

Search Tip:

This is a large document, but you can search quickly and easily by clicking on the binocular icon on your toolbar or using the CTRL+F search function from your keyboard. It will then display a search box for you to type in the name of the drug you want to locate. If you do not know the correct spelling, you can start your search by entering just the first few letters of the name.

**Navitus Key Traditional Formulary
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| abacavir soln (ZIAGEN equiv) | - | 1 | ANTIVIRALS |
| abacavir tab (ZIAGEN equiv) | - | 1 | ANTIVIRALS |
| abacavir/lamivudine tab (EPZICOM equiv) | - | 1 | ANTIVIRALS |
| abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv) | - | 1 | ANTIVIRALS |
| ABILIFY MYCITE PACK | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| ABILIFY MYCITE TAB | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| abiraterone acetate tab 500mg (ZYTIGA equiv) | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day) | LMSP-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ABRILADA INJ | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ABRYSVO INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 | VACCINES |
| ABSORICA CAP | - | NC | DERMATOLOGICALS |
| ABSORICA LD CAP | - | NC | DERMATOLOGICALS |
| ABSTRAL SL TAB | - | NC | ANALGESICS - OPIOID |
| acamprosate calcium DR tab (CAMPRAL equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| acarbose tab (PRECOSE equiv) | - | 1 | ANTIDIABETICS |
| ACCRUFER CAP | - | NC | HEMATOPOIETIC AGENTS |
| ACCU-CHEK GUIDE CARE METER | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| ACCU-CHEK GUIDE ME KIT | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| ACCU-CHEK GUIDE TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| acebutolol cap (SECTRAL equiv) | - | 1 | BETA BLOCKERS |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB | - | NC | ANALGESICS - OPIOID |
| acetaminophen/codeine tab (TYLENOL/CODEINE equiv) | - | 1 | ANALGESICS - OPIOID |
| ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP | - | NC | MIGRAINE PRODUCTS |
| acetaminophen/isometheptene/dichloral cap (MIDRIN equiv) | - | NC | MIGRAINE PRODUCTS |
| acetazolamide ER cap (DIAMOX SEQUEL equiv) | - | 1 | DIURETICS |
| acetazolamide tab | - | 1 | DIURETICS |
| acetic acid otic soln (VOSOL equiv) | - | 1 | OTIC AGENTS |
| acetic acid/hydrocortisone otic soln (VOSOL HC equiv) | - | 1 | OTIC AGENTS |
| acetylcysteine soln (MUCOMYST equiv) | - | 1 | COUGH/COLD/ALLERGY |
| ACIPHEX SPRINKLE CAP | - | NC | ULCER DRUGS |
| ACIPHEX TAB | - | NC | ULCER DRUGS |
| acitretin cap (SORIATANE equiv) | - | 1 | DERMATOLOGICALS |
| ACTHAR GEL AUTO-INJECTOR | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ACTHIB INJ, HIBERIX INJ | VAC | \$0 | VACCINES |
| ACTICLATE TAB 75MG, 150MG | - | NC | TETRACYCLINES |
| ACTIMMUNE INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA | Non-EHB | ANTINEOPLASTICS |
| ACTIQ LOZENGE | - | NC | ANALGESICS - OPIOID |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| EXC | NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---------------------------------|
| ACTIVITE TAB | - | NC | MULTIVITAMINS |
| ACTOPLUS MET TAB | - | NC | ANTIDIABETICS |
| ACUVAIL OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| acyclovir cap (ZOVIRAX equiv) | - | 1 | ANTIVIRALS |
| acyclovir cream (ZOVIRAX equiv) | - | NC | DERMATOLOGICALS |
| acyclovir oint (ZOVIRAX OINT equiv) | - | 1 | DERMATOLOGICALS |
| acyclovir susp (ZOVIRAX equiv) | - | 1 | ANTIVIRALS |
| acyclovir tab (ZOVIRAX equiv) | - | 1 | ANTIVIRALS |
| ACZONE GEL | - | NC | DERMATOLOGICALS |
| ADACEL/BOOSTRIX INJ | VAC | \$0 | TOXOIDS |
| ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fill; 1 fill/plan year) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-ADAZ INJ | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-ADAZ INJ 10/0.1ML | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ADALIMUMAB-RYVK INJ (SIMLANDI equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ADAPALENE SOLN | - | NC | DERMATOLOGICALS |
| adapalene cream (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| adapalene gel (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| ADAPALENE LOTION (DIFFERIN equiv) | - | NC | DERMATOLOGICALS |
| ADAPALENE PAD | - | NC | DERMATOLOGICALS |
| adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv) | - | 1 | DERMATOLOGICALS |
| adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv) | - | 1 | DERMATOLOGICALS |
| ADAPALENE/BENZOYL PEROXIDE PAD | - | NC | DERMATOLOGICALS |
| ADAPALENE/BENZOYL PEROXIDE/CLINDAMYCIN GEL | - | 2 | DERMATOLOGICALS |
| ADAPALENE/BENZOYL PEROXIDE/NIACINAMIDE GEL | - | 2 | DERMATOLOGICALS |
| ADASUVE INHALER | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| ADAZIN CREAM | - | NC | DERMATOLOGICALS |
| ADBRY INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| ADBRY INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| ADCIRCA TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| ADDYI TAB | - | EXC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| adefovir dipivoxil tab (HEPSERA equiv) | - | 1 | ANTIVIRALS |
| ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| ADIPEX-P TAB | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ADLARITY PATCH | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ADMELOG INJ, HUMALOG INJ | - | NC | ANTIDIABETICS |
| ADMELOG SOLOSTAR, HUMALOG TEMPO PEN | - | NC | ANTIDIABETICS |
| ADRENACLICK INJ, EPINEPHRINE INJ | - | NC | VASOPRESSORS |
| ADRENALIN SOLN | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| ADVAIR HFA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ADVANCED ACNE WASH | - | NC | DERMATOLOGICALS |
| ADVATE, KOVALTRY INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ADVICOR TAB | - | NC | ANTIHYPERTENSIVES |
| ADYNOVATE INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| ADZENYS ER SUSP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ADZENYS XR ODT | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| AEMCOLO TAB | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| AEROCHAMBER | OTC | 2 | MEDICAL DEVICES AND SUPPLIES |
| AFINITOR DISPERZ TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AFINITOR TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| AFSTYLA KIT | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| AGAMREE SUSP | - | NC | CORTICOSTEROIDS |
| AIMOVIJ INJ (QL= 1 pack/28 days) | PA-QL | 2 | MIGRAINE PRODUCTS |
| AIRDUO POWDER INHALER W/SENSOR | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| AIRDUO RESPICLICK | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| AIRSUPRA INH | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| AJOVY INJ (QL= 1 pack/28 days) | PA-QL | 2 | MIGRAINE PRODUCTS |
| AKEEGA TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AKLIEF CREAM | - | NC | DERMATOLOGICALS |
| AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist) | QL-RS | 2 | ANTIEMETICS |
| ALA-SCALP LOTION | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| albendazole tab (ALBENZA equiv) | - | NC | ANTHELMINTICS |
| ALBENZA TAB | - | NC | ANTHELMINTICS |
| albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days) | QL | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| albuterol neb soln | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ALBUTEROL NEBULIZER SOLN | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| albuterol sulfate syrup | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| albuterol sulfate tab | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| albuterol/ipratropium neb soln (DUONEB equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| alclometasone cream (ACLOVATE equiv) | - | 1 | DERMATOLOGICALS |
| ALCLOMETASONE OINT | - | 1 | DERMATOLOGICALS |
| alclometasone oint (ACLOVATE OINT equiv) | - | 1 | DERMATOLOGICALS |
| ALCOHOL SWABS | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv) | - | NC | DERMATOLOGICALS |
| ALECENSA CAP (QL= 8 caps/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| alendronate sodium oral soln (FOSAMAX equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| alendronate tab (FOSAMAX equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ALENDRONATE TAB 40MG | - | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ALEVICYN SOLN DERMAL | - | NC | DERMATOLOGICALS |
| ALFERON-N INJ | LMSP | 2 | ANTINEOPLASTICS |
| alfuzosin SR tab (UROXATRAL equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| ALHEMO INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| aliskiren tab (TEKTURNA equiv) | - | 1 | ANTIHYPERTENSIVES |
| ALKINDI SPRINKLE CAP | - | NC | CORTICOSTEROIDS |
| ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 | CORTICOSTEROIDS |
| ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 | CORTICOSTEROIDS |
| ALLEGRA ODT | OTC | EXC | ANTIHISTAMINES |
| ALLEGRA TAB | OTC | EXC | ANTIHISTAMINES |
| ALLEGRA-D 12-HOUR TAB | OTC | EXC | COUGH/COLD/ALLERGY |
| ALLEGRA-D 24-HOUR TAB | OTC | EXC | COUGH/COLD/ALLERGY |
| ALLEGRA-D TAB | OTC | EXC | COUGH/COLD/ALLERGY |
| allopurinol tab (ZYLOPRIM equiv) | - | 1 | GOUT AGENTS |
| allopurinol tab 200mg | - | NC | GOUT AGENTS |
| ALLZITAL TAB | - | NC | ANALGESICS - NONNARCOTIC |
| almotriptan tab (AXERT equiv) | - | NC | MIGRAINE PRODUCTS |
| ALOCRIL OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| ALOGLIPTIN TAB | - | NC | ANTIDIABETICS |
| ALOGLIPTIN TAB, NESINA TAB | - | NC | ANTIDIABETICS |
| ALOGLIPTIN/METFORMIN TAB, KAZANO TAB | - | NC | ANTIDIABETICS |
| ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB | - | NC | ANTIDIABETICS |
| ALOGLIPTIN-METFORMIN TAB | - | NC | ANTIDIABETICS |
| ALOGLIPTIN-PIOGILTAZONE TAB | - | NC | ANTIDIABETICS |
| ALOQUIN GEL | - | NC | DERMATOLOGICALS |
| ALORA PATCH | - | 3 | ESTROGENS |
| alosetron tab (LOTRONEX equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| ALPHANATE, HUMATE-P INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ALPHANINE SD INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| alprazolam ER tab (XANAX XR equiv) | - | 1 | ANTIAXIETY AGENTS |
| alprazolam ODT (NIRAVAM equiv) | - | 1 | ANTIAXIETY AGENTS |
| alprazolam tab (XANAX equiv) | - | 1 | ANTIAXIETY AGENTS |
| ALPROLIX INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ALREX OPHTH SUSP | - | 2 | OPHTHALMIC AGENTS |
| ALREX OPHTH SUSP 0.2% | - | 3 | OPHTHALMIC AGENTS |
| ALSUMA INJ, ZEMBRACE SYMTOUCH INJ | - | NC | MIGRAINE PRODUCTS |
| ALTABAX OINT | - | NC | DERMATOLOGICALS |
| ALTAFRIN OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| ALTOPREV TAB | - | NC | ANTHYPERLIPIDEMICS |
| ALTRENO LOTION (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 | DERMATOLOGICALS |
| ALTUVIIIIO INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ALUNBRIG PAK | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ALVAIZ TAB | - | NC | HEMATOPOIETIC AGENTS |
| ALVESCO INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| alvimopan cap (ENTEREG equiv) | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ALYFTREK TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| ALYFTREK TAB 4-20-50MG (QL= 3 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| ALZAIR NASAL SPRAY | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| amantadine cap (SYMMETREL equiv) | - | 1 | ANTIPARKINSON AGENTS |
| amantadine soln (AMANTADINE equiv) | - | 1 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| amantadine tab | - | 1 | ANTIPARKINSON AGENTS |
| ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 1 | CARDIOVASCULAR AGENTS - MISC. |
| AMCINONIDE CREAM 0.1% | - | NC | DERMATOLOGICALS |
| AMCINONIDE LOTION | - | NC | DERMATOLOGICALS |
| AMCINONIDE OINTMENT | - | NC | DERMATOLOGICALS |
| amethyst tab (LYBREL equiv) | - | \$0 | CONTRACEPTIVES |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| amiloride tab (MIDAMOR equiv) | - | 1 | DIURETICS |
| AMILORIDE/HCTZ TAB | - | 1 | DIURETICS |
| amiloride/hydrochlorothiazide tab (MODURETIC equiv) | - | 1 | DIURETICS |
| aminocaproic acid soln (AMICAR equiv) | - | 1 | HEMOSTATICS |
| aminocaproic acid tab (AMICAR equiv) | - | 1 | HEMOSTATICS |
| amiodarone tab (CORDARONE equiv) | - | 1 | ANTIARRHYTHMICS |
| AMITIZA CAP (QL= 2 caps/day) | QL | 3 | GASTROINTESTINAL AGENTS - MISC. |
| amitriptyline tab (ELAVIL equiv) | - | 1 | ANTIDEPRESSANTS |
| amlodipine tab (NORVASC equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| amlodipine/atorvastatin tab (CADUET equiv) | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| amlodipine/benazepril cap (LOTREL equiv) | - | 1 | ANTIHYPERTENSIVES |
| amlodipine/olmesartan tab (AZOR equiv) | - | 1 | ANTIHYPERTENSIVES |
| amlodipine/valsartan tab (EXFORGE equiv) | - | 1 | ANTIHYPERTENSIVES |
| amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv) | - | NC | ANTIHYPERTENSIVES |
| ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only) | - | 1 | DERMATOLOGICALS |
| ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only) | - | 1 | DERMATOLOGICALS |
| amnesteam cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (AC CUTANE equiv) | - | 1 | DERMATOLOGICALS |
| amoxapine tab (AMOXAPINE equiv) | - | 1 | ANTIDEPRESSANTS |
| amoxicillin cap (TRIMOX equiv) | - | 1 | PENICILLINS |
| AMOXICILLIN CHEW TAB | - | 1 | PENICILLINS |
| amoxicillin susp (TRIMOX equiv) | - | 1 | PENICILLINS |
| amoxicillin tab (AMOXIL equiv) | - | 1 | PENICILLINS |
| AMOXICILLIN/CLAVULANATE CHEW TAB | - | 2 | PENICILLINS |
| amoxicillin/clavulanate susp (AUGMENTIN ES equiv) | - | 1 | PENICILLINS |
| amoxicillin/clavulanate tab (AUGMENTIN equiv) | - | 1 | PENICILLINS |
| amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv) | - | 1 | PENICILLINS |
| amphetamine er odt (ADZENYS XR equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| AMPHETAMINE ER SUSP, DYANA VEL XR SUSP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine tab (EVEKEO equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine/dextroamphetamine tab (ADDERALL equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ampicillin cap (AMPICILLIN equiv) | - | 1 | PENICILLINS |
| AMZEEQ FOAM | - | NC | DERMATOLOGICALS |
| anagrelide cap (AGRYLIN equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| ANALPRAM HC CREAM 2.5-1% | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| ANALPRAM HC CREAM 2.5-1% | - | 3 | ANORECTAL AND RELATED PRODUCTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| ANALPRAM-E KIT | - | 3 | ANORECTAL AGENTS |
| ANALPRAM-HC CREAM | - | 3 | ANORECTAL AND RELATED PRODUCTS |
| ANASTIA LOTION | - | NC | DERMATOLOGICALS |
| anastrozole tab (ARIMIDEX equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ANDEMBRY INJ | - | EXC | HEMATOLOGICAL AGENTS - MISC. |
| ANGELIQ TAB | - | NC | ESTROGENS |
| ANNOVERA RING (QL= 1 ring/year) | QL | 3 | CONTRACEPTIVES |
| ANORO ELLIPTA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ANTARA CAP, FENOFIBRATE MICRONIZED CAP | - | NC | ANTIHYPERLIPIDEMICS |
| ANTARA CAP, LOFIBRA CAP | - | NC | ANTIHYPERLIPIDEMICS |
| antipyrine/benzocaine otic soln (AURALGAN equiv) | - | NC | OTIC AGENTS |
| ANUCORT-HC SUPP 25MG | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| ANUCORT-HC SUPP 30MG | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| ANZEMET TAB (QL= 9 tabs/fill) | QL | 3 | ANTIEMETICS |
| ANZUPGO CREAM | - | EXC | DERMATOLOGICALS |
| APADAZ TAB | - | NC | ANALGESICS - OPIOID |
| APAP/CODEINE SOLN | - | 2 | ANALGESICS - OPIOID |
| APEXICON E CREAM (PSORCON E equiv) | - | NC | DERMATOLOGICALS |
| APIDRA INJ | - | NC | ANTIDIABETICS |
| APIDRA SOLOSTAR INJ | - | NC | ANTIDIABETICS |
| APLENZIN TAB | - | NC | ANTIDEPRESSANTS |
| APOKYN INJ | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| apomorphine inj (APOKYN equiv) | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| apraclonidine ophth soln (IOPIDINE equiv) | - | 1 | OPHTHALMIC AGENTS |
| APRACLONIDINE OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| aprepitant cap (EMEND equiv) (QL= 3 caps/fill) | QL | 1 | ANTIEMETICS |
| aprepitant pak (EMEND equiv) (QL= 3 caps/fill) | QL | 1 | ANTIEMETICS |
| APRETUDE SUSP (QL= 7 inj/year) | PA-QL | \$0 | ANTIVIRALS |
| APRISO CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| APRIZIO PAK KIT | - | NC | DERMATOLOGICALS |
| APTiom TAB | - | NC | ANTICONVULSANTS |
| APTIVUS CAP | - | 2 | ANTIVIRALS |
| AQNEURSA PACKET FOR SUSPENSION (QL= 4 packets/day; Only available through CurantHealth 866-437-8040) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AQVESME TAB 100MG | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| ARAKODA TAB | - | 3 | ANTIMALARIALS |
| ARANELLE TAB | - | \$0 | CONTRACEPTIVES |
| ARANESP INJ | - | NC | HEMATOPOIETIC AGENTS |
| ARAZLO LOTION | - | NC | DERMATOLOGICALS |
| ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older) | PA-QL | 3 | ANTIHYPERTENSIVES |
| ARCALYST INJ | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| AREXVY INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 | VACCINES |
| arformoterol tartrate neb soln (BROVANA equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046) | LD-PA-QL | 2 | AMINOGLYCOSIDES |
| aripiprazole ODT (ABILIFY equiv) | - | NC | ANTI PSYCHOTICS/ANTIMANIC AGENTS |
| aripiprazole soln (ABILIFY equiv) | - | 1 | ANTI PSYCHOTICS/ANTIMANIC AGENTS |
| aripiprazole tab (ABILIFY equiv) | - | 1 | ANTI PSYCHOTICS/ANTIMANIC AGENTS |
| armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day) | QL | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ARMONAIR DIGITAL INHALER 113MCG/ACT | - | NC | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| ARMONAIR DIGITAL INHALER 232MCG/ACT | - | NC | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| ARMONAIR DIGITAL INHALER 55MCG/ACT | - | NC | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| ARMOUR THYROID TAB, NATURE THROID TAB | - | 1 | THYROID AGENTS |
| ARNUITY ELLIPTA INHALER | - | 1 | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| ASACOL HD TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ASACOL HD TAB, MESALAMINE TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day) | QL | 1 | ANTI PSYCHOTICS/ANTIMANIC AGENTS |
| ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv) | - | \$0 | CONTRACEPTIVES |
| ASMANEX HFA INHALER | - | 1 | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| ASMANEX INHALER | - | 1 | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| aspirin chew tab 81mg (Covered for female members only) | OTC | \$0 | ANALGESICS - NONNARCOTIC |
| aspirin EC tab 325mg | OTC | EXC | ANALGESICS - NONNARCOTIC |
| aspirin ec tab 81mg (Covered for female members only) | OTC | \$0 | ANALGESICS - NONNARCOTIC |
| aspirin tab 325mg | OTC | EXC | ANALGESICS - NONNARCOTIC |
| aspirin/dipyridamole cap (AGGRENEX equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| ASPIRIN/OMEPRAZOLE ER TAB | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| ASPRUZYO SPRINKLE GRANULES | - | NC | ANTIANGINAL AGENTS |
| ASTAGRAF XL CAP | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| ASTAMED MYO CAP | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| atazanavir cap (REYATAZ equiv) | - | 1 | ANTIVIRALS |
| atenolol tab (TENORMIN equiv) | - | 1 | BETA BLOCKERS |
| atenolol/chlorthalidone tab (TENORETIC equiv) | - | 1 | ANTI HYPERTENSIVES |
| atomoxetine cap (STRATTERA equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ATORVALIQ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTI HYPERLIPIDEMICS |
| atorvastatin tab (LIPITOR equiv) | - | \$0 | ANTI HYPERLIPIDEMICS |
| atovaquone susp (MEPRON equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| atovaquone/proguanil tab (MALARONE equiv) | - | 1 | ANTIMALARIALS |
| ATRIPLA TAB | - | NC | ANTIVIRALS |
| ATRIX SYSTEM KIT | - | NC | DERMATOLOGICALS |
| atropine ophth oint | - | 1 | OPHTHALMIC AGENTS |
| atropine ophth soln (ISOPTO ATROPINE equiv) | - | 1 | OPHTHALMIC AGENTS |
| ATROPINE SUL SOLN 1% OPHTH | - | 1 | OPHTHALMIC AGENTS |
| ATROPINE SULFATE OPHTH OINT | - | 1 | OPHTHALMIC AGENTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| ATROVENT HFA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ATTRUBY PACK (QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| AUBAGIO TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AURANOFIN CAP, RIDAURA CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| AURYXIA TAB | - | 3 | GASTROINTESTINAL AGENTS - MISC. |
| AUSTEDO TAB (QL= 4 tabs/day) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUSTEDO TITRATION PACK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUSTEDO XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AUVELITY TAB | - | NC | ANTIDEPRESSANTS |
| AUVI-Q INJ | - | NC | VASOPRESSORS |
| AVAGE CREAM | - | EXC | DERMATOLOGICALS |
| avanafil tab (STENDRA equiv) | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| AVAR AEROSOL FOAM | - | NC | DERMATOLOGICALS |
| AVAR CLEANSE LIQ 10-5% | - | 1 | DERMATOLOGICALS |
| AVAR PAD | - | NC | DERMATOLOGICALS |
| AVAR-E EMOLL CREAM | - | 1 | DERMATOLOGICALS |
| AVAR-E LS CREAM 10-2% | - | NC | DERMATOLOGICALS |
| AVERI TAB | - | \$0 | CONTRACEPTIVES |
| AVMAPKI FAKZYNJA CO-PACK (QL= 1 pack/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AVONEX INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| AXERT TAB | - | NC | MIGRAINE PRODUCTS |
| AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| AZASITE SOLN | - | 2 | OPHTHALMIC AGENTS |
| azathioprine tab (IMURAN equiv) | - | 1 | ASSORTED CLASSES |
| azathioprine tab 100mg (AZASAN equiv) | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| azathioprine tab 75mg (AZASAN equiv) | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| azelaic acid gel (FINACEA equiv) | - | 1 | DERMATOLOGICALS |
| AZELAIC ACID/NIACINAMIDE CREAM | - | 2 | DERMATOLOGICALS |
| azelastine nasal spray 0.1% (ASTELIN equiv) | - | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| azelastine nasal spray 0.15% (ASTEPRO equiv) | - | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| azelastine ophth soln (OPTIVAR equiv) | - | 1 | OPHTHALMIC AGENTS |
| azelastine/fluticasone nasal spray (DYMISTA equiv) | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| AZELEX CREAM | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| AZENASE PAK | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| AZESCHEW TAB 13-1MG | - | NC | MULTIVITAMINS |
| AZESCO TAB | - | NC | MULTIVITAMINS |
| azithromycin susp (ZITHROMAX equiv) | - | 1 | MACROLIDES |
| azithromycin tab (ZITHROMAX equiv) | - | 1 | MACROLIDES |
| AZOPT OPHTH SUSP | - | 3 | OPHTHALMIC AGENTS |
| AZSTARYS CAP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| BACIT/POLYMY OPHTH OINT | - | 1 | OPHTHALMIC AGENTS |
| BACITRACIN OPHTH OINT | - | 2 | OPHTHALMIC AGENTS |
| bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv) | - | 1 | OPHTHALMIC AGENTS |
| bacitracin/polymyxin b ophth oint (POLYSPORIN equiv) | - | 1 | OPHTHALMIC AGENTS |
| BACLOFEN CREAM COMPOUND KIT | - | NC | DERMATOLOGICALS |
| baclofen oral soln 10mg/5ml (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| BACLOFEN ORAL SOLN 10MG/5ML (Prior Authorization required for members age 9 years and older) | PA | 3 | MUSCULOSKELETAL THERAPY AGENTS |
| BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization required for members age 9 years and older) | PA | 3 | MUSCULOSKELETAL THERAPY AGENTS |
| baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older) | PA | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| baclofen susp (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| baclofen tab (BACLOFEN equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| baclofen tab 15mg | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| BACTROBAN CREAM | - | NC | DERMATOLOGICALS |
| BAFIERTAM CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| BALCOLTRA TAB | - | 3 | CONTRACEPTIVES |
| balsalazide cap (COLAZAL equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BANZEL SUSP | PA | 3 | ANTICONVULSANTS |
| BANZEL TAB | - | NC | ANTICONVULSANTS |
| BAQSIMI NASAL POWDER (QL= 2 inhalations/fill) | QL | 2 | ANTIDIABETICS |
| BARACLUDE SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTIVIRALS |
| BASAGLAR INJ, INSULIN GLARGINE SOLOSTAR INJ | - | NC | ANTIDIABETICS |
| BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist) | QL-RS | 2 | FLUOROQUINOLONES |
| BCG INJ | VAC | EXC | VACCINES |
| B-D INSULIN SYRINGE | --OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| B-D PEN NEEDLE | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| b-donna tab (DONNATAL equiv) | - | NC | ULCER DRUGS |
| BECONASE AQ NASAL SPRAY | - | 3 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| BELBUCA FILM | - | NC | ANALGESICS - OPIOID |
| BELLADONNA ALKALOID/OPIUM SUPP | - | 2 | ULCER DRUGS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

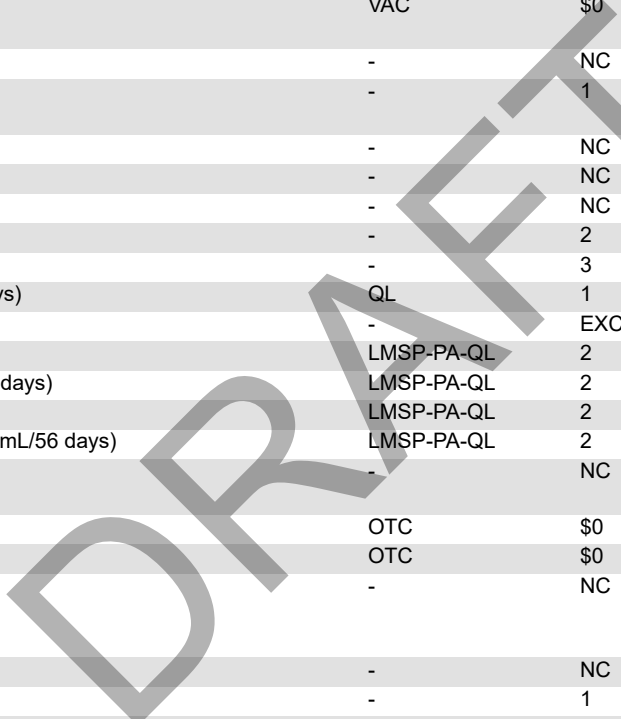
| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| BELSOMRA TAB | - | NC | HYPNOTICS |
| benazepril tab (LOTENSIN equiv) | - | 1 | ANTIHYPERTENSIVES |
| benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv) | - | 1 | ANTIHYPERTENSIVES |
| BENEFIX INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day) | LMSP-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| BENLYSTA INJ (QL= 4 inj/28 day) | LMSP-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| BENTIVITE TAB | - | NC | HEMATOPOIETIC AGENTS |
| BENZACLIN GEL | - | 3 | DERMATOLOGICALS |
| BENZAMYCIN GEL | - | 3 | DERMATOLOGICALS |
| BENZIQLS GEL | - | 2 | DERMATOLOGICALS |
| BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist) | RS | 2 | ANTHELMINTICS |
| benzonatate cap (TESSALON equiv) | - | 1 | COUGH/COLD/ALLERGY |
| BENZONATATE CAP 150MG | - | NC | COUGH/COLD/ALLERGY |
| benzonatate cap 150mg (ZONATUSS equiv) | - | NC | COUGH/COLD/ALLERGY |
| BENZOYL PEROXIDE CLOTH | - | 3 | DERMATOLOGICALS |
| benzoyl peroxide cream | OTC | 1 | DERMATOLOGICALS |
| BENZOYL PEROXIDE CREAM | OTC | 3 | DERMATOLOGICALS |
| benzoyl peroxide gel | - | 1 | DERMATOLOGICALS |
| benzoyl peroxide liquid | - | 1 | DERMATOLOGICALS |
| BENZOYL PEROXIDE LOTION | - | NC | DERMATOLOGICALS |
| BENZOYL PEROXIDE WASH | - | NC | DERMATOLOGICALS |
| BENZOYL PEROXIDE/CLINDAMYCIN/NIACINAMIDE/TRETINOIN GEL | - | 2 | DERMATOLOGICALS |
| BENZOYL PEROXIDE/HYDROCORTISONE LOTION | - | NC | DERMATOLOGICALS |
| benzphetamine tab | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| benztropine tab | - | 1 | ANTIPARKINSON AGENTS |
| bepotastine ophth soln (BEPREVE equiv) | - | 1 | OPHTHALMIC AGENTS |
| BEPREVE OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| BERINERT INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| BESER KIT 0.05% | - | NC | DERMATOLOGICALS |
| BESIFLOXACIN OPHTH SUSP, BESIVANCE OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| betaine powder for oral solution (CYSTADANE equiv) | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| BETAMETH VALERATE LOTION | - | 1 | DERMATOLOGICALS |
| betamethasone augmented cream (DIPROLENE AF CREAM equiv) | - | 1 | DERMATOLOGICALS |
| BETAMETHASONE AUGMENTED GEL | - | 2 | DERMATOLOGICALS |
| betamethasone augmented gel | - | NC | DERMATOLOGICALS |
| betamethasone augmented lotion (DIPROLENE LOTION equiv) | - | 1 | DERMATOLOGICALS |
| betamethasone augmented oint (DIPROLENE OINT equiv) | - | 1 | DERMATOLOGICALS |
| betamethasone dipropionate cream (DIPROSONE CREAM equiv) | - | 1 | DERMATOLOGICALS |
| betamethasone dipropionate lotion | - | 1 | DERMATOLOGICALS |
| betamethasone dipropionate oint (DIPROSONE OINT equiv) | - | 1 | DERMATOLOGICALS |
| betamethasone valerate cream | - | 1 | DERMATOLOGICALS |
| betamethasone valerate foam (LUXIQ equiv) | - | NC | DERMATOLOGICALS |
| betamethasone valerate lotion | - | 1 | DERMATOLOGICALS |
| betamethasone valerate oint | - | 1 | DERMATOLOGICALS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| BETASERON INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| BETAXOLOL OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| betaxolol ophth soln (BETOPTIC-S equiv) | - | 1 | OPHTHALMIC AGENTS |
| betaxolol tab (KERLONE equiv) | - | 1 | BETA BLOCKERS |
| bethanechol tab (URECHOLINE equiv) | - | 1 | URINARY ANTISPASMODICS |
| BETIMOL OPHTH SOLN 0.25% | - | 2 | OPHTHALMIC AGENTS |
| BETOPTIC-S OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| BEVESPI AEROSPHERE INHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| BEXAGLIFLOZIN | - | NC | ANTIDIABETICS |
| bexarotene cap (TARGRETIN equiv) (QL= 10 caps/day) | LMSP-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| bexarotene gel (TARGRETIN equiv) (QL= 60 grams/30 days) | LMSP-PA-QL | 1 | DERMATOLOGICALS |
| BEXSERO INJ | VAC | \$0 | VACCINES |
| BEYAZ TAB | - | 3 | CONTRACEPTIVES |
| BEYFORTUS INJ | VAC | \$0 | PASSIVE IMMUNIZING AND TREATMENT AGENTS |
| BIAFINE EMULSION | - | NC | DERMATOLOGICALS |
| bicalutamide tab (CASODEX equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BIDIL TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| BIFERARX TAB | - | NC | HEMATOPOIETIC AGENTS |
| BIJUVA CAP | - | NC | ESTROGENS |
| BIKTARVY TAB | - | 2 | ANTIVIRALS |
| BILTRICIDE TAB | - | 3 | ANTHELMINTICS |
| bimatoprost ophth soln (QL= 2.5ml/30 days) | QL | 1 | OPHTHALMIC AGENTS |
| bimatoprost ophth soln | - | EXC | DERMATOLOGICALS |
| BIMZELX INJ (QL= 1 mL/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| BIMZELX INJ 320MG/2ML (QL= 2 mL/56 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| BIMZELX SYRINGE (QL= 1 mL/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| BIMZELX SYRINGE 320MG/2ML (QL= 2 mL/56 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| BINOSTO TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| bisacodyl supp | OTC | \$0 | LAXATIVES |
| bisacodyl tab | OTC | \$0 | LAXATIVES |
| bismuth/metro/tetra cap (PYLERA equiv) | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| BISOPROLOL FUMARATE TAB | - | NC | BETA BLOCKERS |
| bisoprolol tab (ZEBETA equiv) | - | 1 | BETA BLOCKERS |
| bisoprolol/hydrochlorothiazide tab (ZIAC equiv) | - | 1 | ANTIHYPERTENSIVES |
| BLANCHE CREAM | - | EXC | DERMATOLOGICALS |
| BLEPHAMIDE OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| BLEPHAMIDE S.O.P. OPHTH OINT | - | 3 | OPHTHALMIC AGENTS |
| BLUJEP A TAB | - | EXC | ANTI-INFECTIVE AGENTS - MISC. |
| BONSITY INJ | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 1 | CARDIOVASCULAR AGENTS - MISC. |



| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 1 | CARDIOVASCULAR AGENTS - MISC. |
| BOSULIF CAP | MSP-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BOSULIF TAB | MSP-PA-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BP 10-1 EMU | - | NC | DERMATOLOGICALS |
| BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BREKIYA INJ | - | NC | MIGRAINE PRODUCTS |
| BREO ELLIPTA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| BREO ELLIPTA INHALER 50-25 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| BREXAFEMME TAB | - | NC | ANTIFUNGALS |
| BREZTRI AEROSPHERE INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv) | - | 1 | OPHTHALMIC AGENTS |
| brimonidine ophth soln 0.2% | - | 1 | OPHTHALMIC AGENTS |
| brimonidine tartrate gel (MIRVASO equiv) | - | EXC | DERMATOLOGICALS |
| brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv) | - | 1 | OPHTHALMIC AGENTS |
| brimonidine/timolol ophth soln (COMBIGAN equiv) | - | 1 | OPHTHALMIC AGENTS |
| BRINSUPRI TAB | - | EXC | RESPIRATORY AGENTS - MISC. |
| brinzolamide ophth susp (AZOPT equiv) | - | 1 | OPHTHALMIC AGENTS |
| BRISDELLE CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| BRIVIACT INJ 50MG/5ML | - | NC | ANTICONSULSANTS |
| BRIVIACT SOLN 10MG/ML | - | NC | ANTICONSULSANTS |
| BRIVIACT TAB | - | NC | ANTICONSULSANTS |
| bromfenac ophth soln (BROMDAY equiv) | - | 1 | OPHTHALMIC AGENTS |
| bromfenac sodium ophth soln 0.07% (PROLENSA equiv) | - | 1 | OPHTHALMIC AGENTS |
| bromfenac sodium ophth soln 0.075% (BROMSITE equiv) | - | NC | OPHTHALMIC AGENTS |
| bromocriptine cap (PARLODEL equiv) | - | 1 | ANTIPARKINSON AGENTS |
| bromocriptine tab (PARLODEL equiv) | - | 1 | ANTIPARKINSON AGENTS |
| BROMSITE DROP 0.075% | - | NC | OPHTHALMIC AGENTS |
| BRONCHITOL CAP | - | NC | RESPIRATORY AGENTS - MISC. |
| BROVEX PEB LIQUID | OTC | EXC | COUGH/COLD/ALLERGY |
| BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BRUKINSA TAB (QL= 2 tabs/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| BRYHALI LOTION | - | NC | DERMATOLOGICALS |
| BRYNOVIN SOLN | - | NC | ANTIADIABETICS |
| B-SERENE PAD | - | NC | HEMATOPOIETIC AGENTS |
| BUCAPSOL CAP | - | NC | ANTIAXIETY AGENTS |
| budesonide ER tab (UCERIS equiv) (QL=1 tab/day) | PA-QL | 1 | CORTICOSTEROIDS |
| budesonide inh susp (PULMICORT equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| budesonide nasal spray (RHINOCORT AQUA equiv) | OTC | EXC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| budesonide rectal foam (UCERIS RECTAL FOAM equiv) | PA | 3 | ANORECTAL AND RELATED PRODUCTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| budesonide SR cap (ENTOCORT EC equiv) | - | 1 | CORTICOSTEROIDS |
| budesonide/formoterol inhaler (SYMBICORT equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| bumetanide tab (BUMEX equiv) | - | 1 | DIURETICS |
| BUNAVAIL FILM | - | NC | ANALGESICS - OPIOID |
| buprenorphine hcl buccal film (BELBUCA equiv) | - | NC | ANALGESICS - OPIOID |
| buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 | ANALGESICS - OPIOID |
| buprenorphine SL tab (SUBUTEX equiv) | - | 1 | ANALGESICS - OPIOID |
| buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv) | - | 1 | ANALGESICS - OPIOID |
| buprenorphine/naloxone SL tab (SUBOXONE equiv) | - | 1 | ANALGESICS - OPIOID |
| bupropion ER tab (WELLBUTRIN equiv) | - | 1 | ANTIDEPRESSANTS |
| bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| bupropion tab (WELLBUTRIN equiv) | - | 1 | ANTIDEPRESSANTS |
| bupropion XL tab (WELLBUTRIN XL equiv) | - | 1 | ANTIDEPRESSANTS |
| bupirone tab (BUSPAR equiv) | - | 1 | ANTIANKXIETY AGENTS |
| butalbital/acetaminophen cap | - | NC | ANALGESICS - NONNARCOTIC |
| butalbital/acetaminophen/caffeine soln | - | NC | ANALGESICS - NONNARCOTIC |
| butalbital/acetaminophen/caffeine tab (FIORICET equiv) | - | 1 | ANALGESICS - NONNARCOTIC |
| BUTALBITAL/ASPIRIN/CAFFEINE TAB | - | NC | ANALGESICS - NONNARCOTIC |
| butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days) | QL | 1 | ANALGESICS - OPIOID |
| BYDUREON BCISE AUTO INJ | - | NC | ANTIDIABETICS |
| BYDUREON INJ | - | NC | ANTIDIABETICS |
| BYDUREON PEN INJ | - | NC | ANTIDIABETICS |
| BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| BYNFEZIA PEN INJ | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| BYVALSON TAB | - | NC | ANTIHYPERTENSIVES |
| CABENUVA IM SUSP (QL= 1 kit/30 days) | LMSP-QL | 2 | ANTIVIRALS |
| CABENUVA SUSP 600MG-900MG/3ML (QL= 1 kit/30 days) | LMSP-QL | 2 | ANTIVIRALS |
| cabergoline tab (DOSTINEX equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| CABOMETYX TAB (QL= 1 tab/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CAFCIT INJ | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| calcipotriene cream (DOVONEX CREAM equiv) | - | 1 | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| calcipotriene cream (TRIONEX equiv) | - | NC | DERMATOLOGICALS |
| CALCIPOTRIENE FOAM | - | NC | DERMATOLOGICALS |
| CALCIPOTRIENE FOAM, SORILUX FOAM | - | NC | DERMATOLOGICALS |
| calcipotriene oint | - | 1 | DERMATOLOGICALS |
| CALCIPOTRIENE SOLN | - | 1 | DERMATOLOGICALS |
| calcipotriene soln (DOVONEX SOLN equiv) | - | 1 | DERMATOLOGICALS |
| calcipotriene/betamethasone dipropionate susp | - | NC | DERMATOLOGICALS |
| calcipotriene/betamethasone oint (TACLONEX equiv) | - | NC | DERMATOLOGICALS |
| calcitonin inj (MIACALCIN equiv) | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| calcitonin nasal spray (MIACALCIN equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| calcitriol cap (ROCALTROL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CALCITRIOL INJ | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CALCITRIOL OINT | - | 3 | DERMATOLOGICALS |
| calcitriol soln (ROCALTROL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| calcium acetate cap (PHOSLO equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| CALIBRATION LIQUID | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CALSODORE PAK | - | NC | DERMATOLOGICALS |
| CAMBIA POWDER | - | NC | MIGRAINE PRODUCTS |
| CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| candesartan tab (ATACAND equiv) | - | 1 | ANTIHYPERTENSIVES |
| candesartan/hydrochlorothiazide tab (ATACAND HCT equiv) | - | NC | ANTIHYPERTENSIVES |
| capecitabine tab (XELODA equiv) | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CAPEX SHAMPOO | - | NC | DERMATOLOGICALS |
| CAPLYTA CAP | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| capsaicin/menthol topical patch (SINELEE equiv) | - | NC | DERMATOLOGICALS |
| captopril tab (CAPOTEN equiv) | - | 1 | ANTIHYPERTENSIVES |
| CAPVAXIVE INJ | VAC | \$0 | VACCINES |
| CARAC CREAM | - | NC | DERMATOLOGICALS |
| CARBAGLU TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| carbamazepine chew tab (TEGRETOL equiv) | - | 1 | ANTICONSULSANTS |
| CARBAMAZEPINE CHEW TAB | - | NC | ANTICONSULSANTS |
| carbamazepine ER cap (CARBATROL equiv) | - | 1 | ANTICONSULSANTS |
| carbamazepine ER tab (TEGRETOL XR equiv) | - | 1 | ANTICONSULSANTS |
| carbamazepine susp (TEGRETOL equiv) | - | 1 | ANTICONSULSANTS |
| carbamazepine tab (TEGRETOL equiv) | - | 1 | ANTICONSULSANTS |
| carbidopa tab (LODOSYN equiv) | - | 1 | ANTIPARKINSON AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| CARBIDOPA/LEVODOPA CAP, RYTARY CAP | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| carbidopa/levodopa ER tab (SINEMET CR equiv) | - | 1 | ANTIPARKINSON AGENTS |
| carbidopa/levodopa ODT (PARCOPA equiv) | - | 1 | ANTIPARKINSON AGENTS |
| carbidopa/levodopa tab (SINEMET equiv) | - | 1 | ANTIPARKINSON AGENTS |
| CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv) | - | 2 | ANTIPARKINSON AGENTS |
| carbidopa-levodopa-entacapone tab (STALEVO equiv) | - | 1 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| carbinoxamine maleate tab 6mg | - | NC | ANTIHISTAMINES |
| CARBINOXAMINE SOLN | - | 1 | ANTIHISTAMINES |
| carbinoxamine tab (PALGIC equiv) | - | 1 | ANTIHISTAMINES |
| CARBZAH SOLN 4MG/5ML | - | NC | ANTIHISTAMINES |
| CARDAMYST NASAL SPRAY | - | EXC | CALCIUM CHANNEL BLOCKERS |
| CARDURA XL TAB | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007) | LD-PA | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| carisoprodol tab (SOMA equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| carisoprodol tab 250mg (SOMA equiv) | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| CARISOPRODOL/ASPIRIN TAB | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| carisoprodol/aspirin tab (SOMA COMPOUND equiv) | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| CARISOPRODOL/ASPIRIN/CODEINE TAB | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| carisoprodol/aspirin/codeine tab (SOMA COMPOUND/CODEINE equiv) | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| CARMOL LOTION | - | NC | DERMATOLOGICALS |
| CARTEOLOL OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| carteolol ophth soln (OCUPRESS equiv) | - | 1 | OPHTHALMIC AGENTS |
| carvedilol phosphate ER cap (COREG CR equiv) | - | NC | BETA BLOCKERS |
| carvedilol tab (COREG equiv) | - | 1 | BETA BLOCKERS |
| CATAPRES-TTS PATCH | - | 3 | ANTIHYPERTENSIVES |
| CAVERJECT INJ | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416) | LD-RS | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| CEFACLOR CAP | - | 1 | CEPHALOSPORINS |
| cefaclor cap (CECLOR equiv) | - | 1 | CEPHALOSPORINS |
| CEFACLOR ER TAB | - | 3 | CEPHALOSPORINS |
| CEFACLOR SUSP | - | 3 | CEPHALOSPORINS |
| cefadroxil cap (DURICEF equiv) | - | 1 | CEPHALOSPORINS |
| cefadroxil susp (DURICEF equiv) | - | 1 | CEPHALOSPORINS |
| cefadroxil tab (DURICEF equiv) | - | 1 | CEPHALOSPORINS |
| CEFADROXIL TAB | - | 2 | CEPHALOSPORINS |
| cefdinir cap (OMNICEF equiv) | - | 1 | CEPHALOSPORINS |
| cefdinir susp (OMNICEF equiv) | - | 1 | CEPHALOSPORINS |
| cefixime cap (SUPRAX equiv) | - | 1 | CEPHALOSPORINS |
| cefixime susp (SUPRAX equiv) | - | 1 | CEPHALOSPORINS |
| CEFIXIME TAB | - | NC | CEPHALOSPORINS |
| CEFPODOXIME PROXETIL SUSP | - | 1 | CEPHALOSPORINS |
| cefpodoxime proxetil tab (VANTIN equiv) | - | 1 | CEPHALOSPORINS |
| cefprozil susp (CEFZIL equiv) | - | 1 | CEPHALOSPORINS |
| cefprozil tab (CEFZIL equiv) | - | 1 | CEPHALOSPORINS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| cefuroxime tab (CEFTIN equiv) | - | 1 | CEPHALOSPORINS |
| CELEBREX CAP | - | 3 | ANALGESICS - ANTI-INFLAMMATORY |
| celecoxib cap (CELEBREX equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| CENTANY OINT | - | 3 | DERMATOLOGICALS |
| cephalexin cap (KEFLEX equiv) | - | 1 | CEPHALOSPORINS |
| cephalexin cap 750mg (KEFLEX equiv) | - | NC | CEPHALOSPORINS |
| cephalexin susp (KEFLEX equiv) | - | 1 | CEPHALOSPORINS |
| cephalexin tab | - | NC | CEPHALOSPORINS |
| CEQUA (PF) OPHTH SOLN, VEVYE OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| CEQR SIMPLICITY | - | NC | MEDICAL DEVICES AND SUPPLIES |
| CERDELGA CAP (QL= 2 caps/day) | LMS-PA-QL | 2 | HEMATOPOIETIC AGENTS |
| CERVICAL CAP | - | \$0 | MEDICAL DEVICES AND SUPPLIES |
| cetirizine cap (ZYRTEC equiv) | OTC | EXC | ANTIHISTAMINES |
| cetirizine chew tab (ZYRTEC equiv) | OTC | EXC | ANTIHISTAMINES |
| cetirizine syrup (ZYRTEC equiv) | OTC | EXC | ANTIHISTAMINES |
| cetirizine tab (ZYRTEC equiv) | OTC | EXC | ANTIHISTAMINES |
| cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| cetrotelix acetate for inj kit (CETROTIDE equiv) | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CETROTIDE KIT | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CETYLEV TAB | - | NC | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| cevimeline cap (EVOXAC equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| CHANTIX STARTER PACK | SMKG | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| CHEMET CAP | - | 2 | ANTIDOTES |
| CHENODAL TAB, CTEXLI TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| chlordiazepoxide cap (LIBRIUM equiv) | - | 1 | ANTIANSXIETY AGENTS |
| CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| CHLORDIAZEPOXIDE/CLIDINIUM CAP | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| chlordiazepoxide/clidinium cap (LIBRAX equiv) | - | 1 | ULCER DRUGS |
| chlorhexidine gluconate soln (PERIDEX equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| CHLOROQUINE TAB | - | 1 | ANTIMALARIALS |
| chloroquine tab (ARALEN equiv) | - | 1 | ANTIMALARIALS |
| CHLORPROMAZINE CONC | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| chlorpromazine hcl conc | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| chlorpromazine tab (THORAZINE equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| chlorthalidone tab | - | 1 | DIURETICS |
| chlorzoxazone tab | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| CHLORZOAZONE TAB 250MG, LORZONE TAB | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| chlorzoxazone tab 500mg | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226) | LD-PA | 2 | GASTROINTESTINAL AGENTS - MISC. |
| cholestyramine lite powder (QUESTRAN LITE equiv) | - | 1 | ANTIHYPERTENSIVES |
| cholestyramine lite powder pack (QUESTRAN LITE equiv) | - | 1 | ANTIHYPERTENSIVES |
| cholestyramine powder (QUESTRAN equiv) | - | 1 | ANTIHYPERTENSIVES |
| cholestyramine powder pack (QUESTRAN equiv) | - | 1 | ANTIHYPERTENSIVES |



| | | | | | |
|---------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMS-PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| CIALIS TAB | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| CIALIS TAB 2.5MG, 5MG | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| CIBINQO TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| CICLODAN KIT | - | NC | DERMATOLOGICALS |
| ciclopirox cream (LOPROX CREAM equiv) | - | 1 | DERMATOLOGICALS |
| ciclopirox gel (LOPROX GEL equiv) | - | 1 | DERMATOLOGICALS |
| ciclopirox nail soln (PENLAC equiv) | - | 1 | DERMATOLOGICALS |
| ciclopirox shampoo (LOPROX SHAMPOO equiv) | - | 1 | DERMATOLOGICALS |
| ciclopirox topical susp (LOPROX SUSP equiv) | - | 1 | DERMATOLOGICALS |
| cilostazol tab (PLETAL equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| CILOXAN OPTH OINT | - | 3 | OPHTHALMIC AGENTS |
| CIMDUO TAB | - | 2 | ANTIVIRALS |
| cimetidine soln (CIMETIDINE equiv) | - | 1 | ULCER DRUGS |
| cimetidine tab (TAGAMET equiv) (Rx Only) | - | 1 | ULCER DRUGS |
| CIMZIA INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| CIMZIA INJ 200MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| cinacalcet tab (SENSIPAR equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | HEMATOLOGICAL AGENTS - MISC. |
| CIPRO HC OTIC SUSP | - | 3 | OTIC AGENTS |
| CIPRO SUSP | - | 3 | FLUOROQUINOLONES |
| CIPROFLOXACIN 100MG TAB | - | 3 | FLUOROQUINOLONES |
| ciprofloxacin hcl otic soln (CETRAXAL equiv) | - | 1 | OTIC AGENTS |
| ciprofloxacin ophth soln (CILOXAN equiv) | - | 1 | OPHTHALMIC AGENTS |
| ciprofloxacin susp (CIPRO equiv) | - | 1 | FLUOROQUINOLONES |
| ciprofloxacin tab (CIPRO equiv) | - | 1 | FLUOROQUINOLONES |
| ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv) | - | 1 | OTIC AGENTS |
| ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv) | - | 1 | OTIC AGENTS |
| CITALOPRAM CAP | - | NC | ANTIDEPRESSANTS |
| citalopram soln (CELEXA equiv) | - | 1 | ANTIDEPRESSANTS |
| citalopram tab (CELEXA equiv) | - | 1 | ANTIDEPRESSANTS |
| CITRANATAL CAP MEDLEY | - | NC | MULTIVITAMINS |
| CITRULLINE EASY TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| cladribine tab therapy pack (MAVENCLAD equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| CLARINEX SYRUP | - | EXC | ANTIHISTAMINES |
| CLARINEX TAB | - | EXC | ANTIHISTAMINES |
| CLARINEX-D TAB | - | EXC | COUGH/COLD/ALLERGY |
| CLARITHROMYC SUSP | - | 2 | MACROLIDES |
| clarithromycin ER tab (BIAXIN XL equiv) | - | 1 | MACROLIDES |
| clarithromycin tab (BIAXIN equiv) | - | 1 | MACROLIDES |
| CLARITIN CAP | OTC | EXC | ANTIHISTAMINES |
| CLARITIN CHEW TAB | OTC | EXC | ANTIHISTAMINES |
| CLARITIN REDITAB | OTC | EXC | ANTIHISTAMINES |
| CLARITIN SYRUP | OTC | EXC | ANTIHISTAMINES |
| CLARITIN TAB | OTC | EXC | ANTIHISTAMINES |
| CLARITIN-D TAB | OTC | EXC | COUGH/COLD/ALLERGY |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|-------------------------------|
| CLEMASTINE SYRUP | - | NC | ANTIHISTAMINES |
| CLEMASTINE TAB | - | NC | ANTIHISTAMINES |
| CLEMASTINE TAB, CLEMAZ TAB | - | NC | ANTIHISTAMINES |
| CLENPIQ SOLN | - | NC | LAXATIVES |
| CLEOCIN VAGINAL SUPP (QL= 3 suppositories/fill) | QL | 3 | VAGINAL PRODUCTS |
| CLEOCIN-T GEL | - | NC | DERMATOLOGICALS |
| CLEOCIN-T LOTION | - | 3 | DERMATOLOGICALS |
| CLIMARA PRO PATCH | - | NC | ESTROGENS |
| CLINDACIN KIT | - | NC | DERMATOLOGICALS |
| clindamycin cap (CLEOCIN equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| clindamycin foam (EVOCLIN equiv) | - | NC | DERMATOLOGICALS |
| clindamycin gel (CLEOCIN GEL equiv) | - | 1 | DERMATOLOGICALS |
| clindamycin lotion (CLEOCIN- T equiv) | - | 1 | DERMATOLOGICALS |
| clindamycin pad (CLEOCIN-T equiv) | - | NC | DERMATOLOGICALS |
| CLINDAMYCIN PHOSPHATE/NIACINAMIDE GEL | - | 2 | DERMATOLOGICALS |
| clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv) | - | NC | DERMATOLOGICALS |
| clindamycin soln (CLEOCIN equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| clindamycin topical soln (CLEOCIN-T equiv) | - | 1 | DERMATOLOGICALS |
| clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill) | QL | 1 | VAGINAL PRODUCTS |
| clindamycin/benzoyl peroxide gel (BENZAACLIN equiv) | - | 1 | DERMATOLOGICALS |
| clindamycin/benzoyl peroxide gel (DUAC GEL equiv) | - | 1 | DERMATOLOGICALS |
| CLINDAMYCIN/BENZOYL PEROXIDE/NIACINAMIDE GEL | - | 2 | DERMATOLOGICALS |
| CLINDAMYCIN/NIACINAMIDE LOTION | - | 2 | DERMATOLOGICALS |
| CLINDAMYCIN/NIACINAMIDE/SPIRONOLACTONE/TRETINOIN GEL | - | 2 | DERMATOLOGICALS |
| CLINDAMYCIN/NIACINAMIDE/TRETINOIN CREAM | - | 2 | DERMATOLOGICALS |
| clindamycin/tretinoin gel (ZIANA equiv) | - | NC | DERMATOLOGICALS |
| CLINDAVIX KIT | - | NC | DERMATOLOGICALS |
| CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill) | QL | 2 | VAGINAL AND RELATED PRODUCTS |
| CLINISTIX TEST STRIP | OTC | 1 | DIAGNOSTIC PRODUCTS |
| clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTICONVULSANTS |
| clobazam tab (ONFI equiv) | - | 1 | ANTICONVULSANTS |
| clobetasol E foam (OLUX E equiv) | - | NC | DERMATOLOGICALS |
| clobetasol foam (OLUX equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol lotion (CLOBEX equiv) | - | 1 | DERMATOLOGICALS |
| CLOBETASOL OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| clobetasol propionate cream (TEMOVATE equiv) | - | 1 | DERMATOLOGICALS |
| CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM | - | NC | DERMATOLOGICALS |
| clobetasol propionate emollient cream (TEMOVATE E equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol propionate gel (TEMOVATE GEL equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol propionate oint (TEMOVATE equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol propionate soln (TEMOVATE equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol shampoo (CLOBEX equiv) | - | 1 | DERMATOLOGICALS |
| clobetasol spray (CLOBEX equiv) | - | 1 | DERMATOLOGICALS |
| CLOBETAVIX KIT | - | NC | DERMATOLOGICALS |
| CLOCORTOLONE CREAM | - | NC | DERMATOLOGICALS |
| clocortolone pivalate cream | - | NC | DERMATOLOGICALS |
| CLODERM CREAM | - | NC | DERMATOLOGICALS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| clomiphene citrate tab (CLOMID equiv) | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CLOMIPHENE TAB | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| clomipramine cap (ANAFRANIL equiv) | - | 1 | ANTIDEPRESSANTS |
| clonazepam ODT (KLONOPIN equiv) | - | 1 | ANTICONVULSANTS |
| clonazepam tab (KLONOPIN equiv) | - | 1 | ANTICONVULSANTS |
| clonidine ER tab (KAPVAY equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| clonidine patch (CATAPRES-TTS equiv) | - | 1 | ANTIHYPERTENSIVES |
| clonidine tab (CATAPRES equiv) | - | 1 | ANTIHYPERTENSIVES |
| clopidogrel tab 75mg (PLAVIX equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| CLOPIDOGREL THERAPY PACK | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| clorazepate tab (TRANXENE-T equiv) | - | 1 | ANTIANKXIETY AGENTS |
| clotrimazole cream (LOTRIMIN AF equiv) | OTC | EXC | DERMATOLOGICALS |
| clotrimazole troches (MYCELEX TROCHES equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| clotrimazole/betamethasone cream (LORTRISONE CREAM equiv) | - | 1 | DERMATOLOGICALS |
| CLOTTRIMAZOLE/BETAMETHASONE LOTION | - | NC | DERMATOLOGICALS |
| clotrimazole/betamethasone lotion (LORTRISONE equiv) | - | NC | DERMATOLOGICALS |
| clozapine odt tab (CLOZAPINE, FAZACLO equiv) | - | NC | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| CLOZAPINE ODT, FAZACLO ODT | - | NC | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| clozapine tab (CLOZARIL equiv) | - | 1 | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| COAGADEX INJ (Only available through CVS/Caremark 800-237-2767 or OptionCare 877-686-2622) | LD-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| COBENFY CAP | - | NC | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| COBENFY CAP STARTER PACK | - | NC | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| COCAINE HCL SOLN | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| codeine sulfate tab | - | 1 | ANALGESICS - OPIOID |
| colchicine cap (MITIGARE equiv) | - | NC | GOUT AGENTS |
| colchicine tab (COLCRYS equiv) | - | 1 | GOUT AGENTS |
| colchicine/probenecid tab (COL-BENEMID equiv) | - | 1 | GOUT AGENTS |
| COLCRYS TAB | - | NC | GOUT AGENTS |
| colesevelam pack (WELCHOL equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| colesevelam tab (WELCHOL equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| colestipol granule (COLESTID equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| colestipol powder packet (COLESTID equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| colestipol tab (COLESTID equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| colistimethate inj (COLY-MYCIN M equiv) | - | NC | ANTI-INFECTION AGENTS - MISC. |
| COLLANEX EXTERNAL POWDER | - | NC | DERMATOLOGICALS |
| COLY-MYCIN S OTIC SUSP | - | 2 | OTIC AGENTS |
| COMBIPATCH | - | 2 | ESTROGENS |
| COMBIVENT RESPIMAT INHALER | - | 2 | ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS |
| COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| COMIRNATY INJ (QL= 1 dose/17 days) | QL-VAC | \$0 | VACCINES |
| COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days) | QL-VAC | \$0 | VACCINES |
| COMPLERA TAB | - | 3 | ANTIVIRALS |
| CONCEPT DHA CAP | - | 1 | MULTIVITAMINS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| CREXONT CAP | - | NC | ANTIPARKINSON AGENTS |
| CRINONE GEL | PA | 2 | VAGINAL PRODUCTS |
| CRIXIVAN CAP | - | 2 | ANTIVIRALS |
| cromolyn conc (GASTROCROM equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| cromolyn neb soln (INTAL equiv) | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| cromolyn ophth soln (CROLOM equiv) | - | 1 | OPHTHALMIC AGENTS |
| CROMOLYN SODIUM OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| CROTAN LOTION | - | NC | DERMATOLOGICALS |
| cryselle tab | - | \$0 | CONTRACEPTIVES |
| CUE COVID-19 INJ TEST CARTRIDGE | OTC | EXC | DIAGNOSTIC PRODUCTS |
| CUE HEALTH MONITOR | OTC | EXC | DIAGNOSTIC PRODUCTS |
| CUTAQUIG INJ | - | NC | PASSIVE IMMUNIZING AND TREATMENT AGENTS |
| CUTIVATE LOTION | - | NC | DERMATOLOGICALS |
| CUVITRU INJ | - | NC | PASSIVE IMMUNIZING AGENTS |
| CUVRIOR TAB | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| cyanocobalamin inj | - | 1 | HEMATOPOIETIC AGENTS |
| cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv) | - | 1 | HEMATOPOIETIC AGENTS |
| CYCLOBENZAPRINE COMPOUND KIT | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| cyclobenzaprine ER cap (AMRIX equiv) | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| cyclobenzaprine tab (FLEXERIL equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| CYCLOGYL OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| CYCLOMYDRIL OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| cyclopentolate ophth soln (CYCLOGYL equiv) | - | 1 | OPHTHALMIC AGENTS |
| cyclophosphamide cap | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CYCLOPHOSPHAMIDE TAB | - | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| CYCLOSERINE CAP | - | NC | ANTIMYCOBACTERIAL AGENTS |
| CYCLOSET TAB | - | 3 | ANTIDIABETICS |
| cyclosporine cap (SANDIMMUNE equiv) | - | 1 | ASSORTED CLASSES |
| cyclosporine modified cap (NEORAL equiv) | - | 1 | ASSORTED CLASSES |
| cyclosporine modified soln (NEORAL equiv) | - | 1 | ASSORTED CLASSES |
| cyclosporine ophth emulsion (RESTASIS equiv) (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist) | QL-RS | 1 | OPHTHALMIC AGENTS |
| CYCLOSPORINE OPHTH EMULSION 0.1% | - | NC | OPHTHALMIC AGENTS |
| CYFOLEX CAP | - | NC | HEMATOPOIETIC AGENTS |
| CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| CYLTEZO INJ (adalimumab-adbm) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| cyproheptadine syrup | - | 1 | ANTIHISTAMINES |
| cyproheptadine tab | - | 1 | ANTIHISTAMINES |
| CYSTADANE POWDER (Only available through AnovoRx 844-288-5007) | LD | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| CYSTADROPS SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-QL-RS | 2 | OPHTHALMIC AGENTS |
| CYSTAGON CAP (Only available through CVS Specialty 800-238-7828) | LD | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | generic = small letters Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| CYSTARAN OPHTH SOLN (QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416) | LD-QL-RS | 2 | OPHTHALMIC AGENTS |
| CYTRA K CRYSTALS | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| CYTRA-3 SYRUP | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| dabigatran etexilate mesylate cap (PRADAXA equiv) | - | 1 | ANTICOAGULANTS |
| dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist) | LMSP-QL-RS | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| DALIRESP TAB | - | 3 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| danazol cap (DANOCRINE equiv) | - | 1 | ANDROGENS-ANABOLIC |
| dantrolene cap (DANTRIUM equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| DANZITEN TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| DAPAGLIFLOZIN PROP-METFORMIN HCL 10-1000MG | - | NC | ANTIDIABETICS |
| DAPAGLIFLOZIN PROP-METFORMIN HCL 5-1000MG | - | NC | ANTIDIABETICS |
| DAPAGLIFLOZIN PROPRANEDIOL TAB 10MG | - | NC | ANTIDIABETICS |
| DAPAGLIFLOZIN PROPRANEDIOL TAB 5MG | - | NC | ANTIDIABETICS |
| dapsone gel (ACZONE equiv) | - | NC | DERMATOLOGICALS |
| dapsone tab | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| DAPSONE/NIACINAMIDE GEL | - | 2 | DERMATOLOGICALS |
| DAPSONE/NIACINAMIDE/SPIRONOLACTONE GEL | - | 2 | DERMATOLOGICALS |
| DAPTACEL INJ, INFANRIX INJ | VAC | \$0 | TOXOIDS |
| darifenacin SR tab (ENABLEX equiv) | - | 1 | URINARY ANTISPASMODICS |
| DARTISLA ODT TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| darunavir tab | - | 1 | ANTIVIRALS |
| dasatinib tab (SPRYCEL equiv) | LMSP-PA | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| DAURISMO TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007) | LD-PA-QL | Non-EHB | NEUROMUSCULAR AGENTS |
| DAYBUE STIX POWDER | - | NC | NEUROMUSCULAR AGENTS |
| DAYVIGO TAB (QL= 1 tab/day) | PA-QL | 3 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| deferasirox granules packet (JADENU equiv) | LMSP | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| deferasirox tab (JADENU equiv) | LMSP | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| deferasirox tab for oral susp (EXJADE equiv) | LMSP | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| deflazacort susp (EMFLAZA equiv) | - | NC | CORTICOSTEROIDS |
| deflazacort tab (EMFLAZA equiv) | - | NC | CORTICOSTEROIDS |
| DEGLUDEC FLEXTOUCH INJ | - | NC | ANTIDIABETICS |
| DEGLUDEC INJ | - | NC | ANTIDIABETICS |
| DELSTRIGO TAB | - | 2 | ANTIVIRALS |
| DELZICOL CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| demeclocycline tab (DECLOMYCIN equiv) | - | 1 | TETRACYCLINES |
| DEMSEER CAP | - | NC | ANTIHYPERTENSIVES |
| DENAVIR CREAM | - | NC | DERMATOLOGICALS |
| DENGVAIXIA SUSP | VAC | \$0 | VACCINES |
| DENTA 5000 CREAM PLUS (\$0 copay for members age 5 years and younger; All other members covered at preferred brand copay) | - | \$0 | MOUTH/THROAT/DENTAL AGENTS |
| DEPACON INJ | - | NC | ANTICONVULSANTS |
| DEPLIN CAP | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| DEPO-ESTRADIOL IM | - | NC | ESTROGENS |
| DEPO-MEDROL INJ | - | 3 | CORTICOSTEROIDS |
| DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ | - | 3 | CORTICOSTEROIDS |
| DEPO-PROVERA INJ | QL | 3 | CONTRACEPTIVES |
| DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days) | QL | \$0 | CONTRACEPTIVES |
| DERMACINRX CREAM | - | NC | DERMATOLOGICALS |
| DERMACINRX KIT | - | NC | DERMATOLOGICALS |
| DERMALID PAK | - | NC | DERMATOLOGICALS |
| DESCOVY TAB | PA | \$0 | ANTIVIRALS |
| desipramine tab (NORPRAMIN equiv) | - | 1 | ANTIDEPRESSANTS |
| DES Loratadine ODT | - | EXC | ANTIHISTAMINES |
| DES Loratadine SOLN | - | EXC | ANTIHISTAMINES |
| desloratadine tab (CLARINEX equiv) | - | EXC | ANTIHISTAMINES |
| desmopressin acetate nasal spray (DDAVP equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| desmopressin acetate tab (DDAVP equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| DESMOPRESSIN NASAL SPRAY | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| DESONATE GEL | - | NC | DERMATOLOGICALS |
| desonide cream (DESOWEN equiv) | - | 1 | DERMATOLOGICALS |
| desonide gel | - | NC | DERMATOLOGICALS |
| desonide lotion (DESOWEN equiv) | - | NC | DERMATOLOGICALS |
| desonide oint (DESOWEN equiv) | - | 1 | DERMATOLOGICALS |
| DESOWEN CREAM | - | NC | DERMATOLOGICALS |
| DESOWEN CREAM KIT | - | NC | DERMATOLOGICALS |
| DESOWEN LOTION | - | NC | DERMATOLOGICALS |
| DESOWEN LOTION KIT | - | NC | DERMATOLOGICALS |
| DESOWEN OINT | - | NC | DERMATOLOGICALS |
| DESOWEN OINT KIT | - | NC | DERMATOLOGICALS |
| desoximetasone cream (TOPICORT CREAM equiv) | - | 1 | DERMATOLOGICALS |
| desoximetasone cream 0.05% (TOPICORT equiv) | - | NC | DERMATOLOGICALS |
| DESOXIMETASONE GEL | - | NC | DERMATOLOGICALS |
| desoximetasone oint (TOPICORT equiv) | - | 1 | DERMATOLOGICALS |
| desoximetasone oint 0.05% (TOPICORT equiv) | - | NC | DERMATOLOGICALS |
| desvenlafaxine ER tab (PRISTIQ equiv) | - | 1 | ANTIDEPRESSANTS |
| DESVENLAFAXINE ER TAB | - | NC | ANTIDEPRESSANTS |
| DEXAMETHASONE CONC | - | 1 | CORTICOSTEROIDS |
| dexamethasone elixir | - | 1 | CORTICOSTEROIDS |
| dexamethasone pak (DEXPAK equiv) | - | NC | CORTICOSTEROIDS |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| DEXAMETHASONE PHOSPHATE INJ | - | 1 | CORTICOSTEROIDS |
| DEXAMETHASONE SODIUM PHOSPHATE INJ | - | 1 | CORTICOSTEROIDS |
| DEXAMETHASONE SOLN | - | 1 | CORTICOSTEROIDS |
| dexamethasone tab (DECADRON equiv) | - | 1 | CORTICOSTEROIDS |
| DEXAMETHASONE TAB | - | NC | CORTICOSTEROIDS |
| DEXCOM G6 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXCOM G6 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXCOM G6 TRANSMITTER (QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXCOM G7 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXCOM G7 SENSOR (QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXCOM G7 SENSOR (15-DAY) (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| DEXILANT DR CAP | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| dexlansoprazole DR cap (DEXILANT equiv) | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| dexmethylphenidate ER cap (FOCALIN XR equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dexmethylphenidate tab (FOCALIN equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| DEXPAK TAB | - | NC | CORTICOSTEROIDS |
| DEXTENZA OPPTH INSERT | - | NC | OPHTHALMIC AGENTS |
| dextroamphetamine ER cap (DEXEDRINE equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine soln (PROCENTRA equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine sulfate tab 15mg (ZENZEDI equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine sulfate tab 20mg (ZENZEDI equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine sulfate tab 30mg (ZENZEDI equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| dextroamphetamine tab (DEXEDRINE equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| DHIVY TAB | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| DIABETIC METER (all other diabetic meters) | OTC | NC | MEDICAL DEVICES AND SUPPLIES |
| DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479) | LD-PA | 2 | ANTICONVULSANTS |
| DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479) | LD-PA | 2 | ANTICONVULSANTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| DIALYVITE TAB | - | 1 | MULTIVITAMINS |
| dialyvite tab (NEPHRO-VITE equiv) | - | NC | MULTIVITAMINS |
| DIALYVITE/ZINC TAB | - | 1 | MULTIVITAMINS |
| DIAPHRAGM | - | \$0 | MEDICAL DEVICES AND SUPPLIES |
| DIASTAT ACDL GEL (QL= 4 doses/fill) | QL | 3 | ANTICONVULSANTS |
| DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 4 doses/fill) | QL | 2 | ANTICONVULSANTS |
| diazepam conc (VALIUM equiv) | - | 1 | ANTIANKXIETY AGENTS |
| DIAZEPAM GEL (QL= 4 doses/fill) | QL | 2 | ANTICONVULSANTS |
| diazepam oral soln 5mg/5ml (DIAZEPAM equiv) | - | 1 | ANTIANKXIETY AGENTS |
| diazepam rectal gel (QL= 4 doses/fill) | QL | 1 | ANTICONVULSANTS |
| diazepam tab (VALIUM equiv) | - | 1 | ANTIANKXIETY AGENTS |
| diazoxide susp (PROGLYCEM equiv) | - | 1 | ANTIDIABETICS |
| dichlorphenamide tab (KEVEYIS equiv) | - | NC | DIURETICS |
| DICLOFENAC CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days) | PA-QL | 1 | DERMATOLOGICALS |
| diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill; Rx Only) | QL | 1 | DERMATOLOGICALS |
| DICLOFENAC PATCH, FLECTOR PATCH | - | NC | DERMATOLOGICALS |
| diclofenac potassium (migraine) packet (CAMBIA equiv) | - | NC | MIGRAINE PRODUCTS |
| diclofenac potassium cap (ZIPSOR equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac potassium tab (CATAFLAM equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac potassium tab 25mg (DICLOFENAC equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac sodium EC tab (VOLTAREN equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac sodium gel kit (VENNGEL equiv) | - | NC | DERMATOLOGICALS |
| diclofenac sodium ophth soln (VOLTAREN equiv) | - | 1 | OPHTHALMIC AGENTS |
| diclofenac sodium soln 2% (PENNSAID equiv) | - | NC | DERMATOLOGICALS |
| diclofenac sodium XR tab (VOLTAREN XR equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| diclofenac soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill) | QL | 1 | DERMATOLOGICALS |
| diclofenac/misoprostol DR tab (ARTHROTEC equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| DICLONA GEL | - | NC | DERMATOLOGICALS |
| DICLOTREX PAK | - | NC | DERMATOLOGICALS |
| dicloxacillin cap (DYNAPEN equiv) | - | 1 | PENICILLINS |
| dicyclomine cap (BENTYL equiv) | - | 1 | ULCER DRUGS |
| dicyclomine soln (BENTYL equiv) | - | 1 | ULCER DRUGS |
| dicyclomine tab (BENTYL equiv) | - | 1 | ULCER DRUGS |
| DICYCLOMINE TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| DIETHYLPROPION ER TAB | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| diethylpropion tab | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| DIFFERIN LOTION | - | NC | DERMATOLOGICALS |
| DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 2 | MACROLIDES |
| DIFICID TAB (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 2 | MACROLIDES |
| DIFLORASONE CREAM | - | NC | DERMATOLOGICALS |
| DIFLORASONE CREAM, PSORCON CREAM | - | NC | DERMATOLOGICALS |
| diflorasone oint | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| diflunisal tab (DOLOBID equiv) | - | 1 | ANALGESICS - NONNARCOTIC |
| difluprednate ophth emulsion (DUREZOL equiv) | - | 1 | OPHTHALMIC AGENTS |
| digoxin soln (LANOXIN equiv) | - | 1 | CARDIOTONICS |
| DIGOXIN SOLN 0.05MG/ML | - | 1 | CARDIOTONICS |
| digoxin tab (LANOXIN equiv) | - | 1 | CARDIOTONICS |
| digoxin tab 62.5mcg (LANOXIN equiv) | - | NC | CARDIOTONICS |
| dihydroergotamine mesylate inj (D.H.E. equiv) | - | NC | MIGRAINE PRODUCTS |
| dihydroergotamine mesylate nasal spray (MIGRANAL equiv) | - | NC | MIGRAINE PRODUCTS |
| DILANTIN CAP 30MG | - | 2 | ANTICONVULSANTS |
| diltiazem ER cap (CARDIZEM CD equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| diltiazem ER cap (CARDIZEM SR equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| diltiazem ER cap (DILACOR XR equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| diltiazem ER cap (TIAZAC equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| diltiazem ER tab (CARDIZEM LA equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| diltiazem tab (CARDIZEM equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| dimethyl fumarate DR cap (TECFIDERA equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| DIPENTUM CAP | - | 3 | GASTROINTESTINAL AGENTS - MISC. |
| diphenhydramine inj (BENADRYL equiv) | - | 1 | ANTIHISTAMINES |
| DIPHENOXYLATE/ATROPINE LIQUID | - | 3 | ANTIDIARRHEAL/PROBIOTIC AGENTS |
| diphenoxylate/atropine tab (LOMOTIL equiv) | - | 1 | ANTIDIARRHEALS |
| DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ | VAC | \$0 | TOXOIDS |
| dipyridamole tab (PERSANTINE equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| DISKETTS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| disopyramide cap (NORPACE equiv) | - | 1 | ANTIARRHYTHMICS |
| disulfiram tab (ANTABUSE equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| disulfiram tab 500mg | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| DIURIL SUSP | - | 2 | DIURETICS |
| divalproex ER tab (DEPAKOTE ER equiv) | - | 1 | ANTICONVULSANTS |
| divalproex sodium DR tab (DEPAKOTE equiv) | - | 1 | ANTICONVULSANTS |
| divalproex sprinkle cap (DEPAKOTE equiv) | - | 1 | ANTICONVULSANTS |
| DIVIGEL GEL | - | NC | ESTROGENS |
| DIVIGEL GEL, ELESTRIN GEL | - | NC | ESTROGENS |
| dofetilide cap (TIKOSYN equiv) | - | 1 | ANTIARRHYTHMICS |
| DOJOLVI ORAL LIQUID | - | NC | NUTRIENTS |
| DOLGIC PLUS TAB | - | NC | ANALGESICS - NONNARCOTIC |
| DOLOBID TAB | - | NC | ANALGESICS - NONNARCOTIC |
| donepezil ODT (ARICEPT equiv) (QL= 1 tab/day) | QL | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| donepezil tab (ARICEPT equiv) (QL= 2 tabs/day) | QL | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day) | QL | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| DONNATAL ELIXIR, PB-BELLADONNA ELIXIR | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| DONNATAL TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | HEMATOPOIETIC AGENTS |
| DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | HEMATOPOIETIC AGENTS |
| DORYX MPC TAB | - | NC | TETRACYCLINES |
| dorzolamide ophth soln (TRUSOPT equiv) | - | 1 | OPHTHALMIC AGENTS |
| dorzolamide/timolol (pf) ophth soln (COSOPT equiv) | - | 1 | OPHTHALMIC AGENTS |
| DORZOLAMIDE/TIMOLOL OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| DOVATO TAB | - | 2 | ANTIVIRALS |
| doxazosin tab (CARDURA equiv) | - | 1 | ANTIHYPERTENSIVES |
| doxepin cap (SINEQUAN equiv) | - | 1 | ANTIDEPRESSANTS |
| doxepin conc (SINEQUAN equiv) | - | 1 | ANTIDEPRESSANTS |
| DOXEPIN HCL CONC | - | 1 | ANTIDEPRESSANTS |
| doxepin hcl cream | - | NC | DERMATOLOGICALS |
| doxepin tab (SILENOR equiv) | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| DOXERCALCIFEROL CAP | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| doxercalciferol cap (HECTOROL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| doxycycline (rosacea) cap delayed release (ORACEA equiv) | - | NC | DERMATOLOGICALS |
| doxycycline hyclate cap (VIBRAMYCIN equiv) | - | 1 | TETRACYCLINES |
| doxycycline hyclate DR tab (DORYX equiv) | - | NC | TETRACYCLINES |
| doxycycline hyclate tab (VIBRATAB equiv) | - | 1 | TETRACYCLINES |
| doxycycline hyclate tab (TARGADOX equiv) | - | NC | TETRACYCLINES |
| doxycycline hyclate tab 75mg, 150mg | - | NC | TETRACYCLINES |
| doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv) | - | NC | TETRACYCLINES |
| doxycycline monohydrate cap 150mg (MONODOX equiv) | - | NC | TETRACYCLINES |
| doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv) | - | 1 | TETRACYCLINES |
| doxycycline monohydrate cap 75mg (MONODOX equiv) | - | NC | TETRACYCLINES |
| doxycycline monohydrate tab (ADOXA equiv) | - | 1 | TETRACYCLINES |
| doxycycline monohydrate tab 150mg (ADOXA equiv) | - | NC | TETRACYCLINES |
| doxycycline susp (VIBRAMYCIN equiv) | - | 1 | TETRACYCLINES |
| doxylamine/pyridoxine dr tab (DICLEGIS equiv) | - | NC | ANTIEMETICS |
| D-PENAMINE TAB | - | 2 | ASSORTED CLASSES |
| DRIZALMA DR CAP | - | NC | ANTIDEPRESSANTS |
| dronabinol cap (MARINOL equiv) | PA | 1 | ANTIEMETICS |
| drosiprenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv) | - | \$0 | CONTRACEPTIVES |
| DROXIA CAP | - | 2 | HEMATOPOIETIC AGENTS |
| droxidopa cap (NORTHERA equiv) | - | NC | VASOPRESSORS |
| DRYSOL SOLN | - | 1 | DERMATOLOGICALS |
| DSUVIA SL TAB | - | NC | ANALGESICS - OPIOID |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| DUAKLIR INHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| DUETACT TAB | - | NC | ANTIDIABETICS |
| DULERA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| duloxetine cap 40mg (IRENKA equiv) | - | NC | ANTIDEPRESSANTS |
| duloxetine EC cap (CYMBALTA equiv) | - | 1 | ANTIDEPRESSANTS |
| DULOXICAININE PACK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| DUOBRII LOTION | - | NC | DERMATOLOGICALS |
| DUOPA ENTERAL SUSP | - | NC | ANTIPARKINSON AGENTS |
| DUOVISC KIT | - | NC | OPHTHALMIC AGENTS |
| DUPIXENT INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| DUPIXENT PEN INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| DURAVENT PE TAB | - | NC | COUGH/COLD/ALLERGY |
| dutasteride cap (AVODART equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| dutasteride/tamsulosin cap (JALYN equiv) | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| DUTOPROL TAB | - | NC | ANTIHYPERTENSIVES |
| DUVYZAT ORAL SUSP | - | NC | NEUROMUSCULAR AGENTS |
| DUZALLO TAB | - | NC | GOUT AGENTS |
| DXEVO 11-DAY PAK | - | NC | CORTICOSTEROIDS |
| DYANAVAL XR CHEW | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| DY-O-DERM SOLN | OTC | EXC | DERMATOLOGICALS |
| DYRENIUM CAP | - | 3 | DIURETICS |
| E.E.S. TAB | - | 1 | MACROLIDES |
| EBGLYSS INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| EBGLYSS PEN INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| EB-N3 DR CAP | - | NC | MULTIVITAMINS |
| ECONASIL KIT | - | NC | DERMATOLOGICALS |
| econazole cream (SPECTAZOLE equiv) | - | 1 | DERMATOLOGICALS |
| ECONAZOLE NITRATE FOAM, ECOZA FOAM | - | NC | DERMATOLOGICALS |
| ECOZA FOAM | - | NC | DERMATOLOGICALS |
| EDARBI TAB | - | NC | ANTIHYPERTENSIVES |
| EDARBYCLOR TAB | - | NC | ANTIHYPERTENSIVES |
| EDEX INJ | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| EDLUAR SL TAB | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| EDURANT PED TAB | - | 2 | ANTIVIRALS |
| EDURANT TAB | - | 2 | ANTIVIRALS |
| EFAVIRENZ CAP | - | 1 | ANTIVIRALS |
| efavirenz tab (SUSTIVA equiv) | - | 1 | ANTIVIRALS |
| efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) | - | 1 | ANTIVIRALS |
| efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv) | - | 1 | ANTIVIRALS |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB | - | 1 | ANTIVIRALS |
| EFFER-K TAB | - | 1 | MINERALS & ELECTROLYTES |
| EGATEN TAB | - | NC | ANTHELMINTICS |

