Individual & Family Metal Plans and Essential Plan Formulary

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

ACCRUFER 30 MG CAPSULE
ACTEMRA 162 MG/0.9 ML SYRINGE
ACTEMRA ACTPEN 162 MG/0.9 ML
ACTHAR 40 UNIT/0.5 ML SELFJECT
ACTHAR 80 UNIT/ML SELFJECT
ACTHAR GEL 400 UNIT/5 ML VIAL
ACTIMMUNE 100 MCG/0.5 ML VIAL
ADDYI 100 MG TABLET
ADEMPAS 0.5 MG TABLET
ADEMPAS 1 MG TABLET
ADEMPAS 1.5 MG TABLET
ADEMPAS 2 MG TABLET
ADEMPAS 2.5 MG TABLET
ADZENYS XR-ODT 12.5 MG TABLET
ADZENYS XR-ODT 15.7 MG TABLET
ADZENYS XR-ODT 18.8 MG TABLET
ADZENYS XR-ODT 3.1 MG TABLET
ADZENYS XR-ODT 6.3 MG TABLET
ADZENYS XR-ODT 9.4 MG TABLET
AGAMREE 40 MG/ML SUSPENSION
AIMOVIG 140 MG/ML AUTOINJECTOR
AIMOVIG 70 MG/ML AUTOINJECTOR
AIRSUPRA 90-80 MCG INHALER
AJOVY 225 MG/1.5 ML AUTOINJECT
AJOVY 225 MG/1.5 ML SYRINGE
AKEEGA 100-500 MG TABLET
AKEEGA 50-500 MG TABLET
ALECENSA 150 MG CAPSULE
ALKINDI SPRINKLE 0.5 MG CAP
ALKINDI SPRINKLE 1 MG CAPSULE
ALKINDI SPRINKLE 2 MG CAPSULE
ALKINDI SPRINKLE 5 MG CAPSULE
ALUNBRIG 180 MG TABLET
ALUNBRIG 30 MG TABLET
ALUNBRIG 90 MG TABLET
ALUNBRIG 90 MG-180 MG TAB PACK
ALVAIZ 18 MG TABLET
ALVAIZ 36 MG TABLET
ALVAIZ 54 MG TABLET
ALVAIZ 9 MG TABLET
ALYQ 20 MG TABLET
AMBRISENTAN 10 MG TABLET
AMBRISENTAN 5 MG TABLET
APOMORPHINE 30 MG/3 ML CARTRDG
ARCALYST 220 MG VIAL
ARIKAYCE 590 MG/8.4 ML VIAL
AUGTYRO 40 MG CAPSULE
AUSTEDO 12 MG TABLET
AUSTEDO 6 MG TABLET
AUSTEDO 9 MG TABLET
AUSTEDO XR 12 MG TABLET
AUSTEDO XR 18 MG TABLET
AUSTEDO XR 24 MG TABLET
AUSTEDO XR 30 MG TABLET
AUSTEDO XR 36 MG TABLET
AUSTEDO XR 42 MG TABLET
AUSTEDO XR 48 MG TABLET
AUSTEDO XR 6 MG TABLET
AUSTEDO XR TITR(12-18-24-30MG)
AUVELITY ER 45-105 MG TABLET
AYVAKIT 100 MG TABLET
AYVAKIT 200 MG TABLET
AYVAKIT 25 MG TABLET
AYVAKIT 300 MG TABLET
AYVAKIT 50 MG TABLET
AZELASTIN-FLUTIC 137-50MCG SPR
BACLOFEN 10 MG/5 ML SOLUTION
BACLOFEN 25 MG/5 ML SUSPENSION
BACLOFEN 5 MG/5 ML SOLUTION
BALVERSA 3 MG TABLET
BALVERSA 4 MG TABLET
BALVERSA 5 MG TABLET
BELBUCA 150 MCG FILM
BELBUCA 300 MCG FILM
BELBUCA 450 MCG FILM
BELBUCA 600 MCG FILM
BELBUCA 75 MCG FILM
BELBUCA 750 MCG FILM
BELBUCA 900 MCG FILM
BERINERT 500 UNIT KIT

Individual & Family Metal Plans and Essential Plan Formulary

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

BESREMI 500 MCG/ML SYRINGE
BEXAROTENE 1% GEL
BEXAROTENE 75 MG CAPSULE
BOSENTAN 125 MG TABLET
BOSENTAN 62.5 MG TABLET
BOSULIF 100 MG CAPSULE
BOSULIF 100 MG TABLET
BOSULIF 400 MG TABLET
BOSULIF 50 MG CAPSULE
BOSULIF 500 MG TABLET
BRAFTOVI 75 MG CAPSULE
BRIMONIDINE 0.33% GEL PUMP
BRUKINSA 80 MG CAPSULE
BUDESONIDE 2 MG RECTAL FOAM
BUPRENORPHINE 10 MCG/HR PATCH
BUPRENORPHINE 15 MCG/HR PATCH
BUPRENORPHINE 20 MCG/HR PATCH
BUPRENORPHINE 5 MCG/HR PATCH
BUPRENORPHINE 7.5 MCG/HR PATCH
BYLVAY 1,200 MCG CAPSULE
BYLVAY 200 MCG PELLET
BYLVAY 400 MCG CAPSULE
BYLVAY 600 MCG PELLET
CABLIVI 11 MG KIT
CABOMETYX 20 MG TABLET
CABOMETYX 40 MG TABLET
CABOMETYX 60 MG TABLET
CALQUENCE 100 MG TABLET
CAMZYOS 10 MG CAPSULE
CAMZYOS 15 MG CAPSULE
CAMZYOS 2.5 MG CAPSULE
CAMZYOS 5 MG CAPSULE
CAPRELSA 100 MG TABLET
CAPRELSA 300 MG TABLET
CARAC 0.5% CREAM
CARAC CREAM
CARGLUMIC ACID 200 MG TAB SUSP
CARISOPRODOL 250 MG TABLET
CERDELGA 84 MG CAPSULE
CETRORELIX ACETATE 0.25 MG VL
CHOLBAM 250 MG CAPSULE
CHOLBAM 50 MG CAPSULE
CHORIONIC GONAD 10,000 UNIT VL
CIMZIA 2X200 MG/ML SYRINGE KIT
CIMZIA 2X200 MG/ML(X3)START KT
CINRYZE 500 UNIT VIAL
CINRYZE 500 UNIT VIAL-DILUENT
CLOMIPRAMINE 25 MG CAPSULE
CLOMIPRAMINE 50 MG CAPSULE
CLOMIPRAMINE 75 MG CAPSULE
COMETRIQ 100 MG DAILY-DOSE PK
COMETRIQ 140 MG DAILY-DOSE PK
COMETRIQ 60 MG DAILY-DOSE PACK
CONTRAVE ER 8-90 MG TABLET
COPIKTRA 15 MG CAPSULE
COPIKTRA 25 MG CAPSULE
CORTROPHIN GEL 400 UNIT/5 ML
CORTROPHIN GEL 80 UNIT/ML VIAL
COSENTYX 150 MG/ML SYRINGE
COSENTYX 300 MG DOSE-2 SYRINGE
COSENTYX 75 MG/0.5 ML SYRINGE
COSENTYX SENSOREADY 150 MG PEN
COSENTYX SNRDY 300MG DOSE-2PEN
COSENTYX UNOREADY 300 MG PEN
COTELLIC 20 MG TABLET
COTEMPLA XR-ODT 17.3 MG TABLET
COTEMPLA XR-ODT 25.9 MG TABLET
COTEMPLA XR-ODT 8.6 MG TABLET
CUVPOSA 1 MG/5 ML SOLUTION
CYLTEZO(CF) 10 MG/0.2 ML SYRNG
CYLTEZO(CF) 20 MG/0.4 ML SYRNG
CYLTEZO(CF) 40 MG/0.4 ML SYRNG
CYLTEZO(CF) 40 MG/0.8 ML SYRNG
CYLTEZO(CF) PEN 40 MG/0.4 ML
CYLTEZO(CF) PEN 40 MG/0.8 ML
CYLTEZO(CF) PEN CRH-UC-HS 40MG
CYLTEZO(CF) PEN PSORIA-UV 40MG
CYSTADROPS 0.37% EYE DROPS
CYSTARAN 0.44% EYE DROPS
DARTISLA ODT 1.7 MG TABLET

