CVS caremark®

TRS-ActiveCare
Prior Authorization, Quantity Limit and Step Therapy List

Certain prescription drugs are subject to step therapy requirements, prior authorization requirements and quantity limits. These programs are in place to help ensure appropriate use of these medications.

Prior Authorization

Your doctor needs to get prior authorization for the drugs listed below before your prescription benefit plan administered by CVS Caremark® will cover them.

Actinic Keratosis

Diclofenac 3% Gel	Solaraze

Anti-Diabetic

Fortamet	Glumetza

Anti-Fungal

Jublia	Kerydin

Anti-Obesity Medications

Adipex-P	Belviq/Belviq XR	Benzphetamine
Bontril PDM	Bontril SR	Contrave
Didrex	Diethylpropion	Phendimetrazine ER/SR
Phentermine	Regimex (benzphetamine)	Saxenda
Suprenza	Xenica	

Attention Deficit Hyperactivity Disorder (ADHD) and Narcolepsy Medications
(Prior Authorization Required for 19 Years and Older)

Adderall	Adzenys XR-ODT	Aptensio XR
Concerta	Daytrana	Desoxyn
Dexedrine	Dyanavel XR	Evekeo
Focalin Products	ProCentra	Metadate Products
Methylin Products	Quillichew ER	Quillivant XR
Ritalin Products	Strattera	Vyvanse
Dextroamphetamine Products		

GLP-1 Agonists

Tanzeum	Trulicity	Victoza

Infertility (Non-Specialty)

Clomid	Clomiphene	Crinone
Endometrin	Serophene	

Lidocaine Products

EMLA	Lidocaine/Prilocaine Cream	Lidocaine Gel
Lidocaine Ointment	Lidocaine Solution	Pliaglis
Synera		

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106-T31719A 042318

Narcolepsy Medications

Nuvigil	Provigil	Xyrem

Ophthalmic/Tear Production

Restasis	Xiidra

Oral/Intranasal Fentanyl Medications

Actiq	Fentora	Lazanda
Onsolis	Subsys	

Osteoarthritis Pain

Diclofenac 1% Gel	Diclofenac 1.5% Solution	Voltaren Gel

Pain

Vanatol LQ

Testosterone Topical/Buccal Medications

Androderm	Axiron	Striant

Topical Acne Medications

(Prior Authorization Required for 35 Years and Older)

Atralin	Avita	Differin
Fabior	Retin-A	Retin-A Micro
Tazorac	Tretinoin	Tretin-X
Veltin	Ziana	

Topical Itch Cream

Doxepin Cream	Prudoxin	Zonalon

Topical Steroids

Aclovate	Apexicon E	Clobex
Clodan	Cloderm	Cordran
Cordran SP	Cormax Scalp	Cutivate
Desonate	Desowen	Elocon
Halog	Kenalog	Locoid
Locid Lipocream	Lokara	Neo-Synalar
Olux	Olux-E	Pandel
Psorcon	Temovate	Temovate Scalp
Temovate E	Topicort	Trainex
Ultravate	Vanos	Verdeso

Ulcer Medications

Zegerid

106-T31719A 042318

Quantity Limits

The drugs listed below have limits based on U.S. Food and Drug Administration (FDA)-approved prescribing information, approved medical guidelines and/or the average utilization quantity for the drugs. The limits listed below affect only the amount of medication that the prescription benefit plan pays for, not whether you can get a greater quantity. The final decision about the amount of medication you receive remains between you and your doctor.

Note: Some of the quantity limits have a prior authorization available if you exceed the drug's limit. Those drugs with a prior authorization available are noted in chart below. If your doctor has determined that a greater amount is appropriate, your doctor should call CVS Caremark at 1-800-294-5979 to request prior authorization for a larger quantity. The prior authorization line is for your doctor's use only.