DRAFT

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| EGRIFTA INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| EGRIFTA WR KIT | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| EKTERLY TAB | - | EXC | HEMATOLOGICAL AGENTS - MISC. |
| ELEPSIA XR TAB | - | NC | ANTICONVULSANTS |
| eletriptan tab (RELPAQ equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| ELIGEN B12 TAB | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| ELIQUIS SPRINKLE CAP | - | 2 | ANTICOAGULANTS |
| ELIQUIS TAB FOR ORAL SUSP | - | 2 | ANTICOAGULANTS |
| ELIQUIS TAB, ELIQUIS STARTER PACK | - | 2 | ANTICOAGULANTS |
| ELIXOPHYLLIN ELIXIR | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ELLA TAB | - | \$0 | CONTRACEPTIVES |
| ELMIRON CAP | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| ELOCTATE INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day) | LMSP-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| eltrombopag olamine tab (PROMACTA equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| eltrombopag olamine tab 50MG (PROMACTA equiv) (QL= 2 tabs/day) | LMSP-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| eltrombopag olamine tab 75MG (PROMACTA equiv) (QL= 2 tabs/day) | LMSP-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| eluryng vaginal ring (NUVARING equiv) | - | \$0 | CONTRACEPTIVES |
| ELYXYB SOLN | - | NC | MIGRAINE PRODUCTS |
| EMBECTA INSULIN SYRINGE | --OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| EMBECTA PEN NEEDLE | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| EMEND SUSP | - | NC | ANTIEMETICS |
| EMFLAZA SUSP | - | NC | CORTICOSTEROIDS |
| EMFLAZA TAB | - | NC | CORTICOSTEROIDS |
| EMGALITY INJ (QL= 1 inj/28 days) | PA-QL | 2 | MIGRAINE PRODUCTS |
| EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year) | PA-QL | 2 | MIGRAINE PRODUCTS |
| EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| EMROSI CAP | - | NC | DERMATOLOGICALS |
| EMSAM PATCH | - | 3 | ANTIDEPRESSANTS |
| emtricitabine cap (EMTRIVA equiv) | - | 1 | ANTIVIRALS |
| emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv) | - | \$0 | ANTIVIRALS |
| emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv) | - | 1 | ANTIVIRALS |
| EMTRIVA CAP | - | 3 | ANTIVIRALS |
| EMTRIVA SOLN | - | 2 | ANTIVIRALS |
| EMVERM TAB | - | NC | ANTHELMINTICS |
| enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTIHYPERTENSIVES |
| enalapril tab (VASOTEC equiv) | - | 1 | ANTIHYPERTENSIVES |
| enalapril/hydrochlorothiazide tab (VASERETIC equiv) | - | 1 | ANTIHYPERTENSIVES |
| ENBREL INJ 25MG (QL= 8 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ENBREL INJ 50MG (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ENBREL MINI INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ENBUMYST SOLN | - | NC | DIURETICS |
| ENDARI POWDER PACKET | - | NC | HEMATOPOIETIC AGENTS |
| ENDOMETRIN INSERT | PA | 2 | VAGINAL PRODUCTS |
| ENDOMETRIN SUPP | PA | 2 | VAGINAL AND RELATED PRODUCTS |
| ENFLONIA INJ | VAC | \$0 | PASSIVE IMMUNIZING AND TREATMENT AGENTS |
| ENGERIX-B INJ, RECOMBIVAX-HB INJ | VAC | \$0 | VACCINES |
| enoxaparin inj (LOVENOX equiv) | - | 1 | ANTICOAGULANTS |
| enpresse tab (TRI-LEVELLEN equiv) | - | \$0 | CONTRACEPTIVES |
| ENSACOVE CAP | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ENSPRYNG INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| ENSTILAR FOAM | - | NC | DERMATOLOGICALS |
| entacapone tab (COMTAN equiv) | - | 1 | ANTIPARKINSON AGENTS |
| ENTADFI CAP | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| entecavir tab (BARACLUDE equiv) (QL= 1 tab/day) | QL | 1 | ANTIVIRALS |
| ENTEREG CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ENTRESTO CAP | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| ENTYVIO SC INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| ENVARUS XR TAB | - | NC | ASSORTED CLASSES |
| EOHILIA SUSP | - | NC | CORTICOSTEROIDS |
| EPCLUSA PAK | - | NC | ANTIVIRALS |
| EPCLUSA TAB | - | NC | ANTIVIRALS |
| EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553) | LD-PA | 2 | ANTICONVULSANTS |
| EPIDUO FORTE GEL 0.3-2.5% | - | 3 | DERMATOLOGICALS |
| EPIDUO GEL 0.1-2.5% | - | 3 | DERMATOLOGICALS |
| EPIFOAM AEROSOL | - | 2 | DERMATOLOGICALS |
| epinastine ophth soln (ELESTAT equiv) | - | 1 | OPHTHALMIC AGENTS |
| epinephrine hcl nasal soln (ADRENALIN equiv) | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| epinephrine pen inj 0.15mg, 0.3mg (EPIPEN (JR) equiv) (QL= 2 inj/fill) | QL | 1 | VASOPRESSORS |
| EPIPEN (JR) INJ | - | NC | VASOPRESSORS |
| EPIVIR HBV SOLN | - | 2 | ANTIVIRALS |
| eplerenone tab (INSPRA equiv) | - | 1 | ANTIHYPERTENSIVES |
| EPRONTIA SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTICONVULSANTS |
| EPSOLAY CREAM | - | NC | DERMATOLOGICALS |
| EQUETRO CAP | - | 2 | ANTI-PSYCHOTICS/ANTI-MANIC AGENTS |
| ERGOCAL CAP | - | NC | VITAMINS |
| ERGOLOID MESYLATES TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ERGOMAR SL TAB | - | NC | MIGRAINE PRODUCTS |
| ERGOTAMINE/CAFFEINE TAB | - | NC | MIGRAINE PRODUCTS |
| ergotamine/caffeine tab (CAFERGOT equiv) | - | NC | MIGRAINE PRODUCTS |
| ERIVEDGE CAP (QL= 1 cap/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ERLEADA TAB (QL= 4 tabs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| ERLEADA TAB 240MG (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| erlotinib tab (TARCEVA equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| erlotinib tab 25mg (TARCEVA equiv) (QL= 3 tabs/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ERMEZA SOLN 150 MCG/5ML | - | NC | THYROID AGENTS |
| ERTACZO CREAM | - | 3 | DERMATOLOGICALS |
| ERY PAD | - | 2 | DERMATOLOGICALS |
| ERYTHROMYCIN CAP DR | - | 2 | MACROLIDES |
| erythromycin DR cap (ERYC equiv) | - | 1 | MACROLIDES |
| ERYTHROMYCIN EC CAP | - | 2 | MACROLIDES |
| erythromycin ethylsuccinate susp (ERYPED equiv) | - | 1 | MACROLIDES |
| erythromycin ethylsuccinate tab (E.E.S. equiv) | - | 1 | MACROLIDES |
| erythromycin gel | - | NC | DERMATOLOGICALS |
| erythromycin ophth oint | - | 1 | OPHTHALMIC AGENTS |
| ERYTHROMYCIN OPHTH OINT | - | NC | OPHTHALMIC AGENTS |
| erythromycin pad | - | 1 | DERMATOLOGICALS |
| erythromycin soln | - | 1 | DERMATOLOGICALS |
| erythromycin tab (ERY-TAB equiv) | - | 1 | MACROLIDES |
| erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE) | - | 1 | MACROLIDES |
| erythromycin/benzoyl peroxide gel | - | 1 | DERMATOLOGICALS |
| ESCITALOPRAM CAP | - | NC | ANTIDEPRESSANTS |
| escitalopram soln (LEXAPRO equiv) | - | 1 | ANTIDEPRESSANTS |
| escitalopram tab (LEXAPRO equiv) | - | 1 | ANTIDEPRESSANTS |
| ESGIC TAB | - | NC | ANALGESICS - NONNARCOTIC |
| ESKATA SOLN | - | NC | DERMATOLOGICALS |
| eslicarbazepine acetate tab (APTiom equiv) | - | NC | ANTICONVULSANTS |
| esomeprazole cap (NEXIUM equiv) | OTC | 1 | ULCER DRUGS |
| esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| ESOMEPRAZOLE-EZS KIT | - | NC | ULCER DRUGS |
| ESPEROCT INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| estazolam tab (PROSOM equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| esterified estrogens/methyltestosterone tab (ESTRATEST equiv) | - | 1 | ESTROGENS |
| ESTRACE VAGINAL CREAM | - | 3 | VAGINAL PRODUCTS |
| estradiol cream (ESTRACE equiv) | - | 1 | VAGINAL PRODUCTS |
| estradiol patch (CLIMARA equiv) | - | 1 | ESTROGENS |
| estradiol patch (VIVELLE-DOT, MINIVELLE equiv) | - | 1 | ESTROGENS |
| estradiol tab (ESTRACE equiv) | - | 1 | ESTROGENS |
| estradiol td gel (DIVIGEL equiv) | - | NC | ESTROGENS |
| estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill) | QL | 1 | VAGINAL PRODUCTS |
| estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill) | QL | 1 | ESTROGENS |
| estradiol/norethindrone tab (ACTIVELLA equiv) | - | 1 | ESTROGENS |
| ESTRING (3 copays per Rx) | - | 2 | VAGINAL PRODUCTS |
| estrogens, conjugated tab (PREMARIN equiv) | - | 1 | ESTROGENS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day) | QL | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| ethacrynic tab (EDECIN equiv) | - | 1 | DIURETICS |
| ethambutol tab (MYAMBUTOL equiv) | - | 1 | ANTIMYCOBACTERIAL AGENTS |
| ethosuximide cap (ZARONTIN equiv) | - | 1 | ANTICONVULSANTS |
| ethosuximide soln (ZARONTIN equiv) | - | 1 | ANTICONVULSANTS |
| etodolac cap (LODINE equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| etodolac ER tab (LODINE XL equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| etodolac tab | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ETOPOSIDE CAP | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| etravirine tab (INTELENCE equiv) | - | 1 | ANTIVIRALS |
| EUCRISA OINT | - | NC | DERMATOLOGICALS |
| EULEXIN CAP | - | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| EVAMIST SPRAY | - | NC | ESTROGENS |
| EVEKEO ODT | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| everolimus tab (AFINITOR equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| everolimus tab (ZORTRESS equiv) | PA | 1 | MISCELLANEOUS THERAPEUTIC CLASSES |
| everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| EVIVO LIQUID | - | NC | ANTIDIARRHEALS |
| EVOCLIN FOAM | - | NC | DERMATOLOGICALS |
| EVOTAZ TAB | - | 2 | ANTIVIRALS |
| EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | NEUROMUSCULAR AGENTS |
| EVRYSDI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | NEUROMUSCULAR AGENTS |
| EVZIO INJ | - | NC | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| EVZIO INJ | - | NC | ANTIDOTES |
| EXELDERM CREAM, SULCONAZOLE CREAM | - | 3 | DERMATOLOGICALS |
| EXELDERM SOLN | - | 3 | DERMATOLOGICALS |
| EXELDERM SOLN, SULCONAZOLE SOLN | - | 3 | DERMATOLOGICALS |
| exemestane tab (AROMASIN equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| EXENATIDE INJ (BYETTA INJ EQUIV) | - | NC | ANTIDIABETICS |
| EXTAVIA INJ | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| EXXUA TAB/EXXUA TITRATION PACK | - | EXC | ANTIDEPRESSANTS |
| EYSUVIS OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| EZALLOR SPRINKLE CAP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTIHYPERTENSIVES |
| ezetimibe tab (ZETIA equiv) | - | 1 | ANTIHYPERTENSIVES |
| EZETIMIBE/ATORVASTATIN TAB | - | NC | ANTIHYPERTENSIVES |
| ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered)) | QL | 1 | ANTIHYPERTENSIVES |
| ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage) | - | NC | ANTIHYPERTENSIVES |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| FABHALTA CAP | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| FABIOR AEROSOL FOAM | - | NC | DERMATOLOGICALS |
| FACTIVE TAB | - | NC | FLUOROQUINOLONES |
| FALESSA KIT | - | NC | CONTRACEPTIVES |
| FALESSA TAB | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| famciclovir tab (FAMVIR equiv) | - | 1 | ANTIVIRALS |
| famotidine susp (PEPCID equiv) | - | 1 | ULCER DRUGS |
| famotidine tab (PEPCID equiv) (Rx Only) | - | 1 | ULCER DRUGS |
| FANAPT TAB | - | NC | ANTIpsychOTICS/ANTIMANIC AGENTS |
| FANAPT TITRATION PACK | - | NC | ANTIpsychOTICS/ANTIMANIC AGENTS |
| FANAPT TITRATION PACK 1MG/2MG/6MG/8MG | - | NC | ANTIpsychOTICS/ANTIMANIC AGENTS |
| FARXIGA TAB (QL= 1 tab/day) | QL | 2 | ANTI DIABETICS |
| FASENRA PEN INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 | ANTI ASTHMATIC AND BRONCHODILATOR AGENTS |
| febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol) | ST | 1 | GOUT AGENTS |
| FEIBA INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| felbamate susp (FELBATOL equiv) | - | 1 | ANTICONVULSANTS |
| felbamate tab (FELBATOL equiv) | - | 1 | ANTICONVULSANTS |
| felodipine ER tab (PLENDIL equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| FEM PH GEL | - | 3 | VAGINAL PRODUCTS |
| FEMALE CONDOMS (QL= 12 condoms/fill) | OTC-QL | \$0 | MEDICAL DEVICES AND SUPPLIES |
| FEMLYV TAB | - | \$0 | CONTRACEPTIVES |
| FEMRING (3 copays per Rx) | - | 3 | VAGINAL PRODUCTS |
| fenofibrate cap 43mg, 130mg (ANTARA equiv) | - | NC | ANTIHYPERLIPIDEMICS |
| fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| FENOFIBRATE CAP, LIPOFEN CAP | - | NC | ANTIHYPERLIPIDEMICS |
| FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG | - | NC | ANTIHYPERLIPIDEMICS |
| fenofibrate tab 40mg, 120mg (FENOGLIDE equiv) | - | NC | ANTIHYPERLIPIDEMICS |
| fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| fenofibric acid DR cap (TRILIPIX equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| FENOFIBRIC TAB | - | 3 | ANTIHYPERLIPIDEMICS |
| FENOFIBRIC TAB, FIBRICOR TAB | - | 3 | ANTIHYPERLIPIDEMICS |
| fenopropfen calcium cap (NALFON equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| FENOPROFEN CAP, NAFLON CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| FENOPROFEN TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| FENOPRON CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| FENTANYL BUCCAL TAB | - | NC | ANALGESICS - OPIOID |
| FENTANYL CITRATE LOLLIPOP | - | NC | ANALGESICS - OPIOID |
| fantanyl citrate lollipop (ACTIQ equiv) | - | NC | ANALGESICS - OPIOID |
| fantanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| fantanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv) | - | NC | ANALGESICS - OPIOID |
| FENTORA TAB | - | NC | ANALGESICS - OPIOID |
| FEONYX TAB | - | NC | HEMATOPOIETIC AGENTS |
| FERIVA 21/7 TAB | - | NC | HEMATOPOIETIC AGENTS |
| FEROTRINSIC CAP | - | 1 | HEMATOPOIETIC AGENTS |
| ferrex 150 forte cap | - | 1 | HEMATOPOIETIC AGENTS |
| FERRIC CITRATE TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071) | LD-PA | 2 | ANTIDOTES |
| FERRO-PLEX TAB | - | NC | HEMATOPOIETIC AGENTS |
| ferrous sulfate elixir | OTC | NC | HEMATOPOIETIC AGENTS |
| FERROUS SULFATE LIQUID | OTC | NC | HEMATOPOIETIC AGENTS |
| ferrous sulfate soln | OTC | NC | HEMATOPOIETIC AGENTS |
| ferrous sulfate SR tab | OTC | NC | HEMATOPOIETIC AGENTS |
| ferrous sulfate tab | OTC | NC | HEMATOPOIETIC AGENTS |
| fesoterodine fumarate ER tab (TOVIAZ equiv) | - | 1 | URINARY ANTISPASMODICS |
| FETZIMA CAP | - | NC | ANTIDEPRESSANTS |
| FETZIMA TITRATION PACK | - | NC | ANTIDEPRESSANTS |
| fexofenadine susp (ALLEGRA equiv) | OTC | EXC | ANTIHISTAMINES |
| fexofenadine tab (ALLEGRA equiv) | OTC | EXC | ANTIHISTAMINES |
| fexofenadine/pseudoephedrine 12-hour tab (ALLEGRA-D 12 hour equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| fexofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| FIASP FLEXTOUCH INJ | - | NC | ANTIDIABETICS |
| FIASP INJ | - | NC | ANTIDIABETICS |
| FIASP PENFILL INJ, FIASP PUMP CARTRIDGE | - | NC | ANTIDIABETICS |
| FIBRIK CAP | - | NC | MULTIVITAMINS |
| FIBRYGA, RIASTAP INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 1 | MACROLIDES |
| FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |
| FILSUVEZ GEL | - | NC | DERMATOLOGICALS |
| FINACEA FOAM | - | 2 | DERMATOLOGICALS |
| FINACEA GEL | - | 3 | DERMATOLOGICALS |
| finasteride tab (PROSCAR equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| finasteride tab (PROPECIA equiv) | - | EXC | DERMATOLOGICALS |
| fingolimod hcl cap 0.5mg (GILENYA equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 | ANTICONVULSANTS |
| FIORICET CAP | - | NC | ANALGESICS - NONNARCOTIC |
| FIORICET/CODEINE CAP | - | NC | ANALGESICS - OPIOID |
| FIORINAL CAP | - | NC | ANALGESICS - NONNARCOTIC |
| FIORINAL/CODEINE CAP | - | NC | ANALGESICS - OPIOID |
| FIRAZYR INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| FIRDAPSE TAB (Only available through AnovoRx 844-288-5007) | LD-PA | 2 | ANTIMYASTHENIC/CHOLINERGIC AGENTS |
| FIRST METRONIDAZOLE SUSP | - | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| FIRST MOUTHWASH BLM | - | 3 | MOUTH/THROAT/DENTAL AGENTS |
| FIRST OMEPRAZOLE SUSP | - | NC | ULCER DRUGS |
| FIRST PANTOPRAZOLE SUSP | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| FIRVANQ SOLN 25MG/ML | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| FIRVANQ SOLN 50MG/ML | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| FLAREX OPHTH SUSP | - | 3 | OPHTHALMIC AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| flavoxate tab (URISPAS equiv) | - | NC | URINARY ANTISPASMODICS |
| flecainide tab (TAMBOCOR equiv) | - | 1 | ANTIARRHYTHMICS |
| FLOLIPID SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTIHYPERTENSIVES |
| FLONASE SENSIMIST NASAL SPRAY | OTC | EXC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| FLO-PRED SUSP | - | NC | CORTICOSTEROIDS |
| FLORIVA CHEW TAB | - | \$0 | MULTIVITAMINS |
| FLORIVA DROPS | - | \$0 | MINERALS & ELECTROLYTES |
| FLORIVA PLUS DROPS | - | NC | MULTIVITAMINS |
| FLOVENT DISKUS INHALER | - | 3 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLOVENT HFA INHALER | - | 3 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUAD INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| FLUBLOK INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| FLUCELVAX INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| fluconazole susp (DIFLUCAN equiv) | - | 1 | ANTIFUNGALS |
| fluconazole tab (DIFLUCAN equiv) | - | 1 | ANTIFUNGALS |
| flucytosine cap (ANCOBON equiv) | - | 1 | ANTIFUNGALS |
| fludrocortisone tab (FLORINEF equiv) | - | 1 | CORTICOSTEROIDS |
| FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| FLUMIST NASAL (QL= 1 dose/28 days) | QL-VAC | \$0 | VACCINES |
| flunisolide nasal soln (QL= 2 bottles/fill) | QL | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| fluocinolone acetonide cream | - | 1 | DERMATOLOGICALS |
| fluocinolone acetonide oil | - | 1 | DERMATOLOGICALS |
| fluocinolone acetonide oint | - | 1 | DERMATOLOGICALS |
| fluocinolone acetonide soln | - | 1 | DERMATOLOGICALS |
| fluocinolone otic oil (DERMOTIC equiv) | - | 1 | OTIC AGENTS |
| fluocinonide cream 0.05% (LIDEX equiv) | - | 1 | DERMATOLOGICALS |
| fluocinonide cream 0.1% (VANOS CREAM equiv) | - | 1 | DERMATOLOGICALS |
| fluocinonide emollient cream | - | 1 | DERMATOLOGICALS |
| fluocinonide gel | - | 1 | DERMATOLOGICALS |
| fluocinonide oint | - | 1 | DERMATOLOGICALS |
| fluocinonide soln | - | 1 | DERMATOLOGICALS |
| FLUOPAR KIT | - | NC | DERMATOLOGICALS |
| FLUORABON SOLN (\$0 copay for members age 5 years and younger; All other members covered at preferred brand copay) | - | \$0 | MINERALS & ELECTROLYTES |
| FLUORAC CREAM | - | NC | DERMATOLOGICALS |
| FLUORIDE CHW 0.25MG (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 | MINERALS & ELECTROLYTES |
| FLUORIDEX SENSITIVITY PASTE | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| fluorometholone ophth soln (FML LIQUIFILM equiv) | - | 1 | OPHTHALMIC AGENTS |
| fluorouracil cream (EFUDEX CREAM equiv) | - | 1 | DERMATOLOGICALS |
| FLUOROURACIL CREAM 0.5% | - | 3 | DERMATOLOGICALS |
| fluorouracil soln (FLUOROURACIL equiv) | - | 1 | DERMATOLOGICALS |
| FLUOROURACIL SOLN | - | 2 | DERMATOLOGICALS |
| FLUOVIX PAK | - | NC | DERMATOLOGICALS |
| fluoxetine cap (PROZAC equiv) | - | 1 | ANTIDEPRESSANTS |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| FLUOXETINE CAP (PMDD) | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| fluoxetine soln (PROZAC equiv) | - | 1 | ANTIDEPRESSANTS |
| fluoxetine tab (PROZAC equiv) | - | 1 | ANTIDEPRESSANTS |
| fluoxetine weekly cap (PROZAC equiv) | - | NC | ANTIDEPRESSANTS |
| fluphenazine tab (PROLIXIN equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| FLURANDRENOL LOTION | - | NC | DERMATOLOGICALS |
| flurandrenolide cream (CORDRAN equiv) | - | NC | DERMATOLOGICALS |
| flurandrenolide oint (CORDRAN equiv) | - | NC | DERMATOLOGICALS |
| FLURAZEPAM CAP | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| FLURBIPROFEN OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| FLURBIPROFEN TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| flurbiprofen tab (ANSAID equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| flutamide cap (EULEXIN equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| FLUTAMIDE CAP | - | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| FLUTICASONE DISKUS INHALER | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/AC | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/AC | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE HFA INHALER | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE LOTION | - | NC | DERMATOLOGICALS |
| fluticasone nasal spray (FLONASE equiv) (QL= 2 bottles/fill; Rx Only) | QL | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| fluticasone propionate cream (CUTIVATE equiv) | - | 1 | DERMATOLOGICALS |
| fluticasone propionate lotion (CUTIVATE equiv) | - | NC | DERMATOLOGICALS |
| fluticasone propionate oint (CUTIVATE equiv) | - | 1 | DERMATOLOGICALS |
| fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| fluvastatin cap (LESCOL equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| fluvastatin ER tab (LESCOL XL equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine) | ST | 1 | ANTIDEPRESSANTS |
| fluvoxamine tab (LUVOX equiv) | - | 1 | ANTIDEPRESSANTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days) | QL-VAC | \$0 | VACCINES |
| FML FORTE OPHTH SUSP | - | 3 | OPHTHALMIC AGENTS |
| FML S.O.P. OPHTH OINT | - | 3 | OPHTHALMIC AGENTS |
| FOLBEE PLUS CZ TAB | - | 1 | MULTIVITAMINS |
| folbee tab (FOLGARD RX equiv) | - | NC | HEMATOPOIETIC AGENTS |
| FOLGARD RX TAB | - | NC | HEMATOPOIETIC AGENTS |
| folic acid tab 1mg (\$0 copay for female members only; All other members covered at generic copay) | - | \$0 | HEMATOPOIETIC AGENTS |
| folic acid tab 400mcg (Covered for female members only) | OTC | \$0 | HEMATOPOIETIC AGENTS |
| folic acid tab 800mcg (Covered for female members only) | OTC | \$0 | HEMATOPOIETIC AGENTS |
| FOLIKA-V TAB | - | NC | MULTIVITAMINS |
| FOLITE TAB | - | NC | HEMATOPOIETIC AGENTS |
| FOLLISTIM AQ INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| FOLTANX TAB | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| FOLVITE-FE TAB | - | NC | HEMATOPOIETIC AGENTS |
| fondaparinux inj (ARIXTRA equiv) | - | 1 | ANTICOAGULANTS |
| FORFIVO XL TAB | - | NC | ANTIDEPRESSANTS |
| formoterol fumarate neb soln (PERFOROMIST equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| FORTAMET TAB | - | NC | ANTIDIABETICS |
| FORTEO INJ | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| FORTESTA GEL 2% | - | NC | ANDROGENS-ANABOLIC |
| FORZINITY INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| FOSAMAX+D TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| fosamprenavir tab (LEXIVA equiv) | - | 1 | ANTIVIRALS |
| fosfomycin tromethamine powder pack (MONUROL equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| fosinopril tab (MONOPRIL equiv) | - | 1 | ANTIHYPERTENSIVES |
| fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv) | - | 1 | ANTIHYPERTENSIVES |
| FOSRENOL CHEW TAB | - | 3 | GASTROINTESTINAL AGENTS - MISC. |
| FOSRENOL POWDER PACK | - | 2 | GASTROINTESTINAL AGENTS - MISC. |
| FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 3 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| FRAGMIN INJ | - | 3 | ANTICOAGULANTS |
| FRAICHE 5000 SENSITIVE GEL | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| FREESTYLE FREEDOM LITE METER | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE INSULINX TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| FREESTYLE LIBRE 2 RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE 2 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE 2-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE 3 READER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| FREESTYLE LIBRE 3 SENSOR (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE 3-PLUS SENSOR (QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE RECEIVER (QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LIBRE SENSOR (14-DAY) (QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin) | QL-ST | 2 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LITE METER | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE LITE TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| FREESTYLE PRECISION NEO METER | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| FREESTYLE PRECISION NEO TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| FREESTYLE TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| FROVA TAB | - | NC | MIGRAINE PRODUCTS |
| frovatriptan tab (FROVA equiv) | - | NC | MIGRAINE PRODUCTS |
| FRUZAQLA CAP 1MG (QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| FRUZAQLA CAP 5MG (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| FULPHILA INJ | LMSP | 2 | HEMATOPOIETIC AGENTS |
| FULVICIN P/G TAB | - | NC | ANTIFUNGALS |
| FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB | - | NC | ANTIFUNGALS |
| FUROSCIX KIT (QL= 8 inj/fill; Only available through Onco360 or CareMed 877-662-6633) | LD-QL | 2 | DIURETICS |
| FUROSEMIDE SOLN | - | 1 | DIURETICS |
| furosemide soln (LASIX equiv) | - | 1 | DIURETICS |
| furosemide tab (LASIX equiv) | - | 1 | DIURETICS |
| FUZEON INJ | - | NC | ANTIVIRALS |
| FYCOMPA TAB | - | NC | ANTICONVULSANTS |
| FYCOMPA SUSP | - | NC | ANTICONVULSANTS |
| FYLNETRA INJ | - | NC | HEMATOPOIETIC AGENTS |
| gabapentin (once-daily) tab (GRALISE equiv) | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day) | QL | 1 | ANTICONVULSANTS |
| gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day) | QL | 1 | ANTICONVULSANTS |
| gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day) | QL | 1 | ANTICONVULSANTS |
| gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day) | QL | 1 | ANTICONVULSANTS |
| GABAPENTIN/NAPROXEN CREAM COMPOUND KIT | - | NC | DERMATOLOGICALS |
| GABARONE TAB | - | NC | ANTICONVULSANTS |
| GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| galantamine ER cap (RAZADYNE ER equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| GALANTAMINE SOLN | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| galantamine tab (RAZADYNE equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| GALZIN CAP | - | NC | MINERALS & ELECTROLYTES |
| GANIRELIX AC INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| ganirelix ac inj (GANIRELIX equiv) | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| GARDASIL 9 INJ | VAC | \$0 | VACCINES |
| gatifloxacin ophth soln (ZYMAXID equiv) | - | 1 | OPHTHALMIC AGENTS |
| GATTEX KIT | PA | Non-EHB | GASTROINTESTINAL AGENTS - MISC. |
| GAVILYTE-C SOLN (\$0 copay for members age 45-75 years; all other members covered at preferred brand copay; Limited to 2 fills/calendar year) | QL | \$0 | LAXATIVES |
| GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GEAMETDRAY GEL | - | NC | DERMATOLOGICALS |
| gefitinib tab (IRESSA equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GELCLAIR GEL | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| gemfibrozil tab (LOPID equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| GEMTESA TAB | - | NC | URINARY ANTISPASMODICS |
| GEN7T LOTION | - | NC | DERMATOLOGICALS |
| GEN7T PAD 3.5% | - | NC | DERMATOLOGICALS |
| GEN7T PLUS LOTION | - | NC | DERMATOLOGICALS |
| GEN7T PLUS PAD | - | NC | DERMATOLOGICALS |
| GENOTROPIN INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| GENOTROPIN INJ 5MG | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| GENTAK OPHTH OINT | - | 1 | OPHTHALMIC AGENTS |
| gentamicin ophth soln (GARAMYCIN equiv) | - | 1 | OPHTHALMIC AGENTS |
| gentamicin sulfate cream | - | 1 | DERMATOLOGICALS |
| gentamicin sulfate oint | - | 1 | DERMATOLOGICALS |
| GENVOYA TAB | - | 2 | ANTIVIRALS |
| GIALAX KIT | - | NC | LAXATIVES |
| gianvi tab, ocella tab (YASMIN, YAZ equiv) | - | \$0 | CONTRACEPTIVES |
| GILENYA CAP 0.25MG | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| GILENYA CAP 0.5MG | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| GILOTRIF TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GIMOTI NASAL SPRAY | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| glatiramer inj (COPAXONE equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| GLEOSTINE CAP | - | 3 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| glimepiride tab (AMARYL equiv) | - | 1 | ANTIDIABETICS |
| GLIMEPIRIDE TAB | - | NC | ANTIDIABETICS |
| glipizide ER tab (GLUCOTROL XL equiv) | - | 1 | ANTIDIABETICS |
| glipizide tab (GLUCOTROL equiv) | - | 1 | ANTIDIABETICS |
| GLIPIZIDE TAB 2.5MG | - | NC | ANTIDIABETICS |
| glipizide/metformin tab (METAGLIP equiv) | - | 1 | ANTIDIABETICS |
| GLOPERBA SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | GOUT AGENTS |
| GLUCAGEN INJ | - | 2 | DIAGNOSTIC PRODUCTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| glucagon (rdna) for inj kit (QL= 2 inj/fill) | QL | 1 | ANTIDIABETICS |
| GLUCAGON DIAGNOSTIC INJ | - | NC | DIAGNOSTIC PRODUCTS |
| GLUCAGON EMR INJ (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |
| GLUCAGON INJ KIT (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |
| GLUMETZA TAB 1000MG | - | NC | ANTIDIABETICS |
| GLUMETZA TAB 500MG | - | NC | ANTIDIABETICS |
| GLYBURID MCR TAB | - | 1 | ANTIDIABETICS |
| glyburide tab (MICRONASE equiv) | - | 1 | ANTIDIABETICS |
| glyburide/metformin tab (GLUCOVANCE equiv) | - | 1 | ANTIDIABETICS |
| GLYCATE TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| GLYCATE TAB, GLYCOPYRROLATE TAB | - | NC | ULCER DRUGS |
| glycerol phenylbutyrate liquid (RAVICTI equiv) | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| glycopyrrolate oral soln (CUVPOSA equiv) | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| glycopyrrolate tab (ROBINUL equiv) | - | 1 | ULCER DRUGS |
| GLYGEST PAK | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| GLYXAMBI TAB (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| GOCOVRI CAP | - | NC | ANTIPARKINSON AGENTS |
| GOLYTELY SOLN (Limited to 2 fills/calendar year) | QL | 3 | LAXATIVES |
| GOMEKLI CAP (QL= 84 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GOMEKLI CAP 1MG (QL= 168 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GOMEKLI TAB FOR ORAL SUSP (QL= 168 tabs/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| GONAL-F RFF INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| GONAL-F RFF INJ, GONAL-F INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| GONITRO POWDER | - | NC | ANTIANGINAL AGENTS |
| GRALISE TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill) | QL | 1 | ANTIEMETICS |
| GRANIX INJ | - | NC | HEMATOPOIETIC AGENTS |
| GRASTEK SL TAB | - | NC | BIOLOGICALS MISC |
| griseofulvin micro tab (GRIFULVIN V equiv) | - | 1 | ANTIFUNGALS |
| griseofulvin susp (GRIFULVIN equiv) | - | 1 | ANTIFUNGALS |
| griseofulvin tab (GRIS-PEG equiv) | - | 1 | ANTIFUNGALS |
| GUAIFENESEN SYRUP | - | NC | COUGH/COLD/ALLERGY |
| guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| guaifenesin-DM oral liquid (ROBITUSSIN equiv) | - | 1 | COUGH/COLD/ALLERGY |
| guanfacine ER tab (INTUNIV equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| guanfacine IR tab (TENEX equiv) | - | 1 | ANTIHYPERTENSIVES |
| GVOKE INJ (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| GVOKE INJ KIT (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |
| GVOKE PFS INJ (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |
| HADLIMA INJ (adalimumab-bwwd) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HADLIMA PUSH INJ (adalimumab-bwwd) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HAEGARDA INJ (Only available through Accredo 800-803-2523) | LD-PA | Non-EHB | HEMATOLOGICAL AGENTS - MISC. |
| halcinonide cream (HALOG equiv) | - | NC | DERMATOLOGICALS |
| HALCINONIDE SOLN | - | NC | DERMATOLOGICALS |
| halcinonide soln (HALOG equiv) | - | NC | DERMATOLOGICALS |
| HALOBETASOL AER | - | NC | DERMATOLOGICALS |
| halobetasol propionate cream (ULTRAVATE equiv) | - | 1 | DERMATOLOGICALS |
| halobetasol propionate foam (LEXETTE equiv) | - | NC | DERMATOLOGICALS |
| halobetasol propionate oint (ULTRAVATE equiv) | - | 1 | DERMATOLOGICALS |
| HALOG CREAM | - | NC | DERMATOLOGICALS |
| HALOG OINT | - | NC | DERMATOLOGICALS |
| HALOG SOLN | - | NC | DERMATOLOGICALS |
| halonate pac kit (ULTRAVATE KIT equiv) | - | NC | DERMATOLOGICALS |
| haloperidol lactate conc (HALDOL equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| haloperidol tab (HALDOL equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| HARLIKU TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| HARVONI PELLET PAK | - | NC | ANTIVIRALS |
| HARVONI TAB | - | NC | ANTIVIRALS |
| HAVRIX INJ, VAQTA INJ | VAC | \$0 | VACCINES |
| HC BUTYRATE CREAM | - | NC | DERMATOLOGICALS |
| HC BUTYRATE SOLN | - | NC | DERMATOLOGICALS |
| HC PRAMOXINE CREAM 1-2.5% | - | 1 | DERMATOLOGICALS |
| HC/IODOQUIN CREAM | - | 1 | DERMATOLOGICALS |
| HC/PRAMOXINE CREAM 1-2.35% | - | NC | DERMATOLOGICALS |
| HC-LIDOCAINE CREAM | - | NC | DERMATOLOGICALS |
| HELIDAC PACK | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| HEMANGEOL SOLN | - | NC | BETA BLOCKERS |
| HEMLIBRA INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| HEMOPIL M, KOATE INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| HEPLISAV-B INJ | VAC | \$0 | VACCINES |
| HERNEXEOS TAB | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| HETLIOZ CAP | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| HETLIOZ SUSP | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| HIXDEFRIMA SOLN | - | NC | DERMATOLOGICALS |
| HIZENTRA INJ | MSP-PA | 2 | PASSIVE IMMUNIZING AGENTS |
| HOMATROPINE OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| HORIZANT TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| HULIO INJ (adalimumab-fkjp) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HULIO KIT (adalimumab-fkjp) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |

DRAFT

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| HUMALOG JR KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| HUMALOG KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| HUMALOG MIX INJ | - | 2 | ANTIDIABETICS |
| HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN | - | 2 | ANTIDIABETICS |
| HUMALOG PEN INJ | - | 2 | ANTIDIABETICS |
| HUMALOG TEMPO PEN | - | 2 | ANTIDIABETICS |
| HUMATIN CAP | - | NC | AMINOGLYCOSIDES |
| HUMATROPE INJ, ZOMACTON INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| HUMIRA INJ 10MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ 20MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ 40MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ 80MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ PEDIATRIC CROHNS STARTER PACK | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ PEDIATRIC UC STARTER PACK | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMIRA PEN INJ 40MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HUMULIN MIX INJ | OTC | 2 | ANTIDIABETICS |
| HUMULIN MIX PEN INJ | OTC | 2 | ANTIDIABETICS |
| HUMULIN N INJ | OTC | 2 | ANTIDIABETICS |
| HUMULIN N PEN INJ | OTC | 2 | ANTIDIABETICS |
| HUMULIN R INJ | OTC | 2 | ANTIDIABETICS |
| HUMULIN R INJ U-500 | - | 2 | ANTIDIABETICS |
| HUMULIN R U-500 KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| HURRISEAL MIS SNAP | - | NC | MEDICAL DEVICES AND SUPPLIES |
| HYCANTIN CAP | LMSP-PA | 2 | ANTINEOPLASTICS |
| HYCLODEX SOLN | - | NC | DERMATOLOGICALS |
| HYCODAN SYRUP | - | 3 | COUGH/COLD/ALLERGY |
| HYCOFENIX SOLN | - | NC | COUGH/COLD/ALLERGY |
| HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days) | QL | 1 | COUGH/COLD/ALLERGY |
| hydralazine tab (APRESOLINE equiv) | - | 1 | ANTIHYPERTENSIVES |
| hydrochlorothiazide cap (MICROZIDE equiv) | - | 1 | DIURETICS |
| hydrochlorothiazide tab (HYDRODIURIL equiv) | - | 1 | DIURETICS |
| HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 | ANALGESICS - OPIOID |
| HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy require step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 | ANALGESICS - OPIOID |
| hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) | - | 1 | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv) | - | 1 | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen tab (LORTAB equiv) | - | 1 | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv) | - | NC | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv) | - | NC | ANALGESICS - OPIOID |
| hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv) | - | NC | ANALGESICS - OPIOID |
| hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days) | QL | 1 | COUGH/COLD/ALLERGY |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| hydrocodone/homatropine syrup (HYCODAN equiv) | - | 1 | COUGH/COLD/ALLERGY |
| hydrocodone/ibuprofen tab (VICOPROFEN equiv) | - | 1 | ANALGESICS - OPIOID |
| HYDROCODONE/IBUPROFEN TAB 10-200MG | - | 3 | ANALGESICS - OPIOID |
| HYDROCORTISONE ACETATE/PRAMOXINE CREAM | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| hydrocortisone butyrate cream (LOCOID equiv) | - | NC | DERMATOLOGICALS |
| HYDROCORTISONE BUTYRATE LIPO CREAM | - | NC | DERMATOLOGICALS |
| hydrocortisone butyrate lipocream (LOCOID equiv) | - | NC | DERMATOLOGICALS |
| HYDROCORTISONE BUTYRATE OINT | - | NC | DERMATOLOGICALS |
| hydrocortisone butyrate oint (LOCOID equiv) | - | NC | DERMATOLOGICALS |
| hydrocortisone butyrate soln (LOCOID equiv) | - | NC | DERMATOLOGICALS |
| HYDROCORTISONE CREAM | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| hydrocortisone cream (PROCTOCORT equiv) | - | 1 | DERMATOLOGICALS |
| hydrocortisone enema (CORTENEMA equiv) | - | 1 | ANORECTAL AGENTS |
| hydrocortisone lotion (HYTONE equiv) | - | 1 | DERMATOLOGICALS |
| hydrocortisone lotion (LOCOID equiv) | - | NC | DERMATOLOGICALS |
| hydrocortisone lotion 2% (ALA SCALP equiv) | - | NC | DERMATOLOGICALS |
| HYDROCORTISONE LOTION 2.5% | - | 1 | DERMATOLOGICALS |
| hydrocortisone oint | - | 1 | DERMATOLOGICALS |
| HYDROCORTISONE PAK | - | NC | DERMATOLOGICALS |
| hydrocortisone pramoxine cream (PRAMOSONE equiv) | - | 1 | DERMATOLOGICALS |
| hydrocortisone succinate inj 100mg (SOLU-CORTEF equiv) (QL= 2 vials/fill) | QL | 2 | CORTICOSTEROIDS |
| hydrocortisone supp (ANUSOL HC equiv) | - | 1 | ANORECTAL AGENTS |
| hydrocortisone tab (CORTEF equiv) | - | 1 | CORTICOSTEROIDS |
| hydrocortisone valerate cream (WESTCORT equiv) | - | NC | DERMATOLOGICALS |
| hydrocortisone valerate oint (WESTCORT equiv) | - | NC | DERMATOLOGICALS |
| HYDROCORTISONE/PRAMOXINE SUPP | - | NC | ANORECTAL AND RELATED PRODUCTS |
| hydromorphone ER tab (EXALGO TAB equiv) | - | NC | ANALGESICS - OPIOID |
| HYDROMORPHONE SUPP | - | NC | ANALGESICS - OPIOID |
| hydromorphone tab (DILAUDID equiv) | - | 1 | ANALGESICS - OPIOID |
| hydroquinone cream (LUSTRA equiv) | - | EXC | DERMATOLOGICALS |
| hydroxychloroquine tab (PLAQUENIL equiv) | - | 1 | ANTIMALARIALS |
| HYDROXYM GEL | - | NC | DERMATOLOGICALS |
| HYDROXYPROGESTERONE CAPROATE INJ | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| hydroxyurea cap (HYDREA equiv) | - | 1 | ANTINEOPLASTICS |
| hydroxyzine pamoate cap (VISTARIL equiv) | - | 1 | ANTIAXIETY AGENTS |
| hydroxyzine syrup (ATARAX equiv) | - | 1 | ANTIAXIETY AGENTS |
| hydroxyzine tab (ATARAX equiv) | - | 1 | ANTIAXIETY AGENTS |
| HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | 2 | DERMATOLOGICALS |
| HYLAMEND GEL FIRST AID | - | NC | ANTISEPTICS & DISINFECTANTS |
| HYLINATE LOTION | - | NC | DERMATOLOGICALS |
| HYMPAVZI INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| HYOPHEN TAB | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| HYOSCYAMINE ELXIR | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| HYOSCYAMINE INJ | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| hyoscyamine sulfate CR tab (LEVBIID equiv) | - | 1 | ULCER DRUGS |
| HYOSCYAMINE SULFATE ER TAB | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| hyoscyamine sulfate ODT (ANASPAZ equiv) | - | 1 | ULCER DRUGS |
| HYOSCYAMINE SULFATE SL TAB | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| hyoscyamine sulfate SL tab (LEVSIN equiv) | - | 1 | ULCER DRUGS |
| hyoscyamine sulfate soln (LEVSIN equiv) | - | 1 | ULCER DRUGS |
| HYOSCYAMINE TAB | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| hyoscyamine tab (LEVSIN equiv) | - | 1 | ULCER DRUGS |
| HYPER-SAL NEB SOLN 7% | - | 3 | COUGH/COLD/ALLERGY |
| HYQVIA INJ | MSP-PA | 2 | PASSIVE IMMUNIZING AGENTS |
| HYRIMOZ INJ (adalimumab-adaz) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HYRIMOZ PFS INJ (adalimumab-adaz) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| HYRNUO TAB | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days) | QL | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| IBRANCE CAP | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IBRANCE TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IBSRELA TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| IBTROZI CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IBU 600-EZS KIT | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ibuprofen tab | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ibuprofen tab ((RX only)) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| IBUPROFEN TAB | - | EXC | ANALGESICS - ANTI-INFLAMMATORY |
| ibuprofen-famotidine tab (DUEXIS equiv) | - | EXC | ANALGESICS - ANTI-INFLAMMATORY |
| ICAR-C PLUS TAB 100-250-0.025-1 MG | - | 3 | HEMATOPOIETIC AGENTS |
| icatibant inj (FIRAZYR equiv) | LMSP-PA | 1 | HEMATOLOGICAL AGENTS - MISC. |
| ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day) | QL | 1 | ANTIHYPERLIPIDEMICS |
| IDACIO INJ (adalimumab-aacf) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| IDELVION INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| IDHIFA TAB (QL= 1 tab/day) | MSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IHEEZO GEL | - | NC | OPHTHALMIC AGENTS |
| ILEVRO OPHTH SUSP | - | 2 | OPHTHALMIC AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| imatinib tab (GLEEVEC equiv) | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA TAB 140MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA TAB 280MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| imipramine pamoate cap (TOFRANIL PM equiv) | - | 1 | ANTIDEPRESSANTS |
| imipramine tab (TOFRANIL equiv) | - | 1 | ANTIDEPRESSANTS |
| imiquimod cream (ALDARA equiv) | - | 1 | DERMATOLOGICALS |
| IMIQUIMOD CREAM 3.75% | - | NC | DERMATOLOGICALS |
| imiquimod cream 3.75% (IMIQUIMOD equiv) | - | NC | DERMATOLOGICALS |
| IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days) | QL | 3 | MIGRAINE PRODUCTS |
| IMITREX INJ 4MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days) | QL | 3 | MIGRAINE PRODUCTS |
| IMKELDI SOLUTION | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IMOVAX INJ | VAC | EXC | VACCINES |
| IMPAVIDO CAP | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| IMPEKLO LOTION | - | NC | DERMATOLOGICALS |
| IMPOYZ CREAM | - | NC | DERMATOLOGICALS |
| IMULDOSA SYRINGE | - | NC | DERMATOLOGICALS |
| IMVEXXY SUPP | - | NC | VAGINAL PRODUCTS |
| INBRIJA INH POWDER (QL= 10 caps/day) | PA-QL | 3 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| INCRELEX INJ (Only available through AnovoRx 844-288-5007) | LD | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| INCRUSE ELLIPTA INHALER | - | 2 | ANTI-ASTHMATIC AND BRONCHODILATOR AGENTS |
| indapamide tab (LOZOL equiv) | - | 1 | DIURETICS |
| INDERAL XL CAP, INNOPRAN XL CAP | - | NC | BETA BLOCKERS |
| INDOCIN SUPP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| INDOCIN SUSP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| indomethacin cap (INDOCIN equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| INDOMETHACIN CAP, TIVORBEX CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| indomethacin CR cap (INDOCIN SR equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| indomethacin suppository (INDOCIN equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| indomethacin susp (INDOCIN equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| INFLATHERM PAK | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| INLURIYO TAB | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| INLYTA TAB (QL=4 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| INLYTA TAB 1MG (QL= 8 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| INPEFA TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| INPEN INSULIN INJECTION DEVICE | - | NC | MEDICAL DEVICES AND SUPPLIES |
| INQOVI TAB (QL= 5 tabs/28 days) | MSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| INREBIC CAP | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv) | - | NC | ANTIDIABETICS |
| INSULIN ASPART INJ | - | NC | ANTIDIABETICS |
| INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv) | - | NC | ANTIDIABETICS |
| INSULIN ASPART MIX INJ (NOVOLOG equiv) | - | NC | ANTIDIABETICS |
| INSULIN ASPART PENFILL INJ | - | NC | ANTIDIABETICS |
| INSULIN GLARGINE INJ | - | NC | ANTIDIABETICS |
| INSULIN GLARGINE SOLN PEN-INJ | - | 2 | ANTIDIABETICS |
| INSULIN GLARGINE-YFGN (SINGLE PEN) | - | NC | ANTIDIABETICS |
| INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML | - | NC | ANTIDIABETICS |
| INSULIN LISPRO INJ (HUMALOG equiv) | - | 1 | ANTIDIABETICS |
| INSULIN LISPRO JR KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| INSULIN LISPRO KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| INSULIN SYRINGE | OTC | NC | MEDICAL DEVICES AND SUPPLIES |
| INTELENCE TAB | - | 2 | ANTIVIRALS |
| INTENSE COUGH LIQUID | - | 3 | COUGH/COLD/ALLERGY |
| INTERMEZZO SL TAB | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| INTRAROSA SUPP | - | NC | VAGINAL PRODUCTS |
| INTRON-A INJ | MSP | 2 | ANTINEOPLASTICS |
| INVELTYS OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| INVIRASE TAB | - | 2 | ANTIVIRALS |
| INVOKAMET TAB | - | NC | ANTIDIABETICS |
| INVOKAMET XR TAB | - | NC | ANTIDIABETICS |
| INVOKANA TAB | - | NC | ANTIDIABETICS |
| INZIRQO SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | DIURETICS |
| IODOFLEX PAD | - | NC | ANTISEPTICS & DISINFECTANTS |
| IDOQUINOL/HC ALOE GEL | - | NC | DERMATOLOGICALS |
| iodoquinol/hydrocortisone cream 1% (VYTONA equiv) | - | 1 | DERMATOLOGICALS |
| iodoquinol/hydrocortisone cream 1.9-1% (VYTONA equiv) | - | NC | DERMATOLOGICALS |
| IDOQUINOL-HYDROCORTISONE CREAM | - | NC | DERMATOLOGICALS |
| iohexol inj (OMNIPAQUE equiv) | - | NC | DIAGNOSTIC PRODUCTS |
| IOPIDINE OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| IPOL INJ | VAC | \$0 | VACCINES |
| ipratropium nasal spray (ATROVENT equiv) | - | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| ipratropium neb soln (ATROVENT equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| IQIRVO TAB (QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416) | LD-PA-QL | 3 | GASTROINTESTINAL AGENTS - MISC. |
| irbesartan tab (AVAPRO equiv) | - | 1 | ANTIHYPERTENSIVES |
| irbesartan/hydrochlorothiazide tab (AVALIDE equiv) | - | 1 | ANTIHYPERTENSIVES |
| IRON TAB | OTC | NC | HEMATOPOIETIC AGENTS |
| ISENTRESS (HD) TAB | - | 2 | ANTIVIRALS |
| ISENTRESS CHEW TAB | - | 2 | ANTIVIRALS |
| ISENTRESS POWDER PACK | - | 2 | ANTIVIRALS |
| isibloom tab, enskyce tab, apri tab (DESOGEN equiv) | - | \$0 | CONTRACEPTIVES |
| isoniazid syrup (ISONIAZID equiv) | - | 3 | ANTIMYCOBACTERIAL AGENTS |
| isoniazid tab | - | 1 | ANTIMYCOBACTERIAL AGENTS |
| isosorbide dinitrate tab (ISORDIL equiv) | - | 1 | ANTIANGINAL AGENTS |
| isosorbide dinitrate tab 40mg (ISORDIL equiv) | - | 1 | ANTIANGINAL AGENTS |
| isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv) | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| isosorbide mononitrate ER tab (IMDUR equiv) | - | 1 | ANTIANGINAL AGENTS |
| isosorbide mononitrate tab (MONOKET equiv) | - | 1 | ANTIANGINAL AGENTS |
| ISOSORBIDE MONONITRATE TAB | - | 3 | ANTIANGINAL AGENTS |
| isotretinoin cap 25mg (ABSORICA equiv) | - | NC | DERMATOLOGICALS |
| isotretinoin cap 35mg (ABSORICA equiv) | - | NC | DERMATOLOGICALS |
| ISOXSUPRINE TAB | - | 1 | CARDIOVASCULAR AGENTS - MISC. |
| isradipine cap (DYNACIRC equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| ISTALOL OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| ISTURISA TAB (QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ITOVEBI TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| itraconazole cap (SPORANOX equiv) | - | 1 | ANTIFUNGALS |
| itraconazole soln (SPORANOX equiv) | PA | 1 | ANTIFUNGALS |
| ivabradine hcl tab (CORLANOR equiv) | - | 1 | CARDIOVASCULAR AGENTS - MISC. |
| IVERMECTIN TAB | - | NC | ANTHELMINTICS |
| IVERMECTIN CREAM | - | NC | DERMATOLOGICALS |
| ivermectin cream (SOOLANTRA equiv) | - | NC | DERMATOLOGICALS |
| IVERMECTIN LOTION | - | NC | DERMATOLOGICALS |
| ivermectin tab (STROMECTOL equiv) | - | 1 | ANTHELMINTICS |
| IWILFIN TAB (QL= 8 tabs/day; Only available through CurantHealth 866-437-8040) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| IXCHIQ INJ | - | EXC | VACCINES |
| IXIARO INJ | VAC | EXC | VACCINES |
| IXINITY INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| IYUZEH OPHTH DROPS | - | NC | OPHTHALMIC AGENTS |
| JADENU SPRINKLE | - | NC | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| JAKAFI TAB (QL= 2 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| JANUMET TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| JANUMET XR TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| JANUVIA TAB (QL= 1 tab/day) | QL-¢ | 2 | ANTIDIABETICS |
| JARDIANCE TAB (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| JASCAYD TAB | - | EXC | RESPIRATORY AGENTS - MISC. |
| JAVADIN SOLN | - | NC | ANTIHYPERTENSIVES |
| JAYPIRCA TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| JENLIVA CAP | - | NC | MULTIVITAMINS |
| JENTADUETO TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| JENTADUETO XR TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| JESDUVROQ TAB | - | NC | HEMATOPOIETIC AGENTS |
| jinteli tab (FEMHRT equiv) | - | 1 | ESTROGENS |
| JIVI INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| JOURNAVX TAB | - | EXC | ANALGESICS - NONNARCOTIC |
| JUBLIA SOLN | - | NC | DERMATOLOGICALS |
| JULUCA TAB | - | 2 | ANTIVIRALS |
| JUXTAPID CAP | - | NC | ANTIHYPERTENSIVES |
| JYLAMVO SOLN, XATMEP SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| JYNARQUE PAK | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| JYNNEOS INJ | VAC | \$0 | VACCINES |
| K CITRATE SOLN CITR ACD | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| K/NA CITRATE SOL CITR ACD | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| KALETRA SOLN | - | 3 | ANTIVIRALS |
| KALETRA TAB | - | 3 | ANTIVIRALS |
| KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| KAPSPARGO CAP | - | NC | BETA BLOCKERS |
| KAPVAY TAB | - | 3 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| KARBINAL ER SUSP | - | NC | ANTIHISTAMINES |
| KATERZIA SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | CALCIUM CHANNEL BLOCKERS |
| KEFLEX CAP 750MG | - | NC | CEPHALOSPORINS |
| kelnor tab (DEMULEN equiv) | - | \$0 | CONTRACEPTIVES |
| KENALOG INJ, TRIAMCINOLONE ACE INJ | - | 3 | CORTICOSTEROIDS |
| KERAFOAM | - | NC | DERMATOLOGICALS |
| KERALAC CREAM | - | NC | DERMATOLOGICALS |
| KERAMATRIX | - | NC | DERMATOLOGICALS |
| KERASTAT CREAM | - | NC | DERMATOLOGICALS |
| KERASTAT GEL | - | NC | DERMATOLOGICALS |
| KERENDIA TAB (QL= 1 tab/day) | PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| KERYDIN SOLN | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| KESIMPTA INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| KETAMINE HCL TROCHES | - | NC | GENERAL ANESTHETICS |
| ketoconazole cream (NIZORAL CREAM equiv) | - | 1 | DERMATOLOGICALS |
| ketoconazole shampoo (NIZORAL equiv) | - | 1 | DERMATOLOGICALS |
| ketoconazole tab (NIZORAL equiv) | - | 1 | ANTIFUNGALS |
| KETO-DIASTIX TEST STRIP | OTC | 1 | DIAGNOSTIC PRODUCTS |
| KETOPROFEN CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| KETOPROFEN ER CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| KETOROLAC INJ | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ketorolac inj (TORADOL equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| ketorolac ophth soln (ACULAR (LS) equiv) | - | 1 | OPHTHALMIC AGENTS |
| ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days) | QL | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| KETOSTIX | OTC | 1 | DIAGNOSTIC PRODUCTS |
| ketotifen ophth soln (ZADITOR equiv) | OTC | EXC | OPHTHALMIC AGENTS |
| KEVEYIS TAB | - | NC | DIURETICS |
| KEVZARA INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 | CORTICOSTEROIDS |
| KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| KINRIX INJ, QUADRACEL DTAP-IPV INJ | VAC | \$0 | TOXOIDS |
| KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE | VAC | \$0 | TOXOIDS |
| KIRSTY INJ | - | NC | ANTIDIABETICS |
| KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KITABIS PAK NEB SOLN | - | NC | AMINOGLYCOSIDES |
| KLARITY-B DROPS | - | NC | OPHTHALMIC AGENTS |
| KLARITY-L DROPS | - | NC | OPHTHALMIC AGENTS |
| KLARON LOTION | - | 3 | DERMATOLOGICALS |
| KLISYRI OINT | - | NC | DERMATOLOGICALS |
| KLOXXADO NASAL SPRAY | - | 2 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| KOGENATE FS INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| KOMBIGLYZE XR TAB | - | NC | ANTIDIABETICS |
| KOMZIFTI CAP | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KONVOMEF SUSP | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERCS |
| KORLYM TAB | - | NC | ANTIDIABETICS |
| KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| KOSELUGO SPRINKLE CAP (QL= 12 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| K-PHOS NEUTRAL TAB 155-852-130MG | - | 3 | MINERALS & ELECTROLYTES |
| K-PHOS TAB | - | 2 | MINERALS & ELECTROLYTES |
| KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| KRINTAFEL TAB | - | 2 | ANTIMALARIALS |
| K-TAB | - | 1 | MINERALS & ELECTROLYTES |
| KUVAN POWDER PACK | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| KUVAN TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| KYBELLA INJ | - | NC | DERMATOLOGICALS |
| KYNAMRO INJ | - | NC | ANTIHYPERTENSIVES |
| KYNMOBI FILM | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| KYNMOBI TITRATION KIT | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| KYZATREX CAP | - | NC | ANDROGENS-ANABOLIC |
| KYZATREX CAP, JATENZO CAP, TLANDO CAP | - | NC | ANDROGENS-ANABOLIC |
| L.E.T. GEL | - | NC | DERMATOLOGICALS |
| labetalol tab (NORMODYNE equiv) | - | 1 | BETA BLOCKERS |
| LABETALOL TAB | - | NC | BETA BLOCKERS |
| lacosamide oral solution (VIMPAT equiv) | - | 1 | ANTICONVULSANTS |
| lacosamide tab (VIMPAT equiv) | - | 1 | ANTICONVULSANTS |
| LACRISERT OPHTH INSERT | - | NC | OPHTHALMIC AGENTS |
| lactulose oral crystal packet | - | NC | LAXATIVES |
| LACTULOSE PACK 10MG | - | NC | LAXATIVES |
| LACTULOSE PAK 10GM | - | NC | LAXATIVES |
| lactulose soln | - | \$0 | GASTROINTESTINAL AGENTS - MISC. |
| LAGEVRIO CAP (EUA) (QL= 40 caps/fill) | QL | \$0 | ANTIVIRALS |
| LAGEVRIO CAP 200MG (QL= 40 caps/fill) | QL | 2 | ANTIVIRALS |
| LAMICTAL ODT KIT, LAMICTAL XR KIT | - | 3 | ANTICONVULSANTS |
| lamivudine soln (EPIVIR equiv) | - | 1 | ANTIVIRALS |
| lamivudine tab (EPIVIR equiv) | - | 1 | ANTIVIRALS |
| lamivudine tab 100mg (EPIVIR HBV equiv) | - | 1 | ANTIVIRALS |
| lamivudine/zidovudine tab (COMBIVIR equiv) | - | 1 | ANTIVIRALS |
| lamotrigine chew tab (LAMICTAL equiv) | - | 1 | ANTICONVULSANTS |
| lamotrigine ER tab (LAMICTAL XR equiv) | - | 1 | ANTICONVULSANTS |
| lamotrigine ODT (LAMICTAL equiv) | - | NC | ANTICONVULSANTS |
| lamotrigine ODT kit (LAMICTAL equiv) | - | NC | ANTICONVULSANTS |
| lamotrigine starter kit (LAMICTAL STARTER KIT equiv) | - | 1 | ANTICONVULSANTS |
| lamotrigine tab (LAMICTAL equiv) | - | 1 | ANTICONVULSANTS |
| LAMPIT TAB (Restricted to Infectious Disease Specialist) | RS | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| LANCET KIT | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| LANCETS | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| LANOXIN INJ | - | NC | CARDIOTONICS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| LANOXIN TAB 62.5MCG | - | NC | CARDIOTONICS |
| lansoprazole cap (PREVACID equiv) | OTC | 1 | ULCER DRUGS |
| lansoprazole odt (PREVACID SOLUTAB equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| LANSOPRAZOLE SUSP | - | NC | ULCER DRUGS |
| lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv) | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| LANSOPRAZOLE/AMOXICILLIN/CLARITHROMYCIN KIT | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| lanthanum carbonate chew tab (FOSRENOL equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| LANTUS INJ | - | 2 | ANTIDIABETICS |
| LANTUS SOLOSTAR INJ | - | 2 | ANTIDIABETICS |
| lapatinib ditosylate tab (TYKERB equiv) | LMSP-PA | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LASIX ONYU INJ 80MG/2.67ML | - | NC | DIURETICS |
| latanoprost ophth soln (XALATAN equiv) (QL= 2.5ml/30 days) | QL | 1 | OPHTHALMIC AGENTS |
| LATUDA TAB | - | 3 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| layolis FE tab, wymzya FE tab (FEMCON FE equiv) | - | \$0 | CONTRACEPTIVES |
| LAZANDA NASAL SPRAY | - | NC | ANALGESICS - OPIOID |
| LAZCLUZE TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANTIVIRALS |
| leflunomide tab (ARAVA equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416) | LD-QL-RS | 1 | MISCELLANEOUS THERAPEUTIC CLASSE |
| LENVIMA CAP (QL= 3 caps/day; Only available through Optum 877-445-6874) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LEQSELVI TAB | - | EXC | DERMATOLOGICALS |
| letrozole tab (FEMARA equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LEUCOVORIN CA TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| leucovorin tab | - | 1 | ANTINEOPLASTICS |
| LEUKERAN TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LEUKINE INJ | - | NC | HEMATOPOIETIC AGENTS |
| leuprolide inj (LUPRON equiv) | INF | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA or an albuterol HFA product) | QL-ST | 3 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| levalbuterol neb soln (XOPENEX equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| LEVBID ER TAB 0.375MG | - | 3 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| LEVEMIR FLEXTOUCH INJ | - | 2 | ANTIDIABETICS |
| LEVEMIR INJ | - | 2 | ANTIDIABETICS |
| levetiracetam ER tab (KEPPRA XR equiv) | - | 1 | ANTICONVULSANTS |
| levetiracetam soln (KEPPRA equiv) | - | 1 | ANTICONVULSANTS |
| levetiracetam tab (KEPPRA equiv) | - | 1 | ANTICONVULSANTS |
| LEVITRA TAB | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| LEVOBUNOLOL OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| levobunolol ophth soln (BETAGAN equiv) | - | 1 | OPHTHALMIC AGENTS |
| levocarnitine soln (CARNITOR equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| levocarnitine tab (CARNITOR equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| levocetirizine soln (XYZAL equiv) | - | EXC | ANTIHISTAMINES |
| levocetirizine tab (XYZAL equiv) | - | EXC | ANTIHISTAMINES |
| levofloxacin ophth soln (QUIXIN equiv) | - | 1 | OPHTHALMIC AGENTS |
| LEVOFLOXACIN OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| LEVOFLOXACIN OPHTH SOLN 0.5% | - | 1 | OPHTHALMIC AGENTS |
| levofloxacin soln (LEVAQUIN equiv) | - | 1 | FLUOROQUINOLONES |
| levofloxacin tab (LEVAQUIN equiv) | - | 1 | FLUOROQUINOLONES |
| levonorgestrel tab (PLAN B equiv) | OTC | \$0 | CONTRACEPTIVES |
| levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv) | - | 3 | CONTRACEPTIVES |
| levorphanol tab (LEVORPHANOL equiv) | - | NC | ANALGESICS - OPIOID |
| LEVOTHYROXINE INJ | - | NC | THYROID AGENTS |
| LEVOTHYROXINE INJ 100MCG/ML | - | NC | THYROID AGENTS |
| levothyroxine tab (SYNTHROID equiv) | - | 1 | THYROID AGENTS |
| LEVSIN SL TAB 0.125MG | - | 3 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| LEVSIN TAB 0.125MG | - | 3 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| LEXIVA SUSP | - | 2 | ANTIVIRALS |
| LEXTOL PAK | - | NC | DERMATOLOGICALS |
| l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day) | LMSP-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| LIBERVANT FILM | - | NC | ANTICONVULSANTS |
| LICART PATCH | - | NC | DERMATOLOGICALS |
| LIDO/MENTHOL SPRAY | - | NC | DERMATOLOGICALS |
| LIDO/RAC/TET GEL | - | NC | DERMATOLOGICALS |
| LIDOCAINE CREAM | - | NC | DERMATOLOGICALS |
| lidocaine cream 3% (LIDAMANTLE equiv) | - | 1 | DERMATOLOGICALS |
| lidocaine cream 3.88% (LIDOTRAL CREAM equiv) | - | NC | DERMATOLOGICALS |
| lidocaine gel (GLYDO equiv) | - | 1 | DERMATOLOGICALS |
| lidocaine gel (XYLOCAINE equiv) | - | NC | DERMATOLOGICALS |
| lidocaine hcl cream 4.12% | - | NC | DERMATOLOGICALS |
| lidocaine lotion | - | NC | DERMATOLOGICALS |
| LIDOCAINE OINT (QL= 107gm/30 days) | QL | 1 | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| lidocaine oint/transparent dressing kit | - | NC | DERMATOLOGICALS |
| LIDOCAINE ORAL SOLN | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| lidocaine patch (QL= 3 patches/day) | QL | 1 | DERMATOLOGICALS |
| lidocaine patch 3.5% (GEN7T equiv) | OTC | NC | DERMATOLOGICALS |
| lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day) | QL | 1 | DERMATOLOGICALS |
| lidocaine soln (XYLOCAINE equiv) | - | 1 | DERMATOLOGICALS |
| LIDOCAINE SUPP | - | NC | ANORECTAL AND RELATED PRODUCTS |
| lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| LIDOCAINE/HC CREAM | - | 1 | ANORECTAL AND RELATED PRODUCTS |
| LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT | - | NC | ANORECTAL AGENTS |
| lidocaine/prilocaine cream (EMLA equiv) | - | 1 | DERMATOLOGICALS |
| LIDOCIN GEL | - | NC | DERMATOLOGICALS |
| LIDO-EP-TETR SOLN | - | NC | DERMATOLOGICALS |
| LIDOLOG KIT | - | NC | CORTICOSTEROIDS |
| LIDOSTREAM KIT | - | NC | DERMATOLOGICALS |
| LIDOTIN PAK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LIDOTRAL CREAM (lidocaine cream equiv) | - | NC | DERMATOLOGICALS |
| LIDOTREX GEL | - | NC | DERMATOLOGICALS |
| LIDOVEX CREAM | - | NC | DERMATOLOGICALS |
| LIKMEZ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| LINDANE SHAMPOO | - | 1 | DERMATOLOGICALS |
| linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist) | RS | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist) | RS | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| LINZESS CAP (QL= 1 cap/day) | PA-QL | 3 | GASTROINTESTINAL AGENTS - MISC. |
| liothyronine tab (CYTOMEL equiv) | - | 1 | THYROID AGENTS |
| LIQREV SUSP | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 1 | ANTIDIABETICS |
| lisdexamphetamine dimesylate cap (VYVANSE equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| lisdexamphetamine dimesylate chew tab (VYVANSE equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| lisinopril tab (PRINIVIL/ZESTRIL equiv) | - | 1 | ANTIHYPERTENSIVES |
| lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv) | - | 1 | ANTIHYPERTENSIVES |
| LITFULO CAP (QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 | DERMATOLOGICALS |
| lithium carbonate cap (ESKALITH ER equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| lithium carbonate ER tab (LITHOBID equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| lithium carbonate tab | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| lithium oral solution (LITHIUM equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| LITHOSTAT TAB | - | 3 | GENITOURINARY AGENTS - MISCELLANEOUS |
| LIVALO TAB | - | 3 | ANTIHYPERLIPIDEMICS |
| LIVDELZI CAP (QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 3 | GASTROINTESTINAL AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| LIVMARLI SOLN 19MG/ML (QL= 60mL/30 days; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| LIVMARLI TAB (QL= 2 tabs/day; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| LIVMARLI TAB 30MG (QL= 1 tab/day; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTIVIRALS |
| L-METHYLFOLATE TAB | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| LO LOESTRIN TAB | - | 3 | CONTRACEPTIVES |
| LOCOID CREAM | - | NC | DERMATOLOGICALS |
| LOCOID LIPOCREAM | - | NC | DERMATOLOGICALS |
| LOCOID OINT | - | NC | DERMATOLOGICALS |
| LOCOID SOLN | - | NC | DERMATOLOGICALS |
| LODOCO TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| loestrin 21 tab | - | 1 | CONTRACEPTIVES |
| loestrin tab | - | 1 | CONTRACEPTIVES |
| lofedidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days) | PA-QL | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| lohist liquid | OTC | EXC | COUGH/COLD/ALLERGY |
| LOKELMA PAK (QL= 1 packet/day) | PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| LOKELMA PAK 10GM | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| LOKELMA PAK 5GM | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| lomustine cap (GLEOSTINE equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LONSURF TAB | MSP-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| loperamide cap (IMODIUM equiv) | - | NC | ANTIDIARRHEALS |
| loperamide hcl soln (LOPERAMIDE equiv) | OTC | NC | ANTIDIARRHEAL/PROBIOTIC AGENTS |
| lopinavir/ritonavir soln (KALETRA equiv) | - | 1 | ANTIVIRALS |
| lopinavir/ritonavir tab (KALETRA equiv) | - | 1 | ANTIVIRALS |
| LOPRESSOR SOLN (QL= 45ml/day; Prior Authorization required for members age 9 years and older) | PA-QL | 3 | BETA BLOCKERS |
| loratadine cap (CLARITIN equiv) | OTC | EXC | ANTIHISTAMINES |
| loratadine chew tab (CLARITIN equiv) | OTC | EXC | ANTIHISTAMINES |
| loratadine ODT (CLARITIN equiv) | OTC | EXC | ANTIHISTAMINES |
| loratadine syrup (CLARITIN equiv) | OTC | EXC | ANTIHISTAMINES |
| loratadine tab (CLARITIN equiv) | OTC | EXC | ANTIHISTAMINES |
| loratadine/pseudoephedrine 12-hour tab (CLARITIN-D equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| loratadine/pseudoephedrine 24-hour tab (CLARITIN-D equiv) | OTC | EXC | COUGH/COLD/ALLERGY |
| lorazepam conc (ATIVAN equiv) | - | 1 | ANTIANKXIETY AGENTS |
| lorazepam tab (ATIVAN equiv) | - | 1 | ANTIANKXIETY AGENTS |
| LORBRENA TAB 100MG (QL= 1 tab/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LORBRENA TAB 25MG (QL= 3 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LOREEV XR CAP | - | NC | ANTIANKXIETY AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| LORTAB ELIXIR | - | 3 | ANALGESICS - OPIOID |
| LORVATUS PHARMAPAK KIT | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| losartan tab (COZAAR equiv) | - | 1 | ANTIHYPERTENSIVES |
| losartan/hydrochlorothiazide tab (HYZAAR equiv) | - | 1 | ANTIHYPERTENSIVES |
| LOTEMAX OPHTH OINT | - | 2 | OPHTHALMIC AGENTS |
| LOTEMAX SM GEL 0.38% | - | NC | OPHTHALMIC AGENTS |
| loteprednol etabonate ophth gel (LOTEMAX equiv) | - | 1 | OPHTHALMIC AGENTS |
| loteprednol etabonate-tobramycin ophth susp (ZYLET equiv) | - | NC | OPHTHALMIC AGENTS |
| loteprednol ophth susp (LOTEMAX, ALREX equiv) | - | 1 | OPHTHALMIC AGENTS |
| LOTRIMIN AF CREAM | - | 3 | DERMATOLOGICALS |
| lovastatin tab (MEVACOR equiv) | - | \$0 | ANTIHYPERLIPIDEMICS |
| loxapine cap (LOXITANE equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day) | QL | 1 | GASTROINTESTINAL AGENTS - MISC. |
| LUCEMYRA TAB (QL= 96 tabs/7 days) | PA-QL | 3 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LULICONAZOLE CREAM, LUZU CREAM | - | 3 | DERMATOLOGICALS |
| LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LUMAKRAS TAB 240MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LUMIGAN OPHTH SOLN (QL= 2.5ml/30 days) | QL | 2 | OPHTHALMIC AGENTS |
| LUMRYZ PACK (QL= 1 pack/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LUMRYZ STARTER PACK (QL= 1 packet/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 3 | MISCELLANEOUS THERAPEUTIC CLASSES |
| lurasidone hcl tab (LATUDA equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| LUSTRA CREAM | - | EXC | DERMATOLOGICALS |
| LUVIRA CAP | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| LUXIQ FOAM | - | NC | DERMATOLOGICALS |
| LYBALVI TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| LYNKUET CAP | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LYSODREN TAB (Only available through Walgreens 888-347-3416) | LD | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| LYUMJEV INJ | - | 2 | ANTIDIABETICS |
| LYUMJEV KWIKPEN INJ | - | 2 | ANTIDIABETICS |
| LYUMJEV TEMPO PEN | - | 2 | ANTIDIABETICS |
| LYUMJEV TEMPO PEN INJ | - | NC | ANTIDIABETICS |
| LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older) | PA | 3 | MUSCULOSKELETAL THERAPY AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| MACRILEN PACK | - | NC | DIAGNOSTIC PRODUCTS |
| MAFENIDE ACETATE SOLN PACK | - | NC | DERMATOLOGICALS |
| magnesium citrate soln | OTC | \$0 | LAXATIVES |
| magnesium hydroxide | OTC | \$0 | LAXATIVES |
| malathion lotion (OVIDE equiv) (QL= 2 bottles/fill) | QL | 1 | DERMATOLOGICALS |
| MALE CONDOMS (QL= 12 condoms/fill) | OTC-QL | \$0 | MEDICAL DEVICES AND SUPPLIES |
| maraviroc tab (SELZENTRY equiv) | - | 1 | ANTIVIRALS |
| MARPLAN TAB | - | 2 | ANTIDEPRESSANTS |
| MATERVIA CAP | - | NC | MULTIVITAMINS |
| MATRONEX TAB 27-1 MG | - | NC | MULTIVITAMINS |
| MATULANE CAP | - | 2 | ANTINEOPLASTICS |
| MAVENCLAD THERAPY PAK | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| MAVYRET PAK (QL= 5 packs/day) | LMSP-PA-QL | 2 | ANTIVIRALS |
| MAVYRET TAB (QL= 3 tabs/day) | LMSP-PA-QL | 2 | ANTIVIRALS |
| MAXIDEX OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| MAYZENT TAB | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| MAYZENT TAB STARTER PACK | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| meclizine chew tab (BONINE equiv) | OTC | EXC | ANTIEMETICS |
| meclizine hcl tab (ANTIVERT equiv) | - | NC | ANTIEMETICS |
| meclizine tab (ANTIVERT equiv) (Rx Only) | - | 1 | ANTIEMETICS |
| MECLOFENAMATE CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| MEDI-PATCH W/LIDOCAINE PATCH | - | NC | DERMATOLOGICALS |
| medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days) | QL | \$0 | CONTRACEPTIVES |
| medroxyprogesterone tab (PROVERA equiv) | - | 1 | PROGESTINS |
| mefenamic acid cap (PONSTEL equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| mefloquine tab (LARIAM equiv) | - | 1 | ANTIMALARIALS |
| megestrol ES susp (MEGACE ES equiv) | - | 1 | PROGESTINS |
| MEGESTROL SUSP | - | 1 | PROGESTINS |
| megestrol susp (MEGACE equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| megestrol tab (MEGACE equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| MEKINIST SOLN | LMSP-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| MEKINIST TAB 0.5MG (QL= 3 tabs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| MEKINIST TAB 2MG (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| MEKTOVI TAB (QL= 6 tabs/day) | MSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| meloxicam cap (VIVLODEX equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| MELOXICAM COMFORT KIT | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| MELOXICAM SUSP, ZYBIC SUSP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| meloxicam tab (MOBIC equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| MELPHALAN TAB | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| memantine ER cap (NAMENDA XR equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv) | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| memantine soln (NAMENDA equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| memantine tab (NAMENDA equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| MEMANTINE TITRATION PAK | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| MENACTRA INJ | VAC | \$0 | VACCINES |
| MENEST TAB | - | 3 | ESTROGENS |
| MENOPUR INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| MENOSTAR PATCH | - | NC | ESTROGENS |
| MENQUADFI INJ | VAC | \$0 | VACCINES |
| MENTAX CREAM | - | 3 | DERMATOLOGICALS |
| MENTHOREAL10 THERAPY PACK | - | NC | DERMATOLOGICALS |
| MENVEO INJ | VAC | \$0 | VACCINES |
| meperidine tab (DEMEROL equiv) | - | NC | ANALGESICS - OPIOID |
| meprobamate tab (MILTOWN equiv) | - | NC | ANTIANKXIETY AGENTS |
| mercaptopurine susp (PURIXAN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| mercaptopurine tab (PURINETHOL equiv) | - | 1 | ANTINEOPLASTICS |
| MERILOG INJ | - | NC | ANTIDIABETICS |
| MERILOG SOLOSTAR INJ | - | NC | ANTIDIABETICS |
| mesalamine DR cap (DELZICOL equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine DR tab (LIALDA equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine enema (ROWASA equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine ER cap (APRISO equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine ER cap (PENTASA CR equiv) | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine supp (CANASA equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesalamine tab (ASACOL equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| mesna tab (MESNEX equiv) | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| MESNEX TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| METANX CAP | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| metaxalone tab (SKELAXIN equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| METAXALONE TAB | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| METDRAY GEL | - | NC | DERMATOLOGICALS |
| metformin ER osmotic tab (FORTAMET equiv) | - | NC | ANTIDIABETICS |
| metformin ER osmotic tab (GLUMETZA equiv) | - | NC | ANTIDIABETICS |
| metformin ER tab (GLUCOPHAGE XR equiv) | - | 1 | ANTIDIABETICS |
| metformin soln (RIOMET equiv) | - | 1 | ANTIDIABETICS |
| metformin tab (GLUCOPHAGE equiv) | - | 1 | ANTIDIABETICS |
| METFORMIN TAB | - | NC | ANTIDIABETICS |
| methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| METHADOSE CONC | ST | 3 | ANALGESICS - OPIOID |
| methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| methamphetamine hcl tab (METHAMPHETAMINE equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methazolamide tab (NEPTAZANE equiv) | - | 1 | DIURETICS |
| METHENAM MAN TAB | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| methenamine hippurate tab (HIPREX equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| methenamine mandelate tab | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| methimazole tab (TAPAZOLE equiv) | - | 1 | THYROID AGENTS |
| METHITEST TAB | - | NC | ANDROGENS-ANABOLIC |
| methocarbamol tab (ROBAXIN equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| methocarbamol tab 1000mg (ROBAXIN equiv) | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| METHOTREXATE INJ | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| METHOTREXATE IV SOLN 1000MG/40ML | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| methotrexate tab (TREXALL equiv) | - | 1 | ANTINEOPLASTICS |
| methoxsalen cap (OXSORALEN ULTRA equiv) | - | 1 | DERMATOLOGICALS |
| METHOXSALEN CAP | - | 2 | DERMATOLOGICALS |
| METHOXSALEN CRYSTALS | - | EXC | DERMATOLOGICALS |
| METHOXSALEN POWDER | - | EXC | DERMATOLOGICALS |
| methscopolamine tab (PAMINE equiv) | - | 1 | ULCER DRUGS |
| methsuximide cap (CELONTIN equiv) | - | 1 | ANTICONSULTANTS |
| methyl dopa tab (ALDOMET equiv) | - | 1 | ANTIHYPERTENSIVES |
| METHYLDOPA TAB | - | 3 | ANTIHYPERTENSIVES |
| methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days) | QL | 1 | OXYTOCICS |
| methylphenidate CD cap (METADATE CD equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate chew tab (METHYLIN equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate ER cap (APTENSIO XR equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate ER cap (RITALIN LA equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| METHYLPHENIDATE ER TAB | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate ER tab 72mg | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate soln (METHYLIN equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate tab (RITALIN equiv) | - | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylphenidate td patch (DAYTRANA equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| methylprednisolone acetate inj (DEPO-MEDROL equiv) | - | 1 | CORTICOSTEROIDS |
| methylprednisolone dose pack (MEDROL equiv) | - | 1 | CORTICOSTEROIDS |
| methylprednisolone tab (MEDROL equiv) | - | 1 | CORTICOSTEROIDS |