Individual & Family Metal Plans and Essential Plan Formulary

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

DASATINIB 100 MG TABLET
DASATINIB 140 MG TABLET
DASATINIB 20 MG TABLET
DASATINIB 50 MG TABLET
DASATINIB 70 MG TABLET
DASATINIB 80 MG TABLET
DAURISMO 100 MG TABLET
DAURISMO 25 MG TABLET
DAYBUE 200 MG/ML SOLUTION
DEFLAZACORT 18 MG TABLET
DEFLAZACORT 22.75 MG/ML SUSP
DEFLAZACORT 30 MG TABLET
DEFLAZACORT 36 MG TABLET
DEFLAZACORT 6 MG TABLET
DEXCOM G6 RECEIVER
DEXCOM G6 SENSOR
DEXCOM G6 TRANSMITTER
DEXCOM G7 RECEIVER
DEXCOM G7 SENSOR
DIACOMIT 250 MG CAPSULE
DIACOMIT 250 MG POWDER PACKET
DIACOMIT 500 MG CAPSULE
DIACOMIT 500 MG POWDER PACKET
DICHLORPHENAMIDE 50 MG TABLET
DICLOFENAC 35 MG CAPSULE
DICLOFENAC SODIUM 3% GEL
DIHYDROERGOTAMINE 1 MG/ML AMP
DIHYDROERGOTAMINE 1 MG/ML VL
DIHYDROERGOTAMINE 4 MG/ML SPRY
DISKETS 40 MG TABLET DISPR
DOPTELET (10 TAB PK) 20 MG TAB
DOPTELET (15 TAB PK) 20 MG TAB
DOPTELET (30 TAB PK) 20 MG TAB
DOXYLAMINE-PYRIDOXINE 10-10 MG
DROXIDOPA 100 MG CAPSULE
DROXIDOPA 200 MG CAPSULE
DROXIDOPA 300 MG CAPSULE
DUPIXENT 200 MG/1.14 ML PEN
DUPIXENT 200 MG/1.14 ML SYRING
DUPIXENT 300 MG/2 ML PEN
DUPIXENT 300 MG/2 ML SYRINGE
DUVYZAT 8.86 MG/ML ORAL SUSP
DYANAVEL XR 2.5 MG/ML SUSP
EGRIFTA SV 2 MG VIAL
EMGALITY 100 MG/ML SYR(1 OF 3)
EMGALITY 120 MG/ML PEN
EMGALITY 120 MG/ML SYRINGE
EMGALITY 300 MG (100 MG X3SYR)
EMPAVELI 1,080 MG/20 ML VIAL
ENALAPRIL 1 MG/ML ORAL SOLN
ENBREL 25 MG/0.5 ML SYRINGE
ENBREL 25 MG/0.5 ML VIAL
ENBREL 50 MG/ML MINI CARTRIDGE
ENBREL 50 MG/ML SURECLICK
ENBREL 50 MG/ML SYRINGE
ENDOMETRIN 100 MG VAG INSERT
ENSPRYNG 120 MG/ML SYRINGE
ENSTILAR 0.005%-0.064% FOAM
ENTERAL FORMULA
ENVARSUS XR 0.75 MG TABLET
ENVARSUS XR 1 MG TABLET
ENVARSUS XR 4 MG TABLET
EPCLUSA 150-37.5 MG PELLET PKT
EPCLUSA 200 MG-50 MG TABLET
EPCLUSA 200-50 MG PELLET PACK
EPCLUSA 400 MG-100 MG TABLET
EPIDIOLEX 100 MG/ML SOLN PACK
EPIDIOLEX 100 MG/ML SOLUTION
ERGOMAR 2 MG TABLET SL
ERIVEDGE 150 MG CAPSULE
ERLEADA 240 MG TABLET
ERLEADA 60 MG TABLET
ERLOTINIB HCL 100 MG TABLET
ERLOTINIB HCL 150 MG TABLET
ERLOTINIB HCL 25 MG TABLET
EVEROLIMUS 1 MG TABLET
EVEROLIMUS 10 MG TABLET
EVEROLIMUS 2 MG TAB FOR SUSP
EVEROLIMUS 2.5 MG TABLET
EVEROLIMUS 3 MG TAB FOR SUSP

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

EVEROLIMUS 5 MG TAB FOR SUSP
EVEROLIMUS 5 MG TABLET
EVEROLIMUS 7.5 MG TABLET
EVRYSDI 60 MG/80 ML(0.75MG/ML)
FABHALTA 200 MG CAPSULE
FABRAZYME 35 MG VIAL
FABRAZYME 5 MG VIAL
FASENRA PEN 30 MG/ML
FENTANYL 100 MCG/HR PATCH
FENTANYL 12 MCG/HR PATCH
FENTANYL 25 MCG/HR PATCH
FENTANYL 37.5 MCG/HR PATCH
FENTANYL 50 MCG/HR PATCH
FENTANYL 62.5 MCG/HR PATCH
FENTANYL 75 MCG/HR PATCH
FENTANYL 87.5 MCG/HR PATCH
FENTANYL CIT 200 MCG BUCCAL TB
FENTANYL CIT 400 MCG BUCCAL TB
FENTANYL CIT 600 MCG BUCCAL TB
FENTANYL CIT 800 MCG BUCCAL TB
FENTANYL CIT OTFC 1,600 MCG
FENTANYL CITRATE OTFC 200 MCG
FENTANYL CITRATE OTFC 600 MCG
FILSPARI 200 MG TABLET
FILSPARI 400 MG TABLET
FILSUVEZ 10% GEL
FINTEPLA 2.2 MG/ML SOLUTION
FIRDAPSE 10 MG TABLET
FLUOROURACIL 0.5% CREAM
FOLLISTIM AQ 300 UNIT CARTRIDG
FOLLISTIM AQ 600 UNIT CARTRIDG
FOLLISTIM AQ 900 UNIT CARTRIDG
FOTIVDA 0.89 MG CAPSULE
FOTIVDA 1.34 MG CAPSULE
FREESTYLE LIBRE 14 DAY READER
FREESTYLE LIBRE 14 DAY SENSOR
FREESTYLE LIBRE 2 READER
FREESTYLE LIBRE 2 SENSOR
FREESTYLE LIBRE 3 READER
FREESTYLE LIBRE 3 SENSOR
FREESTYLE LIBRE 3 PLUS SENSOR
FRUZAQLA 1 MG CAPSULE
FRUZAQLA 5 MG CAPSULE
FULPHILA 6 MG/0.6 ML SYRINGE
FYLNETRA 6 MG/0.6 ML SYRINGE
FYREMADEL 250 MCG/0.5 ML SYR
G-LEVOCARNITINE 1 G/10 ML SOLN
GABAPENTIN ER 300 MG TABLET
GABAPENTIN ER 600 MG TABLET
GALAFOLD 123 MG CAPSULE
GAMMAGARD LIQUID 10% VIAL
GAMMAGARD S-D 10 G (IGA<1) SOL
GAMMAGARD S-D 5 G (IGA<1) SOLN
GAMUNEX-C 1 GRAM/10 ML VIAL
GAMUNEX-C 10 GRAM/100 ML VIAL
GAMUNEX-C 2.5 GRAM/25 ML VIAL
GAMUNEX-C 20 GRAM/200 ML VIAL
GAMUNEX-C 40 GRAM/400 ML VIAL
GAMUNEX-C 5 GRAM/50 ML VIAL
GANIRELIX ACET 250 MCG/0.5 ML
GATTEX 5 MG 30-VIAL KIT
GATTEX 5 MG ONE-VIAL KIT
GATTEX 5 MG VIAL
GAVRETO 100 MG CAPSULE
GEFITINIB 250 MG TABLET
GENOTROPIN 12 MG CARTRIDGE
GENOTROPIN 13.8 MG CARTRIDGE
GENOTROPIN 5 MG CARTRIDGE
GENOTROPIN 5.8 MG CARTRIDGE
GENOTROPIN MINIQUICK 0.2 MG
GENOTROPIN MINIQUICK 0.4 MG
GENOTROPIN MINIQUICK 0.6 MG
GENOTROPIN MINIQUICK 0.8 MG
GENOTROPIN MINIQUICK 1 MG
GENOTROPIN MINIQUICK 1.2 MG
GENOTROPIN MINIQUICK 1.4 MG
GENOTROPIN MINIQUICK 1.6 MG
GENOTROPIN MINIQUICK 1.8 MG
GENOTROPIN MINIQUICK 2 MG
GILOTRIF 20 MG TABLET