Quantity Limits	Maximum Day Supply	Prior Authorization Available (To Exceed Quantity Limit)
Antiemetic Medications		
Anzemet Injection	15 mL per 6 months	No
Aloxi	2 vials (10 mL) per 21 days	Yes
Akynzeo	2 caps per 21 days	Yes
Anzemet	6 tabs per 21 days	Yes
Cesamet	18 per 30 days	Yes
Emend 40 mg	3 caps per 180 days	Yes
Emend 80 mg	4 caps per 21 days	Yes
Emend 125 mg	2 caps per 21 days	Yes
Emend 150 mg injection	2 vials per 21 days	Yes
Emend Tri-Pak	2 tri-packs per 21 days	Yes
Emend Oral Susps-Kit	6 kits per 21 days	Yes
Kytril (Granisetron) 1 mg tab	12 tabs per 21 days	Yes
Kytril (Granisetron) injection	2 mL per 21 days	Yes

106-T31719A 042318

Quantity Limits	Maximum Day Supply	Prior Authorization Available (To Exceed Quantity Limit)
Marinol (dronabinol)	60 per 30 days	Yes
Sancuso	2 patches per 21 days	Yes
Varubi	2 packs (2 tabs/pack) per 21 days	Yes
Zofran (Ondansetron) 4 mg and 8 mg tabs	18 per 21 days	Yes
Zofran (Ondansetron) 4 mg and 8 mg ODT	18 per 21 days	Yes
Zofran (Ondansetron) 24 mg tab	2 tabs per 21 days	Yes
Zofran (Ondansetron) 2 mg/mL injection	20 mL per 21 days	Yes
Zofran (Ondansetron) oral solution	200 mL per 21 days	Yes
Zuplenz 4 mg and 8 mg films	18 per 21 days	Yes
Antimigraine Medications		
Migranal NS	8 mL per 30 days	No
Alsuma (sumatriptan) injection	12 per 30 days	Yes
Amerge (naratriptan)	12 per 30 days	Yes
Axert	12 per 30 days	Yes
Frova	18 per 30 days	Yes
Imitrex (sumatriptan) 5 mg nasal spray	24 per 30 days	Yes
Imitrex (sumatriptan) 20 mg nasal spray	12 per 30 days	Yes
Imitrex (sumatriptan) 4 mg injection	18 per 30 days	Yes
Imitrex (sumatriptan) 6 mg injection	12 per 30 days	Yes
Imitrex (sumatriptan) tabs	12 per 30 days	Yes

Quantity Limits	Maximum Day Supply	Prior Authorization Available (To Exceed Quantity Limit)
Maxalt/Mazalt MLT (rizatriptan) tabs	18 per 30 days	Yes
Onzetra Xsail	1 kit per 30 days	Yes
Relpax	12 per 30 days	Yes
Sumavel 4 mg	18 per 30 days	Yes
Sumavel 6 mg	12 per 30 days	Yes
Treximet	9 per 30 days	Yes
Zembrace Injection	24 per 30 days	Yes
Zomig (zolmitriptan) nasal spray	12 per 30 days	Yes
Zomig/Zomig ZMT (zolmitriptan) tabs	12 per 30 days	Yes
Erectile Dysfunction Medications		
Caverject	8 per 30 days	No
Cialis 10 mg/20 mg	8 per 30 days	No
Edex	8 per 30 days	No
Muse	8 per 30 days	No
Staxyn	8 per 30 days	No
Stendra	8 per 30 days	No
Cialis 2.5 mg/5 mg	8 per 30 days	Yes
Influenza Medications		
Relenza	40 caps per 90 days	Yes
Tamiflu 30 mg caps	28 per 90 days	Yes
Tamiflu 45 mg and 75 mg caps	14 per 90 days	Yes

106-T31719A 042318

Quantity Limits	Maximum Day Supply	Prior Authorization Available (To Exceed Quantity Limit)
Tamiflu oral suspension	180 mL per 90 days	Yes
Lidocaine Products		
EMLA	30 gm / 25 days	No
Lidocaine/Prilocaine Cream	30 gm / 25 days	No
Lidocaine Gel	30 gm / 25 days	No
Lidocaine Ointment	50 gm / 25 days	No
Lidocaine Solution	50 mL / 25 days	No
Pliaglis	30 gm / 25 days	No
Synera	2 patches / 25 days	No
Pain/Stadol Medications		
Stadol NS	2 bottles per 30 days	Yes
Sedative/Hypnotic Medications		
Doral	15 per 30 days	No
Estazolam	15 per 30 days	No
Flurazepam	15 per 30 days	No
Halcion	10 per 30 days	No
Restoril	15 per 30 days	No
Ambien (zolpidem)	15 per 30 days	Yes
Ambien CR (zolpidem)	15 per 30 days	Yes
Lunesta (eszopiclone)	15 per 30 days	Yes

