Healthy Blue
BlueChoice® HealthPlan of SC

Healthy Connections

Effective Date 7/1/2024

Pharmacy Comprehensive Drug List Change Notice

Posted 06/01/2024

We want to tell you about some upcoming changes to the Comprehensive Drug List. The Comprehensive Drug List is a list of drugs covered by Healthy Blue. Please see the table below:

EFFECTIVE FOR ALL MEMBERS ON 7/1/2024			
Therapeutic class	**Drug**	**Revised status**	**Potential alternatives**
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL CAP 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL TAB 1GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR ER TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFPODOXIME TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFPODOXIME TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CLARITHROMYCIN	CLARITHROMYC TAB 500MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO CAP 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 50MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 200MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	LEVOFLOXACIN SOL 25MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMINOGLYCOSIDES	NEOMYCIN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

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AMINOGLYCOSIDES	TOBRAMYCIN NEB 300/4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS	NYSTATIN TAB 500000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	VORICONAZOLE TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	VORICONAZOLE TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HERPES AGENTS	FAMCICLOVIR TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETHASON CON 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	PREDNISONE CON 5MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOSTERONE GEL 1%(25MG)	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOSTERONE GEL 1%(50MG)	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOSTERONE GEL PUMP 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	ADMELOG INJ 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN R INJ RELION	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN R INJ U-100	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN R INJ 100 UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	HUMULIN N INJ U-100	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN N INJ RELION	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN N INJ U-100	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BIGUANIDES	METFORMIN TAB 500MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

MEGLITINIDE ANALOGUES	REPAGLINIDE TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	JANUMET XR TAB 50-500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	JANUMET XR TAB 50-1000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	JANUMET XR TAB 100-1000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY TAB 5-500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY TAB 5-1000MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY TAB 12.5-500	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY TAB	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY XR TAB 5-1000MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY XR TAB 10-1000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY XR TAB	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	SYNJARDY XR TAB 25-1000	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 2.5-250M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 2.5-500M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 5-500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BONE DENSITY REGULATORS	ALENDRONATE SOL 70/75ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HORMONE RECEPTOR MODULATORS	RALOXIFENE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS NON-SELECTIVE	PINDOLOL TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS NON-SELECTIVE	PINDOLOL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS NON-SELECTIVE	TIMOLOL MAL TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS NON-SELECTIVE	TIMOLOL MAL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS NON-SELECTIVE	TIMOLOL MAL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

CALCIUM CHANNEL BLOCKERS	NIFEDIPINE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCIUM CHANNEL BLOCKERS	NIFEDIPINE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	MOEXIPRIL TAB 7.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	MOEXIPRIL TAB 15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	CANDESARTAN TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	CANDESARTAN TAB 8MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	CANDESARTAN TAB 16MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	CANDESARTAN TAB 32MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	VALSARTAN TAB 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	VALSARTAN TAB 80MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	VALSARTAN TAB 160MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANGIOTENSIN II RECEPTOR ANTAGONISTS	VALSARTAN TAB 320MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	METOPRL/HCTZ TAB 50-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	METOPRL/HCTZ TAB 100-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	METOPRL/HCTZ TAB 100-50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CANDESA/HCTZ TAB 16-12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CANDESA/HCTZ TAB 32-12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CANDESA/HCTZ TAB 32-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BILE ACID SEQUESTRANTS	PREVALITE POW 4GM PK	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRIC CAP 45MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE TAB 54MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE TAB 160MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS	ALYQ TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	IPRATROPIUM SOL 0.02%INH	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	SPIRIVA AER 1.25MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BRONCHODILATORS - ANTICHOLINERGICS	SPIRIVA SPR 2.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	ALBUTEROL AER HFA	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	TERBUTALINE TAB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	TERBUTALINE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	IPRATROPIUM/ SOL ALBUTER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BUDES/FORMOT AER 80-4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BREYNA AER 80/4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BUDES/FORMOT AER 160-4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	BREYNA AER 160/4.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 55/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 113/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 100/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 100/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME INH 232/14	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 250/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 250/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	FLUTIC/SALME AER 500/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SYMPATHOMIMETICS	WIXELA INHUB AER 500/50	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLOVENT DISK AER 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROID INHALANTS	FLOVENT DISK AER 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLOVENT DISK AER 250MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	NIZATIDINE CAP 150MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	NIZATIDINE CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIEMETICS - ANTICHOLINERGIC	MECLIZINE TAB 12.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	HUMULIN N INJ U-100KWP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN N INJ 100 UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN INJ 70/30	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN70/30 INJ RELION	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	NOVOLIN INJ 70/30 FP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIEMETICS - ANTICHOLINERGIC	MECLIZINE TAB 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALL DAY ALLG CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY REL CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS	LUBIPROSTONE CAP 8MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS	LUBIPROSTONE CAP 24MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INFLAMMATORY BOWEL AGENTS	MESALAMINE CAP 0.375GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	LANTHANUM CHW 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	LANTHANUM CHW 750MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	LANTHANUM CHW 1000MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	SEVELAMER TAB 800MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	SEVELAMER POW 0.8GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	SEVELAMER POW 2.4GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **

URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE CAP 2MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TOLTERODINE CAP 4MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TROSPIUM CL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	TROSPIUM CHL CAP 60MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS	FLAVOXATE TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MONOAMINE OXIDASE INHIBITORS (MAOIS)	TRANYLCYPROM TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUVOXAMINE CAP 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUVOXAMINE CAP 150MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 1.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	PALIPERIDONE TAB ER 9MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 210MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ZYPREXA RELP INJ 405MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHENOTHIAZINES	COMPRO SUP 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NON-BARBITURATE HYPNOTICS	ESTAZOLAM TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	ESTAZOLAM TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	TRIAZOLAM TAB 0.125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	TRIAZOLAM TAB 0.25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	ZALEPLON CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	ZALEPLON CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 5MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 10MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 15MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 20MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 25MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMPHETAMINES	AMPHET/DEXTR CAP 30MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID CAP 40MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID TAB 27MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID TAB 36MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID TAB 54MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID CAP 10MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID CAP 20MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID CAP 30MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE SOL 4MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	MEMANT TITRA PAK 5-10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

SMOKING DETERRENTS	VARENICLINE TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	VARENICLINE TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	EXTAVIA INJ 0.3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	TERIFLUNOMID TAB 7MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	TERIFLUNOMID TAB 14MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SALICYLATES	DIFLUNISAL TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 400MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 600MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 800MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 1200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	FENTANYL OT LOZ 1600MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 2-0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 4-1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 8-2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUPREN/NALOX MIS 12-3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	BUTORPHANOL SOL 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID PARTIAL AGONISTS	PENTAZ/NALOX TAB 50-0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID COMBINATIONS	APAP/CODEINE SOL 120-12/5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	DICLOFEN POT TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	FLURBIPROFEN TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	KETOPROFEN CAP 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	MECLOFEN SOD CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	MECLOFEN SOD CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	OXAPROZIN TAB 600MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SEROTONIN AGONISTS	NARATRIPTAN TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SEROTONIN AGONISTS	NARATRIPTAN TAB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SEROTONIN AGONISTS	SUMATRIPTAN SPR 5MG/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SEROTONIN AGONISTS	SUMATRIPTAN SPR 20MG/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GOUT AGENTS	COLCHICINE CAP 0.6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GABA MODULATORS	TIAGABINE TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GABA MODULATORS	TIAGABINE TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GABA MODULATORS	TIAGABINE TAB 12MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GABA MODULATORS	TIAGABINE TAB 16MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HYDANTOINS	PHENYTEK CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HYDANTOINS	PHENYTEK CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN SUS 100/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN CAP 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 100MGER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 400MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	OXCARBAZEPIN SUS 300MG/5M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE RELAXANTS	CARISOPRODOL TAB 350MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	DIPYRIDAMOLE TAB 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	DIPYRIDAMOLE TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	DIPYRIDAMOLE TAB 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	MOXIFLOXACIN SOL HCL 0.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC IMMUNOMODULATORS	CYCLOSPORINE EMU 0.05% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN CRE 0.025%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN CRE 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN CRE 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.01%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.025%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	TRETINOIN GEL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDAMYCIN GEL 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ERY/BENZOYL GEL 3-5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ROSACEA AGENTS	METRONIDAZOL GEL 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	ACYCLOVIR CRE 5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	ACYCLOVIR OIN 5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	BETAMETH VAL OIN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	FLUOCINONIDE OIN 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	FLUTICASONE CRE 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **

CORTICOSTEROIDS - TOPICAL	FLUTICASONE OIN 0.005%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
KERATOLYTIC/ANTIMITOTIC AGENTS	PODOFILOX SOL 0.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS - TOPICAL	PIMECROLIMUS CRE 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS - TOPICAL	TACROLIMUS OIN 0.03%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS - TOPICAL	TACROLIMUS OIN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	NALOXONE SPR 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	NALOXONE HCL SPR 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GROWTH HORMONES	HUMATROPE INJ 6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GROWTH HORMONES	HUMATROPE INJ 12MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GROWTH HORMONES	HUMATROPE INJ 24MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	ADMELOG SOLO INJ 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	QC ALL DAY CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CETIRIZINE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANAPHYLAXIS THERAPY AGENTS	EPINEPHRINE INJ 0.15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANAPHYLAXIS THERAPY AGENTS	EPINEPHRINE INJ 0.3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	VARENICLINE TAB 0.5& 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	GLATOPA INJ 20MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	GLATIRAMER INJ 20MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	GLATIRAMER INJ 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	GLATOPA INJ 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	EMGALITY INJ 100MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIPSORIATICS	COSENTYX PEN INJ 150MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	COSENTYX PEN INJ 300DOSE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	COSENTYX UNO INJ 300/2ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	COSENTYX INJ 75MG/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	COSENTYX INJ 150MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	COSENTYX INJ 300DOSE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AMINOGLYCOSIDES	TOBRAMYCIN NEB 300/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSYCHOTICS - MISC.	ZIPRASIDONE CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	MORPHINE SUL SOL 100/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR CAP 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	KETOCONAZOLE TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	QUINAPRIL TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CAPTOPR/HCTZ TAB 25-15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BILE ACID SEQUESTRANTS	CHOLESTYRAM POW 4GM LITE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL SUS 250/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 1ST GENERATION	CEFADROXIL SUS 500/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR CAP 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR SUS 125/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR SUS 250/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 2ND GENERATION	CEFACLOR SUS 375/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFPODO PROX SUS 50MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

