

**Commercial 3-Tier 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

ABILIFY MYCITE	AMPHETAMINE ER SUSPENSION
ABIRATERONE ACETATE 500MG	AMRIX
ABSORICA	ANTARA
ABSORICA LD	APLENZIN
ABSTRAL	APOKYN
ACCRUFER	APOMORPHINE HCL
ACIPHEX SPRINKLE	ARAZLO
ACTEMRA	ARCALYST
ACTEMRA ACTPEN	ARIKAYCE
ACTHAR	ARYMO ER
ACTICLATE	ASPIRIN-OMEPRAZOLE
ACTIMMUNE	ASPRUZYO SPRINKLE
ACTIQ	ASTAGRAF XL
ADALIMUMAB-ADAZ(CF)	AUSTEDO
ADALIMUMAB-ADAZ(CF) PEN	AUSTEDO XR
ADALIMUMAB-FKJP(CF)	AUSTEDO XR TITRATION KT(WK1-4)
ADALIMUMAB-FKJP(CF) PEN	AUVELITY
ADBRY	AYVAKIT
ADCIRCA	AZASAN
ADDYI	AZATHIOPRINE (75 & 100 MG TABLET)
ADEMPAS	AZELASTINE-FLUTICASONE
ADZENYS ER	BACLOFEN 5MG/ML ORAL SOLUTION
ADZENYS XR-ODT	BALVERSA
AFINITOR	BELBUCA
AFINITOR DISPERZ	BERINERT
AIMOVIG AUTOINJECTOR	BESREMI
AJOVY AUTOINJECTOR	BEXAROTENE
AJOVY SYRINGE	BIMATOPROST
AKLIEF	BONJESTA
ALECENSA	BOSENTAN
ALKINDI SPRINKLE	BOSULIF
ALLOPURINOL 200MG TABLET	BRAFTOVI
ALUNBRIG	BRENZAVVY
ALYQ	BRIMONIDINE TARTRATE 0.33% GEL
AMBRISENTAN	BRISDELLE
AMJEVITA(CF)	BRONCHITOL
AMJEVITA(CF) AUTOINJECTOR	BRUKINSA
AMLODIPINE-VALSARTAN	BUDESONIDE RECTAL FOAM
AMLODIPINE-VALSARTAN-HCTZ	BUPRENORPHINE PATCH

**Commercial 3-Tier 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

BUTRANS	COSENTYX UNOREADY PEN
BYLVAY	COTELLIC
CABLIVI	COTEMPLA XR-ODT
CABOMETYX	CUPRIMINE
CALCIPOTRIENE 0.005% FOAM	CUVPOSA
CALCITONIN-SALMON	CUVRIOR
CALQUENCE	CYCLOBENZAPRINE HCL 7.5 MG TABLET
CAMZYOS	CYCLOBENZAPRINE HCL ER CAPSULE
CAPRELSA	CYLTEZO(CF)
CARAC	CYLTEZO(CF) PEN
CARBAGLU	CYLTEZO(CF) PEN CROHN'S-UC-HS
CARBINOXAMINE MALEATE 6 MG	CYLTEZO(CF) PEN PSORIASIS-UV
CARDIZEM CD 360MG CAPSULE	CYPROHEPTADINE HCL SYRUP
CARGLUMIC ACID	CYSTADROPS
CARISOPRODOL 250 MG	CYSTARAN
CARISOPRODOL-ASPIRIN-CODEINE	D.H.E.45
CERDELGA	DARAPRIM
CETRORELIX ACETATE	DARTISLA
CETROTIDE	DAURISMO
CHLORZOXAZONE (250 MG, 375 MG, 750 MG)	DAYBUE
CHOLBAM	DERMACINRX SILAZONE
CHORIONIC GONADOTROPIN	DESOXYN
CIBINQO	DESVENLAFAXINE ER
CIMZIA	DEXCOM
CINRYZE	DEXCOM G4
CITALOPRAM HBR 30 MG CAPSULES	DEXCOM G5
CLEMASTINE FUMARATE SYRUP	DEXCOM G5-G4 SENSOR
CLINDAVIX	DEXCOM G6
CLOMIPRAMINE HCL	DEXCOM G7
CLONIDINE HCL ER 0.17 MG TABLET	DIACOMIT
COMETRIQ	DICHLORPHENAMIDE
CONJUPRI	DICLEGIS
CONSENSI	DICLOFENAC 35 MG CAPSULE
CONTRACE	DICLOFENAC EPOLAMINE PATCH
CONZIP	DICLOFENAC POTASSIUM 25 MG
COPIKTRA	DICLOFENAC SODIUM 2% SOLUTION
CORTROPHIN	DICLOFENAC SODIUM 3% GEL
COSENTYX SENSOREADY PEN	DIHYDROERGOTAMINE MESYLATE
COSENTYX SYRINGE	DILTIAZEM ER (CD) 360MG CAPSULE