106-T31719A 042318

Quantity Limits	Maximum Day Supply	Prior Authorization Available (To Exceed Quantity Limit)
Rozerem	15 per 30 days	Yes
Sonata (zaleplon)	15 per 30 days	Yes
Toradol/Sprix Medications		
Sprix	5 bottles per 30 days	No
Toradol	20 tabs per 30 days	No

Opioid Analgesics ER Quantity Limits Chart
Coverage is provided without prior authorization for 30-day or 90-day ER opioid prescriptions for an amount ≤ 90 MME/day (when Step Therapy criteria met). Coverage for quantities ≤ 200 MME/day (unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day) for a 30-day or 90-day supply is provided through prior authorization when coverage conditions are met. **These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc.)**

Drug/Strength	Initial 30-Day Limit*	Initial 90-Day Limit*	Prior Authorization Available (To Exceed Quantity Limit)
Arymo ER 15 mg	90 tabs	270 tabs	Yes
Arymo ER 30 mg	90 tabs	270 tabs	Yes
Arymo ER 60 mg	0***	0***	Yes
Avinza 30 mg	30 caps	90 caps	Yes
Avinza 45 mg	30 caps	90 caps	Yes
Avinza 60 mg	30 caps	90 caps	Yes
Avinza 75 mg	30 caps	90 caps	Yes
Avinza 90 mg	30 caps	90 caps	Yes
Avinza 120 mg	0***	0***	Yes
Belbuca 75 mcg	60 films	180 films	Yes
Belbuca 150 mcg	60 films	180 films	Yes
Belbuca 300 mcg	60 films	180 films	Yes
Belbuca 450 mcg	60 films	180 films	Yes
Belbuca 600 mcg	0***	0***	Yes
Belbuca 750 mcg	0***	0***	Yes
Belbuca 900 mcg	0***	0***	Yes
Butrans 5 mcg/hr	4 patches	12 patches	Yes
Butrans 7.5 mcg/hr	4 patches	12 patches	Yes
Butrans 10 mcg/hr	4 patches	12 patches	Yes
Butrans 15 mcg/hr	0***	0***	Yes
Butrans 20 mcg/hr	0***	0***	Yes
Conzip 100 mg	30 caps	90 caps	Yes

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106-T31719A 042318

Conzip 200 mg	0***	0***	Yes
Conzip 300 mg	0***	0***	Yes
Dolophine 5 mg	90 tabs	270 tabs	Yes
Dolophine 10 mg	60 tabs	180 tabs	Yes
Duragesic 12 mcg	10 patches	30 patches	Yes
Duragesic 25 mcg	10 patches	30 patches	Yes
Duragesic 37.5 mcg	10 patches	30 patches	Yes
Duragesic 50 mcg	0***	0***	Yes
Duragesic 62.5 mcg	0***	0***	Yes
Duragesic 75 mcg	0***	0***	Yes
Duragesic 87.5 mcg	0***	0***	Yes
Duragesic 100 mcg	0***	0***	Yes
Embeda 20/0.8 mg	60 caps	180 caps	Yes
Embeda 30/1.2 mg	60 caps	180 caps	Yes
Embeda 50/2 mg	30 caps	90 caps	Yes
Embeda 60/2.4 mg	30 caps	90 caps	Yes
Embeda 80/3.2 mg	30 caps	90 caps	Yes
Embeda 100/4 mg	0***	0***	Yes
Exalgo 8 mg	30 tabs	90 tabs	Yes
Exalgo 12 mg	30 tabs	90 tabs	Yes
Exalgo 16 mg	30 tabs	90 tabs	Yes
Exalgo 32 mg	0***	0***	Yes
Hysingla ER 20 mg	30 tabs	90 tabs	Yes
Hysingla ER 30 mg	30 tabs	90 tabs	Yes
Hysingla ER 40 mg	30 tabs	90 tabs	Yes
Hysingla ER 60 mg	30 tabs	90 tabs	Yes
Hysingla ER 80 mg	30 tabs	90 tabs	Yes
Hysingla ER 100 mg	0***	0***	Yes
Hysingla ER 120 mg	0***	0***	Yes
Kadian 10 mg	60 caps	180 caps	Yes
Kadian 20 mg	60 caps	180 caps	Yes
Kadian 30 mg	60 caps	180 caps	Yes
Kadian 40 mg	60 caps	180 caps	Yes
Kadian 50 mg	30 caps	90 caps	Yes
Kadian 60 mg	30 caps	90 caps	Yes
Kadian 70 mg	30 caps	90 caps	Yes
Kadian 80 mg	30 caps	90 caps	Yes
Kadian 100 mg	0***	0***	Yes
Kadian 130 mg	0***	0***	Yes
Kadian 150 mg	0***	0***	Yes
Kadian 200 mg	0***	0***	Yes
Methadone 10 mg/mL Intensol soln	60 mL	180 mL	Yes
Methadone 5 mg/5 mL Oral soln	450 mL	1350 mL	Yes
Methadone 10 mg/5 mL Oral soln	300 mL	900 mL	Yes
Methadone 200 mg/20 mL inj	20 mL (1 multidose vial)	60 mL (3 multidose vials)	Yes
Methadose 5 mg	90 tabs	270 tabs	Yes
Methadose 10 mg	60 tabs	180 tabs	Yes
MorphaBond 15 mg	60 tabs	180 tabs	Yes
MorphaBond 30 mg	60 tabs	180 tabs	Yes
MorphaBond 60 mg	0***	0***	Yes
MorphaBond 100 mg	0***	0***	Yes
MS Contin 15 mg	90 tabs	270 tabs	Yes