DRAFT

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| methylprednisolone sod succinate inj (SOLU-MEDROL equiv) | - | 1 | CORTICOSTEROIDS |
| methyltestosterone cap | - | NC | ANDROGENS-ANABOLIC |
| metoclopramide soln (REGLAN equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| metoclopramide tab (REGLAN equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| metolazone tab (ZAROXOLYN equiv) | - | 1 | DIURETICS |
| metoprolol ER tab (TOPROL XL equiv) | - | 1 | BETA BLOCKERS |
| metoprolol tab (LOPRESSOR equiv) | - | 1 | BETA BLOCKERS |
| METOPROLOL TARTRATE TAB | - | NC | BETA BLOCKERS |
| metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv) | - | 1 | ANTIHYPERTENSIVES |
| METZOZLV ODT | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| METROCREAM | - | 3 | DERMATOLOGICALS |
| METROGEL 1% | - | 3 | DERMATOLOGICALS |
| METROLOTION | - | 3 | DERMATOLOGICALS |
| metronidazole cap (FLAGYL equiv) | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| metronidazole cream (METROCREAM equiv) | - | 1 | DERMATOLOGICALS |
| metronidazole gel (METROGEL equiv) | - | 1 | DERMATOLOGICALS |
| metronidazole gel 0.75% (METROGEL equiv) | - | 1 | DERMATOLOGICALS |
| metronidazole lotion (METROLOTION equiv) | - | 1 | DERMATOLOGICALS |
| metronidazole tab (FLAGYL equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| METRONIDAZOLE TAB | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| metronidazole vaginal gel (METROGEL equiv) | - | 1 | VAGINAL PRODUCTS |
| metyrosine cap (DEMSEER equiv) | - | NC | ANTIHYPERTENSIVES |
| mexiletine hcl cap | - | 1 | ANTIARRHYTHMICS |
| MEXPAROX HC CREAM | - | NC | DERMATOLOGICALS |
| MICARDIS HCT TAB | - | NC | ANTIHYPERTENSIVES |
| MICLARA LIQUID | OTC | NC | ANTIHISTAMINES |
| MICORT-HC CREAM | - | NC | DERMATOLOGICALS |
| MICROVIX LP PAK | - | NC | DERMATOLOGICALS |
| midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist) | RS | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| MIDAZOLAM INJ | - | NC | ANTICONVULSANTS |
| midodrine tab (PROAMATINE equiv) | - | 1 | VASOPRESSORS |
| MIDUELLA, PARAGARD IUD | - | \$0 | CONTRACEPTIVES |
| MIEBO OPHTH SOLN (QL= 1 bottle/30 days; Restricted to Ophthalmology or Optometry Specialist) | QL-RS | 2 | OPHTHALMIC AGENTS |
| mifepristone tab (KORLYM equiv) (QL= 4 tabs/day) | LMSP-PA-QL | 2 | ANTIDIABETICS |
| mifepristone tab 200mg (MIFIPREX equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| MIGERGOT SUPP | - | NC | MIGRAINE PRODUCTS |
| miglitol tab (MIGLITOL equiv) | - | 1 | ANTIDIABETICS |
| MIGLITOL TAB | - | 3 | ANTIDIABETICS |
| miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 1 | HEMATOPOIETIC AGENTS |
| MIGRANAL SPRAY | - | NC | MIGRAINE PRODUCTS |
| MILLIPRED DP PAK | - | NC | CORTICOSTEROIDS |
| MILLIPRED TAB | - | 3 | CORTICOSTEROIDS |
| minocycline cap (MINOCIN equiv) | - | 1 | TETRACYCLINES |
| MINOCYCLINE ER CAP | - | NC | TETRACYCLINES |
| minocycline ER tab (SOLODYN equiv) | - | NC | TETRACYCLINES |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| minocycline tab (DYNACIN equiv) | - | 1 | TETRACYCLINES |
| MINOLIRA TAB | - | NC | TETRACYCLINES |
| minoxidil soln (ROGAINE equiv) | OTC | EXC | DERMATOLOGICALS |
| minoxidil tab (LONITEN equiv) | - | 1 | ANTIHYPERTENSIVES |
| MIPLYFFA CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| mirabegron tab er (MYRBETRIQ equiv) | - | 1 | URINARY ANTISPASMODICS |
| MIRALAX PACKET | OTC | EXC | LAXATIVES |
| MIRALAX POWDER | OTC | EXC | LAXATIVES |
| MIRENA IUD | - | \$0 | CONTRACEPTIVES |
| mirtazapine ODT (REMERON equiv) | - | 1 | ANTIDEPRESSANTS |
| mirtazapine tab (REMERON equiv) | - | 1 | ANTIDEPRESSANTS |
| MIRVASO GEL | - | EXC | DERMATOLOGICALS |
| misoprostol tab (CYTOTEC equiv) | - | 1 | ULCER DRUGS |
| M-M-R II INJ | VAC | \$0 | VACCINES |
| MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days) | QL-VAC | \$0 | VACCINES |
| modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day) | QL | 1 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| MODEYSO CAP | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| moexipril tab (UNIVASC equiv) | - | 1 | ANTIHYPERTENSIVES |
| MOLINDONE TAB | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| mometasone cream (ELOCON equiv) | - | 1 | DERMATOLOGICALS |
| mometasone nasal spray (NASONEX equiv) (QL= 2 bottles/fill) | QL | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| mometasone oint (ELOCON equiv) | - | 1 | DERMATOLOGICALS |
| mometasone soln (ELOCON equiv) | - | 1 | DERMATOLOGICALS |
| montelukast chew tab (SINGULAIR equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| montelukast granule pack (SINGULAIR equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| montelukast tab (SINGULAIR equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| MONUROL GRANULE PACK | - | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| MORPHABOND TAB | - | NC | ANALGESICS - OPIOID |
| MORPHINE SULFATE ER BEAD CAP | - | NC | ANALGESICS - OPIOID |
| morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| MORPHINE SULFATE ORAL SOLN 100MG/5ML | - | 1 | ANALGESICS - OPIOID |
| MORPHINE SULFATE ORAL SOLN 10MG/5ML | - | 1 | ANALGESICS - OPIOID |
| morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv) | - | 1 | ANALGESICS - OPIOID |
| morphine sulfate soln | - | 1 | ANALGESICS - OPIOID |
| MORPHINE SULFATE SOLN 20MG/5ML | - | 1 | ANALGESICS - OPIOID |
| MORPHINE SULFATE SUPP | - | 1 | ANALGESICS - OPIOID |
| MORPHINE SULFATE TAB | - | 1 | ANALGESICS - OPIOID |
| MOTEGRITY TAB (QL= 1 tab/day) | PA-QL | 3 | GASTROINTESTINAL AGENTS - MISC. |
| MOTPOLY XR CAP | - | NC | ANTICONSULSANTS |
| MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 | ANTIDIABETICS |
| MOVANTI TAB (QL= 1 tab/day) | PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| MOVIPREP SOLN | - | NC | LAXATIVES |
| MOXATAG TAB | - | NC | PENICILLINS |
| MOXATAG TAB 775MG | - | NC | PENICILLINS |
| MOXEZA OPHTH SOLN 0.5% | - | NC | OPHTHALMIC AGENTS |
| MOXEZA OPHTH SOLN, MOXIFLOXACIN OPHTH SOLN, VIGAMOX OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv) | - | 1 | OPHTHALMIC AGENTS |
| MOXIFLOXACIN SOLN | - | NC | OPHTHALMIC AGENTS |
| moxifloxacin tab (AVELOX equiv) | - | 1 | FLUOROQUINOLONES |
| MPM PAK | - | NC | OXYTOCICS |
| MRESVIA INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 | VACCINES |
| MS CONTIN TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 3 | ANALGESICS - OPIOID |
| MUCINEX LIQUID | - | NC | COUGH/COLD/ALLERGY |
| MUCINEX TAB | - | NC | COUGH/COLD/ALLERGY |
| MULPLETA TAB | - | NC | HEMATOPOIETIC AGENTS |
| MULTAQ TAB | - | 2 | ANTIARRHYTHMICS |
| MULTIGEN FOLIC TAB | - | 1 | HEMATOPOIETIC AGENTS |
| MULTIGEN PLUS TAB | - | 1 | HEMATOPOIETIC AGENTS |
| MULTIGEN TAB | - | 1 | HEMATOPOIETIC AGENTS |
| MULTI-MAC TAB | - | NC | MULTIVITAMINS |
| MULTIPLE-VITAMIN/FL-FE DROPS | - | NC | MULTIVITAMINS |
| MULTIVITAMIN CHEW TAB | - | NC | MULTIVITAMINS |
| multivitamin/minerals tab (STROVITE equiv) | - | NC | MULTIVITAMINS |
| mupirocin cream (BACTROBAN CREAM equiv) | - | NC | DERMATOLOGICALS |
| mupirocin oint (BACTROBAN OINT equiv) | - | 1 | DERMATOLOGICALS |
| MYALEPT INJ | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| MYCAPSSA CAP | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| mycophenolate DR tab (MYFORTIC equiv) | - | 1 | ASSORTED CLASSES |
| mycophenolate mofetil cap (CELLCEPT equiv) | - | 1 | ASSORTED CLASSES |
| mycophenolate mofetil susp (CELLCEPT SUSP equiv) | - | 1 | ASSORTED CLASSES |
| mycophenolate mofetil tab (CELLCEPT equiv) | - | 1 | ASSORTED CLASSES |
| MYDAYIS CAP 12.5MG | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| MYDAYIS CAP 25MG | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| MYDAYIS CAP 37.5MG | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| MYDAYIS CAP 50MG | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| MYDCOMBI OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| MYFEMBREE TAB (QL= 1 tab/day) | PA-QL | 2 | ESTROGENS |
| MYHIBBIN SUSP | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| MYLERAN TAB | LMSP | 2 | ANTINEOPLASTICS |
| MYNATAL-Z TAB | - | 3 | MULTIVITAMINS |
| MYNEPHRON CAP | - | NC | MULTIVITAMINS |
| MYQORZO TAB | - | EXC | CARDIOVASCULAR AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| MYRBETRIQ SUSP | - | NC | URINARY ANTISPASMODICS |
| MYRBETRIQ TAB | - | 3 | URINARY ANTISPASMODICS |
| MYTESI TAB | - | NC | ANTIDIARRHEALS |
| nabumetone tab (RELAFEN equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| nadolol tab (CORGARD equiv) | - | 1 | BETA BLOCKERS |
| NAFLON CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naftifine cream (NAFTIN equiv) | - | 1 | DERMATOLOGICALS |
| NAFTIFINE CREAM | - | 3 | DERMATOLOGICALS |
| naftifine hcl gel 2% (NAFTIN equiv) | - | NC | DERMATOLOGICALS |
| NAFTIN GEL 2% | - | NC | DERMATOLOGICALS |
| naloxone hcl nasal spray (NARCAN equiv) | OTC | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| naloxone inj | - | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| naloxone prefilled inj | - | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| NALOXONE PREFILLED INJ (QL= 2 inj/fill) | QL | 2 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| naltrexone tab (REVia equiv) | - | 1 | ANTIDOTES |
| NAMENDA XR TITRATION PACK | - | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NAMZARIC CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NAMZARIC STARTER PACK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NAPRELAN CR TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| NAPROSYN EC TAB 500MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| NAPROXEN CREAM COMPOUND KIT | - | NC | DERMATOLOGICALS |
| naproxen EC tab (NAPROSYN EC equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen EC tab 500mg (NAPROSYN EC equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen sodium CR tab (NAPRELAN CR equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen sodium tab (ANAPROX equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| NAPROXEN SUSP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen susp (NAPROSYN equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen tab (NAPROSYN equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| naproxen/esomeprazole magnesium DR tab (VIMOVO equiv) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| NARCAN NASAL SPRAY | OTC | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| NARDIL TAB 15MG | - | 3 | ANTIDEPRESSANTS |
| NASACORT OTC NASAL SPRAY | OTC | EXC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| NASCOBAL SPRAY | - | 3 | HEMATOPOIETIC AGENTS |
| NATACYN OPTH SUSP (QL= 15ml/fill) | QL | 2 | OPHTHALMIC AGENTS |
| NATAZIA TAB | - | 3 | CONTRACEPTIVES |
| nateglinide tab (STARLIX equiv) | - | 1 | ANTIDIABETICS |
| NATESTO GEL | - | NC | ANDROGENS-ANABOLIC |
| NATESTO NASAL GEL | - | NC | ANDROGENS-ANABOLIC |
| NATROBA SUSP (QL= 1 bottle/fill) | QL | 3 | DERMATOLOGICALS |
| NATROBA SUSP 0.90% (QL= 1 bottle/fill) | QL | 3 | DERMATOLOGICALS |
| NAYZILAM SPRAY (QL= 4 doses/fill) | QL | 3 | ANTICONVULSANTS |
| nebivolol hcl tab (BYSTOLIC equiv) | - | 1 | BETA BLOCKERS |
| NEBUSAL NEB SOLN | - | 2 | COUGH/COLD/ALLERGY |
| NEFAZODONE TAB | - | NC | ANTIDEPRESSANTS |
| NEFFY SPRAY (QL= 2 doses/fill) | QL | 2 | VASOPRESSORS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| NEMLUVIO INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| NENDRUX GEL | - | NC | DERMATOLOGICALS |
| NEO/BAC/POLY OPHTH OINT | - | 1 | OPHTHALMIC AGENTS |
| NEO/POLY/BAC/HC OPHTH OINT | - | 1 | OPHTHALMIC AGENTS |
| neomycin tab | - | 1 | AMINOGLYCOSIDES |
| NEOMYCIN/POLYMYXIN/GRAMICIDIN OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv) | - | 1 | OTIC AGENTS |
| neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv) | - | 1 | OTIC AGENTS |
| neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv) | - | 1 | OPHTHALMIC AGENTS |
| neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv) | - | 1 | OPHTHALMIC AGENTS |
| NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| NEONATAL 19 TAB | - | 3 | MULTIVITAMINS |
| NEONATAL FE TAB | - | 3 | MULTIVITAMINS |
| NEOSALUS FOAM | - | NC | DERMATOLOGICALS |
| NEOSALUS LOTION | - | 3 | DERMATOLOGICALS |
| NEOSALUS LOTION | - | NC | DERMATOLOGICALS |
| NEO-SYNALAR CREAM | - | NC | DERMATOLOGICALS |
| NEPHRON FA TAB | - | 2 | HEMATOPOIETIC AGENTS |
| NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| NEULASTA INJ | - | NC | HEMATOPOIETIC AGENTS |
| NEUPOGEN INJ | - | NC | HEMATOPOIETIC AGENTS |
| NEUPRO PATCH | - | 3 | ANTIPARKINSON AGENTS |
| NEVANAC OPHTH SUSP | - | 2 | OPHTHALMIC AGENTS |
| NEVIRAPINE ER TAB | - | 1 | ANTIVIRALS |
| nevirapine ER tab (VIRAMUNE XR equiv) | - | 1 | ANTIVIRALS |
| NEVIRAPINE SUSP | - | 1 | ANTIVIRALS |
| nevirapine tab (VIRAMUNE equiv) | - | 1 | ANTIVIRALS |
| NEXICLON XR TAB | - | NC | ANTIHYPERTENSIVES |
| NEXIUM 24HR TAB | OTC | 3 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| NEXIUM GRANULE PACK | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 | ANTIHYPERLIPIDEMICS |
| NEXLIZET TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 | ANTIHYPERLIPIDEMICS |
| NEXPLANON IMPLANT | - | \$0 | CONTRACEPTIVES |
| NEXTSTELLIS TAB | - | 3 | CONTRACEPTIVES |
| NGENLA INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| niacin ER tab (NIASPAN equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| NIACINAMIDE/SPIRONOLACTONE GEL | - | 2 | DERMATOLOGICALS |
| NIACINAMIDE/SPIRONOLACTONE/TRETINOIN GEL (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 | DERMATOLOGICALS |
| NIACINAMIDE/SULFACETAMIDE CREAM | - | 2 | DERMATOLOGICALS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