**Commercial 3-Tier 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

DOJOLVI	ESBRIET
DOPTELET	ESOMEPRAZOLE STRONTIUM
DOXEPIN HCL 5% CREAM	EVEROLIMUS
DOXYCYCLINE HYCLATE (75 MG, 150 MG)	EVRYSDI
DOXYCYCLINE IR-DR	EXALGO
DOXYLAMINE SUCC-PYRIDOXINE HCL	EXKIVITY
DROXIDOPA	EXSERVAN
DUEXIS	EZETIMIBE-ATORVASTATIN CALCIUM
DULOXETINE HCL 40 MG	FABIOR
DUOBRII	FABRAZYME
DUPIXENT PEN	FASENRA PEN
DUPIXENT SYRINGE	FENOFIBRATE (30MG, 40MG, 50MG, 90MG 120MG, 130MG, 150MG)
DURAGESIC	FENOFIBRIC ACID (35 MG, 105 MG)
DYANAVEL XR SUSPENSION	FENOGLIDE
DYMISTA	FENOPROFEN CALCIUM
EGRIFTA	FENORTHO
EGRIFTA SV	FENTANYL PATCH
EMFLAZA	FENTANYL CITRATE
EMGALITY PEN	FENTORA
EMGALITY SYRINGE	FEXMID
EMPAVELI	FIBRICOR
EMVERM	FILSPARI
ENALAPRIL SOLUTION	FINASTERIDE 1 MG
ENBREL	FINTEPLA
ENBREL MINI	FIRAZYR
ENBREL SURECLICK	FIRDAPSE
ENDARI	FLECTOR
ENDOMETRIN	FLEQSUVY
ENSPRYNG	FLUOROURACIL 0.5% CREAM
ENSTILAR	FOLLISTIM AQ
ENTERAL FORMULA	FORTEO
ENVARUSUS XR	FOTIVDA
EPANED	FREESTYLE LIBRE 14 DAY READER
EPCLUSA	FREESTYLE LIBRE 14 DAY SENSOR
EPIDIOLEX	FREESTYLE LIBRE 2 READER
EPSOLAY 5% CREAM	FREESTYLE LIBRE 2 SENSOR
ERIVEDGE	FREESTYLE LIBRE 3 SENSOR
ERLEADA	FULPHILA
ERLOTINIB HCL	FUROSCIX

**Commercial 3-Tier 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

FYLNETRA	HUMIRA PEDIATRIC CROHN'S
FYREMADEL	HUMIRA PEN
GALAFOLD	HUMIRA(CF)
GAMMAGARD LIQUID	HUMIRA(CF) PEDIATRIC CROHN'S
GAMMAGARD S-D	HUMIRA(CF) PEN
GAMUNEX-C	HYDROCODONE BITARTRATE ER
GANIRELIX ACETATE	HYDROMORPHONE ER
GATTEX	HYDROXYCHLOROQUINE (100 MG, 300 MG, 400 MG)
GAVRETO	HYFTOR
GEFITINIB	HYRIMOZ(CF)
GENOTROPIN	HYRIMOZ(CF) PEDIATRIC CROHN'S
GILOTRIF	HYRIMOZ(CF) PEN
GIMOTI	HYRIMOZ(CF) PEN CROHN-UC START
GLYCATE	HYRIMOZ(CF) PEN PSORIASIS
GLYCOPYRROLATE 1 MG/5ML SOLUTION	HYSINGLA ER
GLYCOPYRROLATE 1.5 MG TABLET	IBRANCE
GOCOVRI	IBUPROFEN-FAMOTIDINE
GONAL-F	ICATIBANT
GONAL-F RFF	ICLUSIG
GONAL-F RFF REDI-JECT	IDACIO(CF)
GONITRO	IDACIO(CF) PEN
GRALISE	IDACIO(CF) PEN CROHN'S-UC
GRANIX	IDACIO(CF) PEN PSORIASIS
HADLIMA	IDHIFA
HADLIMA PUSHTOUCH	IMBRUVICA
HADLIMA(CF)	IMCIVREE
HADLIMA(CF) PUSHTOUCH	IMPAVIDO
HAEGARDA	INBRIJA
HARVONI	INCRELEX
HEMADY	INDERAL XL
HEMLIBRA	INDOCIN
HETLIOZ	INDOMETHACIN 20 MG CAPSULE
HETLIOZ LQ	INGREZZA
HIZENTRA	INGREZZA INITIATION PACK
HORIZANT	INLYTA
HULIO(CF)	INNOPRAN XL
HULIO(CF) PEN	INPEFA
HUMATROPE	INQOVI
HUMIRA	INREBIC