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

GILOTRIF 30 MG TABLET
GILOTRIF 40 MG TABLET
GIMOTI 15 MG NASAL SPRAY
GLYCATE 1.5 MG TABLET
GLYCOPYRROLATE 1 MG/5 ML SOLN
GLYCOPYRROLATE 1.5 MG TABLET
GOCOVRI ER 137 MG CAPSULE
GOCOVRI ER 68.5 MG CAPSULE
GONAL-F 1,050 UNITS VIAL
GONAL-F 450 UNITS VIAL
GONAL-F RFF 75 UNIT VIAL
GONAL-F RFF REDI-JECT 300 UNIT
GONAL-F RFF REDI-JECT 450 UNIT
GONAL-F RFF REDI-JECT 900 UNIT
GRALISE ER 300 MG TABLET
GRALISE ER 450 MG TABLET
GRALISE ER 600 MG TABLET
GRALISE ER 750 MG TABLET
GRALISE ER 900 MG TABLET
GRANIX 300 MCG/0.5 ML SAFE SYR
GRANIX 300 MCG/0.5 ML SYRINGE
GRANIX 300 MCG/ML VIAL
GRANIX 480 MCG/0.8 ML SAFE SYR
GRANIX 480 MCG/0.8 ML SYRINGE
GRANIX 480 MCG/1.6 ML VIAL
HADLIMA 40 MG/0.8 ML SYRINGE
HADLIMA PUSHTOUCH 40 MG/0.8 ML
HADLIMA(CF) 40 MG/0.4 ML SYRNG
HADLIMA(CF) PUSHTOUCH 40MG/0.4
HAEGARDA 2,000 UNIT VIAL
HAEGARDA 3,000 UNIT VIAL
HARVONI 33.75-150 MG PELLET PK
HARVONI 45-200 MG PELLET PACKT
HARVONI 45-200 MG TABLET
HARVONI 90-400 MG TABLET
HEMLIBRA 105 MG/0.7 ML VIAL
HEMLIBRA 12 MG/0.4 ML VIAL
HEMLIBRA 150 MG/ML VIAL
HEMLIBRA 30 MG/ML VIAL
HEMLIBRA 300 MG/2 ML VIAL
HEMLIBRA 60 MG/0.4 ML VIAL
HETLIOZ LQ 4 MG/ML SUSPENSION
HIZENTRA 1 GRAM/5 ML SYRINGE
HIZENTRA 1 GRAM/5 ML VIAL
HIZENTRA 10 GRAM/50 ML SYRINGE
HIZENTRA 10 GRAM/50 ML VIAL
HIZENTRA 2 GRAM/10 ML SYRINGE
HIZENTRA 2 GRAM/10 ML VIAL
HIZENTRA 4 GRAM/20 ML SYRINGE
HIZENTRA 4 GRAM/20 ML VIAL
HORIZANT ER 300 MG TABLET
HORIZANT ER 600 MG TABLET
HUMATROPE 12 MG CARTRIDGE
HUMATROPE 24 MG CARTRIDGE
HUMATROPE 6 MG CARTRIDGE
HUMIRA 40 MG/0.8 ML SYRINGE
HUMIRA PEN 40 MG/0.8 ML
HUMIRA(CF) 10 MG/0.1 ML SYRING
HUMIRA(CF) 20 MG/0.2 ML SYRING
HUMIRA(CF) 40 MG/0.4 ML SYRING
HUMIRA(CF) PEN 40 MG/0.4 ML
HUMIRA(CF) PEN 80 MG/0.8 ML
HUMIRA(CF) PEN CRHN-UC-HS 80MG
HUMIRA(CF) PEN PEDI UC 80 MG
HUMIRA(CF) PEN PS-UV-AHS 80-40
HYDROCODONE ER 10 MG CAPSULE
HYDROCODONE ER 100 MG TABLET
HYDROCODONE ER 120 MG TABLET
HYDROCODONE ER 15 MG CAPSULE
HYDROCODONE ER 20 MG CAPSULE
HYDROCODONE ER 20 MG TABLET
HYDROCODONE ER 30 MG CAPSULE
HYDROCODONE ER 30 MG TABLET
HYDROCODONE ER 40 MG CAPSULE
HYDROCODONE ER 40 MG TABLET
HYDROCODONE ER 50 MG CAPSULE
HYDROCODONE ER 60 MG TABLET
HYDROCODONE ER 80 MG TABLET
HYDROMORPHONE HCL ER 12 MG TAB
HYDROMORPHONE HCL ER 16 MG TAB

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

HYDROMORPHONE HCL ER 32 MG TAB
HYDROMORPHONE HCL ER 8 MG TAB
HYFTOR 0.2% GEL
HYSINGLA ER 100 MG TABLET
HYSINGLA ER 120 MG TABLET
HYSINGLA ER 20 MG TABLET
HYSINGLA ER 30 MG TABLET
HYSINGLA ER 40 MG TABLET
HYSINGLA ER 60 MG TABLET
HYSINGLA ER 80 MG TABLET
IBRANCE 100 MG CAPSULE
IBRANCE 100 MG TABLET
IBRANCE 125 MG CAPSULE
IBRANCE 125 MG TABLET
IBRANCE 75 MG CAPSULE
IBRANCE 75 MG TABLET
ICATIBANT 30 MG/3 ML SYRINGE
ICLUSIG 10 MG TABLET
ICLUSIG 15 MG TABLET
ICLUSIG 30 MG TABLET
ICLUSIG 45 MG TABLET
IDHIFA 100 MG TABLET
IDHIFA 50 MG TABLET
IMBRUVICA 140 MG CAPSULE
IMBRUVICA 140 MG TABLET
IMBRUVICA 280 MG TABLET
IMBRUVICA 420 MG TABLET
IMBRUVICA 70 MG CAPSULE
IMBRUVICA 70 MG/ML SUSPENSION
IMCIVREE 10 MG/ML VIAL
IMPAVIDO 50 MG CAPSULE
INBRIJA 42 MG INHALATION CAP
INCRELEX 40 MG/4 ML VIAL
INGREZZA 40 MG CAPSULE
INGREZZA 40 MG SPRINKLE CAP
INGREZZA 60 MG CAPSULE
INGREZZA 60 MG SPRINKLE CAP
INGREZZA 80 MG CAPSULE
INGREZZA 80 MG SPRINKLE CAP
INGREZZA INITIATION PK(TARDIV)
INLYTA 1 MG TABLET
INLYTA 5 MG TABLET
INQOVI 35 MG-100 MG TABLET
INREBIC 100 MG CAPSULE
IQIRVO 80 MG TABLET
ISOTRETINOIN 25 MG CAPSULE
ISOTRETINOIN 35 MG CAPSULE
ISTURISA 1 MG TABLET
ISTURISA 5 MG TABLET
IVERMECTIN 3 MG TABLET
IWILFIN 192 MG TABLET
JAKAFI 10 MG TABLET
JAKAFI 15 MG TABLET
JAKAFI 20 MG TABLET
JAKAFI 25 MG TABLET
JAKAFI 5 MG TABLET
JAVYGTOR 100 MG POWDER PACKET
JAVYGTOR 100 MG TABLET
JAVYGTOR 500 MG POWDER PACKET
JAYPIRCA 100 MG TABLET
JAYPIRCA 50 MG TABLET
JOENJA 70 MG TABLET
JUXTAPID 10 MG CAPSULE
JUXTAPID 20 MG CAPSULE
JUXTAPID 30 MG CAPSULE
JUXTAPID 5 MG CAPSULE
JYLAMVO 2 MG/ML ORAL SOLUTION
JYNARQUE 15 MG TABLET
JYNARQUE 15 MG-15 MG TABLET
JYNARQUE 30 MG TABLET
JYNARQUE 30 MG-15 MG TABLET
JYNARQUE 45 MG-15 MG TABLET
JYNARQUE 60 MG-30 MG TABLET
JYNARQUE 90 MG-30 MG TABLET
KALYDECO 13.4 MG GRANULES PKT
KALYDECO 150 MG TABLET
KALYDECO 25 MG GRANULES PACKET
KALYDECO 5.8 MG GRANULES PKT
KALYDECO 50 MG GRANULES PACKET
KALYDECO 75 MG GRANULES PACKET