CEPHALOSPORINS - 3RD GENERATION	CEFPODO PROX SUS 100/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFTRIAXONE INJ 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFTRIAXONE INJ 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFTRIAXONE INJ 1GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFTRIAXONE INJ 2GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CEPHALOSPORINS - 3RD GENERATION	CEFTRIAXONE INJ 10GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG BS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG BS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERY-TAB TAB 250MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 250MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERY-TAB TAB 333MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 333MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERY-TAB TAB 500MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN TAB 500MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROMYCIN CAP 250MG EC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	ERYTHROM ETH TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ERYTHROMYCINS	E.E.S. 400 TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DEMECLOCYCL TAB 150MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DEMECLOCYCL TAB 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	MONDOXYNE NL CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO CAP 150MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

TETRACYCLINES	AVIDOXY TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYC MONO TAB 150MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCLINE SUS 25MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	TARGADOX TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	LYMEPAK TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 75MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 80MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 100MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC TAB 150MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXYCYCL HYC INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
TETRACYCLINES	DOXY 100 INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	OFLOXACIN TAB 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FLUOROQUINOLONES	OFLOXACIN TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS	FLUCYTOSINE CAP 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS	FLUCYTOSINE CAP 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	FLUCONAZOLE SUS 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	FLUCONAZOLE SUS 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	ITRACONAZOLE CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	VORICONAZOLE SUS 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMIDAZOLE-RELATED ANTIFUNGALS	VORICONAZOLE INJ 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	ADEFOV DIPIV TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	EPIVIR HBV SOL 5MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

HEPATITIS AGENTS	PEGASYS INJ 180MCG/M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	RIBAVIRIN CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	RIBAVIRIN TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	METRONIDAZOL CAP 375MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TINIDAZOLE TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TINIDAZOLE TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFECTIVE AGENTS - MISC.	TRIMETHOPRIM TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	HYDROXY CAPR INJ 1.25/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	MEGESTROL AC TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS	MEGESTROL AC TAB 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 0.75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DECADRON TAB 6MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 4MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 20MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	DEXAMETH PHO INJ 120MG/30	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 400/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 200/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **

GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 80MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR ACE INJ 400/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	METHYLPR SS INJ 1000MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 40MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 200/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	TRIAMCIN ACE INJ 400/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	BETA-PHOS/AC INJ 3-3MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOST CYP INJ 100MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	DEPO-TESTOST INJ 100MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOST CYP INJ 200MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	DEPO-TESTOST INJ 200MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOSTERONE INJ CYPIONAT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANDROGENS	TESTOST ENAN INJ 200MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	SEMGLEE SOL 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	GLARGIN YFGN SOL 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 2.5-250	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	GLIP/METFORM TAB 2.5-500	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	PIOGLIT/GLIM TAB 30-2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	PIOGLIT/GLIM TAB 30-4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIDIABETIC COMBINATIONS	PIOGLITA/MET TAB 15-500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDIABETIC COMBINATIONS	PIOGLITA/MET TAB 15-850MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BONE DENSITY REGULATORS	ALENDRONATE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GROWTH HORMONES	ZOMACTON INJ 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GROWTH HORMONES	ZOMACTON INJ 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS CARDIO-SELECTIVE	BETAXOLOL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BETA BLOCKERS CARDIO-SELECTIVE	BETAXOLOL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCIUM CHANNEL BLOCKERS	VERAPAMIL CAP 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCIUM CHANNEL BLOCKERS	VERAPAMIL CAP 200MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCIUM CHANNEL BLOCKERS	VERAPAMIL CAP 300MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	FOSINOPRIL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	FOSINOPRIL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	FOSINOPRIL TAB 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	PERINDOPRIL TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	PERINDOPRIL TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	PERINDOPRIL TAB 8MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	QUINAPRIL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	QUINAPRIL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	QUINAPRIL TAB 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	RAMIPRIL CAP 1.25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	RAMIPRIL CAP 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	RAMIPRIL CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ACE INHIBITORS	RAMIPRIL CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	TRANDOLAPRIL TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	TRANDOLAPRIL TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACE INHIBITORS	TRANDOLAPRIL TAB 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIADRENERGIC ANTIHYPERTENSIVES	METHYLDOPA TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIADRENERGIC ANTIHYPERTENSIVES	METHYLDOPA TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIADRENERGIC ANTIHYPERTENSIVES	PRAZOSIN HCL CAP 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIADRENERGIC ANTIHYPERTENSIVES	PRAZOSIN HCL CAP 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIADRENERGIC ANTIHYPERTENSIVES	PRAZOSIN HCL CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CAPTOPR/HCTZ TAB 25-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CAPTOPR/HCTZ TAB 50-15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	CAPTOPR/HCTZ TAB 50-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	FOSINOP/HCTZ TAB 10/12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	FOSINOP/HCTZ TAB 20/12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	QNAPRIL/HCTZ TAB 10-12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	QNAPRIL/HCTZ TAB 20-12.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHYPERTENSIVE COMBINATIONS	QNAPRIL/HCTZ TAB 20-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 43MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 67MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 134MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
FIBRIC ACID DERIVATIVES	FENOFIBRATE CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS	TADALAFIL TAB 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIHISTAMINES - PHENOTHIAZINES	PROMETHAZINE SYP 6.25/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALL DAY ALLG TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY 24HR TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY REL TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELI TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RLF TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLER-TEC TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLGY RELIEF TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CETIRIZINE TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CVS ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	EQL ALL DAY TAB ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	GNP ALL DAY TAB ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	QC ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	SB ALLERGY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	SM ALL DAY TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	SM ALL DAY TAB ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CETIRIZINE CHW 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR CHW 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CETIRIZINE CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIHISTAMINES - NON-SEDATING	ZYRTEC CHW 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ZYRTEC CHILD CHW ALG 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALL DAY ALLG SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALL DAY ALLG SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALL-DAY ALLG SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY CHLD SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY REL SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELF SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELF SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLER-TEC SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CETIRIZINE SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CHILD ALLRGY SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CHILD ALLRGY SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR CHLD SOL 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ZYR CHLD SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELI CHW CETIRIZI	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	12HR ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLER-EASE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELF TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	FEXOFENADINE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIHISTAMINES - NON-SEDATING	FT ALLR RLF TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	HM ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	SM ALLERGY TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-FEX ALRG TAB 60MG 12H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	24HR ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLEGRA HIVE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLER-EASE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLER-FEX TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY 24HR TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RELF TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CVS ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	FEXOFENADINE TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	FT ALRGY RLF TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	HM ALLERGY TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	MM FEXOFENAD TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-FEX TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-FEX ALLR TAB 180MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY CHLD SUS 30MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RLF SUS 30/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLEGRA ALRG TAB 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	XYZAL TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIHISTAMINES - NON-SEDATING	ALLERGY RELF CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	LORATADINE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	QC ALLERGY CAP RELIEF	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERCLEAR TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	LORADAMED TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	QC LORATADIN TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ITIN TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ITIN CHW 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY CHLD SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALLERGY RLF LIQ CHILDREN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CLARITIN SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CVS ALLERGY SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	EQ ALLERGY SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	LORATADINE SOL 10/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	LORATADINE SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	SM ALLERGY SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ITIN SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	WAL-ITIN CHL SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	CVS ALLERGY TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	ALAVERT TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	EQ LORATADIN TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIHISTAMINES - NON-SEDATING	TRIAMINIC TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIHISTAMINES - NON-SEDATING	WAL-VERT TAB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	BUDESONIDE SUS 32MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	BUDESONIDE SUS NASAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLER-FLO SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY NASA SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY RELF SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLGY RELIEF SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	CLARISPRAY SPR 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	FLUTICASONE SUS 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	24 HR NASAL SPR ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLER-CORT SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	ALLERGY NASA SPR 24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	NASAL ALLRGY SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	RA NASAL SPR ALLERGY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	TRIAMCINOLON AER 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL STEROIDS	TRIAMCINOLON SPR 55MCG/AC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	ASTEPRO SPR 205.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	ASTEPRO CHLD SPR 205.5MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	CROMOLYN SOD SPR 5.2/ACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NASAL ANTIALLERGY	AZELASTINE SPR 0.15%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLUTICASONE AER 50MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROID INHALANTS	FLUTICASONE AER 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROID INHALANTS	FLUTICASONE AER 250MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
LAXATIVE COMBINATIONS	PEG-3350/KCL SOL /SODIUM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	FAMOTIDINE INJ 20MG/2ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	FAMOTIDINE INJ 10MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
H-2 ANTAGONISTS	NIZATIDINE SOL 15MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PROTON PUMP INHIBITORS	PANTOPRAZOLE PAK 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIEMETICS - ANTICHOLINERGIC	TRIMETHOBENZ CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
5-HT3 RECEPTOR ANTAGONISTS	ONDANSETRON TAB 24MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PHOSPHATE BINDER AGENTS	CALPHRON TAB 667MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	OXYTROL/WOMN DIS 3.9MG/24	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 2600UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 4000UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 4200UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 8000UNIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 10500UNT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 16000U	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 16800UNT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 21000UNT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PERTZYE CAP 24000U	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIGESTIVE ENZYMES	PANCREAZE CAP 37000	Non-Covered/PA Required	Refer to Comprehensive Drug List **

INFLAMMATORY BOWEL AGENTS	MESALAMINE KIT 4GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INFLAMMATORY BOWEL AGENTS	AVSOLA INJ 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE DIS 7MG/24HR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	DARIFENACIN TAB 7.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC)	DARIFENACIN TAB 15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	ESCITALOPRAM SOL 5MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	ESCITALOP OX SOL 10/10ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUOXETINE TAB 60MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	FLUOXETINE CAP 90MG DR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETINE SUS 10MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETIN ER TAB 12.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETINE TAB 25MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	PAROXETIN ER TAB 37.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)	SERTRALINE CON 20MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIBENZAPINES	LOXAPINE CAP 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	LOXAPINE CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ASENAPINE SUB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ASENAPINE SUB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	ASENAPINE SUB 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIBENZAPINES	OLANZAPINE INJ 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	FLURAZEPAM CAP 15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NON-BARBITURATE HYPNOTICS	FLURAZEPAM CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STIMULANTS - MISC.	METHYLPHENID TAB 18MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	DONEPEZIL TAB 23MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE TAB 8MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE TAB 12MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 8MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 16MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	GALANTAMINE CAP 24MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIDEMENTIA AGENTS	MEMANTINE SOL 10MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	QC NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE DIS 14MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **