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106-T31719A 042318

MS Contin 30 mg	90 tabs	270 tabs	Yes
MS Contin 60 mg	0***	0***	Yes
MS Contin 100 mg	0***	0***	Yes
MS Contin 200 mg	0***	0***	Yes
Nucynta ER 50 mg	60 tabs	180 tabs	Yes
Nucynta ER 100 mg	60 tabs	180 tabs	Yes
Nucynta ER 150 mg	0***	0***	Yes
Nucynta ER 200 mg	0***	0***	Yes
Nucynta ER 250 mg	0***	0***	Yes
Opana ER 5 mg	60 tabs	180 tabs	Yes
Opana ER 7.5 mg	60 tabs	180 tabs	Yes
Opana ER 10 mg	60 tabs	180 tabs	Yes
Opana ER 15 mg	60 tabs	180 tabs	Yes
Opana ER 20 mg	0***	0***	Yes
Opana ER 30 mg	0***	0***	Yes
Opana ER 40 mg	0***	0***	Yes
OxyContin 10 mg	60 tabs	180 tabs	Yes
OxyContin 15 mg	60 tabs	180 tabs	Yes
OxyContin 20 mg	60 tabs	180 tabs	Yes
OxyContin 30 mg	60 tabs	180 tabs	Yes
OxyContin 40 mg	0***	0***	Yes
OxyContin 60 mg	0***	0***	Yes
OxyContin 80 mg	0***	0***	Yes
Targiniq ER 10 mg/5 mg	60 tabs	180 tabs	Yes
Targiniq ER 20 mg/10 mg	60 tabs	180 tabs	Yes
Targiniq ER 40 mg/20 mg	0***	0***	Yes
Tramadol ER 100 mg	30 tabs	90 tabs	Yes
Tramadol ER 150 mg	30 caps	90 caps	Yes
Tramadol ER 200 mg	0***	0***	Yes
Tramadol ER 300 mg	0***	0***	Yes
Troxyca ER 10 mg/1.2 mg	60 caps	180 caps	Yes
Troxyca ER 20 mg/2.4 mg	60 caps	180 caps	Yes
Troxyca ER 30 mg/3.6 mg	60 caps	180 caps	Yes
Troxyca ER 40 mg/4.8 mg	0***	0***	Yes
Troxyca ER 60 mg/7.2 mg	0***	0***	Yes
Troxyca ER 80 mg/9.6 mg	0***	0***	Yes
Ultram ER 100 mg	30 tabs	90 tabs	Yes
Ultram ER 200 mg	0***	0***	Yes
Ultram ER 300 mg	0***	0***	Yes
Vantrela ER 15 mg	60 tabs	180 tabs	Yes
Vantrela ER 30 mg	60 tabs	180 tabs	Yes
Vantrela ER 45 mg	60 tabs	180 tabs	Yes
Vantrela ER 60 mg	0***	0***	Yes
Vantrela ER 90 mg	0***	0***	Yes
Xtampza ER 9 mg	60 caps	180 caps	Yes
Xtampza ER 13.5 mg	60 caps	180 caps	Yes
Xtampza ER 18 mg	60 caps	180 caps	Yes
Xtampza ER 27 mg	60 caps	180 caps	Yes
Xtampza ER 36 mg	0***	0***	Yes
Zohydro ER 10 mg	60 caps	180 caps	Yes
Zohydro ER 15 mg	60 caps	180 caps	Yes
Zohydro ER 20 mg	60 caps	180 caps	Yes
Zohydro ER 30 mg	60 caps	180 caps	Yes
Zohydro ER 40 mg	60 caps	180 caps	Yes
Zohydro ER 50 mg	0***	0***	Yes
XARTEMIS XR	120 tablets****	120 tablets****	No

