements/Limits
peg-electrolyte soln	T2	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	T3	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 500 MG	T5	
prochlorperazine	T2	
prochlorperazine maleate	T1	
PROCTO-MED HC	T2	
PROCTO-PAK	T2	
PROCTOSOL HC TOPICAL	T2	
PROCTOZONE-HC	T2	
rabeprazole oral tablet,delayed release (dr/ec)	T2	QL (62 EA per 31 days)
RECTIV	T3	
scopolamine base	T3	QL (10 EA per 30 days)
SUCRAID	T5	
sucralfate oral suspension	T4	
sucralfate oral tablet	T2	
sulfasalazine	T2	
SUPREP BOWEL PREP KIT	T3	
ursodiol oral capsule 300 mg	T2	
ursodiol oral tablet	T2	
VIBERZI	T5	PA; QL (62 EA per 31 days)
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 10,000-32,000 -42,000 UNIT, 15,000-47,000 -63,000 UNIT, 20,000-63,000- 84,000 UNIT, 3,000-10,000 -14,000- UNIT, 5,000-17,000- 24,000 UNIT	T3	
ZENPEP ORAL CAPSULE,DELAYED RELEASE(DR/EC) 25,000-79,000- 105,000 UNIT, 40,000-126,000- 168,000 UNIT	T5	
Immunology, Vaccines / Biotechnology		
ACTHIB (PF)	T3	
ACTIMMUNE	T5	PA
ADACEL(TDAP ADOLESN/ADULT)(PF)	T3	
ARCALYST	T5	PA
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	T5	QL (4 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	T5	QL (4 EA per 28 days)
bcg vaccine, live (pf)	T3	

Drug Name	Drug Tier	Requirements/Limits
BESREMI	T5	PA-NS; QL (2 ML per 28 days)
BETASERON SUBCUTANEOUS KIT	T5	QL (14 EA per 28 days)
BEXSERO	T3	
BOOSTRIX TDAP	T3	
DAPTACEL (DTAP PEDIATRIC) (PF)	T3	
ENGERIX-B (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
ENGERIX-B PEDIATRIC (PF)	T3	PA-BvD
FULPHILA	T5	
GARDASIL 9 (PF)	T3	
HAVRIX (PF)	T3	
HIBERIX (PF)	T3	
IMOVAX RABIES VACCINE (PF)	T3	PA-BvD
INFANRIX (DTAP) (PF) INTRAMUSCULAR SYRINGE	T3	
INTRON A INJECTION RECON SOLN	T5	PA-NS
IPOL	T3	
IXIARO (PF)	T3	
KINRIX (PF) INTRAMUSCULAR SYRINGE	T3	
LEUKINE INJECTION RECON SOLN	T5	PA
MENACTRA (PF) INTRAMUSCULAR SOLUTION	T3	
MENQUADFI (PF)	T3	
MENVEO A-C-Y-W-135-DIP (PF)	T3	
M-M-R II (PF)	T3	
NIVESTYM	T5	
NYVEPRIA	T5	
OMNITROPE SUBCUTANEOUS CARTRIDGE 10 MG/1.5 ML (6.7 MG/ML)	T5	PA
OMNITROPE SUBCUTANEOUS CARTRIDGE 5 MG/1.5 ML (3.3 MG/ML)	T4	PA
OMNITROPE SUBCUTANEOUS RECON SOLN	T5	PA
PEDIARIX (PF)	T3	PA-BvD
PEDVAX HIB (PF)	T3	
PEGASYS	T5	PA
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	T3	
PLEGRIDY SUBCUTANEOUS PEN INJECTOR 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
PLEGRIDY SUBCUTANEOUS SYRINGE 125 MCG/0.5 ML	T5	QL (1 ML per 28 days)
PREHEVBRIO (PF)	T3	PA-BvD
PRIVIGEN	T5	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML	T3	PA-BvD
PROCRIT INJECTION SOLUTION 20,000 UNIT/ML, 40,000 UNIT/ML	T5	PA-BvD
PROQUAD (PF)	T3	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION	T3	
RABAVERT (PF)	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SUSPENSION 10 MCG/ML, 40 MCG/ML	T3	PA-BvD
RECOMBIVAX HB (PF) INTRAMUSCULAR SYRINGE	T3	PA-BvD
RETACRIT	T3	PA-BvD
ROTARIX	T3	
ROTATEQ VACCINE	T3	
SHINGRIX (PF)	T3	QL (2 EA per 999 days)
TDVAX	T3	
TENIVAC (PF) INTRAMUSCULAR SYRINGE	T3	
tetanus,diphtheria tox ped(pf)	T3	
TICOVAC INTRAMUSCULAR SYRINGE 2.4 MCG/0.5 ML	T3	
TRUMENBA	T3	
TWINRIX (PF)	T3	
TYPHIM VI	T3	
VAQTA (PF)	T3	
VARIVAX (PF)	T3	
YF-VAX (PF)	T3	
ZARXIO	T5	
ZIEXTENZO	T5	
Miscellaneous Supplies		
ASSURE ID INSULIN SAFETY SYRINGE 1 ML 29 GAUGE X 1/2"	T3	
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	T3	
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	T3	

Drug Name	Drug Tier	Requirements/Limits
pen needle, diabetic needle 29 gauge x 1/2"	T3	
Musculoskeletal / Rheumatology		
ACTEMRA ACTPEN	T5	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	T5	PA; QL (3.6 ML per 28 days)
alendronate oral tablet 10 mg, 35 mg, 70 mg	T1	
allopurinol	T1	
BENLYSTA SUBCUTANEOUS	T5	PA; QL (4 ML per 28 days)
colchicine oral tablet	T2	QL (62 EA per 31 days)
ENBREL MINI	T5	PA; QL (7.84 ML per 28 days)
ENBREL SUBCUTANEOUS RECON SOLN	T5	PA; QL (8 EA per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 25 MG/0.5 ML (0.5)	T5	PA; QL (4 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE 50 MG/ML (1 ML)	T5	PA; QL (7.84 ML per 28 days)
ENBREL SURECLICK	T5	PA; QL (7.84 ML per 28 days)
febuxostat	T2	PA
HUMIRA PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA PEN CROHNS-UC-HS START	T5	PA; QL (6 EA per 28 days)
HUMIRA PEN PSOR-UVEITS-ADOL HS	T5	PA; QL (4 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF)	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEDI CROHNS STARTER SUBCUTANEOUS SYRINGE KIT 80 MG/0.8 ML-40 MG/0.4 ML	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN	T5	PA; QL (2 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	T5	PA; QL (3 EA per 28 days)
HUMIRA(CF) PEN PEDIATRIC UC	T5	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	T5	PA; QL (3 EA per 28 days)
ibandronate oral	T2	
leflunomide	T2	
OLUMIANT ORAL TABLET 1 MG, 2 MG	T5	PA; QL (31 EA per 31 days)
ORENCIA CLICKJECT	T5	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	T5	PA; QL (4 ML per 28 days)