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

KERENDIA 10 MG TABLET
KERENDIA 20 MG TABLET
KEVEYIS 50 MG TABLET
KISQALI 200 MG DAILY DOSE
KISQALI 400 MG DAILY DOSE
KISQALI 600 MG DAILY DOSE
KLISYRI 1% (250 MG) OINT PKT
KLISYRI 1% (350 MG) OINT PKT
KOSELUGO 10 MG CAPSULE
KOSELUGO 25 MG CAPSULE
KRAZATI 200 MG TABLET
KRISTALOSE 10 GM PACKET
KRISTALOSE 20 GM PACKET
L-GLUTAMINE 5 GRAM POWDER PKT
L-LEUCINE POWDER
LACTULOSE 10 GM PACKET
LAZCLUZE 240 MG TABLET
LAZCLUZE 80 MG TABLET
LEDIPASVIR-SOFOSBUVIR 90-400MG
LENVIMA 10 MG DAILY DOSE
LENVIMA 12 MG DAILY DOSE
LENVIMA 14 MG DAILY DOSE
LENVIMA 18 MG DAILY DOSE
LENVIMA 20 MG DAILY DOSE
LENVIMA 24 MG DAILY DOSE
LENVIMA 4 MG CAPSULE
LENVIMA 8 MG DAILY DOSE
LEUPROLIDE 1 MG/0.2 ML KIT
LEUPROLIDE 2WK 1 MG/0.2 ML KIT
LEUPROLIDE 2WK 1 MG/0.2 ML KT
LEUPROLIDE 2WK 14 MG/2.8 ML KT
LEVOCARNITINE 1 G/10 ML SOLN
LEVOCARNITINE 1,000 MG/10 ML
LEVORPHANOL 2 MG TABLET
LEVORPHANOL 3 MG TABLET
LIQREV 10 MG/ML ORAL SUSP
LIQSORB 500 MG/5 ML LIQUID
LIQSORB LIQUID
LITFULO 50 MG CAPSULE
LIVDELZI 10 MG CAPSULE
LIVMARLI 19 MG/ML ORAL SOLN
LIVMARLI 9.5 MG/ML ORAL SOLN
LODOCO 0.5 MG TABLET
LONSURF 15 MG-6.14 MG TABLET
LONSURF 20 MG-8.19 MG TABLET
LORBRENA 100 MG TABLET
LORBRENA 25 MG TABLET
LOREEV XR 1 MG CAPSULE
LOREEV XR 1.5 MG CAPSULE
LOREEV XR 2 MG CAPSULE
LOREEV XR 3 MG CAPSULE
LUMAKRAS 120 MG TABLET
LUMAKRAS 320 MG TABLET
LUMRYZ ER 4.5 GM PACKET
LUMRYZ ER 6 GM PACKET
LUMRYZ ER 7.5 GM PACKET
LUMRYZ ER 9 GM PACKET
LUPKYNIS 7.9 MG CAPSULE
LYBALVI 10-10 MG TABLET
LYBALVI 15-10 MG TABLET
LYBALVI 20-10 MG TABLET
LYBALVI 5-10 MG TABLET
LYNPARZA 100 MG TABLET
LYNPARZA 150 MG TABLET
LYTGOBI 12 MG DOSE (3X 4MG TB)
LYTGOBI 16 MG DOSE (4X 4MG TB)
LYTGOBI 20 MG DOSE (5X 4MG TB)
LYVISPAH 10 MG GRANULE PACKET
LYVISPAH 20 MG GRANULE PACKET
LYVISPAH 5 MG GRANULE PACKET
MAVYRET 100-40 MG TABLET
MAVYRET 50-20 MG PELLET PACKET
MEKINIST 0.05 MG/ML SOLUTION
MEKINIST 0.5 MG TABLET
MEKINIST 2 MG TABLET
MEKTOVI 15 MG TABLET
MENOPUR 75 UNIT VIAL
METHADONE 10 MG/5 ML SOLUTION
METHADONE 10 MG/ML ORAL CONC
METHADONE 40 MG TABLET DISPR

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

METHADONE 5 MG/5 ML SOLN CUP
METHADONE 5 MG/5 ML SOLUTION
METHADONE HCL 10 MG TABLET
METHADONE HCL 5 MG TABLET
MIFEPRISTONE 300 MG TABLET
MIGLUSTAT 100 MG CAPSULE
MORPHINE SULF 100 MG TAB SA
MORPHINE SULF 15 MG TAB SA
MORPHINE SULF 200 MG TAB SA
MORPHINE SULF 30 MG TAB SA
MORPHINE SULF 60 MG TAB SA
MORPHINE SULF CR 100 MG TABLET
MORPHINE SULF CR 15 MG TABLET
MORPHINE SULF CR 200 MG TABLET
MORPHINE SULF CR 30 MG TABLET
MORPHINE SULF CR 60 MG TABLET
MORPHINE SULF ER 100 MG TAB
MORPHINE SULF ER 100 MG TABLET
MORPHINE SULF ER 15 MG TABLET
MORPHINE SULF ER 200 MG TAB
MORPHINE SULF ER 200 MG TABLET
MORPHINE SULF ER 30 MG TABLET
MORPHINE SULF ER 60 MG TAB
MORPHINE SULF ER 60 MG TABLET
MORPHINE SULFATE 30 MG TAB SA
MORPHINE SULFATE ER 10 MG CAP
MORPHINE SULFATE ER 100 MG CAP
MORPHINE SULFATE ER 120 MG CAP
MORPHINE SULFATE ER 20 MG CAP
MORPHINE SULFATE ER 30 MG CAP
MORPHINE SULFATE ER 45 MG CAP
MORPHINE SULFATE ER 50 MG CAP
MORPHINE SULFATE ER 60 MG CAP
MORPHINE SULFATE ER 75 MG CAP
MORPHINE SULFATE ER 80 MG CAP
MORPHINE SULFATE ER 90 MG CAP
MOTPOLY XR 100 MG CAPSULE
MOTPOLY XR 150 MG CAPSULE
MOTPOLY XR 200 MG CAPSULE
MOUNJARO 10 MG/0.5 ML PEN
MOUNJARO 12.5 MG/0.5 ML PEN
MOUNJARO 15 MG/0.5 ML PEN
MOUNJARO 2.5 MG/0.5 ML PEN
MOUNJARO 5 MG/0.5 ML PEN
MOUNJARO 7.5 MG/0.5 ML PEN
MULPLETA 3 MG TABLET
MYALEPT 11.3 MG (5 MG/ML) VIAL
MYFEMBREE 40 MG-1 MG-0.5 MG TB
MYTESI 125 MG DR TABLET
NAPROXEN-ESOMEPRAZ DR 375-20MG
NAPROXEN-ESOMEPRAZ DR 500-20MG
NERLYNX 40 MG TABLET
NEUPOGEN 300 MCG/0.5 ML SYR
NEUPOGEN 300 MCG/ML VIAL
NEUPOGEN 480 MCG/0.8 ML SYR
NEUPOGEN 480 MCG/1.6 ML VIAL
NEUPRO 1 MG/24 HR PATCH
NEUPRO 2 MG/24 HR PATCH
NEUPRO 3 MG/24 HR PATCH
NEUPRO 4 MG/24 HR PATCH
NEUPRO 6 MG/24 HR PATCH
NEUPRO 8 MG/24 HR PATCH
NEXAVAR 200 MG TABLET
NEXLETOL 180 MG TABLET
NEXLIZET 180-10 MG TABLET
NGENLA PEN 24 MG/1.2 ML
NGENLA PEN 60 MG/1.2 ML
NINLARO 2.3 MG CAPSULE
NINLARO 3 MG CAPSULE
NINLARO 4 MG CAPSULE
NITISINONE 10 MG CAPSULE
NITISINONE 2 MG CAPSULE
NITISINONE 20 MG CAPSULE
NITISINONE 5 MG CAPSULE
NITYR 10 MG TABLET
NITYR 2 MG TABLET
NITYR 5 MG TABLET
NIVESTYM 300 MCG/0.5 ML SYRING
NIVESTYM 300 MCG/ML VIAL
NIVESTYM 480 MCG/0.8 ML SYRING