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106-T31719A 042318

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*
***Unless minimum FDA-labeled strength/dose/frequency exceeds 200 MME/day.*
****The initial limit is zero. All requests for this drug and strength will be considered through post limit prior authorization*
***** This drug is indicated for acute use; therefore, the 30-day, 90-day, retail and mail limit will be the same. The intent is for prescriptions of Xartemis XR to be filled up to 30 days at a time; there should be no 90-day supplies filled.*

Opioid Analgesics IR Quantity Limits Chart

Coverage is provided without prior authorization (for patients not identified as potential first fills) for 30-day or 90-day IR opioid prescriptions for an amount ≤ 90 MME/day. Coverage for quantities ≤ 200 MME/day for a 30-day or 90-day supply is provided through prior authorization when criteria for approval are met.

These quantity limits should accumulate across all drugs of the same unit limit (i.e., drugs with 30 units accumulate together, drugs with 60 units accumulate together, etc.)

Drug/Strength	Initial 30-Day Limit*	Initial 90-Day Limit*	Prior Authorization Available (To Exceed Quantity Limit)
Codeine sulfate oral soln 30 mg/5 mL	210 mL***	210 mL***	Yes
Codeine sulfate tab 15 mg	42 tabs***	42 tabs***	Yes
Codeine sulfate tab 30 mg	42 tabs***	42 tabs***	Yes
Codeine sulfate tab 60 mg	42 tabs***	42 tabs***	Yes
Hydromorphone liquid 1 mg/mL	600 mL	1800 mL	Yes
Hydromorphone supp 3 mg	120 supps	360 supps	Yes
Hydromorphone tab 2 mg	180 tabs	540 tabs	Yes
Hydromorphone tab 4 mg	150 tabs	450 tabs	Yes
Hydromorphone tab 8 mg	60 tabs	180 tabs	Yes
Levorphanol tab 2 mg	120 tabs	360 tabs	Yes
Meperidine oral soln 50 mg/5 mL	90 mL****	90 mL****	Yes
Meperidine tab 50 mg	18 tabs****	18 tabs****	Yes
Meperidine tab 100 mg	18 tabs****	18 tabs****	Yes
Morphine sulfate (conc) oral soln 20 mg/mL (100 mg/5 mL)	135 mL	405 mL	Yes
Morphine sulfate oral soln 10 mg/5 mL	900 mL	2700 mL	Yes

106-T31719A 042318

Morphine sulfate oral soln 20 mg/5 mL	675 mL	2025 mL	Yes
Morphine sulfate supp 5 mg	180 supps	540 supps	Yes
Morphine sulfate supp 10 mg	180 supps	540 supps	Yes
Morphine sulfate supp 20 mg	120 supps	360 supps	Yes
Morphine sulfate supp 30 mg	90 supps	270 supps	Yes
Morphine sulfate tab 15 mg	180 tabs	540 tabs	Yes
Morphine sulfate tab 30 mg	90 tabs	270 tabs	Yes
Oxycodone cap 5 mg	180 caps	540 caps	Yes
Oxycodone oral concentrate 100 mg/5 mL (20 mg/mL)	90 mL	270 mL	Yes
Oxycodone soln 5 mg/5 mL	900 mL	2700 mL	Yes
Oxaydo 5 mg	180 tabs	540 tabs	Yes
Oxaydo 7.5 mg	180 tabs	540 tabs	Yes
Oxycodone tab 5 mg	180 tabs	540 tabs	Yes
Oxycodone tab 10 mg	180 tabs	540 tabs	Yes
Oxycodone tab 15 mg	120 tabs	360 tabs	Yes
Oxycodone tab 20 mg	90 tabs	270 tabs	Yes
Oxycodone tab 30 mg	60 tabs	180 tabs	Yes
Oxymorphone tab 5 mg	180 tabs	540 tabs	Yes
Oxymorphone tab 10 mg	90 tabs	270 tabs	Yes
Pentazocine/naloxone 50/0.5 mg	120 tabs***	120 tabs***	Yes
RoxyBond 5 mg	180 tabs	540 tabs	Yes
RoxyBond 15 mg	120 tabs	360 tabs	Yes
RoxyBond 30 mg	60 tabs	180 tabs	Yes
Tapentadol 50 mg	120 tabs	360 tabs	Yes
Tapentadol 75 mg	90 tabs	270 tabs	Yes
Tapentadol 100 mg	60 tabs	180 tabs	Yes
Tramadol 50 mg	180 tabs	540 tabs	Yes