Drug Name	Drug Tier	Requirements/Limits
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	T5	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	T5	PA; QL (2.8 ML per 28 days)
OTEZLA	T5	PA; QL (62 EA per 31 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)-20 MG (4)-30 MG (47)	T5	PA; QL (55 EA per 28 days)
penicillamine oral tablet	T5	
probenecid	T2	
probenecid-colchicine	T2	
PROLIA	T3	PA; QL (1 ML per 180 days)
raloxifene	T2	
RIDAURA	T5	
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	T5	PA; QL (31 EA per 31 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	T5	PA; QL (112 EA per 365 days)
risedronate oral tablet 150 mg, 35 mg, 35 mg (12 pack), 35 mg (4 pack), 5 mg	T2	
risedronate oral tablet,delayed release (dr/ec)	T4	
SAVELLA	T3	PA
SIMPONI SUBCUTANEOUS PEN INJECTOR 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS PEN INJECTOR 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (1 ML per 28 days)
SIMPONI SUBCUTANEOUS SYRINGE 50 MG/0.5 ML	T5	PA; QL (0.5 ML per 28 days)
teriparatide	T5	PA; QL (2.48 ML per 28 days)
TYMLOS	T5	PA; QL (1.56 ML per 30 days)
XELJANZ ORAL SOLUTION	T5	PA; QL (310 ML per 31 days)
XELJANZ ORAL TABLET	T5	PA; QL (62 EA per 31 days)
XELJANZ XR	T5	PA; QL (31 EA per 31 days)
Obstetrics / Gynecology		
ALTAVERA (28)	T2	
ALYACEN 1/35 (28)	T2	
AMABELZ	T2	
APRI	T2	
ARANELLE (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
AVIANE	T2	
CAMILA	T2	
CAZIANT (28)	T2	
clindamycin phosphate vaginal	T2	
CRYSELLE (28)	T2	
CYRED EQ	T2	
desogestrel-ethinyl estradiol	T2	
DOTTI	T2	
drospirenone-e.estradiol-lm.fa oral tablet 3-0.02-0.451 mg (24) (4)	T2	
drospirenone-ethinyl estradiol	T2	
ELURYNG	T4	
EMOQUETTE	T2	
ENPRESSE	T2	
ENSKYCE	T2	
ERRIN	T2	
ESTARYLLA	T2	
estradiol oral	T2	
estradiol transdermal	T2	
estradiol vaginal	T2	
estradiol-norethindrone acet	T2	
ethynodiol diac-eth estradiol	T2	
etonogestrel-ethinyl estradiol	T4	
FEMYNOR	T2	
INCASSIA	T2	
INTROVALE	T2	
ISIBLOOM	T2	
JASMIEL (28)	T2	
JINTELI	T4	
JULEBER	T2	
KARIVA (28)	T2	
KELNOR 1/35 (28)	T2	
KELNOR 1-50 (28)	T2	
KURVELO (28)	T2	
l norgest/e.estradiol-e.estrad	T2	
LARISSIA	T2	
LESSINA	T2	
LEVONEST (28)	T2	

Drug Name	Drug Tier	Requirements/Limits
levonorgestrel-ethinyl estrad	T2	
levonorg-eth estrad triphasic	T2	
LEVORA-28	T2	
LORYNA (28)	T2	
LOW-OGESTREL (28)	T2	
LUTERA (28)	T2	
LYLEQ	T2	
LYLLANA	T2	
LYZA	T2	
MARLISSA (28)	T2	
medroxyprogesterone	T2	
metronidazole vaginal	T2	
MICONAZOLE-3 VAGINAL SUPPOSITORY	T2	
MICROGESTIN 1.5/30 (21)	T2	
MICROGESTIN 1/20 (21)	T2	
MICROGESTIN FE 1.5/30 (28)	T2	
MICROGESTIN FE 1/20 (28)	T2	
MILI	T2	
MIMVEY	T2	
norethindrone (contraceptive)	T2	
norethindrone acetate	T2	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	T4	
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	T2	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	T2	
norgestimate-ethinyl estradiol	T2	
NORTREL 0.5/35 (28)	T2	
NORTREL 1/35 (21)	T2	
NORTREL 1/35 (28)	T2	
NORTREL 7/7/7 (28)	T2	
PIMTREA (28)	T2	
PIRMELLA ORAL TABLET 1-35 MG-MCG	T2	
PORTIA 28	T2	
PREMARIN ORAL	T3	
PREMARIN VAGINAL	T3	
PREMPRO	T3	

Drug Name	Drug Tier	Requirements/Limits
progesterone micronized	T2	
RECLIPSEN (28)	T2	
SETLAKIN	T2	
SPRINTEC (28)	T2	
SRONYX	T2	
SYEDA	T2	
terconazole	T2	
TILIA FE	T2	
tranexamic acid oral	T3	
TRI-ESTARYLLA	T2	
TRI-LEGEST FE	T2	
TRI-LO-ESTARYLLA	T2	
TRI-LO-SPRINTEC	T2	
TRI-SPRINTEC (28)	T2	
TRIVORA (28)	T2	
VANDAZOLE	T3	
VELIVET TRIPHASIC REGIMEN (28)	T2	
VESTURA (28)	T2	
VIENVA	T2	
YUVAFEM	T2	
ZAFEMY	T4	
ZOVIA 1-35 (28)	T2	
Ophthalmology		
acetazolamide	T2	
ALOMIDE	T3	
ALPHAGAN P OPHTHALMIC (EYE) DROPS 0.1 %	T3	
apraclonidine	T2	
atropine ophthalmic (eye) drops	T2	
azelastine ophthalmic (eye)	T2	
bacitracin ophthalmic (eye)	T2	
bacitracin-polymyxin b	T2	
bepotastine besilate	T3	
BESIVANCE	T3	
betaxolol ophthalmic (eye)	T2	
bimatoprost ophthalmic (eye)	T2	
BLEPHAMIDE S.O.P.	T4	
brimonidine	T2	