SMOKING DETERRENTS	HABITROL DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE DIS STEP 1	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	QC NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE DIS 21MG/24H	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MG ORIG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 2MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 2MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 2MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE GUM 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	KLS QUIT2 GUM 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE GUM 2MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 2MG REF	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 2MG STRT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 2MG ORIG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	THRIVE GUM 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **

SMOKING DETERRENTS	CVS NICOTINE GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MG ORIG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE GUM 4MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MG ORIG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE GUM 4MGFRUIT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE GUM 4MG FRT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	KLS QUIT4 GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 4MG REF	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL GUM 4MG STRT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE GUM 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING GUM 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 2MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQL NICOTINE LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **

SMOKING DETERRENTS	KLS QUIT2 LOZ 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 2MG CHRY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 2MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING LOZ 2MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	CVS NICOTINE LOZ 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQ NICOTINE LOZ 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	EQL NICOTINE LOZ 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	HM NICOTINE LOZ 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	KLS QUIT4 LOZ 4MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE LOZ 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 4MG CHRY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	NICOTINE POL LOZ 4MG CINN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	RA NICOTINE LOZ 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	STOP SMOKING LOZ 4MG MINT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	APO-VARENICL TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SMOKING DETERRENTS	APO-VARENICL TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AGENTS FOR CHEMICAL DEPENDENCY	ACAMPRO CAL TAB 333MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AGENTS FOR CHEMICAL DEPENDENCY	DISULFIRAM TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
AGENTS FOR CHEMICAL DEPENDENCY	DISULFIRAM TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

COMBINATION PSYCHOTHERAPEUTICS	CDP/AMITRIP TAB 5-12.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	CDP/AMITRIP TAB 10-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	PERPHEN/AMIT TAB 2-10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	PERPHEN/AMIT TAB 2-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	PERPHEN/AMIT TAB 4-10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	PERPHEN/AMIT TAB 4-25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
COMBINATION PSYCHOTHERAPEUTICS	PERPHEN/AMIT TAB 4-50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SALICYLATES	SALSALATE TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SALICYLATES	SALSALATE TAB 750MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID AGONISTS	MORPHINE SUL SOL 10/0.5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID COMBINATIONS	ENDOCET TAB 2.5-325	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID COMBINATIONS	APAP/CODEINE SOL 300-30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID COMBINATIONS	BUT/ASA/CAF/ CAP COD 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	CATAFLAM TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC CAP 300MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC ER TAB 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC ER TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	ETODOLAC ER TAB 600MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	FENOPROFEN CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	FLURBIPROFEN TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	INDOMETHACIN CAP 75MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	KETOPROFEN CAP 25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	KETOPROFEN CAP 75MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	RELAFEN TAB 500MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	RELAFEN TAB 750MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS ALLERGY DRO 0.035%OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS OLOPATAD SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL ITCH/RED	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	NAPROXEN SOD TAB 275MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	NAPROXEN SOD TAB 550MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	TOLMETIN SOD CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	TOLMETIN SOD TAB 600MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS)	CELECOXIB CAP 400MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	NURTEC TAB 75MG ODT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIGRAINE COMBINATIONS	ERGOT/CAFFEN TAB 1-100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIGRAINE COMBINATIONS	MIGERGOT SUP 2/100	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEPAM TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.125MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.25MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	CLONAZEP ODT TAB 2MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - BENZODIAZEPINES	DIAZEPAM GEL 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN CAP 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN CAP 300MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	CARBAMAZEPIN TAB 100MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 35	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTICONVULSANTS - MISC.	SUBVENITE KIT START 35	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 49	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	SUBVENITE KIT START 49	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT START 98	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	SUBVENITE KIT START 98	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIG ODT KIT 25/50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIG ODT KIT 50/100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	LAMOTRIGINE KIT ODT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTICONVULSANTS - MISC.	PREGABALIN SOL 20MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON COMT INHIBITORS	ENTACAPONE TAB 200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	AMANTADINE CAP 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	AMANTADINE TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	AMANTADINE SOL 50MG/5ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	BROMOCRIPTIN CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	BROMOCRIPTIN TAB 2.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO TAB 10-100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO TAB 25-100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO TAB 25-250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO ER TAB 25-100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO ER TAB 50-200MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO 50 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO 75 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ANTIPARKINSON DOPAMINERGICS	CARB/LEVO100 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO125 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO150 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON DOPAMINERGICS	CARB/LEVO200 TAB /ENTACAP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	SELEGILINE CAP 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS	SELEGILINE TAB 5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE RELAXANTS	CARISOPRODOL TAB 250MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CENTRAL MUSCLE RELAXANTS	VANADOM TAB 350MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MUSCLE RELAXANT COMBINATIONS	CARISOPRODOL TAB ASA/COD	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 25MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 40MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 60MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 100MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 200MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 1000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 5000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 5000/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 10000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPARINS AND HEPARINOID-LIKE AGENTS	HEPARIN SOD INJ 20000/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	CILOSTAZOL TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	CILOSTAZOL TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
PLATELET AGGREGATION INHIBITORS	ANAGRELIDE CAP 0.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