**Commercial 3-Tier 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

IRESSA	LETAIRIS
ISOTRETINOIN (25 MG, 35 MG)	LEUPROLIDE ACETATE
ISTURISA	LEVAMLODIPINE MALEATE
IVERMECTIN	LEVORPHANOL TARTRATE
JAKAFI	LICART
JAVYGTOR	LIDOCAINE-TETRACAINE
JAYPIRCA	LIPOFEN
JOENJA	LIPROZONEPAK
JORNAY PM	LIQREV
JUBLIA	LITFULO
JUXTAPID	LIVMARLI
JYNARQUE	LOFENA
KADIAN	LONSURF
KALYDECO	LORBRENA
KATERZIA	LOREEV XR
KERENDIA	LORZONE
KERYDIN	LUMAKRAS
KETOPROFEN 25 MG CAPSULES	LUMRYZ
KETOROLAC NASAL SPRAY	LUPKYNIS
KEVEYIS	LYBALVI
KEVZARA	LYNPARZA
KINERET	LYTGOBI
KISQALI	LYVISPAH
KISQALI FEMARA CO-PACK	MAVENCLAD
KLISYRI	MAVYRET
KLOFENSAID II	MEDOLOR PAK
KORLYM	MEKINIST
KOSELUGO	MEKTOVI
KRAZATI	MELOXICAM CAPSULE
KRISTALOSE	MELOXICAM SUSPENSION
KUVAN	MENOPUR
KYNMOBI	METHADONE HCL
LACTULOSE PACKET	METHADONE INTENSOL
LANREOTIDE ACETATE	METHADOSE
LATISSE	METHAMPHETAMINE HCL
LAZANDA	METHOCARBAMOL 1000 MG TABLET
LEDIPASVIR-SOFOSBUVIR	MIACALCIN
LENALIDOMIDE	MIEBO
LENVIMA	MIGLUSTAT

**Commercial 3-Tier 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

MIGRANAL	NITYR
MINOCYCLINE ER CAPSULE	NIVESTYM
MINOLIRA ER	NORDITROPIN FLEXPRO
MIRAPEX ER	NORLIQVA
MIRVASO	NORTHERA
MORPHINE SULFATE ER	NOURIANZ
MOUNJARO	NOVAREL
MOXATAG	NUBEQA
MS CONTIN	NUCALA
MULPLETA	NUCYNTA ER
MYALEPT	NUDICLO
MYCAPSSA	NUEDEXTA
MYFEMBREE	NUPLAZID
MYTESI	NURTEC ODT
NALFON	NUTROPIN AQ NUSPIN
NALOCET	NUZYRA
NAMZARIC	NYVEPRIA
NAPRELAN	OCALIVA
NAPROSYN SUSPENSION	ODOMZO
NAPROXEN SUSPENSION	OFEV
NAPROXEN SODIUM CR	OLPRUVA
NAPROXEN SODIUM ER	OLUMIANT
NAPROXEN-ESOMEPRAZOLE MAG	OMNITROPE
NATPARA	ONEXTON
NERLYNX	ONUREG
NEULASTA	OPSUMIT
NEULASTA ONPRO	OPZELURA
NEUPOGEN	ORACEA
NEUPRO	ORAVIG
NEXAVAR	ORENCIA
NEXICLON XR	ORENCIA CLICKJECT
NEXLETOL	ORENITRAM ER
NEXLIZET	ORENITRAM TITRATION KT
NGENLA	ORFADIN
NIACIN 500 MG TABLET	ORGOVYX
NINLARO	ORIAHNN
NITISINONE	ORLISSA
NITROGLYCERIN	ORKAMBI
NITROMIST	ORLADEYO