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106-T31719A 042318

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***The limit criteria apply to both brand and generic, if available.*
****This drug is indicated for short-term acute use; therefore, the 30-day limit will be the same as the 90-day limit.*
*****Due to risk of accumulation, the 30-day and 90-day initial limit allows a 3-day supply only and the 30-day and 90-day post limit allows a 4-day supply only.*

Opioid Analgesics IR Combo Products Quantity Limits Chart

Coverage is provided without prior authorization for 30-day or 90-day IR opioid combo product prescriptions for an amount ≤ 90 MME; quantity limits are set at ≤ 4 g APAP or ASA and ≤ 3200 mg ibuprofen OR the maximum recommended dose based on prescribing information, whichever is lower. If the patient is requesting more than the initial quantity limit, then the claim will reject with a message indicating that quantity limits are exceeded.

Drug/Strength	Initial 30-Day Limit*	Initial 90-Day Limit*	Prior Authorization Available (To Exceed Quantity Limit)
APAP/codeine soln 120-12 mg/5 mL	2700 mL	8100 mL	No
APAP/codeine susp 120-12 mg/5 mL	2700 mL	8100 mL	No
Hydrocodone/APAP soln 7.5/325 mg/ 15 mL	2700 mL	8100 mL	No
Hydrocodone/APAP soln 7.5/500 mg/15 mL	2700 mL	8100 mL	No
Hydrocodone/APAP elixir 10/300 mg/15 mL	2025 mL	6075 mL	No
Hydrocodone/APAP soln 10/325 mg/ 15 mL	2700 mL	8100 mL	No
Hydrocodone/APAP soln 10/500 mg/15 mL	2700 mL	8100 mL	No
Oxycodone/APAP soln 5-325 mg/5 mL	1800 mL	5400 mL	No
APAP/codeine tab 300/15 mg	400 tabs	1200 tabs	No
APAP/codeine tab 300/30 mg	360 tabs	1080 tabs	No
APAP/codeine tab 300/60 mg	180 tabs	540 tabs	No
APAP/caffeine/dihydrocodeine cap 320.5/30/16 mg	300 caps	900 caps	No
APAP/caffeine/dihydrocodeine tab 325/30/16 mg	300 tabs	900 tabs	No
APAP/caffeine/dihydrocodeine cap 356.4/30/16 mg	300 caps	900 caps	No
APAP/caffeine/dihydrocodeine tab 712.8/60/32 mg	150 tabs	450 tabs	No
Hydrocodone/APAP tab 2.5/325 mg	360 tabs	1080 tabs	No

106-T31719A 042318

Hydrocodone/APAP tab 2.5/500 mg	240 tabs	720 tabs	No
Hydrocodone/APAP tab 5/300 mg	240 tabs	720 tabs	No
Hydrocodone/APAP tab 5/325 mg	240 tabs	720 tabs	No
Hydrocodone/APAP tab 5/400 mg	240 tabs	720 tabs	No
Hydrocodone/APAP tab 5/500 mg	240 tabs	720 tabs	No
Hydrocodone/APAP tab 7.5/300 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 7.5/325 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 7.5/400 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 7.5/500 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 7.5/650 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 7.5/750 mg	150 tabs	450 tabs	No
Hydrocodone/APAP tab 10/300 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 10/325 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 10/400 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 10/500 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 10/650 mg	180 tabs	540 tabs	No
Hydrocodone/APAP tab 10/660 mg	150 tabs	450 tabs	No
Hydrocodone/APAP tab 10/750 mg	150 tabs	450 tabs	No
Oxycodone/APAP tab 2.5/325 mg	360 tabs	1080 tabs	No
Oxycodone/APAP tab 5/300 mg	360 tabs	1080 tabs	No
Oxycodone/APAP tab 5/325 mg	360 tabs	1080 tabs	No
Oxycodone/APAP tab 5/400 mg	300 tabs	900 tabs	No
Oxycodone/APAP cap 5/500 mg	240 caps	720 caps	No
Oxycodone/APAP tab 7.5/300 mg	240 tabs	720 tabs	No
Oxycodone/APAP tab 7.5/325 mg	240 tabs	720 tabs	No
Oxycodone/APAP tab 7.5/400 mg	240 caps	720 caps	No