PLATELET AGGREGATION INHIBITORS	ANAGRELIDE CAP 1MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	BACITRACIN OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	ERYTHROMYCIN OIN 5MG/GM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	GATIFLOXACIN SOL 0.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	GENTAMICIN SOL 0.3% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	GENTAK OIN 0.3% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	LEVOFLOXACIN SOL 0.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	LEVOFLOXACIN SOL 1.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	MOXIFLOXACIN SOL 0.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	OFLOXACIN DRO 0.3% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	TOBRAMYCIN SOL 0.3% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	SULFACET SOD SOL 10% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	SULFACET SOD OIN 10% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	TRIFLURIDINE SOL 1% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	AK-POLY-BAC OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	BACIT/POLYMY OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	POLYCIN OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	POLYMYXIN B/ SOL TRIMETHP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	TRIMETHOPRIM SOL POLYMYXN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	NEO/BAC/POLY OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	NEO-POLYCIN OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ANTI-INFECTIVES	NEO/POLY/BAC OIN OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **

OPHTHALMIC ANTI-INFECTIVES	NEO/POLY/GRA SOL OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 1% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 2% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MIOTICS	PILOCARPINE SOL 4% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ADRENERGIC AGENTS	APRACLONIDIN SOL 0.5% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMIC ADRENERGIC AGENTS	BRIMONIDINE SOL 0.15%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	AZELASTINE DRO 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EPINASTINE DRO 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	OLOPATADINE DRO 0.1% OP	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	CVS OLOPATAD SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	EYE ALLERGY SOL ITCH REL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	GNP OLOPATAD SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	SM OLOPATADI SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPHTHALMICS - MISC.	PATADAY SOL 0.7%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OTIC ANTI-INFECTIVES	CIPROFLOXACN SOL 0.2%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OTIC COMBINATIONS	NEO/POLY/HC SUS 1% OTIC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	TRIAMCINOLON PST DEN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	ORALONE DENT PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
STEROIDS - MOUTH/THROAT/DENTAL	KOURZEQ PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **

STEROIDS - MOUTH/THROAT/DENTAL	TRIAMCINOLON PST 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INTRARECTAL STEROIDS	HYDROCORT ENE 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AMNESTEEM CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 10MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AMNESTEEM CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 20MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 30MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ZENATANE CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	MYORISAN CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLARAVIS CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

ACNE PRODUCTS	AMNESTEEM CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ISOTRETINOIN CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	ACCUTANE CAP 40MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	AVITA GEL 0.025%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDAMYCIN MIS 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDACIN-P PAD 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ACNE PRODUCTS	CLINDACIN MIS ETZ 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ROSACEA AGENTS	ROSADAN CRE 0.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ROSACEA AGENTS	ROSADAN GEL 0.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIBIOTICS - TOPICAL	GENTAMICIN CRE 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIBIOTICS - TOPICAL	GENTAMICIN OIN 0.1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIFUNGALS - TOPICAL	MYCOZYL AL SOL 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-INFLAMMATORY AGENTS - TOPICAL	DICLOFENAC SOL 1.5%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	DOCOSANOL CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	FT DOCOSAN CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIPSORIATICS	CALCITRENE OIN 0.005%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTIVIRALS - TOPICAL	HM DOCOSAN CRE 10%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	DESONIDE GEL 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	DESRX GEL 0.05%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CORTICOSTEROIDS - TOPICAL	ALA-CORT CRE 1%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOMODULATING AGENTS - TOPICAL	IMIQUIMOD CRE 3.75%	Non-Covered/PA Required	Refer to Comprehensive Drug List **
SCABICIDES & PEDICULICIDES	SPINOSAD SUS 0.9%	Non-Covered/PA Required	Refer to Comprehensive Drug List **