Drug Name	Drug Tier	Requirements/Limits
brimonidine-timolol	T3	
brinzolamide	T4	
bromfenac	T2	
BROMSITE	T3	
carteolol	T2	
ciprofloxacin hcl ophthalmic (eye)	T2	
COMBIGAN	T3	
cromolyn ophthalmic (eye)	T2	
cyclosporine ophthalmic (eye)	T3	QL (60 EA per 30 days)
CYSTARAN	T5	PA; QL (60 ML per 28 days)
dexamethasone sodium phosphate ophthalmic (eye)	T2	
diclofenac sodium ophthalmic (eye)	T2	
difluprednate	T3	
dorzolamide	T2	
dorzolamide-timolol	T2	
dorzolamide-timolol (pf) ophthalmic (eye) dropperette	T2	
erythromycin ophthalmic (eye)	T2	
EYSUVIS	T3	QL (8.3 ML per 30 days)
fluorometholone	T2	
flurbiprofen sodium	T2	
gatifloxacin	T2	
GENTAK OPHTHALMIC (EYE) OINTMENT	T2	
gentamicin ophthalmic (eye) drops	T2	
ILEVRO	T3	
ketorolac ophthalmic (eye)	T2	
latanoprost	T1	
levobunolol ophthalmic (eye) drops 0.5 %	T2	
levofloxacin ophthalmic (eye) drops 0.5 %	T3	
loteprednol etabonate ophthalmic (eye) drops,gel	T3	
loteprednol etabonate ophthalmic (eye) drops,suspension	T2	
LUMIGAN OPHTHALMIC (EYE) DROPS 0.01 %	T3	QL (5 ML per 31 days)
methazolamide	T4	
moxifloxacin ophthalmic (eye) drops	T2	
NATACYN	T4	

Drug Name	Drug Tier	Requirements/Limits
neomycin-bacitracin-poly-hc	T2	
neomycin-bacitracin-polymyxin	T2	
neomycin-polymyxin b-dexameth	T2	
neomycin-polymyxin-gramicidin	T2	
neomycin-polymyxin-hc ophthalmic (eye)	T3	
ofloxacin ophthalmic (eye)	T2	
olopatadine ophthalmic (eye)	T2	
OXERVATE	T5	PA; QL (112 ML per 56 days)
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	T2	
polymyxin b sulf-trimethoprim	T2	
prednisolone acetate	T2	
prednisolone sodium phosphate ophthalmic (eye)	T2	
PROLENSA	T3	
RESTASIS	T3	QL (60 EA per 30 days)
RESTASIS MULTIDOSE	T3	QL (5.5 ML per 27 days)
RHOPRESSA	T3	ST
ROCKLATAN	T3	ST
SIMBRINZA	T4	
sulfacetamide sodium ophthalmic (eye)	T2	
sulfacetamide-prednisolone	T2	
timolol maleate ophthalmic (eye) drops	T1	
timolol maleate ophthalmic (eye) drops, once daily	T2	
timolol maleate ophthalmic (eye) gel forming solution	T3	
TOBRADEX OPHTHALMIC (EYE) OINTMENT	T3	
tobramycin ophthalmic (eye)	T2	
tobramycin-dexamethasone	T3	
travoprost	T3	
trifluridine	T3	
XIIDRA	T3	QL (60 EA per 30 days)
ZIRGAN	T4	ST
Respiratory And Allergy		
acetylcysteine	T2	PA-BvD
ADEMPAS	T5	PA; QL (93 EA per 31 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	T2	QL (17 GM per 30 days)

Drug Name	Drug Tier	Requirements/Limits
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020503)	T2	QL (13.4 GM per 30 days)
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation (nda020983)	NF	
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	T2	PA-BvD
albuterol sulfate oral syrup	T2	
albuterol sulfate oral tablet	T4	
ALYQ	T5	PA; QL (62 EA per 31 days)
ambrisentan	T5	PA; QL (31 EA per 31 days)
ANORO ELLIPTA	T3	QL (60 EA per 30 days)
arformoterol	T3	PA-BvD
ASMANEX HFA	T3	QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (120), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	T3	QL (1 EA per 30 days)
ATROVENT HFA	T3	QL (25.8 GM per 30 days)
azelastine-fluticasone	T2	QL (23 GM per 30 days)
bosentan	T5	PA; QL (62 EA per 31 days)
BREO ELLIPTA	T3	QL (60 EA per 30 days)
BREZTRI AEROSPHERE	T3	QL (10.7 GM per 30 days)
budesonide inhalation	T4	PA-BvD
cetirizine oral solution 1 mg/ml	T2	QL (310 ML per 31 days)
CINRYZE	T5	PA; QL (20 EA per 28 days)
COMBIVENT RESPIMAT	T3	QL (4 GM per 30 days)
cromolyn inhalation	T5	PA-BvD
DALIRESP	T4	QL (31 EA per 31 days)
desloratadine oral tablet	T2	QL (31 EA per 31 days)
desloratadine oral tablet,disintegrating	T3	QL (31 EA per 31 days)
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml	T3	
ESBRIET ORAL CAPSULE	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 267 MG	T5	PA; QL (279 EA per 31 days)
ESBRIET ORAL TABLET 801 MG	T5	PA; QL (93 EA per 31 days)
FASENRA	T5	PA; QL (1 ML per 56 days)
FASENRA PEN	T5	PA; QL (1 ML per 56 days)