**Commercial 3-Tier 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

ORLISTAT	PURIXAN
ORSERDU	PYRUKYND
ORTIKOS	QBRELIS
OSMOLEX ER	QELBREE
OTEZLA	QINLOCK
OTREXUP	QMIIZ ODT
OVIDREL	QSYMIA
OXAYDO	QUALAQUIN
OXBRYTA	QUILLICHEW ER
OXERVATE	QUILLIVANT XR
OXYCODONE HCL ER	QUININE SULFATE
OXYCODONE-ACETAMINOPHEN 2.5-300 MG	QULIPTA
OXYCODONE-ACETAMINOPHEN SOLUTION 10-300MG	RADICAVA ORS SYRUP
OXYCONTIN	RASUVO
OXYMORPHONE HCL ER	RAVICTI
OZOBAX	RAYALDEE
PALFORZIA	RAYOS
PALYNZIQ	RECORLEV
PEGASYS	REDITREX
PEGASYS PROCLICK	REFISSA
PEMAZYRE	RELAFEN DS
PENICILLAMINE CAPSULE	RELEUKO
PENNSAICIN	RELTONE
PENNSAID	RELYVRIO
PEXEVA	RENOVA
PIQRAY	RENOVA PUMP
PIRFENIDONE	RETEVMO
PLIAGLIS	REVATIO
POMALYST	REVCOVI
PRADAXA	REVLIMID
PRAMIPEXOLE ER	REYVOW
PREGNYL	REZLIDHIA
PRIMLEV	REZUROCK
PRIVIGEN	RHOFADE
PROCYSBI	RIBAVIRIN
PROFENO	RINVOQ
PROLATE	ROXYBOND
PROMACTA	ROZLYTREK
PROPECIA	RUBRACA

**Commercial 3-Tier 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

RUCONEST	SOGROYA
RUKOBIA	SOLARAZE
RUZURGI	SOLTAMOX
RYALTRIS	SOMA 250 MG
RYDAPT	SOMAVERT
RYPLAZIM	SORAFENIB
RYTARY	SORILUX
RYVENT	SOTYKTU
SABRIL	SOTYLIZE
SAIZEN	SOVALDI
SAIZEN-SAIZENPREP	SPRIX
SAJAZIR	SPRYCEL
SANDOSTATIN LAR DEPOT	STELARA
SAPROPTERIN DIHYDROCHLORIDE	STIMUFEND
SAXENDA	STIVARGA
SCSEMBLIX	STRENSIQ
SEGLENTIS	STROMECTOL
SEMGLEE (YFGN)	SUBSYS
SEMGLEE (YFGN) PEN	SUCRAID
SEROSTIM	SUNITINIB MALATE
SERTRALINE HCL CAPSULE	SUNLENCA
SEYSARA	SUNOSI
SIGNIFOR	SUTENT
SIKLOS	SYMDEKO
SILAZONE-II	SYNAREL
SILDENAFIL CITRATE SUSPENSION	SYNDROS
SILDENAFIL CITRATE 20 MG	SYNERA
SILIQ	SYPRINE
SIMPONI	TABRECTA
SITAVIG	TADALAFIL 20 MG TABLET
SIVEXTRO	TADLIQ
SKYCLARYS	TAFINLAR
SKYRIZI	TAGRISSO
SKYRIZI ON-BODY	TAKHZYRO
SKYRIZI PEN	TALTZ AUTOINJECTOR
SKYTROFA	TALTZ SYRINGE
SOAANZ	TALZENNA
SODIUM OXYBATE	TARCEVA
SOFOSBUVIR-VELPATASVIR	TARGETIN