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

NIVESTYM 480 MCG/1.6 ML VIAL
NORDITROPIN FLEXPRO 10 MG/1.5
NORDITROPIN FLEXPRO 15 MG/1.5
NORDITROPIN FLEXPRO 30 MG/3 ML
NORDITROPIN FLEXPRO 5 MG/1.5
NOVAREL 5,000 UNIT VIAL
NUBEQA 300 MG TABLET
NUCALA 100 MG/ML AUTO-INJECTOR
NUCALA 100 MG/ML SYRINGE
NUCALA 40 MG/0.4 ML SYRINGE
NUCYNTA ER 100 MG TABLET
NUCYNTA ER 150 MG TABLET
NUCYNTA ER 200 MG TABLET
NUCYNTA ER 250 MG TABLET
NUCYNTA ER 50 MG TABLET
NUEDEXTA 20-10 MG CAPSULE
NUPLAZID 10 MG TABLET
NUPLAZID 34 MG CAPSULE
NURTEC ODT 75 MG TABLET
NUTROPIN AQ NUSPIN 10 INJECTOR
NUTROPIN AQ NUSPIN 20 INJECTOR
NUTROPIN AQ NUSPIN 5 INJECTOR
NUZYRA 150 MG TABLET
NYVEPRIA 6 MG/0.6 ML SYRINGE
OCALIVA 10 MG TABLET
OCALIVA 5 MG TABLET
ODOMZO 200 MG CAPSULE
OFEV 100 MG CAPSULE
OFEV 150 MG CAPSULE
OGSIVEO 100 MG TABLET
OGSIVEO 150 MG TABLET
OGSIVEO 50 MG TABLET
OHTUVAYRE 3 MG/2.5ML INHAL SUS
OJEMDA 100 MG TAB (400MG DOSE)
OJEMDA 100 MG TAB (500MG DOSE)
OJEMDA 100 MG TAB (600MG DOSE)
OJEMDA 25 MG/ML ORAL SUSP
OJJAARA 100 MG TABLET
OJJAARA 150 MG TABLET
OJJAARA 200 MG TABLET
OLPRUVA 2 GRAM DOSE ENVELOPE
OLPRUVA 2 GRAM DOSE KIT
OLPRUVA 2 GRAM PACKET
OLPRUVA 3 GRAM DOSE ENVELOPE
OLPRUVA 3 GRAM DOSE KIT
OLPRUVA 3 GRAM PACKET
OLPRUVA 4 GRAM DOSE ENVELOPE
OLPRUVA 4 GRAM DOSE KIT
OLPRUVA 5 GRAM DOSE ENVELOPE
OLPRUVA 5 GRAM DOSE KIT
OLPRUVA 6 GRAM DOSE ENVELOPE
OLPRUVA 6 GRAM DOSE KIT
OLPRUVA 6.67 GM DOSE ENVELOPE
OLPRUVA 6.67 GRAM DOSE KIT
OLUMIANT 1 MG TABLET
OLUMIANT 2 MG TABLET
OLUMIANT 4 MG TABLET
OMNIPOD 10 PACK
OMNIPOD 5 (G6/LIBRE 2 PLUS)
OMNIPOD 5 DEXG7G6 INTRO(GEN 5)
OMNIPOD 5 DEXG7G6 PODS (GEN 5)
OMNIPOD 5 G6-G7 INTRO KT(GEN5)
OMNIPOD 5 G6-G7 PODS (GEN 5)
OMNIPOD 5 INTRO(G6/LIBRE2PLUS)
OMNIPOD CLASSIC PODS(GEN3) 5PK
OMNIPOD DASH INTRO KIT (GEN 4)
OMNIPOD DASH PODS (GEN 4) 5PK
OMNITROPE 10 MG/1.5 ML CRTG
OMNITROPE 5 MG/1.5 ML CRTG
OMNITROPE 5.8 MG VIAL
ONEXTON GEL PUMP
ONUREG 200 MG TABLET
ONUREG 300 MG TABLET
OPSUMIT 10 MG TABLET
OPSYNVI 10-20 MG TABLET
OPSYNVI 10-40 MG TABLET
OPZELURA 1.5% CREAM
ORENCIA 125 MG/ML SYRINGE
ORENCIA 50 MG/0.4 ML SYRINGE
ORENCIA 87.5 MG/0.7 ML SYRINGE

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

ORENCIA CLICKJECT 125 MG/ML
ORENITRAM ER 0.125 MG TABLET
ORENITRAM ER 0.25 MG TABLET
ORENITRAM ER 1 MG TABLET
ORENITRAM ER 2.5 MG TABLET
ORENITRAM ER 5 MG TABLET
ORENITRAM MONTH 1 TITRATION KT
ORENITRAM MONTH 2 TITRATION KT
ORENITRAM MONTH 3 TITRATION KT
ORFADIN 4 MG/ML SUSPENSION
ORGOVYX 120 MG TABLET
ORIAHNN 300-1-0.5MG/300MG CAPS
ORILISSA 150 MG TABLET
ORILISSA 200 MG TABLET
ORKAMBI 100 MG-125 MG TABLET
ORKAMBI 100-125 MG GRANULE PKT
ORKAMBI 150-188 MG GRANULE PKT
ORKAMBI 200 MG-125 MG TABLET
ORKAMBI 75-94 MG GRANULE PKT
ORLADEYO 110 MG CAPSULE
ORLADEYO 150 MG CAPSULE
ORLISTAT 120 MG CAPSULE
ORMALVI 50 MG TABLET
ORSERDU 345 MG TABLET
ORSERDU 86 MG TABLET
OSMOLEX ER 129 MG TABLET
OTEZLA 10-20 MG STARTER 28 DAY
OTEZLA 10-20-30MG START 28 DAY
OTEZLA 20 MG TABLET
OTEZLA 30 MG TABLET
OTREXUP 10 MG/0.4 ML AUTO-INJ
OTREXUP 12.5 MG/0.4 ML AUTOINJ
OTREXUP 15 MG/0.4 ML AUTO-INJ
OTREXUP 17.5 MG/0.4 ML AUTOINJ
OTREXUP 20 MG/0.4 ML AUTO-INJ
OTREXUP 22.5 MG/0.4 ML AUTOINJ
OTREXUP 25 MG/0.4 ML AUTO-INJ
OVIDREL 250 MCG/0.5 ML SYRG
OXERVATE 0.002% EYE DROP
OXYCODONE-ACETAMINOPH 10-300/5
OXYCODONE HCL ER 10 MG TABLET
OXYCODONE HCL ER 20 MG TABLET
OXYCODONE HCL ER 40 MG TABLET
OXYCODONE HCL ER 80 MG TABLET
OXYMORPHONE HCL ER 10 MG TAB
OXYMORPHONE HCL ER 15 MG TAB
OXYMORPHONE HCL ER 20 MG TAB
OXYMORPHONE HCL ER 30 MG TAB
OXYMORPHONE HCL ER 40 MG TAB
OXYMORPHONE HCL ER 5 MG TABLET
OXYMORPHONE HCL ER 7.5 MG TAB
OZEMPIC 0.25-0.5 MG/DOSE PEN
OZEMPIC 1 MG/DOSE (4 MG/3 ML)
OZEMPIC 2 MG/DOSE (8 MG/3 ML)
OZOBAX 5 MG/5 ML SOLUTION
OZOBAX DS 10 MG/5 ML SOLUTION
PALFORZIA 12 MG (LEVEL 3)
PALFORZIA 120 MG (LEVEL 7)
PALFORZIA 160 MG (LEVEL 8)
PALFORZIA 20 MG (LEVEL 4)
PALFORZIA 200 MG (LEVEL 9)
PALFORZIA 240 MG (LEVEL 10)
PALFORZIA 3 MG (LEVEL 1)
PALFORZIA 300 MG (LEVEL 11)
PALFORZIA 300 MG (MAINTENANCE)
PALFORZIA 40 MG (LEVEL 5)
PALFORZIA 6 MG (LEVEL 2)
PALFORZIA 80 MG (LEVEL 6)
PALFORZIA INITIAL DOSE PACK
PALYNZIQ 10 MG/0.5 ML SYRINGE
PALYNZIQ 2.5 MG/0.5 ML SYRINGE
PALYNZIQ 20 MG/ML SYRINGE
PAZOPANIB HCL 200 MG TABLET
PEGASYS 180 MCG/0.5 ML SYRINGE
PEGASYS 180 MCG/ML VIAL
PEMAZYRE 13.5 MG TABLET
PEMAZYRE 4.5 MG TABLET
PEMAZYRE 9 MG TABLET
PIQRAY 200 MG DAILY DOSE PACK
PIQRAY 250 MG DAILY DOSE PACK