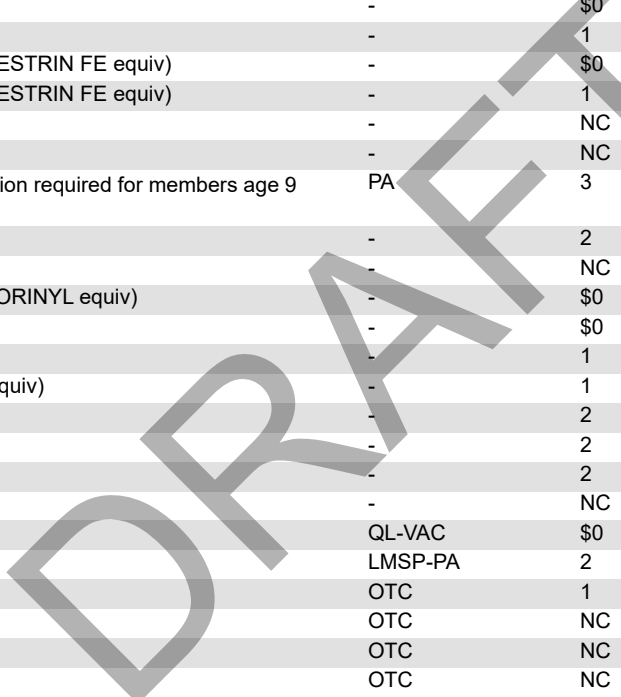
| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| NIACINAMIDE/TAZAROTENE CREAM (Acne Only - Prior Authorization require for members age 35 years and older) | PA | 2 | DERMATOLOGICALS |
| NIACINAMIDE/TRETINOIN CREAM (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 | DERMATOLOGICALS |
| NIACINAMIDE/TRETINOIN GEL (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 | DERMATOLOGICALS |
| NIACOR TAB | - | NC | ANTIHYPERLIPIDEMICS |
| NIASPAN ER TAB | - | 3 | ANTIHYPERLIPIDEMICS |
| nicardipine cap (CARDENE equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NICOTINE KIT | OTC-QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| nicotine patch (NICODERM equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NICOTROL INHALER (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| NICOTROL NASAL SPRAY (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| nifedipine cap (PROCARDIA equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| nifedipine ER tab (ADALAT CC equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| NILOTINB TAR CAP | - | EXC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| nilotinib hcl cap (TASIGNA equiv) | LMSP-PA | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| nilutamide tab (NILANDRON equiv) | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| nimodipine cap (NIMOTOP equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566) | LD-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| nisoldipine ER tab (SULAR equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| NISOLDIPINE ER TAB 20MG, 30MG, 40MG | - | 1 | CALCIUM CHANNEL BLOCKERS |
| nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days) | PA-QL | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| nitisnone cap (ORFADIN equiv) | LMSP-PA | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| NITRO-BID OINT | - | 2 | ANTIANGINAL AGENTS |
| NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR | - | 3 | ANTIANGINAL AGENTS |
| nitrofurantoin macrocrystals cap (MACRODANTIN equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv) | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| nitrofurantoin monohydrate cap (MACROBID equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| nitrofurantoin susp (FURADANTIN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| NITROFURANTOIN SUSP | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| NITROGLYCERIN ER CAP | - | 1 | ANTIANGINAL AGENTS |
| nitroglycerin lingual spray (NITROLINGUAL equiv) | - | 1 | ANTIANGINAL AGENTS |
| nitroglycerin oint (RECTIV equiv) | - | NC | ANORECTAL AND RELATED PRODUCTS |
| nitroglycerin patch (NITRO-DUR equiv) | - | 1 | ANTIANGINAL AGENTS |
| nitroglycerin SL tab (NITROSTAT equiv) | - | 1 | ANTIANGINAL AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| NITROMIST SPRAY | - | 3 | ANTIANGINAL AGENTS |
| NITYR TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| NIVESTYM INJ | LMSP | 2 | HEMATOPOIETIC AGENTS |
| NIZATIDINE CAP | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| nizatidine cap (AXID equiv) | - | 1 | ULCER DRUGS |
| NOCDURNA SL TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| NOCTIVA EMULSION SPRAY | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| NORDITROPIN INJ, NUTROPIN AQ INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv) | - | 1 | CONTRACEPTIVES |
| norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv) | - | \$0 | CONTRACEPTIVES |
| norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv) | - | \$0 | CONTRACEPTIVES |
| norethindrone tab (NORA-QD equiv) | - | \$0 | CONTRACEPTIVES |
| norethindrone tab (AYGESTIN equiv) | - | 1 | PROGESTINS |
| norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv) | - | \$0 | CONTRACEPTIVES |
| norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv) | - | 1 | CONTRACEPTIVES |
| NORGESIC TAB FORTE | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| NORITATE CREAM | - | NC | DERMATOLOGICALS |
| NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | CALCIUM CHANNEL BLOCKERS |
| NORPACE CR CAP | - | 2 | ANTIARRHYTHMICS |
| NORTHERA CAP | - | NC | VASOPRESSORS |
| nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv) | - | \$0 | CONTRACEPTIVES |
| nortrel tab (OVCON 35 equiv) | - | \$0 | CONTRACEPTIVES |
| nortriptyline cap (PAMELOR equiv) | - | 1 | ANTIDEPRESSANTS |
| nortriptyline oral soln (NORTRIPTYLINE equiv) | - | 1 | ANTIDEPRESSANTS |
| NORVIR CAP | - | 2 | ANTIVIRALS |
| NORVIR POWDER PACK | - | 2 | ANTIVIRALS |
| NORVIR SOLN | - | 2 | ANTIVIRALS |
| NOVACORT GEL | - | NC | DERMATOLOGICALS |
| NOVAVAX INJ (QL= 1 dose/24 days) | QL-VAC | \$0 | VACCINES |
| NOVOEIGHT INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| NOVOFINE PEN NEEDLE | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| NOVOLIN 70/30 FLEXPEN INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN 70/30 FLEXPEN RELION INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN 70/30 INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN 70/30 RELION INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN N FLEXPEN INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN N INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN N RELION 100UNIT/ML | OTC | NC | ANTIDIABETICS |
| NOVOLIN R FLEXPEN INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN R INJ | OTC | NC | ANTIDIABETICS |
| NOVOLIN R RELION INJ | OTC | NC | ANTIDIABETICS |
| NOVOLOG FLEXPEN INJ | - | NC | ANTIDIABETICS |



| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| NOVOLOG FLEXPEN RELION INJ | - | NC | ANTIDIABETICS |
| NOVOLOG INJ | - | NC | ANTIDIABETICS |
| NOVOLOG MIX FLEXPEN INJ | - | NC | ANTIDIABETICS |
| NOVOLOG MIX INJ | - | NC | ANTIDIABETICS |
| NOVOLOG PENFILL INJ | - | NC | ANTIDIABETICS |
| NOVOSEVEN RT INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| NOVOTWIST PEN NEEDLE | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| NOVOTWIST/NOVOFINE PEN NEEDLE | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| NOXAFIL PAK | - | 3 | ANTIFUNGALS |
| NOXAFIL TAB | - | NC | ANTIFUNGALS |
| np thyroid tab (ARMOUR THYROID, NATURE THROID equiv) | - | 1 | THYROID AGENTS |
| NUBEQA TAB (QL= 4 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| NUCALA INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| NUCARACLINPA KIT | - | NC | DERMATOLOGICALS |
| NUCARARXPAK KIT | - | NC | DERMATOLOGICALS |
| NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 | ANALGESICS - OPIOID |
| NUCYNTA TAB | - | 3 | ANALGESICS - OPIOID |
| NUDEXTA CAP (QL= 2 caps/day) | PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| nulido pad (NULIDO equiv) | - | NC | DERMATOLOGICALS |
| NUPLAZID CAP | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| NUPLAZID TAB | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| NURTEC ODT | - | NC | MIGRAINE PRODUCTS |
| NUVAKAAN II KIT | - | NC | DERMATOLOGICALS |
| NUVARING | - | 3 | CONTRACEPTIVES |
| NUVIGIL TAB (QL= 1 tab/day) | QL | 3 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| NUWIQ INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| NUWIQ KIT | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| NUZYRA TAB | - | NC | TETRACYCLINES |
| NYMALIZE SOLN | - | NC | CALCIUM CHANNEL BLOCKERS |
| NYPOZI INJ | - | NC | HEMATOPOIETIC AGENTS |
| nystatin cream (MYCOSTATIN CREAM equiv) | - | 1 | DERMATOLOGICALS |
| nystatin oint | - | 1 | DERMATOLOGICALS |
| nystatin susp | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| NYSTATIN SUSP | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| nystatin tab | - | 1 | ANTIFUNGALS |
| nystatin topical powder | - | 1 | DERMATOLOGICALS |
| nystatin/triamcinolone cream | - | 1 | DERMATOLOGICALS |
| nystatin/triamcinolone oint | - | 1 | DERMATOLOGICALS |
| NYVEPRIA INJ | LMSP | 2 | HEMATOPOIETIC AGENTS |
| OBIZUR INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| octreotide inj (SANDOSTATIN equiv) | LMSP | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| OCTREOTIDE INJ 100MCG | LMSP | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| ODACTRA SL TAB | PA | 3 | ALLERGENIC EXTRACTS/BIOLOGICALS MISC |
| ODEFSEY TAB | - | 2 | ANTIVIRALS |
| ODOMZO CAP (QL= 1 cap/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| OFEV CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL-SF | 2 | RESPIRATORY AGENTS - MISC. |
| ofloxacin ophth soln (OCUFLOX equiv) | - | 1 | OPHTHALMIC AGENTS |
| ofloxacin otic soln (FLOXIN equiv) | - | 1 | OTIC AGENTS |
| OFLOXACIN TAB | - | 1 | FLUOROQUINOLONES |
| OGSIVEO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| OGSIVEO TAB 50MG (QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| OHTUVAYRE SUSP (QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144) | LD-PA-QL | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| OJEMDA SUSP (QL= 96ml/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| OJEMDA TAB (QL= 24 tabs/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| olanzapine ODT (ZYPREXA equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| olanzapine tab (ZYPREXA equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| olanzapine/fluoxetine cap (SYMBYAX equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| OLLIZAC POWDER | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| olmesartan tab (BENICAR equiv) | - | 1 | ANTIHYPERTENSIVES |
| olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv) | - | NC | ANTIHYPERTENSIVES |
| olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv) | - | 1 | ANTIHYPERTENSIVES |
| olopatadine hcl ophth soln 0.1% (PATADAY equiv) | OTC | EXC | OPHTHALMIC AGENTS |
| olopatadine hcl ophth soln 0.2% (PATADAY equiv) | OTC | EXC | OPHTHALMIC AGENTS |
| olopatadine nasal spray (PATANASE equiv) | - | 1 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| olopatadine ophth soln (PATANOL equiv) (Rx Only) | - | 1 | OPHTHALMIC AGENTS |
| olopatadine ophth soln 0.2% (PATADAY equiv) (QL= 2.5ml/30 days; Rx Only) | QL | 1 | OPHTHALMIC AGENTS |
| OLPRUVA PACK | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| OLUMIANT TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| OLUX E FOAM | - | NC | DERMATOLOGICALS |
| OMEGA-3 RX PAK COMPLETE | - | NC | ANTIHYPERLIPIDEMICS |
| omega-3-acid ethyl esters cap (LOVAZA equiv) | - | 1 | ANTIHYPERLIPIDEMICS |
| omeprazole DR cap (PRILOSEC equiv) | - | 1 | ULCER DRUGS |
| omeprazole magnesium DR tab 20mg (PRILOSEC equiv) | OTC | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| omeprazole tab | OTC | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| omeprazole/sodium bicarbonate cap (ZEGERID equiv) | - | NC | ULCER DRUGS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| omeprazole/sodium bicarbonate powder pack (ZEGERID equiv) | - | NC | ULCER DRUGS |
| OMLONTI OPHTH SOLN | - | EXC | OPHTHALMIC AGENTS |
| OMNARIS NASAL SPRAY | - | 3 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| OMNIPAQUE INJ | - | NC | DIAGNOSTIC PRODUCTS |
| OMNIPAQUE SOLN | - | NC | DIAGNOSTIC PRODUCTS |
| OMNIPOD 5 DEX G7G6 INTRO KIT (QL= 1 kit/year) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 DEX G7G6 PODS (QL= 10 pods/month) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 G7 KIT INTRO (QL= 1 kit/year) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 G7 MIS PODS (QL= 10 pods/30 days) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT (QL= 1 kit/year) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 LIBRE2 PLUS G6 PODS (QL= 10 pods/30 days) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD 5 PACK PODS (QL= 10 pods/month) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD DASH INTRO KIT (QL= 1 kit/year) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD DASH PDM KIT | - | NC | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD DASH PODS (QL= 10 pods/month) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD GO KIT (QL= 10 pods/month) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNIPOD STARTER KIT (QL= 1 kit/year) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| OMNITROPE INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| OMVOH INJ | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ONAPGO INJ | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| ondansetron ODT (ZOFTRAN equiv) | - | 1 | ANTIEMETICS |
| ondansetron soln (ZOFTRAN equiv) | - | 1 | ANTIEMETICS |
| ondansetron tab (ZOFTRAN equiv) | - | 1 | ANTIEMETICS |
| ONDANSETRON TAB | - | NC | ANTIEMETICS |
| ONDANSETRON TAB ODT | - | NC | ANTIEMETICS |
| ONEXTON GEL 1.2-3.75% | - | NC | DERMATOLOGICALS |
| ONFI TAB | - | NC | ANTICONVULSANTS |
| ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill) | PA-QL | 3 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| ONGLYZA TAB | - | NC | ANTIDIABETICS |
| ONUREG TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ONYCHO-MED KIT | - | NC | DERMATOLOGICALS |
| ONYDA XR SUSP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| ONZETRA XSAIL | - | NC | MIGRAINE PRODUCTS |
| OPANA TAB | - | NC | ANALGESICS - OPIOID |
| OPILL TAB | OTC | \$0 | CONTRACEPTIVES |
| OPIPIZA FILM | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| OPIUM TINCTURE | - | 1 | ANTIDIARRHEAL/PROBIOTIC AGENTS |
| OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| OPSYNVI TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| OPVEE NASAL SPRAY | - | 2 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| OPZELURA CREAM (QL= 12 tubes/year) | PA-QL | 3 | DERMATOLOGICALS |
| ORACEA CAP | - | NC | DERMATOLOGICALS |

DRAFT

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| ORACIT SOLN | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| ORALAIR SL TAB | - | NC | BIOLOGICALS MISC |
| ORAPRED ODT TAB, PREDNISOLONE ODT TAB | - | 3 | CORTICOSTEROIDS |
| ORAVIG TAB | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| ORENCIA CLICK INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| ORENITRAM TAB | PA | Non-EHB | CARDIOVASCULAR AGENTS - MISC. |
| ORENITRAM TAB MONTH PAK | - | Non-EHB | CARDIOVASCULAR AGENTS - MISC. |
| ORFADIN CAP | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ORFADIN SUSP | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ORIAHNN CAP (QL= 2 caps/day) | PA-QL | 2 | ESTROGENS |
| ORLISSA TAB 150MG (QL= 1 tab/day) | PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ORLISSA TAB 200MG (QL= 2 tabs/day) | PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| ORLADEYO CAP | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| ORLYNVAH TAB | - | EXC | ANTI-INFECTIVE AGENTS - MISC. |
| orphenadrine citrate ER tab (NORFLEX equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| ORSERDU TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ORTIKOS ER CAP | - | NC | CORTICOSTEROIDS |
| ORUDIS CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill) | QL | 1 | ANTIVIRALS |
| oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill) | QL | 1 | ANTIVIRALS |
| oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill) | QL | 1 | ANTIVIRALS |
| OSMOLEX ER TAB | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| OSMOPREP TAB | - | NC | LAXATIVES |
| OSPHENA TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| OTEZLA STARTER PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| OTEZLA TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| OTEZLA XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| otomax-HC otic soln (CORTANE-B equiv) | - | NC | OTIC AGENTS |
| OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN | - | NC | OTIC AGENTS |
| OTULFI INJ | - | NC | DERMATOLOGICALS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| OTULFI, USTEKINUMAB-AAUZ SYRINGE | - | NC | DERMATOLOGICALS |
| OVACE PLUS CREAM | - | 3 | DERMATOLOGICALS |
| OVACE PLUS LIQ WASH 10% | - | 3 | DERMATOLOGICALS |
| OVACE PLUS LOTION | - | 3 | DERMATOLOGICALS |
| OVACE PLUS SHAMPOO | - | NC | DERMATOLOGICALS |
| OVACE PLUS FOAM | - | 3 | DERMATOLOGICALS |
| OVEEZA CAP | - | NC | HEMATOPOIETIC AGENTS |
| OVIDREL INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| oxaprozin tab (DAYPRO equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| oxazepam cap (SERAX equiv) | - | 1 | ANTIANKXIETY AGENTS |
| OXBRYTA TAB | - | NC | HEMATOPOIETIC AGENTS |
| OXBRYTA TAB FOR ORAL SUSP | - | NC | HEMATOPOIETIC AGENTS |
| oxcarbazepine er tab (OXTELLAR equiv) | - | NC | ANTICONVULSANTS |
| oxcarbazepine susp (TRILEPTAL equiv) | - | 1 | ANTICONVULSANTS |
| oxcarbazepine tab (TRILEPTAL equiv) | - | 1 | ANTICONVULSANTS |
| OXERVATE OPHTH SOLN (QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | OPHTHALMIC AGENTS |
| OXIANUJO CREAM | - | NC | DERMATOLOGICALS |
| oxiconazole nitrate cream (OXISTAT equiv) | - | 1 | DERMATOLOGICALS |
| OXISTAT CREAM | - | 3 | DERMATOLOGICALS |
| OXISTAT LOTION | - | 3 | DERMATOLOGICALS |
| OXTELLAR XR TAB | - | NC | ANTICONVULSANTS |
| oxybutynin ER tab (DITROPAN XL equiv) | - | 1 | URINARY ANTISPASMODICS |
| oxybutynin syrup | - | 1 | URINARY ANTISPASMODICS |
| oxybutynin tab (DITROPAN equiv) | - | 1 | URINARY ANTISPASMODICS |
| OXYBUTYNIN TAB | - | NC | URINARY ANTISPASMODICS |
| oxycodone cap (OXYIR equiv) | - | 1 | ANALGESICS - OPIOID |
| oxycodone conc (ROXICODONE equiv) | - | 1 | ANALGESICS - OPIOID |
| oxycodone soln (ROXICODONE equiv) | - | 1 | ANALGESICS - OPIOID |
| oxycodone tab (ROXICODONE equiv) | - | 1 | ANALGESICS - OPIOID |
| OXYCODONE TAB | - | NC | ANALGESICS - OPIOID |
| OXYCODONE/ACETAMINOPHEN SOLN | - | 1 | ANALGESICS - OPIOID |
| OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML | - | NC | ANALGESICS - OPIOID |
| oxycodone/acetaminophen tab (PERCOCET equiv) | - | 1 | ANALGESICS - OPIOID |
| OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG | - | NC | ANALGESICS - OPIOID |
| OXYCONTIN CR TAB | - | NC | ANALGESICS - OPIOID |
| OXYMORPHONE ER TAB | - | NC | ANALGESICS - OPIOID |
| oxymorphone tab (OPANA equiv) | - | NC | ANALGESICS - OPIOID |
| OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 | ANTIDIABETICS |
| PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416) | LD-PA | 2 | ALLERGENIC EXTRACTS/BIOLOGICALS MISC |
| PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416) | LD-PA | 2 | ALLERGENIC EXTRACTS/BIOLOGICALS MISC |
| paliperidone ER tab (INVEGA equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| PALSONIFY TAB | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| PANCREAZE CAP, PERTZYE CAP, ULTRESA CAP, ZENPEP CAP | - | NC | DIGESTIVE AIDS |
| PANDEL CREAM | - | NC | DERMATOLOGICALS |
| pantoprazole EC tab (PROTONIX equiv) | - | 1 | ULCER DRUGS |
| pantoprazole sodium packet (PROTONIX equiv) | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEFCS |
| paramox hc gel (NOVACORT GEL equiv) | - | NC | DERMATOLOGICALS |
| PAREGORIC TINCTURE | - | NC | ANTIIDIARRHEALS |
| paricalcitol cap (ZEMPLAR equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| paroxetine cap (BRISDELLE equiv) | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| paroxetine ER tab (PAXIL CR equiv) | - | 1 | ANTIDEPRESSANTS |
| PAROXETINE SUSP | - | 1 | ANTIDEPRESSANTS |
| paroxetine tab (PAXIL equiv) | - | 1 | ANTIDEPRESSANTS |
| PATANOL OPTH SOLN | OTC | EXC | OPHTHALMIC AGENTS |
| PAXLOVID PAK (QL= 11 tabs/90 days) | QL | 2 | ANTIVIRALS |
| PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days) | QL | 2 | ANTIVIRALS |
| PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days) | QL | 2 | ANTIVIRALS |
| PAZEO OPTH SOLN 0.7% | OTC | 3 | OPHTHALMIC AGENTS |
| pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| PAZOPANIB TAB 400MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| PEAK FLOW METER | OTC | 1 | MEDICAL DEVICES AND SUPPLIES |
| PEDIARIX INJ | VAC | \$0 | TOXOIDS |
| pediatric multiple vitamins/fluoride soln | - | NC | MULTIVITAMINS |
| pediatric multiple vitamins/fluoride/iron soln | - | NC | MULTIVITAMINS |
| PEDIZOLPAK THERAPY PACK | - | NC | DERMATOLOGICALS |
| PEDVAXHIB INJ | VAC | \$0 | VACCINES |
| peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 | LAXATIVES |
| peg 3350/electrolytes soln (COLYTE equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 | LAXATIVES |
| peg 3350/electrolytes soln (NULYTELY equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 | LAXATIVES |
| PEGASYS INJ | LMSP | 2 | ANTIVIRALS |
| PEG-PREP KIT | - | NC | LAXATIVES |
| PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| PEN NEEDLE | OTC | NC | MEDICAL DEVICES AND SUPPLIES |
| PENBRAYA INJ | VAC | \$0 | VACCINES |
| penciclovir cream (DENA VIR equiv) | - | NC | DERMATOLOGICALS |
| penicillamine cap (CUPRIMINE equiv) | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| penicillamine tab (DEPEN TITRATAB equiv) | - | 1 | MISCELLANEOUS THERAPEUTIC CLASSES |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

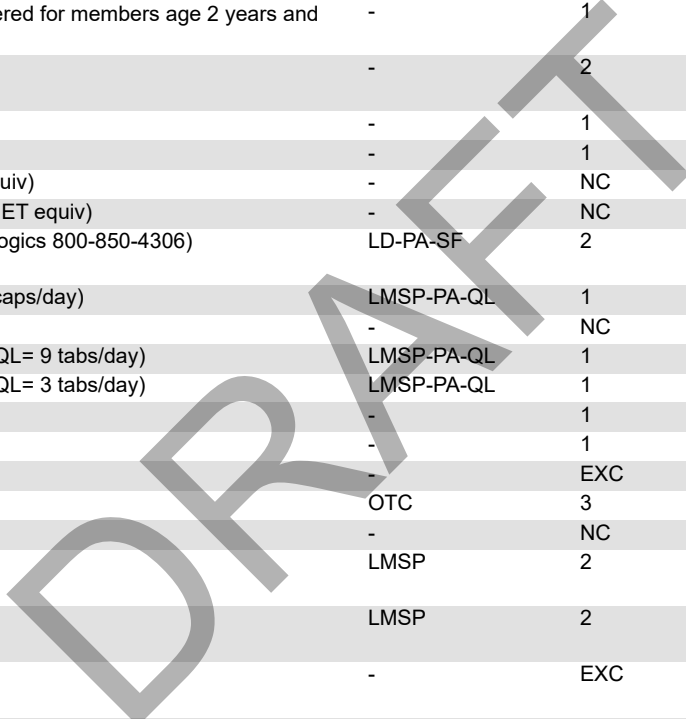
| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| penicillin vk tab (VEETIDS equiv) | - | 1 | PENICILLINS |
| PENLAC SOLN | - | NC | DERMATOLOGICALS |
| PENMENVY INJ | VAC | \$0 | VACCINES |
| PENNSAID SOLN | - | NC | DERMATOLOGICALS |
| PENTACEL INJ | VAC | \$0 | TOXOIDS |
| pentamidine neb soln (NEBUPENT equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| PENTASA CR CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| PENTASA CR CAP 500MG | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| pentazocine/naloxone tab (TALWIN NX equiv) | - | 1 | ANALGESICS - OPIOID |
| PENTOSAN CAP | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| pentoxifylline ER tab (TRENTAL equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| PEPCID TAB (Rx Only) | - | 3 | ULCER DRUGS |
| perampanel susp (FYCOMPA equiv) | - | NC | ANTICONVULSANTS |
| perampanel tab (FYCOMPA equiv) | - | NC | ANTICONVULSANTS |
| PERINDOPRIL TAB | - | 1 | ANTIHYPERTENSIVES |
| perindopril tab (ACEON equiv) | - | 1 | ANTIHYPERTENSIVES |
| permethrin cream (ELIMITE CREAM equiv) | - | 1 | DERMATOLOGICALS |
| perphenazine tab (TRILAFON equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| PERPHENAZINE/ AMITRIPTYLINE TAB | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| PEXEVA TAB | - | NC | ANTIDEPRESSANTS |
| PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523) | LD | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| PHENAZOPYRIDINE TAB | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| phenazopyridine tab (PYRIDIUM equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| PHENDIMETRAZINE ER TAB | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| phendimetrazine tab (BONTRIL PDM equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| PHENELZINE SULFATE TAB | - | 1 | ANTIDEPRESSANTS |
| phenelzine tab (NARDIL equiv) | - | 1 | ANTIDEPRESSANTS |
| phenobarbital elixir | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| PHENOBARBITAL ELXIR | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| phenobarbital tab | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| phenoxybenzamine cap (DIBENZYLINE equiv) | - | 1 | ANTIHYPERTENSIVES |
| phentermine cap (ADIPEX equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| phentermine hcl-topiramate cap er 24hr (QSYMIA equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| phentermine tab (ADIPEX equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| phentermine tab 8mg (ADIPEX equiv) | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| phenylephrine ophth soln (MYDFRIN equiv) | - | 1 | OPHTHALMIC AGENTS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| phenytoin cap (DILANTIN equiv) | - | 1 | ANTICONVULSANTS |
| phenytoin chew tab (DILANTIN equiv) | - | 1 | ANTICONVULSANTS |
| phenytoin susp (DILANTIN equiv) | - | 1 | ANTICONVULSANTS |
| PHEXXI GEL (QL= 1 box/fill) | QL | \$0 | VAGINAL AND RELATED PRODUCTS |
| PHOSPHA 250 NEUTRAL TAB | - | 1 | MINERALS & ELECTROLYTES |
| PHOSPHOLINE OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| PHOSPHO-TRIN K500 TAB | - | 2 | MINERALS & ELECTROLYTES |
| PHOTREXA OP KIT | - | NC | OPHTHALMIC AGENTS |
| PHOTREXA VISCOUS OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| PHYRAGO TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| phytonadione tab (MEPHYTON equiv) | - | 1 | VITAMINS |
| PIFELTRO TAB | - | 2 | ANTIVIRALS |
| pilocarpine hcl ophth soln 1.25% (VUITY equiv) | - | NC | OPHTHALMIC AGENTS |
| pilocarpine ophth soln (ISOPTO CARPINE equiv) | - | 1 | OPHTHALMIC AGENTS |
| pilocarpine tab (SALAGEN equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older) | - | 1 | DERMATOLOGICALS |
| PIMOZIDE TAB | - | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| pindolol tab (VISKEN equiv) | - | 1 | BETA BLOCKERS |
| pioglitazone tab (ACTOS equiv) | - | 1 | ANTIDIABETICS |
| pioglitazone/glimepiride tab (DUETACT equiv) | - | NC | ANTIDIABETICS |
| pioglitazone/metformin tab (ACTOPLUS MET equiv) | - | NC | ANTIDIABETICS |
| PIQRAY TAB (Only available through Biologics 800-850-4306) | LD-PA-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day) | LMSP-PA-QL | 1 | RESPIRATORY AGENTS - MISC. |
| PIRFENIDONE TAB | - | NC | RESPIRATORY AGENTS - MISC. |
| pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day) | LMSP-PA-QL | 1 | RESPIRATORY AGENTS - MISC. |
| pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day) | LMSP-PA-QL | 1 | RESPIRATORY AGENTS - MISC. |
| piroxicam cap (FELDENE equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| pitavastatin calcium tab (LIVALO equiv) | - | 1 | ANTIHYPERTENSIVES |
| PIVYA TAB | - | EXC | PENICILLINS |
| PLAN B TAB | OTC | 3 | CONTRACEPTIVES |
| PLAVIX TAB 300MG | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| PLEGRIDY INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| PLEGRIDY PEN INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| PLENITY CAP | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| PLENVU SOLN | - | NC | LAXATIVES |
| PLEXION CREAM 9.8-4.8% | - | NC | DERMATOLOGICALS |
| PLIAGLIS CREAM | - | NC | DERMATOLOGICALS |
| PLIAGLIS KIT | - | NC | DERMATOLOGICALS |
| PNEUMOVAX INJ | VAC | \$0 | VACCINES |
| PODIAPN CAP | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| PODOCON SOLN | - | 2 | DERMATOLOGICALS |



| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| podofilox gel (CONDYLOX equiv) | - | 3 | DERMATOLOGICALS |
| PODOFILOX SOLN | - | 1 | DERMATOLOGICALS |
| podofilox soln (CONDYLOX equiv) | - | 1 | DERMATOLOGICALS |
| POKONZA POWDER | - | NC | MINERALS & ELECTROLYTES |
| polyethylene glycol 3350 powder (MIRALAX equiv) | OTC | \$0 | LAXATIVES |
| POLYETHYLENE GLYCOL 8000 GRANULES | - | 2 | PHARMACEUTICAL ADJUVANTS |
| polyethylene glycol packet (MIRALAX equiv) | OTC | \$0 | LAXATIVES |
| POLY-IRON CAP 150 FORTE | - | 1 | HEMATOPOIETIC AGENTS |
| polymyxin b/trimethoprim ophth soln (POLYTRIM equiv) | - | 1 | OPHTHALMIC AGENTS |
| POLY-TUSSIN DM SYRUP | - | NC | COUGH/COLD/ALLERGY |
| POLY-VI-FLOR SUSP | - | \$0 | MULTIVITAMINS |
| POMALYST CAP (QL= 21 caps/28 days) | MSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| PONVORY TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| PONVORY TAB STARTER PACK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| posaconazole DR tab (NOXAFIL equiv) | - | 1 | ANTIFUNGALS |
| posaconazole susp (NOXAFIL equiv) | - | 1 | ANTIFUNGALS |
| potassium bicarbonate effer tab (K-LYTE equiv) | - | 1 | MINERALS & ELECTROLYTES |
| potassium chloride ER cap (MICRO-K equiv) | - | 1 | MINERALS & ELECTROLYTES |
| potassium chloride ER tab (K-TAB equiv) | - | 1 | MINERALS & ELECTROLYTES |
| potassium chloride micro tab (K-DUR equiv) | - | 1 | MINERALS & ELECTROLYTES |
| potassium chloride powder packet (KLOR-CON equiv) | - | 1 | MINERALS & ELECTROLYTES |
| potassium chloride soln | - | 1 | MINERALS & ELECTROLYTES |
| POTASSIUM CHLORIDE TAB ER | - | 1 | MINERALS & ELECTROLYTES |
| potassium citrate CR tab (UROCIT-K TAB equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| potassium citrate/citric acid powder pack (POLYCITRA equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| POTASSIUM IODIDE ORAL SOLN | - | 1 | COUGH/COLD/ALLERGY |
| PRADAXA PELLETT PACK | - | NC | ANTICOAGULANTS |
| pramipexole ER tab (MIRAPEX ER equiv) | - | 1 | ANTIPARKINSON AGENTS |
| pramipexole tab (MIRAPEX equiv) | - | 1 | ANTIPARKINSON AGENTS |
| PRAMOSONE CREAM 1-1% | - | NC | DERMATOLOGICALS |
| PRAMOSONE LOTION | - | NC | DERMATOLOGICALS |
| PRAMOSONE OINT | - | NC | DERMATOLOGICALS |
| PRANDIMET TAB | - | NC | ANTIDIABETICS |
| prasugrel tab (EFFIENT equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| pravastatin tab (PRAVACHOL equiv) | - | \$0 | ANTIHYPERTENSIVES |
| praziquantel tab (BILTRICIDE equiv) | - | 1 | ANTHELMINTICS |
| prazosin cap (MINIPRESS equiv) | - | 1 | ANTIHYPERTENSIVES |
| PRECISION XTRA KETONE TEST STRIP | OTC | NC | DIAGNOSTIC PRODUCTS |
| PRECISION XTRA METER | OTC | \$0 | MEDICAL DEVICES AND SUPPLIES |
| PRECISION XTRA TEST STRIP | OTC | 2 | DIAGNOSTIC PRODUCTS |
| PRED FORTE OPHTH SUSP | - | 3 | OPHTHALMIC AGENTS |
| PRED MILD OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| PRED-G OPHTH SOLN | - | 2 | OPHTHALMIC AGENTS |
| PREDNICARBATE OIN | - | 2 | DERMATOLOGICALS |

DRAFT

| | | |
|---|--|------------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| prednisolone acetate ophth susp (PRED FORTE equiv) | - | 1 | OPHTHALMIC AGENTS |
| prednisolone ODT (ORAPRED equiv) | - | 1 | CORTICOSTEROIDS |
| PREDNISOLONE OPHTH SUSP | - | 1 | OPHTHALMIC AGENTS |
| PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| prednisolone soln | - | 1 | CORTICOSTEROIDS |
| prednisolone soln (PEDIAPRED equiv) | - | 1 | CORTICOSTEROIDS |
| PREDNISOLONE SOLN | - | 3 | CORTICOSTEROIDS |
| prednisolone tab (MILLIPRED equiv) | - | 3 | CORTICOSTEROIDS |
| PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| PREDNISOLONE/NEPAFENAC OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| PREDNISON DR TAB | - | NC | CORTICOSTEROIDS |
| prednison pack | - | 1 | CORTICOSTEROIDS |
| PREDNISON PACK | - | 3 | CORTICOSTEROIDS |
| PREDNISON SOLN | - | 2 | CORTICOSTEROIDS |
| prednison tab (DELTASONE equiv) | - | 1 | CORTICOSTEROIDS |
| PREDNISON/DIPHENHYDRAMINE KIT | - | NC | CORTICOSTEROIDS |
| PREFEST TAB | - | 3 | ESTROGENS |
| pregabalin cap (LYRICA equiv) (QL= 3 caps/day) | QL | 1 | ANTICONVULSANTS |
| pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day) | QL | 1 | ANTICONVULSANTS |
| pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day) | QL | 1 | ANTICONVULSANTS |
| pregabalin ER tab (LYRICA CR equiv) | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| pregabalin soln (LYRICA equiv) (QL= 30ml/day) | QL | 1 | ANTICONVULSANTS |
| PREGEN DHA CAP | - | NC | MULTIVITAMINS |
| PREGENNA TAB | - | NC | MULTIVITAMINS |
| PREGNYL INJ, NOVAREL INJ | INF | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| PREHEVBRIO SUSP | VAC | \$0 | VACCINES |
| PREMARIN TAB | - | 2 | ESTROGENS |
| PREMARIN VAGINAL CREAM | - | 2 | VAGINAL PRODUCTS |
| PREMPHASE TAB, PREMPRO TAB | - | 2 | ESTROGENS |
| PRENARA CAP | - | NC | MULTIVITAMINS |
| PRENATABS RX TAB | - | 1 | MULTIVITAMINS |
| PRENATAL 19 CHEW TAB | - | 1 | MULTIVITAMINS |
| PRENATAL 19 TAB | - | 1 | MULTIVITAMINS |
| PRENATAL VITAMINS (NON-PREFERRED) | - | 3 | MULTIVITAMINS |
| PRENATAL VITAMINS (PRENATAL PLUS, PREPLUS, PRENAPLUS) | - | 1 | MULTIVITAMINS |
| PRENATE MAX TAB | - | NC | MULTIVITAMINS |
| PRENATOL-M TAB 27-1.2MG | - | NC | MULTIVITAMINS |
| PRENATRIX TAB | - | NC | MULTIVITAMINS |
| PRENATRYL TAB | - | NC | MULTIVITAMINS |
| PRESTALIA TAB | - | NC | ANTIHYPERTENSIVES |
| PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist) | QL-RS | 2 | ANTIMYCOBACTERIAL AGENTS |