Drug Name	Drug Tier	Requirements/Limits
FLOVENT HFA INHALATION HFA AEROSOL INHALER 110 MCG/ACTUATION	T4	QL (12 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 220 MCG/ACTUATION	T4	QL (24 GM per 30 days)
FLOVENT HFA INHALATION HFA AEROSOL INHALER 44 MCG/ACTUATION	T4	QL (10.6 GM per 30 days)
flunisolide	T2	QL (50 ML per 25 days)
fluticasone propionate nasal	T2	QL (16 GM per 30 days)
fluticasone propion-salmeterol inhalation aerosol powdr breath activated	T3	QL (1 EA per 30 days)
fluticasone propion-salmeterol inhalation blister with device	T1	QL (60 EA per 30 days)
formoterol fumarate	T3	PA-BvD
hydroxyzine hcl oral tablet	T2	PA
icatibant	T5	PA; QL (18 ML per 30 days)
INCRUSE ELLIPTA	T3	QL (30 EA per 30 days)
ipratropium bromide inhalation	T2	PA-BvD
ipratropium-albuterol	T2	PA-BvD
KALYDECO ORAL GRANULES IN PACKET 25 MG	T5	PA; QL (62 EA per 31 days)
KALYDECO ORAL GRANULES IN PACKET 50 MG, 75 MG	T5	PA; QL (56 EA per 28 days)
KALYDECO ORAL TABLET	T5	PA; QL (62 EA per 31 days)
levalbuterol hcl inhalation solution for nebulization 0.31 mg/3 ml, 0.63 mg/3 ml, 1.25 mg/0.5 ml	T2	PA-BvD
levalbuterol hcl inhalation solution for nebulization 1.25 mg/3 ml	T3	PA-BvD
levalbuterol tartrate	T3	QL (30 GM per 30 days)
levocetirizine oral solution	T2	QL (310 ML per 31 days)
levocetirizine oral tablet	T2	QL (31 EA per 31 days)
mometasone nasal	T2	QL (34 GM per 30 days)
montelukast oral tablet	T2	QL (31 EA per 31 days)
montelukast oral tablet,chewable	T2	QL (31 EA per 31 days)
NUCALA SUBCUTANEOUS AUTO-INJECTOR	T5	PA; QL (3 ML per 28 days)
NUCALA SUBCUTANEOUS RECON SOLN	T5	PA; QL (3 EA per 28 days)
NUCALA SUBCUTANEOUS SYRINGE 100 MG/ML	T5	PA; QL (3 ML per 28 days)
OFEV	T5	PA; QL (62 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
OPSUMIT	T5	PA; QL (31 EA per 31 days)
ORKAMBI ORAL GRANULES IN PACKET	T5	PA; QL (62 EA per 31 days)
ORKAMBI ORAL TABLET	T5	PA; QL (124 EA per 31 days)
ORLADEYO	T5	PA; QL (31 EA per 31 days)
pirfenidone oral tablet 267 mg	T5	PA; QL (279 EA per 31 days)
pirfenidone oral tablet 801 mg	T5	PA; QL (93 EA per 31 days)
promethazine oral	T4	PA
PULMOZYME	T5	PA
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 40 MCG/ACTUATION	T3	QL (10.6 GM per 30 days)
QVAR REDIHALER INHALATION HFA AEROSOL BREATH ACTIVATED 80 MCG/ACTUATION	T3	QL (21.2 GM per 30 days)
SAJAZIR	T5	PA; QL (18 ML per 30 days)
SEREVENT DISKUS	T3	QL (60 EA per 30 days)
sildenafil (pulm.hypertension) oral tablet	T3	PA; QL (93 EA per 31 days)
SPIRIVA RESPIMAT	T3	QL (4 GM per 30 days)
SPIRIVA WITH HANDIHALER	T3	QL (30 EA per 30 days)
STIOLTO RESPIMAT	T3	QL (4 GM per 30 days)
STRIVERDI RESPIMAT	T3	QL (4 GM per 30 days)
SYMBICORT	T3	QL (10.2 GM per 30 days)
SYMDEKO	T5	PA; QL (56 EA per 28 days)
SYMJEPI	T4	
tadalafil (pulm. hypertension)	T5	PA; QL (62 EA per 31 days)
terbutaline oral	T4	
THEO-24	T3	
theophylline oral solution	T2	
theophylline oral tablet extended release 12 hr 300 mg, 450 mg	T2	
theophylline oral tablet extended release 24 hr	T2	
TRELEGY ELLIPTA	T3	QL (60 EA per 30 days)
TRIKAFTA	T5	PA; QL (84 EA per 28 days)
WIXELA INHUB	T1	QL (60 EA per 30 days)
XOLAIR	T5	PA
zafirlukast oral tablet 10 mg	T2	QL (93 EA per 31 days)
zafirlukast oral tablet 20 mg	T2	QL (62 EA per 31 days)
Urologicals		
alfuzosin	T2	QL (31 EA per 31 days)

Drug Name	Drug Tier	Requirements/Limits
bethanechol chloride oral tablet 10 mg, 25 mg, 5 mg	T2	
bethanechol chloride oral tablet 50 mg	T3	
CIALIS ORAL TABLET 2.5 MG	T4	PA; QL (62 EA per 31 days)
CIALIS ORAL TABLET 5 MG	T4	PA; QL (31 EA per 31 days)
CYSTAGON	T4	
dutasteride	T2	QL (31 EA per 31 days)
dutasteride-tamsulosin	T2	QL (31 EA per 31 days)
ELMIRON	T5	
finasteride oral tablet 5 mg	T2	
MYRBETRIQ ORAL SUSPENSION,EXTENDED REL RECON	T3	QL (300 ML per 30 days)
MYRBETRIQ ORAL TABLET EXTENDED RELEASE 24 HR	T3	QL (31 EA per 31 days)
oxybutynin chloride oral syrup	T3	
oxybutynin chloride oral tablet	T3	
oxybutynin chloride oral tablet extended release 24hr 10 mg, 5 mg	T3	QL (31 EA per 31 days)
oxybutynin chloride oral tablet extended release 24hr 15 mg	T3	QL (62 EA per 31 days)
potassium citrate oral tablet extended release	T2	
silodosin	T2	
tadalafil oral tablet 2.5 mg	T4	PA; QL (62 EA per 31 days)
tadalafil oral tablet 5 mg	T4	PA; QL (31 EA per 31 days)
tamsulosin	T1	
tolterodine oral capsule,extended release 24hr	T2	QL (31 EA per 31 days)
tolterodine oral tablet	T2	QL (62 EA per 31 days)
trospium oral capsule,extended release 24hr	T3	QL (31 EA per 31 days)
trospium oral tablet	T2	QL (93 EA per 31 days)
Vitamins, Hematinics / Electrolytes		
calcium acetate(phosphat bind) oral capsule	T2	
calcium acetate(phosphat bind) oral tablet	T3	
CLINIMIX 5%/D15W SULFITE FREE	T4	PA-BvD
CLINIMIX 4.25%/D10W SULF FREE	T4	PA-BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	T4	PA-BvD
fluoride (sodium) oral tablet	T2	
INTRALIPID INTRAVENOUS EMULSION 20 %	T4	PA-BvD
ISOLYTE S PH 7.4	T4	PA-BvD
ISOLYTE-P IN 5 % DEXTROSE	T4	PA-BvD