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

PIQRAY 300 MG DAILY DOSE PACK
PIRFENIDONE 267 MG CAPSULE
PIRFENIDONE 267 MG TABLET
PIRFENIDONE 801 MG TABLET
POMALYST 1 MG CAPSULE
POMALYST 2 MG CAPSULE
POMALYST 3 MG CAPSULE
POMALYST 4 MG CAPSULE
PREGNYL 10,000 UNIT VIAL
PREGNYL 10,000 UNITS VIAL
PRIVIGEN 10% VIAL
PROCYSBI DR 25 MG CAPSULE
PROCYSBI DR 300 MG GRANULE PKT
PROCYSBI DR 75 MG CAPSULE
PROCYSBI DR 75 MG GRANULE PKT
PROLIA 60 MG/ML SYRINGE
PROMACTA 12.5 MG SUSPEN PACKET
PROMACTA 12.5 MG TABLET
PROMACTA 25 MG SUSPENSION PCKT
PROMACTA 25 MG TABLET
PROMACTA 50 MG TABLET
PROMACTA 75 MG TABLET
PURIXAN 20 MG/ML ORAL SUSP
PYRUKYND 20 MG TABLET
PYRUKYND 20 MG TAPER PACK
PYRUKYND 20-5 MG TAPER PACK
PYRUKYND 5 MG TABLET
PYRUKYND 5 MG TAPER PACK
PYRUKYND 50 MG TABLET
PYRUKYND 50 MG TAPER PACK
PYRUKYND 50-20 MG TAPER PACK
QBRELIS 1MG/ML SOLUTION
QELBREE ER 100 MG CAPSULE
QELBREE ER 150 MG CAPSULE
QELBREE ER 200 MG CAPSULE
QINLOCK 50 MG TABLET
QSYMIA 11.25 MG-69 MG CAPSULE
QSYMIA 15 MG-92 MG CAPSULE
QSYMIA 3.75 MG-23 MG CAPSULE
QSYMIA 7.5 MG-46 MG CAPSULE
QUILLICHEW ER 20 MG CHEW TAB
QUILLICHEW ER 30 MG CHEW TAB
QUILLICHEW ER 40 MG CHEW TAB
QUILLIVANT XR 25 MG/5 ML SUSP
QUININE SULFATE 324 MG CAP
QUININE SULFATE 324 MG CAPSULE
QULIPTA 10 MG TABLET
QULIPTA 30 MG TABLET
QULIPTA 60 MG TABLET
RADICAVA ORS 105 MG/5 ML SUSP
RADICAVA ORS STARTER KIT SUSP
RASUVO 10 MG/0.2 ML AUTOINJ
RASUVO 12.5 MG/0.25 ML AUTOINJ
RASUVO 15 MG/0.3 ML AUTOINJ
RASUVO 17.5 MG/0.35 ML AUTOINJ
RASUVO 20 MG/0.4 ML AUTOINJ
RASUVO 22.5 MG/0.45 ML AUTOINJ
RASUVO 25 MG/0.5 ML AUTOINJ
RASUVO 30 MG/0.6 ML AUTOINJ
RASUVO 7.5 MG/0.15 ML AUTOINJ
RAVICTI 1.1 GRAM/ML LIQUID
RAYALDEE ER 30 MCG CAP (HARD)
RAYALDEE ER 30 MCG CAP (SOFT)
RAYOS DR 1 MG TABLET
RAYOS DR 2 MG TABLET
RAYOS DR 5 MG TABLET
RECORLEV 150 MG TABLET
RELEUKO 300 MCG/0.5 ML SYRINGE
RELEUKO 480 MCG/0.8 ML SYRINGE
RELTONE 200 MG CAPSULE
RELTONE 400 MG CAPSULE
RETEVMO 120 MG TABLET
RETEVMO 160 MG TABLET
RETEVMO 40 MG CAPSULE
RETEVMO 40 MG TABLET
RETEVMO 80 MG CAPSULE
RETEVMO 80 MG TABLET
REVCOVI 2.4 MG/1.5 ML VIAL
REZDIFFRA 100 MG TABLET
REZDIFFRA 60 MG TABLET

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

REZDIFFRA 80 MG TABLET
REZLIDHIA 150 MG CAPSULE
REZUROCK 200 MG TABLET
RIBAVIRIN 200 MG CAPSULE
RIBAVIRIN 200 MG TABLET
RINVOQ ER 15 MG TABLET
RINVOQ ER 30 MG TABLET
RINVOQ ER 45 MG TABLET
RINVOQ LQ 1 MG/ML SOLUTION
RIVFLOZA 128 MG/0.8 ML SYRINGE
RIVFLOZA 160 MG/ML SYRINGE
RIVFLOZA 80 MG/0.5 ML VIAL
ROZLYTREK 100 MG CAPSULE
ROZLYTREK 200 MG CAPSULE
ROZLYTREK 50 MG PELLET PACKET
RUBRACA 250 MG TABLET
RUBRACA 300 MG TABLET
RUCONEST 2,100 UNIT VIAL
RYBELSUS 14 MG TABLET
RYBELSUS 3 MG TABLET
RYBELSUS 7 MG TABLET
RYDAPT 25 MG CAPSULE
RYPLAZIM 68.8 MG VIAL
RYTARY ER 23.75 MG-95 MG CAP
RYTARY ER 36.25 MG-145 MG CAP
RYTARY ER 48.75 MG-195 MG CAP
RYTARY ER 61.25 MG-245 MG CAP
SAJAZIR 30 MG/3 ML SYRINGE
SAPROPTERIN 100 MG POWDER PKT
SAPROPTERIN 100 MG TABLET
SAPROPTERIN 500 MG POWDER PKT
SAXENDA 18 MG/3 ML PEN
SCEMBLIX 100 MG TABLET
SCEMBLIX 20 MG TABLET
SCEMBLIX 40 MG TABLET
SEROSTIM 4 MG VIAL
SEROSTIM 5 MG VIAL
SEROSTIM 6 MG VIAL
SIGNIFOR 0.3 MG/ML AMPULE
SIGNIFOR 0.6 MG/ML AMPULE
SIGNIFOR 0.9 MG/ML AMPULE
SIKLOS 1,000 MG TABLET
SIKLOS 100 MG TABLET
SILDENAFIL 10 MG/ML ORAL SUSP
SILDENAFIL 20 MG TABLET
SIMLANDI(CF) AI 40 MG/0.4 ML
SIVEXTRO 200 MG TABLET
SKYCLARYS 50 MG CAPSULE
SKYRIZI 150 MG/ML PEN
SKYRIZI 150 MG/ML SYRINGE
SKYRIZI 180 MG/1.2 ML ON-BODY
SKYRIZI 360 MG/2.4 ML ON-BODY
SKYTROFA 11 MG CARTRIDGE
SKYTROFA 13.3 MG CARTRIDGE
SKYTROFA 3 MG CARTRIDGE
SKYTROFA 3.6 MG CARTRIDGE
SKYTROFA 4.3 MG CARTRIDGE
SKYTROFA 5.2 MG CARTRIDGE
SKYTROFA 6.3 MG CARTRIDGE
SKYTROFA 7.6 MG CARTRIDGE
SKYTROFA 9.1 MG CARTRIDGE
SODIUM OXYBATE 0.5 G/ML SOLN
SOFOSBUVIR-VELPATASVIR 400-100
SOGROYA 10 MG/1.5 ML PEN
SOGROYA 15 MG/1.5 ML PEN
SOGROYA 5 MG/1.5 ML PEN
SOHONOS 1 MG CAPSULE
SOHONOS 1.5 MG CAPSULE
SOHONOS 10 MG CAPSULE
SOHONOS 2.5 MG CAPSULE
SOHONOS 5 MG CAPSULE
SOLTAMOX 10 MG/5 ML SOLN
SOLTAMOX 20 MG/10 ML SOLN
SOMAVERT 10 MG VIAL
SOMAVERT 15 MG VIAL
SOMAVERT 20 MG VIAL
SOMAVERT 25 MG VIAL
SOMAVERT 30 MG VIAL
SORAFENIB 200 MG TABLET
SOTYKTU 6 MG TABLET