| | | | | | |
|------|---|-----|--|------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| PREVACID CAP | - | NC | ULCER DRUGS |
| PREVACID SOLUTAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| PREVIDENT 5000 PASTE 1.1% | - | 2 | MOUTH/THROAT/DENTAL AGENTS |
| PREVIDENT GEL | - | 2 | MOUTH/THROAT/DENTAL AGENTS |
| PREVIDENT SOLN 0.2% | - | 2 | MOUTH/THROAT/DENTAL AGENTS |
| PREVNAR 20 INJ | VAC | \$0 | VACCINES |
| PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days) | LMSP-PA-QL | 2 | ANTIVIRALS |
| PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days) | LMSP-PA-QL | 2 | ANTIVIRALS |
| PREZCOBIX TAB | - | 2 | ANTIVIRALS |
| PREZISTA SUSP | - | 2 | ANTIVIRALS |
| PREZISTA TAB | - | 2 | ANTIVIRALS |
| PREZISTA TAB | - | 3 | ANTIVIRALS |
| PRIFTIN TAB | - | 2 | ANTIMYCOBACTERIAL AGENTS |
| primaquine tab (PRIMAQUINE equiv) | - | 1 | ANTIMALARIALS |
| primidone tab (MYSOLINE equiv) | - | 1 | ANTICONVULSANTS |
| PRIMIDONE TAB | - | NC | ANTICONVULSANTS |
| PRIMLEV TAB 10-300MG | - | NC | ANALGESICS - OPIOID |
| PRIMLEV TAB 5-300MG | - | NC | ANALGESICS - OPIOID |
| PRIMSOL SOLN | - | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| PRIORIX INJ | VAC | \$0 | VACCINES |
| probenecid tab (BENEMID equiv) | - | 1 | GOUT AGENTS |
| prochlorperazine supp (COMPAZINE equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| prochlorperazine tab (COMPAZINE equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| PROCRIT INJ | - | NC | HEMATOPOIETIC AGENTS |
| PROCTOCORT SUPP | - | 3 | ANORECTAL AND RELATED PRODUCTS |
| PROCTOFOAM HC FOAM | - | 2 | ANORECTAL AGENTS |
| proctosol HC cream (ANUSOL HC equiv) | - | 1 | ANORECTAL AGENTS |
| PROCYSBI CAP | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| PROCYSBI GRANULES PACKET | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| PRODRIN TAB | - | NC | MIGRAINE PRODUCTS |
| PROFILNINE INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| PROFINAC PAK | - | NC | DERMATOLOGICALS |
| progesterone cap (PROMETRIUM equiv) | - | 1 | PROGESTINS |
| progesterone oil inj | - | 1 | PROGESTINS |
| PROGESTERONE SUPP | PA | 3 | VAGINAL PRODUCTS |
| progesterone vaginal insert (ENDOMETRIN equiv) | PA | 1 | VAGINAL AND RELATED PRODUCTS |
| PROGRAF PACKET | - | NC | MISCELLANEOUS THERAPEUTIC CLASSE |
| PROLATE TAB 7.5-300MG | - | NC | ANALGESICS - OPIOID |
| PROLENSA OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| PROMACTA POWDER | - | NC | HEMATOPOIETIC AGENTS |
| PROMACTA TAB 12.5MG, 25MG | - | NC | HEMATOPOIETIC AGENTS |
| promethazine DM syrup | - | 1 | COUGH/COLD/ALLERGY |
| promethazine supp (PHENERGAN equiv) | - | 1 | ANTIHISTAMINES |
| promethazine syrup | - | 1 | ANTIHISTAMINES |
| promethazine tab (PHENERGAN equiv) | - | 1 | ANTIHISTAMINES |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| PROMETHAZINE VC SYRUP | - | 1 | COUGH/COLD/ALLERGY |
| promethazine VC syrup (PHENERGAN VC equiv) | - | 1 | COUGH/COLD/ALLERGY |
| PROMETHAZINE VC/CODEINE SYRUP | - | 1 | COUGH/COLD/ALLERGY |
| promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv) | - | 1 | COUGH/COLD/ALLERGY |
| promethazine/codeine syrup (PHENERGAN/CODEINE equiv) | - | 1 | COUGH/COLD/ALLERGY |
| PROMETHEGAN SUPP | - | 1 | ANTIHISTAMINES |
| PROMISEB CREAM | - | NC | DERMATOLOGICALS |
| propafenone ER cap (RYTHMOL SR equiv) | - | 1 | ANTIARRHYTHMICS |
| propafenone tab (RYTHMOL equiv) | - | 1 | ANTIARRHYTHMICS |
| proparacaine ophth soln (ALCAINE equiv) | - | 1 | OPHTHALMIC AGENTS |
| PROPECIA TAB | - | EXC | DERMATOLOGICALS |
| propranolol ER cap (INDERAL LA equiv) | - | 1 | BETA BLOCKERS |
| PROPRANOLOL SOLN | - | 1 | BETA BLOCKERS |
| PROPRANOLOL SOLN 20MG/5ML | - | 1 | BETA BLOCKERS |
| propranolol tab (INDERAL equiv) | - | 1 | BETA BLOCKERS |
| propylthiouracil tab | - | 1 | THYROID AGENTS |
| PROQUAD INJ | VAC | \$0 | VACCINES |
| PROQUIN XR TAB | - | NC | FLUOROQUINOLONES |
| PROSED DS TAB | - | NC | URINARY ANTI-INFECTIVES |
| PROTHELIAL PASTE | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| PROTONIX EC TAB | - | NC | ULCER DRUGS |
| PROTONIX PAK | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| protriptyline tab (VIVACTIL equiv) | - | 1 | ANTIDEPRESSANTS |
| PROZAC WEEKLY CAP | - | NC | ANTIDEPRESSANTS |
| PROZENA PAD | - | NC | DERMATOLOGICALS |
| prucalopride succinate tab (MOTEGRITY equiv) (QL= 1 tab/day) | PA-QL | 1 | GASTROINTESTINAL AGENTS - MISC. |
| PULMICORT FLEXHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| PULMOZYME INH SOLN | LMSP | 2 | RESPIRATORY AGENTS - MISC. |
| PUREFOLIX TAB | - | NC | HEMATOPOIETIC AGENTS |
| PYLERA CAP | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| pyrazinamide tab | - | 1 | ANTIMYCOBACTERIAL AGENTS |
| PYRIDIDIUM TAB 100MG | - | 3 | GENITOURINARY AGENTS - MISCELLANEOUS |
| PYRIDIDIUM TAB 200MG | - | 3 | GENITOURINARY AGENTS - MISCELLANEOUS |
| pyridostigmine CR tab (MESTINON equiv) | - | 1 | ANTIMYASTHENIC/CHOLINERGIC AGENTS |
| pyridostigmine tab (MESTINON equiv) | - | 1 | ANTIMYASTHENIC/CHOLINERGIC AGENTS |
| PYRIDOSTIGMINE TAB 30MG | - | NC | ANTIMYASTHENIC/CHOLINERGIC AGENTS |
| pyridstigmine soln (MESTINON equiv) | - | 1 | ANTIMYASTHENIC/CHOLINERGIC AGENTS |
| pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 | ANTIMALARIALS |
| PYRIMETHAMINE/LEUCOVORIN CAP | - | NC | ANTIMALARIALS |
| PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| PYZCHIVA INJ | - | NC | DERMATOLOGICALS |
| QBRELIS SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTIHYPERTENSIVES |
| QBREXZA PAD | - | NC | DERMATOLOGICALS |
| QDOLO SOLN, TRAMADOL SOLN | - | NC | ANALGESICS - OPIOID |
| QELBREE ER CAP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| QFITLIA INJ | - | EXC | HEMATOLOGICAL AGENTS - MISC. |
| QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| QLOSI OPHTH SOLN, VUIITY OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| QMIIZ ODT TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| QNASL NASAL SPRAY | - | 3 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| QSYMIA CAP | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| QTERN TAB | - | NC | ANTIDIABETICS |
| QUALAQUIN CAP | - | NC | ANTIMALARIALS |
| QUAZEPAM TAB | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| QUDEXY XR CAP | - | NC | ANTICONVULSANTS |
| quetiapine tab (SEROQUEL equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| QUETIAPINE TAB | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| quetiapine XR tab (SEROQUEL XR equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| QUILLICHEW ER TAB | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| QUILLIVANT XR SUSP | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| quinapril tab (ACCUPRIL equiv) | - | 1 | ANTIHYPERTENSIVES |
| QUINAPRIL/HCTZ TAB | - | NC | ANTIHYPERTENSIVES |
| quinapril/hydrochlorothiazide tab (ACCURETIC equiv) | - | NC | ANTIHYPERTENSIVES |
| quinidine gluconate CR tab | - | 1 | ANTIARRHYTHMICS |
| quinidine sulfate tab | - | 1 | ANTIARRHYTHMICS |
| QUINIDINE SULFATE TAB | - | NC | ANTIARRHYTHMICS |
| quinine sulfate cap (QUALAQUIN equiv) | - | NC | ANTIMALARIALS |
| QUINIXIL PAK | - | NC | DERMATOLOGICALS |
| QULIPTA TAB | - | NC | MIGRAINE PRODUCTS |
| QUVIVIQ TAB | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| QVAR REDIHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| RABAVERT INJ | VAC | EXC | VACCINES |
| rabeprazole EC tab (ACIPHEX equiv) | - | 1 | ULCER DRUGS |
| RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | NEUROMUSCULAR AGENTS |
| RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | NEUROMUSCULAR AGENTS |
| RAGWITEK SL TAB | - | NC | BIOLOGICALS MISC |
| RALDESY SOLN | - | NC | ANTIDEPRESSANTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| raloxifene tab (EVISTA equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ramelteon tab (ROZEREM equiv) (QL= 1 tab/day) | QL | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| ramipril cap (ALTACE equiv) | - | 1 | ANTIHYPERTENSIVES |
| RANITIDINE TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| ranolazine tab (RANEXA equiv) | - | 1 | ANTIANGINAL AGENTS |
| rasagiline tab (AZILECT equiv) | - | 1 | ANTIPARKINSON AGENTS |
| RAVICTI LIQUID | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| RAYALDEE CAP | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| RAYOS TAB | - | NC | CORTICOSTEROIDS |
| REBIF INJ | LMSP | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| REBINYN INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| RECOMBINATE INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| RECORLEV TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| RECTIV OINT | - | NC | ANORECTAL AND RELATED PRODUCTS |
| REDEMPLO PFS INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| REDITREX INJ | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| REGRANEX GEL (QL= 30gm/fill) | QL | 2 | DERMATOLOGICALS |
| RELAFEN DS TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| RELENZA DISKHALER (QL= 1 inhaler/fill) | QL | 2 | ANTIVIRALS |
| RELEUKO INJ | - | NC | HEMATOPOIETIC AGENTS |
| RELEUKO PREFILLED SYRINGE INJ | - | NC | HEMATOPOIETIC AGENTS |
| RELEXXII ER TAB | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| RELISTOR INJ | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| RELISTOR INJ KIT | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| RELISTOR TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| RELTONE CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| RENAGEL TAB 800MG | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| renaphro cap (NEPHROCAP equiv) | - | NC | MULTIVITAMINS |
| RENOVA CREAM | - | EXC | DERMATOLOGICALS |
| REVELA TAB | - | 3 | GASTROINTESTINAL AGENTS - MISC. |
| repaglinide tab (PRANDIN equiv) | - | 1 | ANTIDIABETICS |
| REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 | ANTHYPERLIPIDEMICS |
| REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 | ANTHYPERLIPIDEMICS |
| RESERVAPAK SYRUP | - | NC | ALTERNATIVE MEDICINES |
| RESTASIS MULTI-DOSE | - | NC | OPHTHALMIC AGENTS |
| RETACRIT INJ | - | 2 | HEMATOPOIETIC AGENTS |
| RETEVMO CAP (QL= 2 caps/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| RETEVMO CAP 40MG (QL= 3 caps/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| RETEVMO TAB (QL= 2 tabs/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| RETEVMO TAB 40MG (QL= 3 tabs/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| RETIN-A MICRO GEL 0.04%, 0.1% | - | NC | DERMATOLOGICALS |
| RETIN-A MICRO GEL 0.08%, 0.06% | - | NC | DERMATOLOGICALS |
| RETIN-A MICRO GEL, RETIN-A MICRO GEL PUMP | - | NC | DERMATOLOGICALS |
| REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416) | LD-QL-RS | 3 | MISCELLANEOUS THERAPEUTIC CLASSES |
| REVUFORJ TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| REVUFORJ TAB 110MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| REVUFORJ TAB 25MG (QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| REXAPHENAC CREAM | - | NC | DERMATOLOGICALS |
| REXASIL KIT | - | NC | DERMATOLOGICALS |
| REXULTI TAB | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| REYATAZ POWDER PACK | - | 2 | ANTIVIRALS |
| REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year) | PA-QL | 2 | MIGRAINE PRODUCTS |
| REZDIFFRA TAB (QL= 1 tab/day; Only available through Optum 877-445-6874) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| REZVOGLAR INJ | - | NC | ANTIDIABETICS |
| REZYST CHEW TAB | - | NC | ANTIDIARRHEALS |
| RHAPSIDO TAB | - | EXC | MISCELLANEOUS THERAPEUTIC CLASSES |
| RHEUMATREX TAB | - | 3 | ANALGESICS - ANTI-INFLAMMATORY |
| RHOFADE CREAM | - | EXC | DERMATOLOGICALS |
| RHOPRESSA OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| RIAX FOAM | - | 2 | DERMATOLOGICALS |
| RIBAVIRIN CAP | LMSP | 1 | ANTIVIRALS |
| ribavirin cap (REBETOL equiv) | LMSP | 1 | ANTIVIRALS |
| ribavirin inh soln (VIRAZOLE equiv) | - | NC | ANTIVIRALS |
| RIBAVIRIN TAB | LMSP | 1 | ANTIVIRALS |
| rifabutin cap (MYCOBUTIN equiv) | - | 1 | ANTIMYCOBACTERIAL AGENTS |
| rifampin cap (RIFADIN equiv) | - | 1 | ANTIMYCOBACTERIAL AGENTS |
| riluzole tab (RILUTEK equiv) | - | 1 | NEUROMUSCULAR AGENTS |
| RIMANTADINE TAB | - | 3 | ANTIVIRALS |
| RINVOQ ER TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| RINVOQ ORAL SOLN (QL= 12ml/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate) | ST | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| risedronate tab (ACTONEL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| risperidone ODT (RISPERDAL M equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| RISPERIDONE ODT | - | 2 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| risperidone soln (RISPERDAL equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| risperidone tab (RISPERDAL equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| ritonavir tab (NORVIR equiv) | - | 1 | ANTIVIRALS |
| rivaroxaban for susp (XARELTO equiv) | - | 1 | ANTICOAGULANTS |
| rivaroxaban tab 2.5mg (XARELTO equiv) | - | 1 | ANTICOAGULANTS |
| rivastigmine cap (EXELON equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| rivastigmine patch (EXELON equiv) | - | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| RIVFLOZA INJ (QL= 1 inj/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |
| RIVFLOZA INJ 160MG (QL= 1 inj/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |
| RIVFLOZA VIAL (QL= 2 vials/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | Non-EHB | GENITOURINARY AGENTS - MISCELLANEOUS |
| RIVIVE, REXTOVY SPRAY | OTC | 1 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| RIXUBIS INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days) | QL | 1 | MIGRAINE PRODUCTS |
| rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days) | QL | 1 | MIGRAINE PRODUCTS |
| ROAOXIA GEL | - | NC | DERMATOLOGICALS |
| ROCKLATAN OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| roflumilast tab | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ROGAINE SOLN | OTC | EXC | DERMATOLOGICALS |
| ROMVIMZA CAP (QL= 8 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ropinirole ER tab (REQUIP XL equiv) | - | 1 | ANTIPARKINSON AGENTS |
| ropinirole tab (REQUIP equiv) | - | 1 | ANTIPARKINSON AGENTS |
| ROPIVICAINE/CLONIDINE/KETOROLAC INJ | - | NC | LOCAL ANESTHETICS-PARENTERAL |
| ROSADAN KIT | - | NC | DERMATOLOGICALS |
| rosuvastatin tab (CRESTOR equiv) | - | \$0 | ANTIHYPERTENSIVES |
| ROSZET TAB | - | NC | ANTIHYPERTENSIVES |
| ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB | - | NC | ANTIHYPERTENSIVES |
| ROTARIX SUSP | VAC | \$0 | VACCINES |
| ROTATEQ INJ | VAC | \$0 | VACCINES |
| ROWASA KIT | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ROXYBOND TAB | - | NC | ANALGESICS - OPIOID |
| ROZLYTREK CAP (QL= 3 caps/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ROZLYTREK PAK (QL= 6 packs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| RUCONEST INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| rufinamide susp (BANZEL equiv) | PA | 1 | ANTICONVULSANTS |
| rufinamide tab (BANZEL equiv) | PA | 1 | ANTICONVULSANTS |
| RUKOBIA ER TAB (Restricted to Infectious Disease Specialist) | RS | 2 | ANTIVIRALS |
| RYALTRIS SPRAY | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 | ANTIDIABETICS |
| RYBIX ODT | - | NC | ANALGESICS - OPIOID |
| RYDAPT CAP (QL= 56 caps/28 days) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SABRIL TAB | - | NC | ANTICONVULSANTS |
| sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day) | QL | 1 | CARDIOVASCULAR AGENTS - MISC. |
| SAFYRAL TAB | - | \$0 | CONTRACEPTIVES |
| SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SALEX LOTION KIT | - | NC | DERMATOLOGICALS |
| SALEX SHAMPOO | - | 3 | DERMATOLOGICALS |
| SALICATE LIQUID | - | NC | DERMATOLOGICALS |
| SALICYLIC AC SOLN ER, XALIX SOLN | - | NC | DERMATOLOGICALS |
| salicylic acid cream (CERAVE PSORIASIS equiv) | - | NC | DERMATOLOGICALS |
| SALICYLIC ACID/SULFACETAMIDE SUSP | - | 2 | DERMATOLOGICALS |
| SALIMEZ FORTE CREAM | - | NC | DERMATOLOGICALS |
| SALSALATE TAB | - | 1 | ANALGESICS - NONNARCOTIC |
| salsalate tab (DISALCID equiv) | - | 1 | ANALGESICS - NONNARCOTIC |
| SANCUSO PATCH (QL= 4 patches/fill) | QL | 3 | ANTIEMETICS |
| SANDIMMUNE SOLN 100MG/ML | - | 2 | ASSORTED CLASSES |
| SANTYL OINT (QL= 90gm/30 days) | QL | 2 | DERMATOLOGICALS |
| sapropterin dihydrochloride powder packet (KUVAN equiv) | LMSP-PA | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| sapropterin dihydrochloride soluble tab (KUVAN equiv) | LMSP-PA | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SARAFEM TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| SAVAYSA TAB | - | NC | ANTICOAGULANTS |
| SAVELLA PAK | - | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| SAVELLA TAB (QL= 2 tabs/day) | QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| saxagliptin hcl tab (ONGLYZA equiv) | - | NC | ANTIDIABETICS |
| saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv) | - | NC | ANTIDIABETICS |
| SAXENDA INJ | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| SCARCIN GEL | - | NC | DERMATOLOGICALS |
| SCARCIN LIQUID ROLL-ON | - | NC | DERMATOLOGICALS |
| SCEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SCEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| scopolamine patch (TRANSDERM-SCOP equiv) | - | 1 | ANTIEMETICS |
| SDAMLO SOLN | - | NC | CALCIUM CHANNEL BLOCKERS |
| SECUADO PATCH | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| SEGLENTIS TAB | - | NC | ANALGESICS - OPIOID |
| SEGLUROMET TAB | - | NC | ANTIDIABETICS |
| SELARSDI INJ | - | NC | DERMATOLOGICALS |
| selegiline cap (ELDEPRYL equiv) | - | 1 | ANTIPARKINSON AGENTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| selegiline tab (ELDEPRYL equiv) | - | 1 | ANTIPARKINSON AGENTS |
| SELENIUM SUL SHA | - | 1 | DERMATOLOGICALS |
| SELENIUM SUL SHA 2% | - | 1 | DERMATOLOGICALS |
| SELENIUM SULFIDE LOTION | - | 1 | DERMATOLOGICALS |
| selenium sulfide lotion 2.5% (SELSUN equiv) | - | 1 | DERMATOLOGICALS |
| selenium sulfide shampoo (SELSEB equiv) | - | 1 | DERMATOLOGICALS |
| selenium sulfide shampoo 2.3% (SELRX equiv) | - | 1 | DERMATOLOGICALS |
| SELZENTRY SOLN | - | 2 | ANTIVIRALS |
| SELZENTRY TAB | - | 2 | ANTIVIRALS |
| SELZENTRY TAB | - | 3 | ANTIVIRALS |
| SEMGLEE INJ (SINGLE PEN) | - | NC | ANTIDIABETICS |
| SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ | - | 2 | ANTIDIABETICS |
| SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN | - | 2 | ANTIDIABETICS |
| SEMGLEE SOLN | - | NC | ANTIDIABETICS |
| SEMPREX-D CAP | - | EXC | COUGH/COLD/ALLERGY |
| senna cap | OTC | \$0 | LAXATIVES |
| senna chew tab | OTC | \$0 | LAXATIVES |
| senna tab | OTC | \$0 | LAXATIVES |
| SENSIPAR TAB | - | 3 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SEPHIENCE POWDER | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SEREVENT DISKUS INHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| SERNIVO SPRAY | - | NC | DERMATOLOGICALS |
| SERTRALINE CAP | - | NC | ANTIDEPRESSANTS |
| sertraline conc (ZOLOFT equiv) | - | 1 | ANTIDEPRESSANTS |
| sertraline hcl cap | - | NC | ANTIDEPRESSANTS |
| sertraline tab (ZOLOFT equiv) | - | 1 | ANTIDEPRESSANTS |
| sevelamer hydrochloride tab (RENAGEL equiv) | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| sevelamer powder pak (RENVELA equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| sevelamer tab (RENVELA TAB equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| SEVENFACT INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| SEYSARA TAB | - | NC | TETRACYCLINES |
| SHINGRIX INJ (Covered for members age 19 years and older) | VAC | \$0 | VACCINES |
| SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SIKLOS TAB | - | NC | HEMATOPOIETIC AGENTS |
| SILALITE PAK MIS | - | NC | DERMATOLOGICALS |
| SILATRIX GEL | - | NC | MOUTH/THROAT/DENTAL AGENTS |
| sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | CARDIOVASCULAR AGENTS - MISC. |
| sildenafil tab (VIAGRA equiv) | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| sildenafil tab 20mg (REVATIO equiv) | PA | 1 | CARDIOVASCULAR AGENTS - MISC. |
| SILIPAC KIT | - | NC | DERMATOLOGICALS |
| SILIQ INJ | - | NC | DERMATOLOGICALS |
| silodosin cap (RAPAFLO equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| silver sulfadiazine cream (SILVADENE CREAM equiv) | - | 1 | DERMATOLOGICALS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| SILVERA PAD | - | NC | DERMATOLOGICALS |
| SIMBRINZA OPHTH SUSP | - | 2 | OPHTHALMIC AGENTS |
| SIMCOR TAB | - | NC | ANTIHYPERLIPIDEMICS |
| SIMLANDI INJ, ADALIMUMAB-RYVK INJ (QUALLENT) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| SIMPONI AUTO-INJECTOR 50MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| SIMPONI INJ 100MG (QL=1 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| SIMPONI INJ 50MG | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| simvastatin tab (ZOCOR equiv) (80mg is Not Covered) | - | \$0 | ANTIHYPERLIPIDEMICS |
| simvastatin tab 80mg (ZOCOR equiv) | - | NC | ANTIHYPERLIPIDEMICS |
| sirolimus soln (RAPAMUNE equiv) | - | 1 | MISCELLANEOUS THERAPEUTIC CLASSES |
| sirolimus tab (RAPAMUNE equiv) | - | 1 | ASSORTED CLASSES |
| SIRTURO TAB | - | NC | ANTIMYCOBACTERIAL AGENTS |
| SITAGLIPTIN/METFORMIN TAB | - | NC | ANTIDIABETICS |
| SITAVIG TAB | - | NC | ANTIVIRALS |
| SITZMARKS CAP | - | NC | DIAGNOSTIC PRODUCTS |
| SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist) | QL-RS | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist) | QL-RS | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| SKLICE LOTION | - | NC | DERMATOLOGICALS |
| SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 | NEUROMUSCULAR AGENTS |
| SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| SKYTROFA INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SLYND TAB | - | 3 | CONTRACEPTIVES |
| smz/tmp (DS) tab (BACTRIM DS equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| smz/tmp susp (BACTRIM, SEPTRA equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| SOAANZ TAB | - | NC | DIURETICS |
| SOD SUL/SULF LIQ 9-4.5% | - | 1 | DERMATOLOGICALS |
| SOD SUL/SULF SUSP 10-5% | - | 1 | DERMATOLOGICALS |
| SOD SUL/SULF SUSP 8-4% | - | 1 | DERMATOLOGICALS |
| sodium citrate/citric acid soln (BICITRA equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| sodium fluoride chew tab (LURIDE equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 | MINERALS & ELECTROLYTES |
| sodium fluoride cream (PREVIDENT equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 | MOUTH/THROAT/DENTAL AGENTS |
| SODIUM FLUORIDE GEL | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| SODIUM FLUORIDE PASTE | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| sodium fluoride soln (LURIDE equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 | MINERALS & ELECTROLYTES |
| SODIUM FLUORIDE SOLN | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| SODIUM FLUORIDE TAB (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 | MINERALS & ELECTROLYTES |
| SODIUM IODIDE I-131 SOLN | - | NC | THYROID AGENTS |
| SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| sodium phenylbutyrate powder (BUPHENYL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| sodium phenylbutyrate tab (BUPHENYL equiv) | - | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| sodium phosphates enema | OTC | \$0 | LAXATIVES |
| sodium polystyrene powder (KAYEXALATE equiv) | - | 1 | ASSORTED CLASSES |
| sodium polystyrene susp (SPS equiv) | - | 1 | ASSORTED CLASSES |
| SODIUM SULFA LIQ WASH | - | 1 | DERMATOLOGICALS |
| sodium sulfacetamide lotion (KLARON equiv) | - | 1 | DERMATOLOGICALS |
| sodium sulfacetamide shampoo (OVACE equiv) | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide wash (OVACE WASH equiv) | - | 1 | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE WASH, OVACE PLUS GEL WASH | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv) | - | 1 | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv) | - | 1 | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE/SULFUR CREAM 10-2% | - | 1 | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur emulsion (ROSULA equiv) | - | 1 | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE/SULFUR EMULSION | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv) | - | 1 | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur lotion (SULFACET R equiv) | - | 1 | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE/SULFUR LOTION | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv) | - | NC | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE/SULFUR SUSP | - | 3 | DERMATOLOGICALS |
| SODIUM SULFACETAMIDE/SULFUR WASH | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv) | - | NC | DERMATOLOGICALS |
| sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv) | - | NC | DERMATOLOGICALS |
| sodium/magnesium/potassium soln (SUPREP equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 | LAXATIVES |
| SOFDRA GEL | - | NC | DERMATOLOGICALS |
| SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANTIVIRALS |
| SOGROYA INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SOHONOS CAP 1.5MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | MUSCULOSKELETAL THERAPY AGENTS |
| SOHONOS CAP 10MG (QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | MUSCULOSKELETAL THERAPY AGENTS |
| SOHONOS CAP 1MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | MUSCULOSKELETAL THERAPY AGENTS |
| SOHONOS CAP 2.5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | MUSCULOSKELETAL THERAPY AGENTS |
| SOHONOS CAP 5MG (QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 | MUSCULOSKELETAL THERAPY AGENTS |
| SOLAICE PATCH | - | NC | DERMATOLOGICALS |
| SOLARAVIX PAK | - | NC | DERMATOLOGICALS |
| solifenacin tab (VESICARE equiv) | - | 1 | URINARY ANTISPASMODICS |
| SOLQUA INJ (QL= 15ml/25 days) | QL | 2 | ANTIDIABETICS |
| SOLOSEC GRANULES PACKET (QL= 1 packet/fill) | PA-QL | 3 | AMEBICIDES |
| SOLU-CORTEF INJ (QL= 1 vial/fill) | QL | 2 | CORTICOSTEROIDS |
| SOLU-CORTEF INJ 100MG (QL= 2 vials/fill) | QL | 2 | CORTICOSTEROIDS |
| SOLU-MEDROL INJ 2GM | - | 2 | CORTICOSTEROIDS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| SOLU-MEDROL PF INJ | - | 3 | CORTICOSTEROIDS |
| SOMA TAB 250MG | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SOOLANTRA CREAM | - | NC | DERMATOLOGICALS |
| sorafenib tosylate tab (NEXAVAR equiv) | LMSP-PA | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| sotalol AF tab (BETAPACE AF equiv) | - | 1 | BETA BLOCKERS |
| sotalol tab (BETAPACE equiv) | - | 1 | BETA BLOCKERS |
| SOTYKTU TAB | - | NC | DERMATOLOGICALS |
| SOTYLIZE SOLN | - | NC | BETA BLOCKERS |
| SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 years and older) | PA | 3 | BETA BLOCKERS |
| SOVALDI PELLETT PAK | - | NC | ANTIVIRALS |
| SOVALDI TAB | - | NC | ANTIVIRALS |
| SOVUNA TAB | - | NC | ANTIMALARIALS |
| SPEVIGO INJ (QL= 2ml/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | DERMATOLOGICALS |
| SPIKEVAX INJ (QL= 1 dose/24 days) | QL-VAC | \$0 | VACCINES |
| SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days) | QL-VAC | \$0 | VACCINES |
| SPINOSAD SUSP (QL= 1 bottle/fill) | QL | 2 | DERMATOLOGICALS |
| SPIRIVA HANDIHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL)) | QL-ST | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| SPIRIVA RESPIMAT INHALER 2.5MCG/ACT | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | DIURETICS |
| spironolactone tab (ALDACTONE equiv) | - | 1 | DIURETICS |
| spironolactone/hydrochlorothiazide tab (ALDACTAZIDE equiv) | - | 1 | DIURETICS |
| SPORANOX SOLN | PA | 3 | ANTIFUNGALS |
| sprintec 28 tab (ORTHO-CYCLEN equiv) | - | \$0 | CONTRACEPTIVES |
| SPRITAM TAB | - | NC | ANTICONVULSANTS |
| SPRIX NASAL SPRAY | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| SPRYCEL TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SPS | - | NC | MISCELLANEOUS THERAPEUTIC CLASSES |
| SSKI ORAL SOLN | - | 3 | COUGH/COLD/ALLERGY |
| STARJEMZA INJ | - | NC | DERMATOLOGICALS |
| STARJEMZA PFS INJ | - | NC | DERMATOLOGICALS |
| STAVUDINE CAP | - | 1 | ANTIVIRALS |
| stavudine cap (ZERIT equiv) | - | 1 | ANTIVIRALS |
| STAVZOR CAP | - | NC | ANTICONVULSANTS |
| STAXYN ODT | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| STEGLATRO TAB | - | NC | ANTIDIABETICS |
| STEGLUJAN TAB | - | NC | ANTIDIABETICS |
| STELARA INJ | - | NC | DERMATOLOGICALS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| STENDRA TAB | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| STEQEYMA INJ (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| STEQEYMA INJ 90MG (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| STIMATE NASAL SOLN | - | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| STIMUFEND INJ | - | NC | HEMATOPOIETIC AGENTS |
| STIOLTO INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| STIVARGA TAB (QL= 4 tabs/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479) | LD-PA | Non-EHB | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| STRIANT FILM | - | NC | ANDROGENS-ANABOLIC |
| STRIBILD TAB | - | 2 | ANTIVIRALS |
| STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days) | QL | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| SUBLOCADE SOLN, BRIXADI SOLN | LMSP | 2 | ANALGESICS - OPIOID |
| SUBOXONE SL FILM | - | NC | ANALGESICS - OPIOID |
| SUBSYS SPRAY | - | NC | ANALGESICS - OPIOID |
| SUBVENITE SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTICONVULSANTS |
| SUCRAID SOLN | - | NC | DIGESTIVE AIDS |
| sucrafate susp (CARAFATE equiv) | - | 1 | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| sucrafate tab (CARAFATE equiv) | - | 1 | ULCER DRUGS |
| SUFLAVE SOLN (QL= 2 fills/calendar year) | QL | 2 | LAXATIVES |
| SULFACETAMIDE SOD OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| sulfacetamide sodium ophth soln (BLEPH-10 equiv) | - | 1 | OPHTHALMIC AGENTS |
| sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv) | - | 1 | OPHTHALMIC AGENTS |
| sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv) | - | 1 | DERMATOLOGICALS |
| sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv) | - | 1 | DERMATOLOGICALS |
| SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-9.8% | - | 1 | DERMATOLOGICALS |
| SULFAMYLON CREAM | - | 2 | DERMATOLOGICALS |
| sulfasalazine EC tab (AZULFIDINE equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| sulfasalazine tab (AZULFIDINE equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| sulindac tab (CLINORIL equiv) | - | 1 | ANALGESICS - ANTI-INFLAMMATORY |
| SUMADAN KIT, SUMAXIN KIT | - | NC | DERMATOLOGICALS |
| SUMADAN WASH 9-4.5% | - | 3 | DERMATOLOGICALS |
| SUMADEN XLT KIT | - | NC | DERMATOLOGICALS |
| SUMANSETRON PAK | - | NC | MIGRAINE PRODUCTS |
| SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| sumatriptan/naproxen tab (TREMIMET equiv) | - | NC | MIGRAINE PRODUCTS |
| SUMAVEL DOSEPRO INJ | - | NC | MIGRAINE PRODUCTS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| SUMAXIN WASH | - | NC | DERMATOLOGICALS |
| sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day) | LMSP-PA-QL | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SUNLENCA INJ (QL= 2 vials/26 weeks; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 | ANTIVIRALS |
| SUNLENCA TAB (QL= 4 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 | ANTIVIRALS |
| SUNLENCA TAB 300MG (QL= 5 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 | ANTIVIRALS |
| SUNOSI TAB (QL= 1 tab/day) | PA-QL | 2 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY//NOREXIANTS |
| SUPRAX CAP | - | 3 | CEPHALOSPORINS |
| SUPRAX CHEW TAB | - | 3 | CEPHALOSPORINS |
| SUPRAX SUSP 500MG/5ML | - | 3 | CEPHALOSPORINS |
| SUPREP BOWEL PREP PACK | - | NC | LAXATIVES |
| SUSTIVA TAB | - | 3 | ANTIVIRALS |
| SUSTOL INJ | - | NC | ANTIEMETICS |
| SUTAB TAB | - | NC | LAXATIVES |
| SUTENT CAP | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SYLATRON INJ | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| SYMBRAVO TAB | - | NC | MIGRAINE PRODUCTS |
| SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| SYMFI (LO) TAB | - | 3 | ANTIVIRALS |
| SYMLINPEN INJ | - | NC | ANTIDIABETICS |
| SYMPAZAN ORAL FILM | - | NC | ANTICONSULTANTS |
| SYMPROIC TAB (QL= 1 tab/day) | PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| SYMTUZA TAB | - | 2 | ANTIVIRALS |
| SYNAREL NASAL SOLN | - | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| SYNDROS SOLN | - | NC | ANTIEMETICS |
| SYNJARDY TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| SYNVEXIA TC CREAM | - | NC | DERMATOLOGICALS |
| TABLOID TAB | - | 2 | ANTINEOPLASTICS |
| TABRECTA TAB (QL= 4 tabs/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| tacrolimus cap (PROGRAF equiv) | - | 1 | ASSORTED CLASSES |
| tacrolimus oint (PROTOPIC OINT equiv) | - | 1 | DERMATOLOGICALS |
| tadalafil tab (CIALIS equiv) | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| tadalafil tab (PAH) (ADCIRCA equiv) | PA | 1 | CARDIOVASCULAR AGENTS - MISC. |
| tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap) | QL-ST | 1 | CARDIOVASCULAR AGENTS - MISC. |
| TADLIQ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | CARDIOVASCULAR AGENTS - MISC. |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| TAFINLAR CAP (QL= 4 caps/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TAFINLAR TAB | LMSP-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| tafluprost preservative free (pf) ophth soln (ZIOPTAN OPHTH SOLN equiv) | - | NC | OPHTHALMIC AGENTS |
| TAGAMET TAB | - | 3 | ULCER DRUGS |
| TAGRISSE TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | HEMATOLOGICAL AGENTS - MISC. |
| TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | HEMATOLOGICAL AGENTS - MISC. |
| TALICIA CAP | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| TALTZ INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| TALZENNA CAP 0.1MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TALZENNA CAP 0.25MG (QL= 3 caps/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TALZENNA CAP 0.35MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| tamoxifen tab (NOLVADEX equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| tamsulosin cap (FLOMAX equiv) | - | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |
| TANZEUM INJ | - | NC | ANTIDIABETICS |
| TARCEVA TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TARGRETIN GEL | - | NC | DERMATOLOGICALS |
| TARPEYO CAP | - | NC | CORTICOSTEROIDS |
| TASCENSO ODT TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| TASIGNA CAP | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| tasimelteon cap (HETLIOZ equiv) | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| TASOPROL CREAM KIT | - | NC | DERMATOLOGICALS |
| tavaborole soln (KERYDIN equiv) | - | NC | DERMATOLOGICALS |
| TAVALISSE TAB | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| tazarotene cream 0.05% (TAZORAC equiv) | - | 1 | DERMATOLOGICALS |
| tazarotene cream 0.1% (TAZORAC equiv) | - | 1 | DERMATOLOGICALS |
| tazarotene gel (TAZORAC equiv) | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TECFIDERA CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| TECFIDERA STARTER PACK | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| TEKTURNA HCT TAB | - | 3 | ANTIHYPERTENSIVES |
| telmisartan tab (MICARDIS equiv) | - | 1 | ANTIHYPERTENSIVES |
| TELMISARTAN/AMLODIPINE TAB | - | NC | ANTIHYPERTENSIVES |
| telmisartan/amlodipine tab (TWINSTA equiv) | - | NC | ANTIHYPERTENSIVES |
| telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv) | - | NC | ANTIHYPERTENSIVES |
| temazepam cap 15mg (RESTORIL equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| temazepam cap 22.5mg (RESTORIL equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| temazepam cap 30mg (RESTORIL equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| temazepam cap 7.5mg (RESTORIL equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| temozolomide cap (TEMODAR equiv) | LMSP | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TEMPO SMART BUTTON (QL= 1 button/8 months) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| tenofovir disoproxil fumarate tab (VIREAD equiv) | - | 1 | ANTIVIRALS |
| TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TERAVAX CAP | - | NC | MULTIVITAMINS |
| terazosin cap (HYTRIN equiv) | - | 1 | ANTIHYPERTENSIVES |
| terbinafine tab (LAMISIL equiv) | - | 1 | ANTIFUNGALS |
| terbutaline sulfate tab (BRETHINE equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| terconazole cream (TERAZOL equiv) | - | 1 | VAGINAL PRODUCTS |
| TERCONAZOLE CREAM 0.8% | - | 1 | VAGINAL PRODUCTS |
| terconazole supp (TERAZOL equiv) | - | 1 | VAGINAL PRODUCTS |
| teriflunomide tab (AUBAGIO equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| teriparatide (recombinant) soln pen-inj (FORTEO equiv) | LMSP | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| TEST STRIP (all other test strips) | OTC | NC | DIAGNOSTIC PRODUCTS |
| testosterone cypionate inj (DEPO-TESTOSTERONE equiv) | - | 1 | ANDROGENS-ANABOLIC |
| TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill) | QL | 2 | ANDROGENS-ANABOLIC |
| testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day) | PA-QL | 2 | ANDROGENS-ANABOLIC |
| testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv) (QL= 4 bottles/30 days) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| TESTOSTERONE GEL 10MG/ACT | - | NC | ANDROGENS-ANABOLIC |
| testosterone gel 2% (FORTESTA equiv) | - | NC | ANDROGENS-ANABOLIC |
| TESTOSTERONE GEL 20.25MG/1.25GM (QL= 1 packet/day) | PA-QL | 1 | ANDROGENS-ANABOLIC |

| | | | | | |
|------|---|-----|--|------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