OPIOID ANTAGONISTS	NALMEFENE INJ 1MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	OPVEE SPR 2.7/0.1	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	KLOXXADO SPR 8MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	NALTREXONE TAB 50MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIAGNOSTIC TESTS	TRUE METRIX TES GLUCOSE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIAGNOSTIC TESTS	RELION TRUE TES METRIX	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIAGNOSTIC TESTS	TRU METRIX TES STRIPS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIAGNOSTIC TESTS	GNP TRU METR TES STRIPS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	OMNIPOD MIS CLASSIC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	OMNIPOD PDM KIT CLASSIC	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	OMNIPOD DASH KIT PDM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FREESTYLE MIS READER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DEXCOM G7 MIS RECEIVER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DEXCOM G7 MIS SENSOR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS ORIGINAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION LANCE MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION LANCE MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION MICRO MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	SURE COMFORT MIS LANC 18G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURE COMFORT MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FIFTY50 SAFE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SURELITE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CLEANLET 28G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FORA MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PSS SEL LANC MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PSS SAFE LAN MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS HI FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS NOR FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFE-T-LANCE MIS LOW FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THINLETS GP MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	TRUPLUS LANC MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRUPLUS LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS ORIGINAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ULTRA THIN MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MYGLUCOHEALT MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AUTO LANCET MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS LITE 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS UNIV 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ACTI-LANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS 30G PLUS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	IN TOUCH LAN MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SUPER THIN MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THIN LANCETS MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	THIN LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET STAND MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MICRO THIN MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	EQL LANCETS MIS 33G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TGT LANCET MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION ULTRA MIS THIN PLS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TOPCARE MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SM LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS THIN MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET SUPER MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LONGS LANCET MIS STANDARD	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LONGS LANCET MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LONGS LANCET MIS ULTRA TH	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GNP LANCETS MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GNP LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 21G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET ULTRA MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	E-Z JECT MIS 21G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PHARMACY COU MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS ULT THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SUPER THIN MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CVS LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TGT LANCET MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EQL LANCETS MIS 21G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-Z JECT MIS 32G COLR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS THIN 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	E-ZJECT LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET MICRO MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIVERSA	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SMART SENSE MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	E-Z JECT MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RA E-ZJECT MIS THIN 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS LANC 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TGT LANCET MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIV 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS UNIV 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	REALITY TRIG MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	REALITY MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS EXTR 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE PLS MIS 0.8MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ACTI-LANCE MIS LITE 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ACTI-LANCE MIS UNIV 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ACTI-LANCE MIS SPEC 17G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DROPLET LANC MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS PLUS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	COMFORT ASSU MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	COMFORT ASSU MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRAVEL LANCE MIS ADV 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS MICR MIS THIN 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS SUPR MIS THIN 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET CMFR MIS TCH 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PERFECT 28G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PERFECT 30G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLET MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCT MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET CMFR MIS TCH 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RIGHTEST MIS GL300	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	NOVA SURE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK SAFE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK SAFE MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK TOUC MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANC MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET GP 28 MIS ULT THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	SUREFLEX MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	NOVA SAFETY MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	NOVA SAFETY MIS LANC 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SAFETY 21G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS GENT 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/32G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AGAMATRIX MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EASY TOUCH MIS LANC/33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SMARTEST MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	STERILANCE MIS TL 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	STERILANCE MIS TL 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	STERILANCE MIS TL 32G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET G.P. MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	COMFORTOUCH MIS LANCET	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET SUPER MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET SUPER MIS G.P. 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GLUCOCOM MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GLUCOCOM MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GLUCOCOM MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET EXCEL MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET EX II MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	LANCETS MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCETS THIN MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS SAFE 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS SAFE 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SB LANCETS MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	SB LANCETS MIS ULTR THN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TECHLITE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TECHLITE MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TECHLITE AST MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS PEDIATRI	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS HIGH 18G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS NORM 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS LOW 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE PLUS MIS MCRO 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS LOW FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS MICRO	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FORA LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EZ-LETS 21G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EZ-LETS 26G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EZ-LETS 28G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	EZ-LETS 30G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	LANCETS ULTR MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	FINE 30 MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS LITE 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS UNV 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS EXTR 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEIJER LANCE MIS COLOR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KROGER LANCE MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNIVERSAL 1 MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	READYLANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LITE TOUCH MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LITETOUCH MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDLANCE MIS PLUS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CAREONE LANC MIS THIN 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AURORA LANCE MIS THIN 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KINNEY MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	KINNEY THIN MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	INCONTROL MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET ULTRA MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	TRAVEL LANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ON-THE-GO MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MEDICHOICE MIS LANCET	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CAREONE LANC MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LB LANCET MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PX LANCETS MIS ULT THIN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCE MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PC LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	INCONTROL MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AURORA LANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	INCONTROL MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HLTHY ACCNTS MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS LOW FLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS RETRACT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PX LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS PLUS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS PLUS PED	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS PLUS MAX	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS HIGH FLO	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	HAEMOLANCE MIS PLUS LOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	COMFORT MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET G.P MIS SUPR 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET LANCE MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	QC LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	QC LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ADV TRAVEL MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MOBILE LANCE MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MM TWIST MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLETTOR MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MONOLET OPD MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 23G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK PRO MIS LANC 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GOODSENSE MIS LANC 26G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK PRO MIS LANC 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	MPD SFTY LAN MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNITSTIK PRO MIS LANC 25G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNILET MICRO MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	AIMSCO TWIST MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AIMSCO TWIST MIS 32G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DIATHRIVE MIS UT 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PIP LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DIATHRIVE MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	ASSURE LANCE MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	VIVAGUARD MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RELION ULTRA MIS THIN 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PIP LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	CARESENS 30G MIS LANCETS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	DROPLET PERS MIS LANC 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GNP LANCETS MIS 30G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GNP LANCETS MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GNP LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PX LANCETS MIS 33G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	VIVAGUARD MIS 28G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTLE-LET MIS PLATFORM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	PSS SEL PLAT MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	LANCET CARRY MIS CASE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	RIGHTEST ALT MIS ADAPTOR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 1 MIS 2.4MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 1 MIS 3.0MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	UNISTIK 2 MIS NORMAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 23G MIS NORMAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS EXTRA	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS COMFORT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS SUPER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS NEONATAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS NORMAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK CZT MIS NORMAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS EXTRA	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS XTR 21G	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS COMFORT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK CZT MIS COMFORT	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS NEONATAL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	STERILANCE MIS 1.8MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AUTOLET PLAT MIS 2.4MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AUTOLET PLAT MIS 3.0MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	AUTOLET PLAT MIS 1.8MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 3 MIS 1.8MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS 2.4MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	UNISTIK 2 MIS 1.8MM	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS YELLOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **

DIABETIC SUPPLIES	GENTEEL TIPS MIS GREEN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS BLUE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS VIOLET	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL MIS NOZZLES	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS RAINBOW	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS CLEAR	Non-Covered/PA Required	Refer to Comprehensive Drug List **
DIABETIC SUPPLIES	GENTEEL TIPS MIS ORANGE	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS	UPLIZNA SOL 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS	AZASAN TAB 75 MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS	AZASAN TAB 100MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEPATITIS AGENTS	PEGASYS INJ	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	TAPERDEX PAK 6 DAY	Non-Covered/PA Required	Refer to Comprehensive Drug List **
GLUCOCORTICOSTEROIDS	HIDEX 6-DAY PAK 1.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	SEMGLEE INJ 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
INSULIN	GLARGIN YFGN INJ 100U/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANAPHYLAXIS THERAPY AGENTS	SYMJEPI INJ 0.15MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANAPHYLAXIS THERAPY AGENTS	SYMJEPI INJ 0.3MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	RISPERIDONE INJ 12.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	RISPERIDONE INJ 25MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	RISPERIDONE INJ 37.5MG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
BENZISOXAZOLES	RISPERIDONE INJ 50MG ER	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF REBIDO INJ 22/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **

MULTIPLE SCLEROSIS AGENTS	REBIF REBIDO INJ 44/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF REBIDO INJ TITRATN	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF INJ 22/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF INJ 44/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
MULTIPLE SCLEROSIS AGENTS	REBIF TITRTN INJ PACK	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	YUSIMRY INJ 40/0.8ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 40/0.4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 40/0.8ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 80/0.8ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 10/0.2ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 20/0.2ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	AMJEVITA INJ 20/0.4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA PUSH INJ 40/0.4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA PUSH INJ 40/0.8ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA INJ 40/0.4ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES	HADLIMA INJ 40/0.8ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AIMOVIG INJ 70MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG	AIMOVIG INJ 140MG/ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 10MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 150MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 300MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ARANESP INJ 500MCG	Non-Covered/PA Required	Refer to Comprehensive Drug List **

HEMATOPOIETIC GROWTH FACTORS	ZARXIO INJ 300/0.5	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ZARXIO INJ 480/0.8	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NEULASTA INJ 6MG/0.6M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NEULASTA KIT 6MG/0.6M	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	NYVEPRIA INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	ZIEXTENZO INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	UDENYCA INJ 6MG/0.6	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	UDENYCA INJ 6MG/.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
HEMATOPOIETIC GROWTH FACTORS	FULPHILA INJ 6/0.6ML	Non-Covered/PA Required	Refer to Comprehensive Drug List **
OPIOID ANTAGONISTS	ZIMHI SOL	Non-Covered/PA Required	Refer to Comprehensive Drug List **
IMMUNOSUPPRESSIVE AGENTS	ENSPRYNG INJ	Non-Covered/PA Required	Refer to Comprehensive Drug List **
UM EDITS – EFFECTIVE FOR ALL MEMBERS NO LATER THAN 7/1/2024 *NO CHANGES IN COVERED/NON-COVERED STATUS. REVISION OR ADDITION TO UM EDIT ONLY*			
Analgesics – Opioid	OPIOID ANALGESICS – INITIAL USE	UPDATE TO REQUIRE PA FOR OPIOID NAÏVE – RESTRICT TO 5 DAYS' SUPPLY AND 90 MG MORPHINE EQUIVALENTS	
Antihypertensives	TEKTURNA TEKTURNA HCT	NEW STEP THERAPY – REQUIRE TRIAL OF ARB	
Anticonvulsants	BANZEL SUSPENSION/TABLET CLOBAZAM SUSPENSION/TABLET FYCOMPA SUSPENSION/TABLET GABITRIL TABLET SABRIL POWDER PACKET/TABLET VIGOPODER POWDER PACKET VIMPAT SOLUTION/TABLET	NEW PA	
Antidiabetics	SYMLIN	NEW STEP THERAPY – REQUIRE RECENT CLAIM FOR INSULIN THERAPY	
Antihistamines – minimally sedating	CETIRIZINE SYRUP (RX) LORATADINE 5 MG CHEWABLE (OTC) LORATADINE 10 MG ODT (OTC)	NEW AGE EDIT – PA REQUIRED FOR INDIVIDUALS 13 AND OLDER FOR ALL LIQUID AND ODT FORMULATIONS	

Antineoplastic / Adjunctive Therapies	OJEMDA	ADD PA
Anticonvulsants	LIBERVANT	ADD PA

**UM UPDATES WILL APPLY WHEN THE MEDICATION BECOMES AVAILABLE ON THE MARKET*

*** COMPREHENSIVE DRUG LIST WILL BE AVAILABLE 7/1/2024*

What action do I need to take?

Some drugs may no longer be covered. Determine if a change to a covered drug can be done. If so, a new prescription needs to be sent to the pharmacy.

If the non-covered drug cannot be changed, a prior authorization may be needed.

What if I have questions?

For members, call Pharmacy Customer Service at **866-781-5094 (TTY 1-866-773-9634)**, 24 hours a day, seven days a week.

For providers, you can find the *Comprehensive Drug List* on our website by visiting **www.HealthyBlueSC.com** and selecting **Providers**. If you need assistance with any other item, contact Provider Service at **866-757-8286**.