**Commercial 3-Tier 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

TARPEYO	TYVASO STARTER KIT
TASCENSO ODT	UBRELVY
TASIGNA	UCERIS
TASIMELTEON	UDENYCA
TAVABOROLE	UDENYCA AUTOINJECTOR
TAVALISSE	UPTRAVI
TAVNEOS	URSODIOL (200 MG, 400 MG)
TAZAROTENE 0.1% FOAM	VALCHLOR
TAZVERIK	VALSARTAN SOLUTION
TEGSEDI	VANFLYTA
TEPMETKO	VANIQA
TERIPARATIDE	VENCLEXTA
TETRABENAZINE	VENCLEXTA STARTING PACK
TEZSPIRE	VEOZAH
THIOLA	VERKAZIA 0.1%
THIOLA EC	VERQUVO
TIBSOVO	VERZENIO
TIGLUTIK	VESICARE LS
TIOPRONIN	VIGABATRIN
TIVORBEX	VIGADRONE
TOLSURA	VIJOICE
TRACLEER	VIMOVO
TRAMADOL HCL ER	VITRAKVI
TREMFYA	VIVJOA CAPSULE
TRETINOIN 0.05% EMOLLIENT CREAM	VIVLODEX
TRIAMCINOLONE 0.05% OINTMENT	VIZIMPRO
TRIANEX	VONJO
TRIENTINE HCL	VOSEVI
TRIKAFTA	VOTRIENT
TRI-LUMA	VOWST
TRUDHESA	VOXZOGO
TRUSELTIQ	VTAMA
TUKYSA	VYLEESI
TURALIO	VYNDAMAX
TYMLOS	VYNDAQEL
TYVASO	WAKIX
TYVASO DPI	WEGOVY
TYVASO INSTITUTIONAL START KIT	WELIREG
TYVASO REFILL KIT	WHYTEDERM TRILASIL PAK

**Commercial 3-Tier 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

WINLEVI	ZONALON
WYNZORA	ZONISADE
XALKORI	ZONTIVITY
XATMEP	ZORBTIVE
XDEMVY	ZORVOLEX
XELJANZ	ZORYVE 0.3% CREAM
XELJANZ XR	ZTALMY
XENAZINE	ZYDELIG
XENICAL	ZYKADIA
XENLETA	ZYTIGA
XERMELO	
XIMINO	
XOLAIR	
XOSPATA	
XPOVIO	
XTAMPZA ER	
XTANDI	
XURIDEN	
XYREM	
XYWAV	
YONSA	
YOSPRALA	
YUFLYMA(CF)	
YUFLYMA(CF) AUTOINJECTOR	
YUSIMRY(CF) PEN	
ZAVESCA	
ZAVZPRET	
ZEJULA	
ZELAPAR	
ZELBORAF	
ZELNORM	
ZEPATIER	
ZEPOSIA	
ZIEXTENZO	
ZIPSOR	
ZOKINVY	
ZOLINZA	
ZOLPIDEM TARTRATE CAPSULE	
ZOMACTON	

**Commercial 3-Tier 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

ACZONE	DAYVIGO
ADAPALENE 0.1% (LOTION, SOLUTION, SWAB)	DENAVIR
ADLARITY	DEXILANT
ADLYXIN	DEXLANSOPRAZOLE DR
ADMELOG	DIFFERIN 0.1% LOTION
ADMELOG SOLOSTAR	DORYX
AIRDUO DIGIHALER	DORYX MPC
AIRDUO RESPICLICK	DOXYCYCLINE HYCLATE DR
ALOGLIPTIN	DRIZALMA SPRINKLE
ALOGLIPTIN-METFORMIN	DUAKLIR PRESSAIR
ALOGLIPTIN-PIOGLITAZONE	DYANAVEL XR
ALVESCO	ECOZA
AMITIZA	EDARBI
AMZEEQ	EDARBYCLOR
ANZEMET	EDLUAR
APIDRA	EMSAM
APIDRA SOLOSTAR	ERTACZO
ARMONAIR DIGIHALER	ESTRING
ATRIPLA	EUCRISA
ATROPINE SULFATE 1% EYE DROPS	FANAPT
AUBAGIO	FIASP
AZSTARYS	FIASP FLEXTOUCH
BAFIERTAM	FIASP PENFILL
BELSOMRA	FLUTICASONE PROPIONATE HFA
BREXAFEMME	FLUTICASONE-SALMETEROL HFA
BREZTRI AEROSPHERE	FLUTICASONE-VILANTEROL
BRYHALI	FORFIVO XL
BUDESONIDE-FORMOTEROL FUMARATE	FORTAMET
BYDUREON	GELNIQUE
BYDUREON BCISE	GEMTESA
BYDUREON PEN	GLUCOSE METER (OTHER THAN ABBOTT, ONE TOUCH)
BYETTA	GLUMETZA
CAPLYTA	HALCINONIDE
CLINDAGEL	HALOBETASOL PROPIONATE 0.05% FOAM
CLINDAMYCIN PHOSPHATE 1% GEL	HALOG
CLOCORTOLONE PIVALATE	IBSRELA
CLODERM	IMPEKLO
CORDRAN	IMPOYZ
DALIRESP	INSULIN ASPART
DAPSONE	INSULIN ASPART FLEXPEN
DAYTRANA	INSULIN ASPART PENFILL