Drug Name	Drug Tier	Requirements/Limits
KLOR-CON	T4	
KLOR-CON M10	T1	
KLOR-CON M15	T2	
KLOR-CON M20	T1	
magnesium sulfate injection	T2	
PLENAMINE	T4	PA-BvD
potassium chlorid-d5-0.45%nacl	T2	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	T2	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	T2	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	T2	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	T2	
potassium chloride intravenous	T2	
potassium chloride oral capsule, extended release	T1	
potassium chloride oral liquid	T2	
potassium chloride oral packet	T2	
potassium chloride oral tablet extended release	T1	
potassium chloride oral tablet,er particles/crystals 10 meq, 20 meq	T1	
potassium chloride oral tablet,er particles/crystals 15 meq	T2	
potassium chloride-0.45 % nacl	T2	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	T2	
potassium chloride-d5-0.9%nacl	T2	
PRENATAL VITAMIN PLUS LOW IRON	T2	PA
sodium chloride 0.45 % intravenous parenteral solution	T2	
sodium chloride 3 % hypertonic	T2	
sodium chloride 5 % hypertonic	T2	
TRAVASOL 10 %	T4	PA-BvD
TROPHAMINE 10 %	T4	PA-BvD

Index of Drugs

This formulary was updated on 9/1/2022.
For more recent information or other questions, please contact:
Highmark Blue Shield of Northeastern New York Customer Service
at 1-800-329-2792.

For TTY users, 711 National Relay Service, Oct. 1 – March 31, 8 a.m. – 8 p.m. EST, seven days a week, and April 1 – Aug. 30, 8 a.m. – 8 p.m. EST, Monday – Friday, or visit **medicare.highmark.com**.

The Formulary may change at any time. You will receive notice when necessary.

Highmark Blue Shield of Northeastern New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

Highmark Blue Shield of Northeastern New York is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark Blue Shield of Northeastern New York complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

09/22 Z MX1911819

Additional Information

About our benefits and premiums

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for Extra Help, call one of the following:

- 1-800-MEDICARE (1-800-633-4227) (TTY 711), 24 hours a day/7 days a week
- The Social Security office at 1-800-772-1213 (TTY 711), between 7 a.m. and 7 p.m., Monday through Friday
- Your state Medicaid office

About us

BlueShield of Northeastern New York (BSNENY) is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. BSNENY is a division of HealthNow New York Inc., an independent licensee of the Blue Cross and Blue Shield Association.

About our partners

Express Scripts® is a separate company. Livongo® is a registered trademark and an independent company.

TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the routine hearing exam and hearing-aid benefit.

SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit.

Doctor On Demand® is a separate company that provides telemedicine services to BSNENY members.

Care at Home℠ is a program for BSNENY members and is administered by Landmark Health, a separate company.

Mom's Meals, an independent company, administers meal benefits on behalf of BSNENY.

Davis Vision, a subsidiary of Versant Health, administers vision benefits on behalf of BSNENY.

Other pharmacies/physicians/providers are available in our network. Out-of-network/ noncontracted providers are under no obligation to treat BSNENY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services.

Notice of Nondiscrimination

BlueShield of Northeastern New York

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

BlueShield of Northeastern New York:

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

If you need these services, please call the customer service number on the back of your ID card or contact the Director, Corporate Compliance and Privacy Officer.

If you believe that BlueShield of Northeastern New York 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:

Director, Corporate Compliance and Privacy Officer, 257 West Genesee Street, Buffalo, NY 14202, 1-800-798-1453, (716) 887-6056 (fax), complaint.compliance@bsneny.com. You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Notice of Nondiscrimination

BlueShield of Northeastern New York

For assistance in English, call customer service at the number listed on your ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার্ডে তালিকাভুক্ত নম্বরে ক্রেতা পরিষেবায় ফোন করুন।

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں۔

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2023 Medicare Star Ratings

Highmark BCBS of WNY and Highmark BS of NENY - H3384

For 2023, Highmark BCBS of WNY and Highmark BS of NENY - H3384 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★☆
Health Services Rating:	★★★★☆
Drug Services Rating:	★★★★☆

Every year, Medicare evaluates plans based on a 5-star rating system.

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Get More Information on Star Ratings Online
Compare Star Ratings for this and other plans online at medicare.gov/plan-compare.

Questions about this plan?
Contact Highmark BCBS of WNY and Highmark BS of NENY 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at **800-248-9296** (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-329-2792 (toll-free) or 711 (TTY).

HIGHMARK WESTERN NEW YORK

IMPORTANT INFORMATION:

Official U.S. Government Medicare Information

2023 Medicare Star Ratings

Highmark BCBS of WNY and Highmark BS of NENY - H5526

For 2023, Highmark BCBS of WNY and Highmark BS of NENY - H5526 received the following Star Ratings from Medicare:

Overall Star Rating:	★★★★★
Health Services Rating:	★★★★½
Drug Services Rating:	★★★★½

Every year, Medicare evaluates plans based on a 5-star rating system.