Oxycodone/APAP tab 7.5/500 mg	240 caps	720 caps	No
Oxycodone/APAP tab 10/300 mg	180 tabs	540 tabs	No
Oxycodone/APAP tab 10/325 mg	180 tabs	540 tabs	No
Oxycodone/APAP tab 10/400 mg	180 tabs	540 tabs	No
Oxycodone/APAP tab 10/500 mg	180 tabs	540 tabs	No
Oxycodone/APAP tab 10/650 mg	180 tabs	540 tabs	No
Pentazocine/APAP tab 25/650 mg	180 caps	540 caps	No
Tramadol/APAP 37.5/325 mg	40 tabs	40 tabs	No
ASA/caffeine/dihydrocodeine cap 356.4/30/16 mg	300 caps	900 caps	No
Oxycodone/ASA tab 4.8355/325 mg	360 tabs	1080 tabs	No
Hydrocodone/ibuprofen tab 2.5/200 mg	50 tabs	50 tabs	No
Hydrocodone/ibuprofen tab 5/200 mg	50 tabs	50 tabs	No
Hydrocodone/ibuprofen tab 7.5/200 mg	50 tabs	50 tabs	No
Hydrocodone/ibuprofen tab 10/200 mg	50 tabs	50 tabs	No
Oxycodone/ibuprofen tab 5/400 mg	28 tabs	28 tabs	No

**The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.*

Step Therapy

You are required to try a specific drug before your prescription benefit plan will cover one of the drugs listed below. Your doctor may call CVS Caremark to request prior authorization for these drugs.

Atypical Antipsychotics

Abilify
Fanapt
Geodon (Brand Only)
Invega oral tablets
Latuda
Rexulti
Saphris
Seroquel (Brand Only)
Vraylar

Minocycline ER Brand Only

Solodyn

Log in to **Caremark.com** to check coverage and copay information for a specific drug. Discuss this information with your doctor or health care provider. This information is not a substitute for medical advice or treatment. Talk to your doctor or health care provider about this information and any health-related questions you have. CVS Caremark assumes no liability whatsoever for the information provided or for any diagnosis or treatment made as a result of this information. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Caremark. This list is subject to change. There may be additional plan restrictions. Please consult your plan for further information.

Generic Step Therapy

Drug Class *Condition Treated**	**Step 1:** You may have to try one or two** of these generic medications first:	**Step 2:** Before you can try one of these brand drugs:	These preferred select brand drugs do not require use of a generic first:
ACE Inhibitors/Angiotensin II Receptor Antagonists (ARBs)/ Direct Renin Inhibitors/ Combinations** *High Blood Pressure*	amlodipine-benazepril benazepril/benazepril HCTZ candesartan/candesartan HCTZ captopril/captopril HCTZ enalapril/enalapril HCTZ eprosartan fosinopril/fosinopril HCTZ irbesartan/irbesartan HCTZ lisinopril/lisinopril HCTZ losartan/losartan HCTZ olmesartan/olmesartan HCTZ quinapril/quinapril HCTZ ramipril telmisartan/telmisartan HCTZ trandolapril trandolapril-verapamil ext-rel valsartan/valsartan HCTZ	Tekturna/Tekturna HCT	*Preferred select brand not available in class*