**Commercial 3-Tier 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

INSULIN ASPART PROT MIX 70-30	OXYTROL
KAZANO	OZEMPIC
KOMBIGLYZE XR	PANCREAZE
LATUDA	PANDEL
LEXETTE	PERTZYE
LIVALO	PONVORY
LONHALA MAGNAIR REFILL	PRALUENT PEN
LONHALA MAGNAIR STARTER	PRALUENT SYRINGE
LULICONAZOLE	PROGRAF 0.2 MG GRANULE PACKET
LUZU	PULMICORT FLEXHALER
METFORMIN ER GASTRIC	QTERN
METFORMIN ER OSMOTIC	QUVIVIQ
METFORMIN HCL 625 MG TABLET	RELISTOR
METHYLPHENIDATE PATCH	RESTASIS
MOTEGRITY	RESTASIS MULTIDOSE
MYDAYIS	REXULTI
NAFTIFINE HCL	REZVOGLAR KWIKPEN
NAFTIN	RHOPRESSA
NESINA	ROCKLATAN
NORGESIC FORTE	ROFLUMILAST
NORITATE	RYBELSUS
NOVOLOG	SANCUSO
NOVOLOG FLEXPEN	SAVAYSA
NOVOLOG MIX 70-30	SAVELLA
NOVOLOG MIX 70-30 FLEXPEN	SECUADO
NOVOLOG PENFILL	SERNIVO
OMEPRAZOLE-SODIUM BICARBONATE PACKETS	SYMPROIC
OMNIPOD 5 G6 INTRO KIT (GEN 5)	TAFLUPROST
OMNIPOD 5 G6 PODS (GEN 5)	TEMPO REFILL KIT
OMNIPOD CLASSIC PODS (GEN 3)	TEMPO WELCOME KIT
OMNIPOD DASH INTRO KIT (GEN 4)	TERIFLUNOMIDE 7 MG
OMNIPOD DASH PODS (GEN 4)	TEST STRIPS (OTHER THAN ABBOTT, ONE TOUCH)
OMNIPOD GO PODS	THALITONE
ONGLYZA	TOSYMRA
ONZETRA XSAIL	TRULICITY
ORPHENADRINE-ASPIRIN-CAFFEINE	TUDORZA PRESSAIR
ORPHENGESIC FORTE	TUSSIONEX
OSENI	ULTRAVATE 0.05% LOTION
OSPHENA	VELTASSA
OXISTAT	VENLAFAXINE BESYLATE ER 112 MG
OXYCODONE-ACETAMINOPHEN (10-300, 5-300)	VENLAFAXINE HCL ER TABLET

**Commercial 3-Tier 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

VERDESO  
VICTOZA  
VRAYLAR  
VUMERITY  
VYZULTA  
XADAGO  
XELPROS  
XELSTRYM  
XERESE  
XOLEGEL  
YUPELRI  
ZEGERID PACKETS  
ZEMBRACE SYMTOUCH  
ZERVIAE  
ZILXI  
ZIOPTAN  
ZOLMITRIPTAN NASAL SPRAY  
ZOLPIMIST  
ZOMIG  
ZOVIRAX  
ZUPLENZ  
ZYPITAMAG

**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**