This plan got MEDICARE'S HIGHEST RATING (5 stars)

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
★★★★☆ ABOVE AVERAGE
★★★☆☆ AVERAGE
★★☆☆☆ BELOW AVERAGE
★☆☆☆☆ POOR

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online
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Questions about this plan?
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HIGHMARK WESTERN NEW YORK

Highmark Blue Cross Blue Shield of Western New York (Highmark BCBS of WNY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Highmark BCBS of WNY is a Medicare Advantage plan with a Medicare contract and enrollment depends on contract renewal. Highmark BCBS of WNY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Y0037_22_1732_M

2023 Summary of Benefits

Albany Medicare portfolio/11448676
Forever Blue 799 (PPO) Plan CF38 TRx (2023)
PPO-H5526 808
This is a summary of drug and health services covered by Forever Blue 799 (PPO) Plan CF38 TRx (2023)
January 1, 2023 – December 31, 2023

Forever Blue 799 (PPO) Plan CF38 TRx (2023) is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in the plan depends on contract renewal.

The benefit information provided does not list every service that we cover, limitation, or exclusion. To get a complete list of services we cover, please request the "Evidence of Coverage".

To join **Forever Blue 799 (PPO) Plan CF38 TRx (2023)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and your former employer must reside in our service area. Our service area includes the following counties in New York State: Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services. If you see a provider who participates in the Medicare Advantage PPO Network Sharing Program outside of our service area, you pay your in-network copay. If you receive care from out of-network providers, your cost may be higher.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800 -633-4227). TTY users should call 1-877-486-2048. This document is also available in large print.

Please call us at 1-855-215-9239 (TTY 711) or visit us at **bsneny.com/medicare.**

Our office hours are:
Monday-Friday: 8 a.m. - 5 p.m.

Premiums and Benefits	Forever Blue 799 (PPO) Plan CF38 TRx (2023)	
	In-Network	Out-of-Network
Monthly plan premium	*If you currently pay a premium for your coverage please reach out to your Group Benefit Administrator to find out your cost.	
Deductible	This plan does not have a medical deductible	
Maximum out-of -pocket responsibility (does not include prescription drugs)	You pay no more than $4,500 annually Includes copays and other costs for medical services for the year.	You pay no more than $4,500 annually Includes copays and other costs for medical services for the year.
Inpatient hospital	You pay $0 per stay Services may require a prior authorization	You pay $0 per stay

Premiums and Benefits	Forever Blue 799 (PPO) Plan CF38 TRx (2023)	
Outpatient hospital	You pay $0 Services may require a prior authorization	You pay $0
Doctor visit Primary Specialist	 You pay $15 You pay $15	 You pay $20 You pay $20
Preventive care (e.g. flu vaccine, diabetic screenings)	You pay $0	You pay $0
Emergency care	You pay $0 If you are admitted to the hospital within 1 day, then you do not have to pay $0	You pay $0 If you are admitted to the hospital within 1 day, then you do not have to pay $0
Surgery – ambulatory center	You pay $0 Services may require a prior authorization	You pay $0
Urgently needed services	You pay $0 If you are admitted to the hospital within 1 day, then you do not have to pay $0	You pay $0 If you are admitted to the hospital within 1 day, then you do not have to pay $0
Diagnostic services/labs/imaging Diagnostic and procedures Lab services Advanced radiology — MRI, MRA, PET, and CT Outpatient X-Rays Therapeutic radiology services (such as radiation treatment for cancer)	 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0 Services may require a prior authorization	 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0
Hearing services Diagnostic hearing exam Routine hearing exam – TruHearing™ Hearing aid benefit – TruHearing™	 You pay $15 You pay $45, one routine hearing exam allowed annually $699/$999, one aid per ear per year	 You pay $20 You pay $45, one routine hearing exam allowed annually $699/$999, one aid per ear per year
Dental services Medicare covered dental services Dental allowance	 You pay $0 You pay $200 annual allowance	 You pay $20 You pay $200 annual allowance

Premiums and Benefits	Forever Blue 799 (PPO) Plan CF38 TRx (2023)	
Vision services Routine eye exam* Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening) Annual screening for diabetic retinopathy (for people with diabetes) Eyeglass or contact lenses after cataract surgery* Eyewear allowance* *A Davis Vision provider must be used to be considered in-network	 You pay $15 You pay $15 You pay $0 You pay $0 $200 annual allowance (INN and OON combined)	 You pay $0 You pay $20 You pay $0 You pay $0 $200 annual allowance (INN and OON combined)
Mental health services Mental health (inpatient, 190-day lifetime limit) Outpatient group therapy/ individual therapy visit	 You pay $0 per stay You pay $0 Services may require a prior authorization	 You pay $0 per stay You pay $0
Skilled nursing facility	You pay $0 per stay Services may require a prior authorization	You pay $0 per stay
Physical therapy	You pay $0	You pay $0
Ambulance	You pay $0 Services may require a prior authorization	You pay $0
Transportation	Not covered	
Medicare Part B drugs Immunosuppressive drugs Oral chemotherapy drugs Physician administered injectables Nebulizer drugs other Part B drugs	 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0 Services may require a prior authorization	 You pay $0 You pay $0 You pay $0 You pay $0 You pay $0
Outpatient Prescription Drugs		
Deductible	You pay $0	

Outpatient Prescription Drugs**			
	Preferred Retail Rx 30-day supply	Non-Preferred Retail Rx 30-day supply	Mail Order 90-day supply
Initial coverage Tier 1: Preferred generic Tier 2: Generic Tier 3: Preferred brand Tier 4: Non-preferred drug Tier 5: Specialty tier	 You pay $0 You pay $5 You pay $5 You pay $10 You pay $10	 You pay $5 You pay $10 You pay $10 You pay $15 You pay $15	 You pay $0 You pay $10 You pay $10 You pay $20 Not covered
Coverage gap or donut hole	No coverage gap		
Cost-sharing may change depending on the pharmacy you choose and when you enter another of the four phases of the Part D benefit.			
Additional Benefits			
Other rehabilitation services Occupational therapy Speech therapy Cardiac rehab Chiropractor	 You pay $0 You pay $0 You pay $15 You pay $15 Services may require a prior authorization		 You pay $0 You pay $0 You pay $20 You pay $20
Supplies, equipment and devices Durable medical equipment Prosthetics Diabetic supplies - Part B	 You pay $0 compression stockings; 20% all other items You pay $0 diabetic shoes/inserts; 20% all other items You pay $0 Services may require a prior authorization		 You pay 20% You pay 20% You pay 20%
Fitness program - Silver Sneakers®	Covered in full		
Hospital observation	You pay $0		You pay $0
Dialysis	You pay $0		You pay Inside service area: 20% for non-participating providers. Outside service area: $0 for non-participating providers.
Shingles	You pay $0 Preferred / $5 Standard		

**Important Message: If you have prescription cost sharing more than $35/month - What You Pay for Insulin – The maximum copayment for a one-month supply of covered insulin products is $35, no matter what cost-sharing tier it is on or if you have not met your Rx deductible (if applicable).