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

SOTYLIZE 5 MG/ML ORAL SOLUTION
SOVALDI 150 MG PELLET PACKET
SOVALDI 200 MG PELLET PACKET
SOVALDI 200 MG TABLET
SOVALDI 400 MG TABLET
SPEVIGO 150 MG/ML SYRINGE
SPRYCEL 100 MG TABLET
SPRYCEL 140 MG TABLET
SPRYCEL 20 MG TABLET
SPRYCEL 50 MG TABLET
SPRYCEL 70 MG TABLET
SPRYCEL 80 MG TABLET
STELARA 45 MG/0.5 ML SYRINGE
STELARA 45 MG/0.5 ML VIAL
STELARA 90 MG/ML SYRINGE
STIMUFEND 6 MG/0.6 ML SYRINGE
STIVARGA 40 MG TABLET
STRENSIQ 18 MG/0.45 ML VIAL
STRENSIQ 28 MG/0.7 ML VIAL
STRENSIQ 40 MG/ML VIAL
STRENSIQ 80 MG/0.8 ML VIAL
SUCRAID 17,000 UNIT/2 ML SOLN
SUCRAID 8,500 UNIT/ML SOLN
SUCRAID 8,500 UNITS/ML SOLN
SUNITINIB MALATE 12.5 MG CAP
SUNITINIB MALATE 25 MG CAPSULE
SUNITINIB MALATE 37.5 MG CAP
SUNITINIB MALATE 50 MG CAPSULE
SUNOSI 150 MG TABLET
SUNOSI 75 MG TABLET
SYMDEKO 100/150 MG-150 MG TABS
SYMDEKO 50/75 MG-75 MG TABLETS
SYNAREL 2 MG/ML NASAL SPRAY
SYNDROS 5 MG/ML SOLUTION
TABRECTA 150 MG TABLET
TABRECTA 200 MG TABLET
TADALAFIL 20 MG TABLET (PULM HYPERTENSION)
TAFINLAR 10 MG TABLET FOR SUSP
TAFINLAR 50 MG CAPSULE
TAFINLAR 75 MG CAPSULE
TAGRISSO 40 MG TABLET
TAGRISSO 80 MG TABLET
TAKHZYRO 150 MG/ML SYRINGE
TAKHZYRO 300 MG/2 ML SYRINGE
TAKHZYRO 300 MG/2 ML VIAL
TALZENNA 0.1 MG CAPSULE
TALZENNA 0.1 MG SOFTGEL
TALZENNA 0.25 MG CAPSULE
TALZENNA 0.25 MG SOFTGEL
TALZENNA 0.35 MG CAPSULE
TALZENNA 0.35 MG SOFTGEL
TALZENNA 0.5 MG CAPSULE
TALZENNA 0.5 MG SOFTGEL
TALZENNA 0.75 MG CAPSULE
TALZENNA 0.75 MG SOFTGEL
TALZENNA 1 MG CAPSULE
TALZENNA 1 MG SOFTGEL
TARPEYO DR 4 MG CAPSULE
TASIGNA 150 MG CAPSULE
TASIGNA 200 MG CAPSULE
TASIGNA 50 MG CAPSULE
TASIMELTEON 20 MG CAPSULE
TAVABOROLE 5% TOPICAL SOLUTION
TAVALISSE 100 MG TABLET
TAVALISSE 150 MG TABLET
TAVNEOS 10 MG CAPSULE
TAZVERIK 200 MG TABLET
TEPMETKO 225 MG TABLET
TERIPARATIDE 600 MCG/2.4ML PEN
TETRABENAZINE 12.5 MG TABLET
TETRABENAZINE 25 MG TABLET
TIBSOVO 250 MG TABLET
TIOPRONIN 100 MG TABLET
TIOPRONIN DR 100 MG TABLET
TIOPRONIN DR 300 MG TABLET
TRAMADOL ER 100 MG TABLET
TRAMADOL ER 200 MG TABLET
TRAMADOL ER 300 MG TABLET
TRAMADOL HCL ER 100 MG CAPSULE
TRAMADOL HCL ER 100 MG TABLET

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

TRAMADOL HCL ER 200 MG CAPSULE
TRAMADOL HCL ER 200 MG TABLET
TRAMADOL HCL ER 300 MG CAPSULE
TRAMADOL HCL ER 300 MG TABLET
TREMFYA 100 MG/ML INJECTOR
TREMFYA 100 MG/ML SYRINGE
TREMFYA 200 MG/2 ML PEN
TREMFYA 200 MG/2 ML SYRINGE
TRETINOIN 0.05% EMOLLIENT CRM
TRI-LUMA CREAM
TRIENTINE HCL 250 MG CAPSULE
TRIENTINE HCL 500 MG CAPSULE
TRIKAFTA 100-50-75 MG/150 MG
TRIKAFTA 100-50-75 MG/75MG PKT
TRIKAFTA 50-25-37.5 MG/75 MG
TRIKAFTA 80-40-60MG/59.5MG PKT
TRULICITY 0.75 MG/0.5 ML PEN
TRULICITY 1.5 MG/0.5 ML PEN
TRULICITY 3 MG/0.5 ML PEN
TRULICITY 4.5 MG/0.5 ML PEN
TRUQAP 160 MG TABLET
TRUQAP 200 MG TABLET
TUKYSA 150 MG TABLET
TUKYSA 50 MG TABLET
TURALIO 125 MG CAPSULE
TYMLOS 80 MCG DOSE PEN INJECTR
TYSABRI 300 MG/15 ML VIAL
TYVASO 1.74 MG/2.9 ML SOLUTION
TYVASO DPI 16 MCG CARTRIDGE
TYVASO DPI 16-32 MCG TITR KIT
TYVASO DPI 16-32-48 MCG TITRAT
TYVASO DPI 32 MCG CARTRIDGE
TYVASO DPI 48 MCG CARTRIDGE
TYVASO DPI 64 MCG CARTRIDGE
TYVASO INHALATION REFILL KIT
TYVASO INHALATION STARTER KIT
TYVASO INSTITUTIONAL START KIT
UBRELVY 100 MG TABLET
UBRELVY 50 MG TABLET
UCERIS 2 MG RECTAL FOAM
UPTRAVI 1,000 MCG TABLET
UPTRAVI 1,200 MCG TABLET
UPTRAVI 1,400 MCG TABLET
UPTRAVI 1,600 MCG TABLET
UPTRAVI 200 MCG TABLET
UPTRAVI 200-800 TITRATION PACK
UPTRAVI 400 MCG TABLET
UPTRAVI 600 MCG TABLET
UPTRAVI 800 MCG TABLET
URSODIOL 200 MG CAPSULE
URSODIOL 400 MG CAPSULE
VALCHLOR 0.016% GEL
VANFLYTA 17.7 MG TABLET
VANFLYTA 26.5 MG TABLET
VENCLEXTA 10 MG TAB (10MG X 2)
VENCLEXTA 10 MG TABLET
VENCLEXTA 100 MG TABLET
VENCLEXTA 50 MG TABLET
VENCLEXTA STARTING PACK
VERKAZIA 0.1% EYE EMULSION
VERQUVO 10 MG TABLET
VERQUVO 2.5 MG TABLET
VERQUVO 5 MG TABLET
VERZENIO 100 MG TABLET
VERZENIO 150 MG TABLET
VERZENIO 200 MG TABLET
VERZENIO 50 MG TABLET
VESICARE LS 5 MG/5 ML SUSP
VICTOZA 2-PAK 18 MG/3 ML PEN
VICTOZA 3-PAK 18 MG/3 ML PEN
VIGABATRIN 500 MG POWDER PACKT
VIGABATRIN 500 MG TABLET
VIGADRONE 500 MG POWDER PACKET
VIGADRONE 500 MG TABLET
VIJOICE 125 MG TABLET
VIJOICE 250 MG DAILY DOSE PACK
VIJOICE 50 MG GRANULE PACKET
VIJOICE 50 MG TABLET
VITRAKVI 100 MG CAPSULE
VITRAKVI 20 MG/ML SOLUTION