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106-T31719A 042318

Drug Class *Condition Treated**	**Step 1:** You may have to try one or two** of these generic medications first:	**Step 2:** Before you can try one of these brand drugs:	These preferred select brand drugs do not require use of a generic first:
Acne/Topical *Skin*	benzoyl peroxide clindamycin solution clindamycin-benzoyl peroxide erythromycin solution erythromycin-benzoyl peroxide sulfacetamide sodium	Acanya Aczone Azelex Clindagel Fabior Riax Tretin-X	*Preferred select brand not available in class*
Benign Prostatic Hyperplasia-Alpha blockers *Prostate*	alfuzosin ext-rel doxazosin dutasteride dutasteride-tamsulosin finasteride tamulosin terazosin	Cardura XL Rapaflo	*Preferred select brand not available in class*
Bisphosphonates/Combinations *Osteoporosis*	alendronate ibandronate risedronate	Binosto Fosamax Plus D	*Preferred select brand not available in class*

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106-T31719A 042318

Drug Class *Condition Treated**	**Step 1:** You may have to try one or two** of these generic medications first:	**Step 2:** Before you can try one of these brand drugs:	These preferred select brand drugs do not require use of a generic first:
COX-2 Inhibitors/Nonsteroidal Anti-Inflammatory (NSAIDs)/ Combinations** *Pain and Inflammation*	celecoxib diclofenac sodium/misoprostol fenoprofen 400 mg ibuprofen meloxicam naproxen/naproxen ext-rel (additional generic NSAIDs available)	Cambia fenoprofen 200 mg Fenortho 200 mg Flector Nalfon Tivorbex Vivlodex Zipsor Zorvolex	*Preferred select brand not available in class*
Fibrates *High Triglycerides*	gemfibrozil fenofibrate fenofibric acid	Triglide	*Preferred select brand not available in class*
Ophthalmic/Prostaglandins *Glaucoma*	latanoprost travoprost	Travatan Z Zioptan	*Preferred select brand not available in class*
Proton Pump Inhibitors (PPIs)** *Stomach Acid*	esomeprazole lansoprazole delayed-rel omeprazole delayed-rel pantoprazole delayed-rel rabeprazole	Dexilant Prilosec Packets	*Preferred select brand not available in class*

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106-T31719A 042318

Drug Class *Condition Treated**	**Step 1:** You may have to try one or two** of these generic medications first:	**Step 2:** Before you can try one of these brand drugs:	These preferred select brand drugs do not require use of a generic first:
Selective Serotonin Agonists/ Combinations *Migraine*	almotriptan eletriptan frovatriptan naratriptan rizatriptan sumatriptan zolmitriptan	Alsuma Onzetra Xsail Sumavel Dosepro Treximet Zembrace Sym Touch	*Preferred select brand not available in class*
Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) *Depression*	desvenlafaxine succinate ext-rel duloxetine delayed-rel venlafaxine/venlafaxine ext-rel capsule	Fetzima Irenka Khedelza	*Preferred select brand not available in class*
Selective Serotonin Reuptake Inhibitors (SSRIs) *Depression*	citalopram escitalopram fluoxetine fluvoxamine/fluvoxamine ext-rel paroxetine/paroxetine ext-rel sertraline	Pexeva Trintellix Viibryd	*Preferred select brand not available in class*
Sleeping Agents *Insomnia/Sleep Problems*	eszopiclone zaleplon zolpidem/zolpidem ext-rel zolpidem sublingual	Edluar Silenor Zolpimist	*Preferred select brand not available in class*

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106-T31719A 042318

Drug Class *Condition Treated**	**Step 1:** You may have to try one or two** of these generic medications first:	**Step 2:** Before you can try one of these brand drugs:	These preferred select brand drugs do not require use of a generic first:
Urinary Antispasmodics** *Overactive Bladder/Incontinence*	darifenacin ext-rel oxybutynin/oxybutynin ext-rel tolterodine/tolterodine ext-rel trospium/trospium ext-rel	Gelnique Myrbetriq Vesicare	*Preferred select brand not available in class*

*This list indicates the common uses for which the drug is prescribed. Some medicines are prescribed for more than one condition. Brand-name drugs not listed here may be covered by your plan without the use of a generic first. Information provided here is not a substitute for medical advice or treatment. Discuss this information with your doctor or health care provider. CVS Caremark assumes no liability for the information provided or for any diagnosis or treatment made in reliance thereon, nor is it responsible for the reliability of the content.
**Please note: A member's plan determines whether the member must try one or two generics before a brand-name drug is allowed in select drug classes.

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106-T31719A 042318