Additional Benefits		
Telemedicine Amwell Your health provider	You pay $0 Your regular copay: Primary = $15 Specialist = $15 Mental health professional = $0 Mental health psychiatrist = $0 Alcohol & Substance Abuse = $0	You pay $0 Not covered
Home health care	You pay $0	You pay $0

Highmark Blue Shield of Northeastern New York (Highmark BSNENY) is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association. Amwell is a separate company that provides telemedicine services to Highmark BSNENY members. TruHearing® is a registered trademark of TruHearing, Inc. TruHearing is an independent company that administers the hearing-aid benefit. Davis Vision, a subsidiary of Versant Health, administers vision benefits. SilverSneakers® is a registered trademark of Tivity Health, Inc. Tivity Health is an independent company that administers the SilverSneakers gym benefit. Other pharmacies/physicians/providers are available in our network. Out-of-network/non-contracted providers are under no obligation to treat Highmark BSNENY members, except in emergency situations. Please call our customer service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. Highmark BSNENY complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencialingüística.Llame al 1-833-735-4515. (TTY 711). 注意：如果您使用繁體中文，您可以免費獲得語言 援助服務。請致電 1-833-735-4515 (TTY 711).

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-329-2792, or for TTY users (TTY 711), October 1 – March 31, 8 a.m. to 8 p.m., 7 days a week and April 1 – September 30, 8 a.m. to 8 p.m. Monday – Friday.

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.bsneny.com/medicare or call 1-800-329-2792 to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2022
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.

Medicare Advantage Dental Receipt Reimbursement

Please attach a copy of your itemized bill and paid receipt. Keep a copy of all documents for your records, as copies submitted with your request will not be returned. Not all plans include dental coverage or dental allowances. If your plan does not include dental coverage or dental allowances, disregard this form. You must submit your claim to us within 12 months of the date you received the service.

Date	
Name	
Address	
Date of birth	

Subscriber ID	
Dental provider's national provider identifier (NPI)/ taxpayer identification number (TIN)	
Dental provider's name	
Dental provider's address	

Please mail to:

Dental Claims Administrator
P.O. Box 69421
Harrisburg, PA 17106-9421

Allow four to six weeks for reimbursement. If you have any questions, feel free to contact customer service at 1-800-329-2792 (TTY 711), Monday – Friday, 8 a.m. – 8 p.m. EST.

HIGHMARK
NORTHEASTERN NEW YORK

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MEDICARE ADVANTAGE 2023 GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. – 5 p.m.

HIGHMARK. NORTHEASTERN NEW YORK

Mailing Address: P.O. Box 15013 • Albany, NY 12212
Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 **PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN**

Employer or Union Name **CASHIC - Cobleskill CSD Medicare** Location: _____

Member plan selection:

☑ Forever Blue PPO 799 Plan CF38 TRx (PPO)☐ ☐ ☐

☐ ☐ ☐ ☐

Effective Date _____ **Member bill level selection:** ☑ **Group bill** ☐ **Member bill**

PART 2 **PLEASE TELL US ABOUT YOURSELF**

Last Name _____ First Name _____ Middle Initial __

Date of Birth (MM/DD/YYYY) _____ Gender ☐M ☐F ☐Mr. ☐Mrs. ☐Ms.

Email Address (optional) _____

PERMANENT RESIDENCE ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____

City _____ State _____ County _____ ZIP Code_____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ ZIP Code_____

PART 3 **MEDICAL ELIGIBILITY INFORMATION**

Please take out your red, white, and blue Medicare card to complete this section.

or

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____/ _____/ _____

Medical (Part B) Effective Date _____/ _____/ _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY) _____

   If NO, name of retiree _____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse _____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or EPIC. Will you have other <u>prescription drug coverage</u> in addition to the plan in which you are re-enrolling?** ☐ Yes ☐ No

   If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____

   ID# for this coverage _____ Group# for this coverage _____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No _____

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name _____ Street _____ Suite# _____

   City _____ State _____ ZIP Code _____

   Phone ( ) _____ County _____ Date of Admission _____ (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

9. **Please check one of the boxes below if you want us to send you information in a language other than English.**

   ☐ Spanish ☐ Chinese ☐ Russian ☐ Other _____

10. **Please check one of the boxes below if you would prefer we send you information in another format.**

    ☐ Large print ☐ Braille ☐ Audio CD ☐ Other _____

PART 6 **PLEASE READ AND SIGN ON PAGE 4**

By completing this enrollment application, I agree to the following:

Highmark Blue Shield of Northeastern New York is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year if an enrollment period is available (example: annual enrollment period from October 15 – December 7), or under certain special circumstances.

Senior Blue HMO and Forever Blue PPO serve a specific service area. If I move out of the area that Senior Blue HMO or Forever Blue PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Senior Blue HMO or Forever Blue PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Blue HMO or Forever Blue PPO once I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that, beginning on the date Senior Blue HMO coverage begins, I must get all of my health care from Highmark Blue Shield of Northeastern New York, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Forever Blue PPO coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Forever Blue PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield of Northeastern New York and other services contained in my Senior Blue HMO or Forever Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD OF NORTHEASTERN NEW YORK WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Highmark Blue Shield of Northeastern New York, the employee may be paid based on my enrollment in Senior Blue HMO or Forever Blue PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield of Northeastern New York will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield of Northeastern New York will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

PART 7 **ENROLLEE AUTHORIZATION**

Enrollee Authorization

_____ _____

Signature Today's Date

If you are an authorized representative, you must sign above and provide the following information:

Last Name _____ First Name _____ Middle Initial ___

Street/Apartment#_____

City _____ State _____ County _____ ZIP Code_____

Home Phone Number ( ) _____ Relationship to Enrollee _____

Please include a copy of your Power of Attorney paperwork.