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

VITRAKVI 25 MG CAPSULE
VIVJOA 150 MG CAPSULE
VIZIMPRO 15 MG TABLET
VIZIMPRO 30 MG TABLET
VIZIMPRO 45 MG TABLET
VONJO 100 MG CAPSULE
VORANIGO 10 MG TABLET
VORANIGO 40 MG TABLET
VOSEVI 400-100-100 MG TABLET
VOWST CAPSULE
VOXZOGO 0.4 MG VIAL
VOXZOGO 0.56 MG VIAL
VOXZOGO 1.2 MG VIAL
VOYDEYA 100 MG TABLET
VOYDEYA 150 MG DOSE TABLET
VYLEESI 1.75 MG/0.3 ML AUTOINJ
VYNDAMAX 61 MG CAPSULE
VYNDAQEL 20 MG CAPSULE
WAINUA 45 MG/0.8 ML AUTOINJECT
WEGOVY 0.25 MG/0.5 ML PEN
WEGOVY 0.5 MG/0.5 ML PEN
WEGOVY 1 MG/0.5 ML PEN
WEGOVY 1.7 MG/0.75 ML PEN
WEGOVY 2.4 MG/0.75 ML PEN
WELIREG 40 MG TABLET
WINLEVI 1% CREAM
WINREVAIR 45 MG ONE-VIAL KIT
WINREVAIR 45 MG TWO-VIAL KIT
WINREVAIR 45 MG VIAL
WINREVAIR 60 MG ONE-VIAL KIT
WINREVAIR 60 MG TWO-VIAL KIT
WINREVAIR 60 MG VIAL
WYNZORA 0.005%-0.064% CREAM
XALKORI 150 MG PELLET
XALKORI 20 MG PELLET
XALKORI 200 MG CAPSULE
XALKORI 250 MG CAPSULE
XALKORI 50 MG PELLET
XATMEP 2.5 MG/ML ORAL SOLUTION
XDEMVY 0.25% DROP
XELJANZ 1 MG/ML SOLUTION
XELJANZ 10 MG TABLET
XELJANZ 5 MG TABLET
XELJANZ XR 11 MG TABLET
XELJANZ XR 22 MG TABLET
XENICAL 120 MG CAPSULE
XENLETA 600 MG TABLET
XERMELO 250 MG TABLET
XOLAIR 150 MG/1.2 ML POWDER VL
XOLAIR 150 MG/ML AUTOINJECTOR
XOLAIR 150 MG/ML SYRINGE
XOLAIR 300 MG/2 ML AUTOINJECT
XOLAIR 300 MG/2 ML SYRINGE
XOLAIR 75 MG/0.5 ML AUTOINJECT
XOLAIR 75 MG/0.5 ML SYRINGE
XOLREMDI 100 MG CAPSULE
XOSPATA 40 MG TABLET
XPOVIO 100 MG ONCE WEEKLY DOSE
XPOVIO 40 MG ONCE WEEKLY DOSE
XPOVIO 40 MG TWICE WEEKLY DOSE
XPOVIO 60 MG ONCE WEEKLY DOSE
XPOVIO 60 MG TWICE WEEKLY DOSE
XPOVIO 80 MG ONCE WEEKLY DOSE
XPOVIO 80 MG TWICE WEEKLY DOSE
XTAMPZA ER 13.5 MG CAPSULE
XTAMPZA ER 18 MG CAPSULE
XTAMPZA ER 27 MG CAPSULE
XTAMPZA ER 36 MG CAPSULE
XTAMPZA ER 9 MG CAPSULE
XTANDI 40 MG CAPSULE
XTANDI 40 MG TABLET
XTANDI 80 MG TABLET
XURIDEN 2 GM GRANULE PACKET
XYREM 500 MG/ML ORAL SOLN
XYREM 500 MG/ML ORAL SOLUTION
XYWAV 0.5 GM/ML ORAL SOLUTION
YARGESA 100 MG CAPSULE
YONSA 125 MG TABLET
YORVIPATH 168 MCG/0.56 ML PEN
YORVIPATH 294 MCG/0.98 ML PEN

Prior Authorization List

The following prescription drugs require Prior Authorization

Certain medications require prior authorization, which means approval is needed before the prescription can be filled. If approval is not received, the drug may not be covered. This list may not apply to all plans or benefits. List subject to change.

YORVIPATH 420 MCG/1.4 ML PEN
ZEJULA 100 MG TABLET
ZEJULA 200 MG TABLET
ZEJULA 300 MG TABLET
ZELAPAR 1.25 MG ODT TABLET
ZELBORAF 240 MG TABLET
ZEPBOUND 10 MG/0.5 ML PEN
ZEPBOUND 12.5 MG/0.5 ML PEN
ZEPBOUND 15 MG/0.5 ML PEN
ZEPBOUND 2.5 MG/0.5 ML PEN
ZEPBOUND 5 MG/0.5 ML PEN
ZEPBOUND 7.5 MG/0.5 ML PEN
ZEPOSIA 0.92 MG CAPSULE
ZEPOSIA STARTER KIT (28-DAY)
ZEPOSIA STARTER PACK (7-DAY)
ZIEXTENZO 6 MG/0.6 ML SYRINGE
ZILBRYSQ 16.6 MG/0.416 ML SYRN
ZILBRYSQ 23 MG/0.574 ML SYRING
ZILBRYSQ 32.4 MG/0.81 ML SYRNG
ZOKINVY 50 MG CAPSULE
ZOKINVY 75 MG CAPSULE
ZOLINZA 100 MG CAPSULE
ZOMACTON 10 MG VIAL
ZOMACTON 5 MG VIAL
ZORYVE 0.15% CREAM
ZTALMY 50 MG/ML SUSPENSION
ZURZUVAE 20 MG CAPSULE
ZURZUVAE 25 MG CAPSULE
ZURZUVAE 30 MG CAPSULE
ZYDELIG 100 MG TABLET
ZYDELIG 150 MG TABLET
ZYKADIA 150 MG TABLET

Individual & Family Metal Plans and Essential Plan Formulary

Step Therapy List

The following prescription drugs require Step Therapy

Step Therapy requires that members try certain First Line options before other medications will be considered medically necessary for treatment of a specific condition. Step therapy requirements may apply to both brand and generics. Typically, First Line medications are classified as generics, but there are instances where brand name medications may be preferred. This list may not apply to all plans or benefits. List subject to change.

ADLARITY 10MG/DAY WEEKLY PATCH
ADLARITY 5 MG/DAY WEEKLY PATCH
ALVESCO 160 MCG INHALER
ALVESCO 80 MCG INHALER
AUBAGIO 14 MG TABLET
AUBAGIO 7 MG TABLET
DAYVIGO 10 MG TABLET
DAYVIGO 5 MG TABLET
DEXLANSOPRAZOLE DR 30 MG CAP
DEXLANSOPRAZOLE DR 60 MG CAP
EUCRISA 2% OINTMENT
FANAPT 1 MG TABLET
FANAPT 10 MG TABLET
FANAPT 12 MG TABLET
FANAPT 2 MG TABLET
FANAPT 4 MG TABLET
FANAPT 6 MG TABLET
FANAPT 8 MG TABLET
FANAPT TITRATION PACK
INVOKAMET 150-1,000 MG TABLET
INVOKAMET 150-500 MG TABLET
INVOKAMET 50-1,000 MG TABLET
INVOKAMET 50-500 MG TABLET
INVOKAMET XR 150-1,000 MG TAB
INVOKAMET XR 150-500 MG TABLET
INVOKAMET XR 50-1,000 MG TAB
INVOKAMET XR 50-500 MG TABLET
INVOKANA 100 MG TABLET
INVOKANA 300 MG TABLET
LATUDA 120 MG TABLET
LATUDA 20 MG TABLET
LATUDA 40 MG TABLET
LATUDA 60 MG TABLET
LATUDA 80 MG TABLET
OSPHENA 60 MG TABLET
OXYTROL 3.9 MG/24HR PATCH
PHEBURANE PELLET
RHOPRESSA 0.02% OPHTH SOLUTION
ROCKLATAN 0.02%-0.005% EYE DRP
SANCUSO 3.1 MG/24 HR PATCH
SAVELLA 100 MG TABLET
SAVELLA 12.5 MG TABLET
SAVELLA 25 MG TABLET
SAVELLA 50 MG TABLET
SAVELLA TITRATION PACK
SEGLUROMET 2.5-1,000 MG TABLET
SEGLUROMET 2.5-500 MG TABLET
SEGLUROMET 7.5-1,000 MG TABLET
SEGLUROMET 7.5-500 MG TABLET
STEGLATRO 15 MG TABLET
STEGLATRO 5 MG TABLET
VRAYLAR 1.5 MG CAPSULE
VRAYLAR 3 MG CAPSULE
VRAYLAR 4.5 MG CAPSULE
VRAYLAR 6 MG CAPSULE
VYZULTA 0.024% OPHTH SOLUTION
XERESE 5%-1% CREAM

Please submit completed PA and Step Therapy forms to:
Pharmacy Help Desk
Mail to: 165 Court Street, Rochester, NY 14647
Fax: 1 (800) 956-2397
Phone: 1 (800) 499-1275