Please contact Highmark Blue Shield of Northeastern New York at 1-855-215-9239 if you need information in another language or format (like Braille, audio tape, or large print). TTY users should call 711.

Our office hours are: Monday – Friday, 8 a.m. – 5 p.m.

MX1874260_NENY_08_22

MEDICARE ADVANTAGE 2023 GROUP ENROLLMENT APPLICATION

If you have any questions about our plans, need help filling out this application, or need information in another format (Braille), please call 1-855-215-9239 (TTY 711).

Monday – Friday, 8 a.m. – 5 p.m.

HIGHMARK NORTHEASTERN NEW YORK

Mailing Address: P.O. Box 15013 • Albany, NY 12212
Physical Address: 40 Century Hill Drive • Latham, NY 12110

PART 1 **PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN**

Employer or Union Name CASHIC - Cobleskill CSD Medicare Location: _____

Member plan selection:

☑ Forever Blue PPO 799 Plan CF38 TRx (PPO)☐ ☐ ☐

☐ ☐ ☐ ☐

Effective Date _____ **Member bill level selection:** ☑ **Group bill** ☐ **Member bill**

PART 2 **PLEASE TELL US ABOUT YOURSELF**

Last Name _____ First Name _____ Middle Initial __

Date of Birth (MM/DD/YYYY) _____ Gender ☐M ☐F ☐Mr. ☐Mrs. ☐Ms.

Email Address (optional) _____

PERMANENT RESIDENCE ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____

City _____ State _____ County _____ ZIP Code_____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

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PART 3 **MEDICAL ELIGIBILITY INFORMATION**

Please take out your red, white, and blue Medicare card to complete this section.

or

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____/ _____/ _____

Medical (Part B) Effective Date _____/ _____/ _____

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

PART 4 **PLEASE LIST A PRIMARY CARE DOCTOR FROM THE PROVIDER DIRECTORY**

Doctor's Last Name _____ First Name _____

Current Patient? ☐ Yes ☐ No

PART 5 **PLEASE READ AND ANSWER THESE QUESTIONS**

1. **Are you the retiree?** ☐ Yes ☐ No

   If YES, retirement date (MM/DD/YYYY) _____

   If NO, name of retiree _____

2. **Are you the spouse of the retiree?** ☐ Yes ☐ No

3. **Are you covering a spouse or dependents under this employer or union plan?** ☐ Yes ☐ No

   If YES, name of spouse _____

   Name of dependents _____

4. **Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal Employee Health Benefits coverage, VA benefits, or EPIC. Will you have other <u>prescription drug coverage</u> in addition to the plan in which you are re-enrolling?** ☐ Yes ☐ No

   If YES, please list your other coverage and your identification (ID) number(s) for this coverage:

   Name of other coverage _____

   ID# for this coverage _____ Group# for this coverage _____

5. **Are you a resident in a long-term care facility such as a nursing home?** ☐ Yes ☐ No _____

   If YES, please list the institution's name, address, phone number, and date of admission.

   Name _____ Street _____ Suite# _____

   City _____ State _____ ZIP Code _____

   Phone ( ) _____ County _____ Date of Admission _____ (MM/DD/YYYY)

6. **Are you enrolled in your state Medicaid program?** ☐ Yes ☐ No

   If YES, please provide your Medicaid number _____

7. **Do you, on your own or through your spouse, have any health insurance other than Medicare, such as private insurance, workers' compensation, or VA benefits?** ☐ Yes ☐ No

   If YES, what kind of insurance do you have? _____

   What is the name of your insurance? _____

8. **Do you or does your spouse work?** ☐ Yes ☐ No

9. **Please check one of the boxes below if you want us to send you information in a language other than English.**

   ☐ Spanish ☐ Chinese ☐ Russian ☐ Other _____

10. **Please check one of the boxes below if you would prefer we send you information in another format.**

    ☐ Large print ☐ Braille ☐ Audio CD ☐ Other _____

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Senior Blue HMO and Forever Blue PPO serve a specific service area. If I move out of the area that Senior Blue HMO or Forever Blue PPO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Senior Blue HMO or Forever Blue PPO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Senior Blue HMO or Forever Blue PPO once I receive it to know which rules I must follow to get coverage with this Medicare Advantage plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that, beginning on the date Senior Blue HMO coverage begins, I must get all of my health care from Highmark Blue Shield of Northeastern New York, except for emergency or urgently needed services or out-of-area dialysis services. I understand that, beginning on the date Forever Blue PPO coverage begins, using services in network can cost less than using services out of network, except for emergency or urgently needed services or out-of-area dialysis services. If medically necessary, Forever Blue PPO provides refunds for all covered benefits, even if I get services out of network. Services authorized by Highmark Blue Shield of Northeastern New York and other services contained in my Senior Blue HMO or Forever Blue PPO Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, NEITHER MEDICARE NOR HIGHMARK BLUE SHIELD OF NORTHEASTERN NEW YORK WILL PAY FOR THE SERVICES.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with Highmark Blue Shield of Northeastern New York, the employee may be paid based on my enrollment in Senior Blue HMO or Forever Blue PPO.

Release of Information:

By joining this Medicare health plan, I acknowledge that Highmark Blue Shield of Northeastern New York will release my information to Medicare and other plans as is necessary for treatment, payment, and health care operations. I also acknowledge that Highmark Blue Shield of Northeastern New York will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

PART 7 **ENROLLEE AUTHORIZATION**

Enrollee Authorization

_____ _____

Signature Today's Date

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City _____ State _____ County _____ ZIP Code_____

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Please contact Highmark Blue Shield of Northeastern New York at 1-855-215-9239 if you need information in another language or format (like Braille, audio tape, or large print). TTY users should call 711.

Our office hours are: Monday – Friday, 8 a.m. – 5 p.m.

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