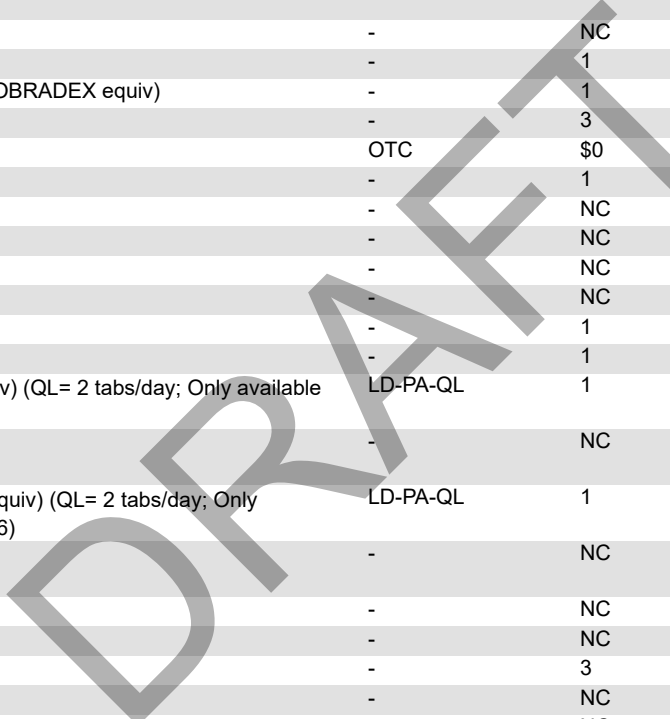
| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| TESTOSTERONE GEL PUMP 1% (QL= 4 bottles/30 days) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| TESTOSTERONE GEL, VOGELXO GEL | - | NC | ANDROGENS-ANABOLIC |
| testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days) | PA-QL | 1 | ANDROGENS-ANABOLIC |
| TETANUS/DIPHThERIA TOXOID INJ | VAC | \$0 | TOXOIDS |
| tetrabenazine tab (XENAZINE equiv) | LMSP | 1 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| tetracaine hcl ophth soln | - | 1 | OPHTHALMIC AGENTS |
| TETRACAINE OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| tetracycline cap | - | 1 | TETRACYCLINES |
| TETRACYCLINE TAB | - | NC | TETRACYCLINES |
| TEXACORT SOLN | - | NC | DERMATOLOGICALS |
| TEZRULY SOLN | - | NC | ANTIHYPERTENSIVES |
| TEZSPIRE INJ (QL= 1 pen/28 days) | LMSP-PA-QL | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| THALITONE TAB | - | NC | DIURETICS |
| THALOMID CAP | MSP | 2 | ASSORTED CLASSES |
| theophylline er tab (THEOPHYLLINE ER equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| theophylline ER tab (UNIPHYL equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| theophylline soln | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| THEOPHYLLINE TAB ER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| THIOLA EC TAB | - | NC | GENITOURINARY AGENTS - MISCELLANEOUS |
| thioridazine hcl tab (THIORIDAZINE equiv) | - | 1 | ANTIpsychOTICS/ANTIMANIC AGENTS |
| thiothixene cap (NAVANE equiv) | - | 1 | ANTIpsychOTICS/ANTIMANIC AGENTS |
| THYQUIDITY SOLN | - | NC | THYROID AGENTS |
| tiagabine tab (GABITRIL equiv) | - | 1 | ANTICONVULSANTS |
| TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ticagrelor tab (BRILINTA equiv) | - | 1 | HEMATOLOGICAL AGENTS - MISC. |
| TICANASE PAK | - | NC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| TICOVAC INJ | VAC | EXC | VACCINES |
| TIGAN INJ | - | 3 | ANTIEMETICS |
| TIGLUTIK SUSP | - | NC | NEUROMUSCULAR AGENTS |
| timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv) | - | 1 | OPHTHALMIC AGENTS |
| timolol maleate ophth gel (TIMOPTIC-XE equiv) | - | 1 | OPHTHALMIC AGENTS |
| timolol maleate ophth soln (TIMOPTIC equiv) | - | 1 | OPHTHALMIC AGENTS |
| timolol maleate ophth soln 0.5% (ISTALOL equiv) | - | 1 | OPHTHALMIC AGENTS |
| timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv) | - | 1 | OPHTHALMIC AGENTS |
| TIMOLOL MALEATE TAB | - | 1 | BETA BLOCKERS |
| timolol maleate tab (BLOCADREN equiv) | - | 1 | BETA BLOCKERS |
| timolol ophth soln (BETIMOL equiv) | - | 1 | OPHTHALMIC AGENTS |
| tinidazole tab (TINDAMAX equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| tiopronin tab (THIOLA equiv) | LMSP-PA | 1 | GENITOURINARY AGENTS - MISCELLANEOUS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| tiopronin tab delayed release (THIOLA EC equiv) | LMSP-PA | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |
| tiotropium bromide cap inhaler (SPIRIVA equiv) | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| TIROSINT CAP | - | NC | THYROID AGENTS |
| TIROSINT-SOL (QL= 1ml/day; Prior Authorization required for members age 9 years and older) | PA-QL | 3 | THYROID AGENTS |
| TIVICAY PD TAB | - | 2 | ANTIVIRALS |
| TIVICAY TAB | - | 2 | ANTIVIRALS |
| tizanidine cap (ZANAFLEX equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| TIZANIDINE COMFORT KIT | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| tizanidine tab (ZANAFLEX equiv) | - | 1 | MUSCULOSKELETAL THERAPY AGENTS |
| TOBI PODHALER (Only available through Walgreens 888-347-3416) | LD-PA | 3 | AMINOGLYCOSIDES |
| TOBRADEX OPHTH OINT | - | 2 | OPHTHALMIC AGENTS |
| TOBRADEX ST OPHTH SUSP | - | 3 | OPHTHALMIC AGENTS |
| tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist) | LMSP-RS | 1 | AMINOGLYCOSIDES |
| tobramycin neb soln (BETHKIS equiv) | - | NC | AMINOGLYCOSIDES |
| tobramycin ophth soln (TOBEX equiv) | - | 1 | OPHTHALMIC AGENTS |
| tobramycin/dexamethasone ophth soln (TOBRADEX equiv) | - | 1 | OPHTHALMIC AGENTS |
| TOBEX OPHTH OINT | - | 3 | OPHTHALMIC AGENTS |
| TODAY SPONGE | OTC | \$0 | VAGINAL PRODUCTS |
| tolcapone tab (TASMAR equiv) | - | 1 | ANTIPARKINSON AGENTS |
| TOLECTIN TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| TOLMETIN CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| TOLMETIN TAB, TOLECTIN TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| TOLSURA CAP | - | NC | ANTIFUNGALS |
| tolterodine SR cap (DETROL LA equiv) | - | 1 | URINARY ANTISPASMODICS |
| tolterodine tab (DETROL equiv) | - | 1 | URINARY ANTISPASMODICS |
| tolvaptan tab (SAMSCA, JYNARQUE equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| TOLVAPTAN TAB | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| tolvaptan tab therapy pack (JYNARQUE equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| TONMYA SUB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| TOPICORT CREAM 0.05% | - | NC | DERMATOLOGICALS |
| TOPICORT GEL | - | NC | DERMATOLOGICALS |
| TOPICORT OINT | - | 3 | DERMATOLOGICALS |
| topiramate ER cap (QUDEXY equiv) | - | NC | ANTICONVULSANTS |
| topiramate er cap (TROKENDI XR equiv) | - | NC | ANTICONVULSANTS |
| topiramate oral soln (EPRONTIA equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 | ANTICONVULSANTS |
| topiramate sprinkle cap (TOPAMAX equiv) | - | 1 | ANTICONVULSANTS |
| topiramate tab (TOPAMAX equiv) | - | 1 | ANTICONVULSANTS |
| toremifene tab (FARESTON equiv) | - | 1 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| torsemide tab (DEMADEX equiv) | - | 1 | DIURETICS |
| TOSYMRA SOLN | - | NC | MIGRAINE PRODUCTS |



| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| TOUJEO MAX SOLOSTAR INJ | - | 2 | ANTIDIABETICS |
| TOUJEO SOLOSTAR INJ | - | 2 | ANTIDIABETICS |
| TOVET KIT | - | NC | DERMATOLOGICALS |
| TOVIAZ TAB | - | 3 | URINARY ANTISPASMODICS |
| TRACLEER TAB | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| TRADJENTA TAB (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| TRAMADOL COMPOUND KIT | - | NC | DERMATOLOGICALS |
| TRAMADOL ER CAP | - | NC | ANALGESICS - OPIOID |
| tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 | ANALGESICS - OPIOID |
| TRAMADOL HCL TAB | - | NC | ANALGESICS - OPIOID |
| tramadol hcl tab 100mg | - | NC | ANALGESICS - OPIOID |
| tramadol tab (ULTRAM equiv) | - | 1 | ANALGESICS - OPIOID |
| tramadol/acetaminophen tab (ULTRACET equiv) | - | 1 | ANALGESICS - OPIOID |
| trandolapril tab (MAVIK equiv) | - | 1 | ANTIHYPERTENSIVES |
| TRANDOLAPRIL/VERAPAMIL ER TAB | - | NC | ANTIHYPERTENSIVES |
| tranexamic acid tab (LYSTEDA equiv) | - | 1 | HEMOSTATICS |
| TRANSDERM-SCOP PATCH | - | 3 | ANTIEMETICS |
| tranylcypromine tab (PARNATE equiv) | - | 1 | ANTIDEPRESSANTS |
| travoprost ophth soln (TRAVATAN Z equiv) (QL= 2.5ml/30 days) | QL | 1 | OPHTHALMIC AGENTS |
| trazodone tab (DESYREL equiv) | - | 1 | ANTIDEPRESSANTS |
| trazodone tab 300mg (DESYREL equiv) | - | NC | ANTIDEPRESSANTS |
| TRECATOR TAB | - | NC | ANTIMYCOBACTERIAL AGENTS |
| TRELEGY ELLIPTA INHALER | - | 2 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| TREMFYA INDUCTION INJ 200MG/ML (QL= 2 inj/28 days; 6 inj/year) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| TREMFYA INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| TREMFYA INJ 200MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| TRESIBA FLEXTOUCH INJ | - | 2 | ANTIDIABETICS |
| TRESIBA INJ | - | 2 | ANTIDIABETICS |
| tretinoin cap (VESANOID equiv) | LMSP | 1 | ANTINEOPLASTICS |
| tretinoin cream (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| tretinoin gel (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| tretinoin gel (RETIN-A GEL equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| tretinoin gel 0.08% (RETIN-A MICRO equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| TRETINOIN MICROSPHERE GEL 0.04% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| TRETINOIN MICROSPHERE GEL 0.1% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| TRETINOIN MICROSPHERE GEL PUMP 0.04% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| TRETINOIN MICROSPHERE GEL PUMP 0.1% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 | DERMATOLOGICALS |
| TRETIN-X CREAM | - | NC | DERMATOLOGICALS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| TRETTEN INJ | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| TREXALL TAB | - | NC | ANTINEOPLASTICS |
| TREXIMET TAB | - | NC | MIGRAINE PRODUCTS |
| TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP | - | NC | ANALGESICS - OPIOID |
| triamcinolone acetonide inj (KENALOG equiv) | - | 1 | CORTICOSTEROIDS |
| triamcinolone acetonide oint (TRIANEX equiv) | - | NC | DERMATOLOGICALS |
| triamcinolone cream | - | 1 | DERMATOLOGICALS |
| triamcinolone in orabase paste (KENALOG/ORABASE equiv) | - | 1 | MOUTH/THROAT/DENTAL AGENTS |
| triamcinolone lotion | - | 1 | DERMATOLOGICALS |
| triamcinolone oint | - | 1 | DERMATOLOGICALS |
| triamcinolone OTC nasal spray (NASACORT equiv) | OTC | EXC | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| TRIAMCINOLONE SPRAY | - | NC | DERMATOLOGICALS |
| triamcinolone spray (KENALOG equiv) | - | NC | DERMATOLOGICALS |
| triamterene cap (DYRENIUM equiv) | - | 1 | DIURETICS |
| triamterene/hydrochlorothiazide cap (DYAZIDE equiv) | - | 1 | DIURETICS |
| triamterene/hydrochlorothiazide tab (MAXZIDE equiv) | - | 1 | DIURETICS |
| TRIAMVEX KIT | - | EXC | DERMATOLOGICALS |
| TRIANEX OINT | - | NC | DERMATOLOGICALS |
| triazolam tab (HALCION equiv) | - | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| TRIBENZOR TAB | - | NC | ANTIHYPERTENSIVES |
| TRICHOPHYTON MENTAGROPHYTES (DIAGNOSTIC) SOLN | - | NC | DIAGNOSTIC PRODUCTS |
| TRICHOPHYTON MENTAGROPHYTES SOLN | - | NC | ALLERGENIC EXTRACTS/BIOLOGICALS MISC |
| TRICHOSOL SOLN | - | NC | PHARMACEUTICAL ADJUVANTS |
| trientine cap (SYPRINE equiv) | LMSP-PA | 1 | MISCELLANEOUS THERAPEUTIC CLASSE |
| TRIENTINE CAP | - | NC | MISCELLANEOUS THERAPEUTIC CLASSE |
| trifluoperazine tab (STELAZINE equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| TRIFLURIDINE OPHTH SOLN | - | 1 | OPHTHALMIC AGENTS |
| TRIGLIDE TAB | - | NC | ANTIHYPERLIPIDEMICS |
| trihexyphenidyl elixir (ARTANE equiv) | - | 1 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| TRIHXYPHENIDYL SOLN | - | 1 | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| trihexyphenidyl tab (ARTANE equiv) | - | 1 | ANTIPARKINSON AGENTS |
| TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | RESPIRATORY AGENTS - MISC. |
| TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB | PASSIVE IMMUNIZING AND TREATMENT AGENTS |
| tri-legest tab (ESTROSTEP FE equiv) | - | \$0 | CONTRACEPTIVES |
| TRILIPIX CAP | - | NC | ANTIHYPERLIPIDEMICS |
| TRILOCICLO KIT | - | NC | DERMATOLOGICALS |
| TRI-LUMA CREAM | - | EXC | DERMATOLOGICALS |
| trimethobenzamide cap (TIGAN equiv) | - | 1 | ANTIEMETICS |
| TRIMETHOPRIM TAB | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| trimethoprim tab (PROLOPRIM equiv) | - | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| trimipramine cap (SURMONTIL equiv) | - | 1 | ANTIDEPRESSANTS |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| TRINTELLIX TAB (QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine) | QL-ST-¢ | 3 | ANTIDEPRESSANTS |
| TRIONEX PAK | - | NC | DERMATOLOGICALS |
| tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv) | - | \$0 | CONTRACEPTIVES |
| TRIUMEQ PD TAB | - | 2 | ANTIVIRALS |
| TRIUMEQ TAB | - | 2 | ANTIVIRALS |
| TRI-VITAMIN FLUORIDE DROPS | - | NC | MULTIVITAMINS |
| TRIZIVIR TAB | - | 2 | ANTIVIRALS |
| TROKENDI XR CAP | - | NC | ANTICONVULSANTS |
| tropicamide ophth soln (MYDRIACYL equiv) | - | 1 | OPHTHALMIC AGENTS |
| TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| tropium chloride SR cap (SANCTURA XR equiv) | - | 1 | URINARY ANTISPASMODICS |
| tropium tab (SANCTURA equiv) | - | 1 | URINARY ANTISPASMODICS |
| TRUDHESA NASAL SPRAY | - | NC | MIGRAINE PRODUCTS |
| TRULANCE TAB (QL= 1 tab/day) | PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 | ANTIDIABETICS |
| TRUMENBA INJ | VAC | \$0 | VACCINES |
| TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TRUVADA TAB | - | NC | ANTIVIRALS |
| TRYNGOLZA INJ (QL= 1 inj/28 days; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| TRYPTYR SOLN | - | EXC | OPHTHALMIC AGENTS |
| TRYVIO TAB | - | EXC | ANTIHYPERTENSIVES |
| TUDORZA PRESSAIR INHALER | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| TUKYSA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TUSSICAPS | - | NC | COUGH/COLD/ALLERGY |
| tussigon tab (HYCODAN equiv) | - | 1 | COUGH/COLD/ALLERGY |
| TUXARIN ER TAB | - | NC | COUGH/COLD/ALLERGY |
| TUZISTRA XR SUSP | - | NC | COUGH/COLD/ALLERGY |
| TWIIST REFILL KIT | - | NC | MEDICAL DEVICES AND SUPPLIES |
| TWIIST STARTER KIT | - | NC | MEDICAL DEVICES AND SUPPLIES |
| TWINRIX INJ | VAC | \$0 | VACCINES |
| TWIRLA PATCH | - | 3 | CONTRACEPTIVES |
| TWYNEO CREAM | - | NC | DERMATOLOGICALS |
| TYBLUME TAB | - | \$0 | CONTRACEPTIVES |
| TYBOST TAB | - | 2 | ANTIVIRALS |
| TYENNE INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| TYKERB TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| TYMLOS INJ | LMSP | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| TYPHIM VI INJ | VAC | EXC | VACCINES |
| TYRVAYA NASAL SPRAY (QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist) | QL-RS | 2 | OPHTHALMIC AGENTS |
| TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG (QL= 224 cartridges/2 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year) | PA-QL | 2 | MIGRAINE PRODUCTS |
| UCERIS RECTAL FOAM | PA | 3 | ANORECTAL AND RELATED PRODUCTS |
| UDENYCA INJ | - | NC | HEMATOPOIETIC AGENTS |
| ULORIC TAB | - | NC | GOUT AGENTS |
| ULTRAVATE LOTION | - | NC | DERMATOLOGICALS |
| ULTRAVATE PAC KIT | - | NC | DERMATOLOGICALS |
| UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| UMECTA EMULSION | - | NC | DERMATOLOGICALS |
| UMECTA PD EMULSION | - | NC | DERMATOLOGICALS |
| UMECTA SUSP | - | NC | DERMATOLOGICALS |
| UPNEEQ SOLN | - | EXC | OPHTHALMIC AGENTS |
| UPTRAVI INJ | - | NC | CARDIOVASCULAR AGENTS - MISC. |
| UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| URAMAXIN CREAM | - | NC | DERMATOLOGICALS |
| URAMAXIN GEL | - | NC | DERMATOLOGICALS |
| urea cream | - | NC | DERMATOLOGICALS |
| urea emulsion | - | NC | DERMATOLOGICALS |
| urea gel (URAMAXIN equiv) | - | NC | DERMATOLOGICALS |
| UREA LOT | - | NC | DERMATOLOGICALS |
| UREA NAIL KIT | - | NC | DERMATOLOGICALS |
| UREA SUSP | - | NC | DERMATOLOGICALS |
| urea susp 40% (UMECTA equiv) | - | NC | DERMATOLOGICALS |
| UREA/SALICYLIC CREAM | - | NC | DERMATOLOGICALS |
| ursodiol cap (ACTIGALL equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| URSODIOL CAP | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ursodiol tab (URSO (FORTE) equiv) | - | 1 | GASTROINTESTINAL AGENTS - MISC. |
| USTEKINUMAB INJ 45/0.5ML | - | NC | DERMATOLOGICALS |
| USTEKINUMAB INJ 90MG/ML | - | NC | DERMATOLOGICALS |
| USTEKINUMAB-AEKN 45MG/0.5ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 | DERMATOLOGICALS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| USTEKINUMAB-AEKN 90MG/ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 | DERMATOLOGICALS |
| UTA CAP | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| VAFSEO TAB | - | NC | HEMATOPOIETIC AGENTS |
| valacyclovir tab (VALTREX equiv) | - | 1 | ANTIVIRALS |
| VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | DERMATOLOGICALS |
| valganciclovir soln (VALCYTE equiv) | - | 1 | ANTIVIRALS |
| valganciclovir tab (VALCYTE equiv) | - | 1 | ANTIVIRALS |
| valproate inj (DEPAICON equiv) | - | NC | ANTICONVULSANTS |
| valproic acid cap (DEPAKENE equiv) | - | 1 | ANTICONVULSANTS |
| valproic acid syrup (DEPAKENE equiv) | - | 1 | ANTICONVULSANTS |
| valsartan oral soln (VALSARTAN equiv) | - | NC | ANTIHYPERTENSIVES |
| valsartan tab (DIOVAN equiv) | - | 1 | ANTIHYPERTENSIVES |
| valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv) | - | 1 | ANTIHYPERTENSIVES |
| VALTOCO NASAL SPRAY (QL= 5 doses/fill) | QL | 3 | ANTICONVULSANTS |
| VANOCIN CAP (QL= 56 caps/fill) | QL | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| vancomycin cap (VANOCIN equiv) (QL= 56 caps/fill) | QL | 1 | ANTI-INFECTIVE AGENTS - MISC. |
| vancomycin hcl soln (VANCOMYCIN equiv) | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| VANCOMYCIN ORAL SOLN | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| VANCOMYCIN SOLN | - | NC | ANTI-INFECTIVE AGENTS - MISC. |
| VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VANIQA CREAM | - | EXC | DERMATOLOGICALS |
| VANOS CREAM | - | NC | DERMATOLOGICALS |
| VANRAFIA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405) | LD-PA-QL | 2 | GENITOURINARY AGENTS - MISCELLANEOUS |
| vardenafil ODT (STAXYN equiv) | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| vardenafil tab (LEVITRA equiv) | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| VARENICLINE TAB (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| VARIVAX INJ | VAC | \$0 | VACCINES |
| VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist) | QL-RS | 2 | ANTIEMETICS |
| vasoex oint (XENADERM equiv) | - | NC | DERMATOLOGICALS |
| VAXCHORA SUSP | VAC | EXC | VACCINES |
| VAXELIS INJ | VAC | \$0 | TOXOIDS |
| VAXNEUVANCE INJ | VAC | \$0 | VACCINES |
| V-C FORTE CAP | - | NC | MULTIVITAMINS |
| v-c forte cap (V-C FORTE equiv) | - | NC | MULTIVITAMINS |
| VECAMYL TAB | - | NC | ANTIHYPERTENSIVES |
| VECTICAL OINT | - | NC | DERMATOLOGICALS |
| VELIVET PAK | - | \$0 | CONTRACEPTIVES |

| | | | | | |
|------|---|-----|--|------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| velivet tab (CYCLESSA equiv) | - | \$0 | CONTRACEPTIVES |
| VELPHORO CHEW TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| VELSIPITY TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| VELTASSA POWDER (QL= 1 packet/day) | PA-QL | 2 | ASSORTED CLASSES |
| VELTASSA POWDER 1GM (QL= 4 packets/day) | PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| VEMLIDY TAB | - | 2 | ANTIVIRALS |
| VENCLEXTA STARTER PACK (Only available through Optum 877-445-6874) | LD-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VENCLEXTA TAB (Only available through Optum 877-445-6874) | LD-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| venlafaxine ER cap (EFFEXOR XR equiv) | - | 1 | ANTIDEPRESSANTS |
| VENLAFAXINE ER TAB | - | NC | ANTIDEPRESSANTS |
| venlafaxine tab (EFFEXOR equiv) | - | 1 | ANTIDEPRESSANTS |
| VENLAFAXINE TAB | - | NC | ANTIDEPRESSANTS |
| VENNGEL ONE KIT | - | NC | DERMATOLOGICALS |
| VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB | CARDIOVASCULAR AGENTS - MISC. |
| VENTOLIN HFA INHALER (QL= 2 inhalers/30 days) | QL | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| VEOZAH TAB (QL= 1 tab/day) | PA-QL | 3 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| VERAPAMIL CR CAP, VERELAN CAP | - | NC | CALCIUM CHANNEL BLOCKERS |
| VERAPAMIL ER CAP | - | NC | CALCIUM CHANNEL BLOCKERS |
| verapamil SR cap (VERELAN equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| verapamil SR tab (CALAN SR, ISOPTIN SR equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| verapamil tab (CALAN equiv) | - | 1 | CALCIUM CHANNEL BLOCKERS |
| VERDESO FOAM | - | NC | DERMATOLOGICALS |
| VERDROCET TAB 2.5MG-325MG | - | NC | ANALGESICS - OPIOID |
| VEREGEN OINT | - | NC | DERMATOLOGICALS |
| VERELAN CAP | - | 3 | CALCIUM CHANNEL BLOCKERS |
| VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist) | QL-RS | 2 | CARDIOVASCULAR AGENTS - MISC. |
| VERSACLOZ SUSP | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| VERSAPENN AL GEL ANHYDROU | - | NC | PHARMACEUTICAL ADJUVANTS |
| VERZENIO TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VESICARE LS SUSP | - | NC | URINARY ANTISPASMODICS |
| VFEND SUSP | - | 3 | ANTIFUNGALS |
| V-GO INJ KIT (QL= 1 kit/day) | QL | 2 | MEDICAL DEVICES AND SUPPLIES |
| VIAGRA TAB | - | EXC | CARDIOVASCULAR AGENTS - MISC. |
| VIBERZI TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| VICTOZA INJ | - | NC | ANTIDIABETICS |
| vienna tab, lessina tab, kurvelo tab (ALESSE equiv) | - | \$0 | CONTRACEPTIVES |
| vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 | ANTICONVULSANTS |
| vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 | ANTICONVULSANTS |
| vigadrone powder pack (Only available through PantheRx 855-726-8479) | LD-PA | 1 | ANTICONVULSANTS |
| VIGAFYDE SOLN | - | NC | ANTICONVULSANTS |
| VIGAMOX OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| VIIBRYD STARTER KIT | - | NC | ANTIDEPRESSANTS |
| VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 | MISCELLANEOUS THERAPEUTIC CLASSES |
| VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 | MISCELLANEOUS THERAPEUTIC CLASSES |
| VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 | MISCELLANEOUS THERAPEUTIC CLASSES |
| vilazodone hcl tab (VIIBRYD equiv) | - | 1 | ANTIDEPRESSANTS |
| VIMKUNYA INJ | VAC | EXC | VACCINES |
| VIMOVO TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| VIMPAT SOLN | - | NC | ANTICONSULTANTS |
| VIMPAT TAB | - | NC | ANTICONSULTANTS |
| viorele tab, kariva tab (MIRCETTE equiv) | - | \$0 | CONTRACEPTIVES |
| VIRACEPT TAB | - | 2 | ANTIVIRALS |
| VIREAD TAB | - | 2 | ANTIVIRALS |
| VISTOGARD PAK | - | NC | ANTIDOTES |
| VITADYE LOTION | OTC | EXC | DERMATOLOGICALS |
| VITAFOL STRIPS | - | 3 | MULTIVITAMINS |
| vitamin D cap | OTC | \$0 | VITAMINS |
| vitamin D cap (RX strength only) | - | 1 | VITAMINS |
| vitamin D cap 1000unit | OTC | \$0 | VITAMINS |
| vitamin D cap 400unit | OTC | \$0 | VITAMINS |
| vitamin D chew liquid | - | \$0 | VITAMINS |
| vitamin D chew tab | OTC | \$0 | VITAMINS |
| VITAMIN D TAB 400UNIT | OTC | NC | VITAMINS |
| VITAMIN D3 DROPS | - | \$0 | VITAMINS |
| VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VIVITROL INJ | LMSP | 2 | ANTIDOTES |
| VIVJOA CAP | - | NC | ANTIFUNGALS |
| VIVLODEX CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| VIVOTIF CAP | VAC | EXC | VACCINES |
| VIZIMPRO TAB (QL= 1 tab/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VIZZ OPHTH SOLN | - | EXC | OPHTHALMIC AGENTS |
| VOGELXO GEL PUMP 1% (QL= 4 bottles/30 days) | PA-QL | 3 | ANDROGENS-ANABOLIC |
| VOLTAREN GEL | OTC | EXC | DERMATOLOGICALS |
| VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VONVENDI INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| VOPAC 5 CREAM | - | NC | DERMATOLOGICALS |
| VOPAC CREAM | - | NC | DERMATOLOGICALS |
| VOPAC GB CREAM | - | NC | DERMATOLOGICALS |
| VOQUEZNA DUAL PAK | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|--|
| VOQUEZNA TAB | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| VOQUEZNA TRIP PAK | - | NC | ULCER DRUGS/ANTISPASMODICS/ANTICHOLINEF CS |
| VORANIGO TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VORANIGO TAB 10MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| voriconazole susp (VFEND equiv) | - | 1 | ANTIFUNGALS |
| voriconazole tab (VFEND equiv) | - | 1 | ANTIFUNGALS |
| VOSEVI TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANTIVIRALS |
| VOTRIENT TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 | GASTROINTESTINAL AGENTS - MISC. |
| VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| VOYDEYA TAB (QL= 6 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| VOYDEYA TAB THERAPY PACK (QL= 6 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| VOYXACT INJ | - | EXC | GENITOURINARY AGENTS - MISCELLANEOUS |
| VP-PNV-DHA CAP | - | 1 | MULTIVITAMINS |
| VRAYLAR CAP | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| VRAYLAR PACK | - | NC | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| VSL #3 CAP | - | NC | ANTIDIARRHEALS |
| VTAMA CREAM | - | NC | DERMATOLOGICALS |
| VTOL SOLN | - | NC | ANALGESICS - NONNARCOTIC |
| VUITY OPHTH SOLN 1.25% | - | NC | OPHTHALMIC AGENTS |
| VUMERITY CAP | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| VYALEV INJ | - | NC | ANTIPARKINSON AND RELATED THERAPY AGENTS |
| VYKAT XR TAB (QL= 4 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| VYKAT XR TAB 150MG (QL= 3 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| VYKAT XR TAB 75MG (QL= 7 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| VYLEESI INJ | - | EXC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| VYSCOXA SUSP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| VYTONE CREAM 1.9-1% | - | NC | DERMATOLOGICALS |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| VYVANSE CAP | - | 3 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| VYVANSE CHEW TAB | - | 3 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| VYVGART HYTRULO INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSE |
| VYZULTA SOLN | - | NC | OPHTHALMIC AGENTS |
| WAINUA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| warfarin tab (COUMADIN equiv) | - | 1 | ANTICOAGULANTS |
| WAYRILZ TAB | - | EXC | HEMATOLOGICAL AGENTS - MISC. |
| WEGOVY INJ | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| WEGOVY INJ 1.7MG/0.75ML | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| WEGOVY INJ 2.4MG/0.75ML | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| WEGOVY TAB | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| WELCHOL PACK | - | 3 | ANTIHYPERLIPIDEMICS |
| WELCHOL TAB | - | 3 | ANTIHYPERLIPIDEMICS |
| WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| WESTCORT OINT | - | NC | DERMATOLOGICALS |
| WEZLANA INJ | - | NC | DERMATOLOGICALS |
| WEZLANA SYRINGE | - | NC | DERMATOLOGICALS |
| WILATE INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| WINLEVI CREAM | - | NC | DERMATOLOGICALS |
| WINREVAIR INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 | CARDIOVASCULAR AGENTS - MISC. |
| WOUND-DRESSING GELS | - | NC | DERMATOLOGICALS |
| WPR PLUS | - | NC | DERMATOLOGICALS |
| WYNZORA CREAM | - | NC | DERMATOLOGICALS |
| XACIATO GEL (QL= 1 applicator/fill) | QL | 2 | VAGINAL AND RELATED PRODUCTS |
| XADAGO TAB (QL= 1 tab/day) | PA-QL | 3 | ANTIPARKINSON AGENTS |
| XALKORI CAP (QL= 2 caps/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XALKORI SPRINKLE CAP (QL= 4 caps/day) | MSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XARELTO STARTER PACK | - | 2 | ANTICOAGULANTS |
| XARELTO SUSP | - | 2 | ANTICOAGULANTS |
| XARELTO TAB | - | 2 | ANTICOAGULANTS |
| XCOPRI PAK 100-150MG (QL= 2 tabs/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI PAK 150-200MG (QL= 2 tabs/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI TAB 25MG (QL= 1 tab/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI TAB 50MG, 100MG (QL= 1 tab/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day) | QL | 2 | ANTICONVULSANTS |
| XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day) | QL | 2 | ANTICONVULSANTS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|--|
| XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day) | QL | 2 | ANTICONVULSANTS |
| XDEMVY DROP | - | NC | OPHTHALMIC AGENTS |
| XELJANZ SOLN (QL= 10 ml/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| XELJANZ TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| XELJANZ XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 | ANALGESICS - ANTI-INFLAMMATORY |
| XELPROS OPTH EMULSION | - | NC | OPHTHALMIC AGENTS |
| XELSTRYM PAD | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 | PASSIVE IMMUNIZING AND TREATMENT AGENTS |
| XENADERM OINT | - | NC | DERMATOLOGICALS |
| XENAZINE TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| XENICAL CAP | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist) | QL-RS | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| XEPI CREAM | - | NC | DERMATOLOGICALS |
| XERESE CREAM | - | NC | DERMATOLOGICALS |
| XERMELO TAB | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| XHANCE NASAL EXHALER | - | 3 | NASAL AGENTS - SYSTEMIC AND TOPICAL |
| XIFAXAN TAB 200MG (QL= 9 tabs/3 days) | QL | 3 | ANTI-INFECTIVE AGENTS - MISC. |
| XIFAXAN TAB 550MG (QL= 60 tabs/30 days) | QL | 2 | ANTI-INFECTIVE AGENTS - MISC. |
| XIGDUO XR TAB (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| XIGDUO XR TAB 10-1000MG (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day) | QL | 2 | ANTIDIABETICS |
| XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day) | QL | 2 | ANTIDIABETICS |
| XIIDRA OPTH SOLN (QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist) | QL-RS | 2 | OPHTHALMIC AGENTS |
| XODOL TAB 10MG-300MG | - | NC | ANALGESICS - OPIOID |
| XODOL TAB 5MG-300MG | - | NC | ANALGESICS - OPIOID |
| XODOL TAB 7.5MG-300MG | - | NC | ANALGESICS - OPIOID |
| XOFLUZA TAB (QL= 1 tab/fill) | QL | 3 | ANTIVIRALS |
| XOLAIR INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLAIR INJ 150MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLAIR SYRINGE (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLAIR SYRINGE 300MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 | ASTHMA AND BRONCHODILATOR AGENTS |
| XOLEGEL | - | 3 | DERMATOLOGICALS |
| XOLREMDI CAP (QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 | HEMATOPOIETIC AGENTS |
| XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| XPHOZAH TAB (QL= 2 tabs/day) | MSP-PA-QL | 3 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| XPROVIO PAK (QL= 32 tabs/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XROMI SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 | HEMATOPOIETIC AGENTS |
| XRYLIX PAK | - | NC | DERMATOLOGICALS |
| XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 | ANALGESICS - OPIOID |
| XTANDI CAP | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XTANDI TAB 40MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XTANDI TAB 80MG | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| XULTOPHY INJ (QL= 15ml/30 days) | QL | 2 | ANTIDIABETICS |
| XURIDEN POWDER | - | NC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| XYNTHA INJ | LMSP-PA | 2 | HEMATOLOGICAL AGENTS - MISC. |
| XYOSTED INJ | - | NC | ANDROGENS-ANABOLIC |
| XYREM SOLN | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| XYWAV SOLN | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| XYZAL SOLN | - | EXC | ANTIHISTAMINES |
| XYZAL TAB | - | EXC | ANTIHISTAMINES |
| XYZBAC TAB | - | EXC | DIETARY PRODUCTS/DIETARY MANAGEMENT PRODUCTS |
| YBUPHEN TAB | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| YESINTEK INJ (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| YESINTEK SYRINGE (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| YESINTEK SYRINGE 90MG (QL= 1 inj/84 days) | LMSP-PA-QL | 2 | DERMATOLOGICALS |
| YEZTUGO INJ (QL= 2 inj/180 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | \$0 | ANTIVIRALS |
| YEZTUGO TAB (QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | \$0 | ANTIVIRALS |
| YF-VAX INJ | VAC | EXC | VACCINES |
| YONSA TAB | - | NC | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| YORVIPATH INJ (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| YORVIPATH INJ 294MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| YORVIPATH INJ 420MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| YOSPRALA TAB | - | NC | HEMATOLOGICAL AGENTS - MISC. |
| YUFLYMA INJ KIT (adalimumab-aaty) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| YUFLYMA KIT (adalimumab-aaty) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| YUPELRI SOLN | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| YUSIMRY INJ (adalimumab-aqvh) | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| YUTREPIA CAP (QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767) | LD-PA-QL | 2 | CARDIOVASCULAR AGENTS - MISC. |
| zafemy patch (XULANE equiv) | - | \$0 | CONTRACEPTIVES |
| zafirlukast tab (ACCOLATE equiv) | - | 1 | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| zaleplon cap (SONATA equiv) (QL= 1 cap/day) | QL | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDEF AGENTS |
| ZANAFLEX CAP | - | NC | MUSCULOSKELETAL THERAPY AGENTS |
| ZARXIO INJ | LMSP | 2 | HEMATOPOIETIC AGENTS |
| ZAVESCA CAP | - | NC | HEMATOPOIETIC AGENTS |
| ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days) | PA-QL | 2 | MIGRAINE PRODUCTS |
| ZECUITY PAD | - | NC | MIGRAINE PRODUCTS |
| ZEGALOGUE INJ (QL= 2 inj/fill) | QL | 2 | ANTIDIABETICS |
| ZEGERID POWDER PACK | - | NC | ULCER DRUGS |
| ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ZELAPAR ODT | - | NC | ANTIPARKINSON AGENTS |
| ZELBORAF TAB (QL= 8 tabs/day) | LMSP-PA-QL | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days) | PA-QL | 2 | DERMATOLOGICALS |
| zenzedi tab 10mg (DEXEDRINE equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| zenzedi tab 5mg (DEXEDRINE equiv) | - | NC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ZEPATIER TAB | - | NC | ANTIVIRALS |
| ZEPBOUND INJ | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ZEPBOUND VIAL INJ | - | EXC | ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY// NOREXIANTS |
| ZEPOSIA CAP (QL= 1 cap/day) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ZEPOSIA STARTER PACK (QL= 1 cap/day) | LMSP-PA-QL | 2 | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ZERVIAE OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| ZETIA TAB | - | NC | ANTIHYPERLIPIDEMICS |
| ZIANA GEL | - | NC | DERMATOLOGICALS |
| zidovudine cap (RETROVIR equiv) | - | 1 | ANTIVIRALS |
| zidovudine syrup (RETROVIR equiv) | - | 1 | ANTIVIRALS |
| zidovudine tab (RETROVIR equiv) | - | 1 | ANTIVIRALS |
| ZIEXTENZO INJ | - | NC | HEMATOPOIETIC AGENTS |
| ZILACAINE PAK | - | NC | DERMATOLOGICALS |
| ZILBRYSQ INJ (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ZILBRYSQ INJ 23MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| ZILBRYSQ INJ 32.4MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 | HEMATOLOGICAL AGENTS - MISC. |
| zileuton ER tab (ZYFLO CR equiv) | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |

| | | | | | |
|------|--|-----|--|------|---------------------------------|
| EXC | Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | NC = Not Covered | | generic = small letters | | BRANDS = CAPITAL LETTERS |
| | NC/3P = Not Covered, Third Party Reviewer | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Alphabetical Index
Last Updated 2/1/2026

| Drug Name | Special Code | Tier | Category |
|---|---------------------|-------------|---|
| ZILXI FOAM | - | NC | DERMATOLOGICALS |
| ZIMHI SOLN | - | 2 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| ZINBRYTA INJ | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ZINC GLUCONATE TAB | OTC | 1 | MINERALS & ELECTROLYTES |
| ZIOPTAN OPHTH SOLN | - | NC | OPHTHALMIC AGENTS |
| ziprasidone cap (GEODON equiv) | - | 1 | ANTIPSYCHOTICS/ANTIMANIC AGENTS |
| ZIPSOR CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ZIRGAN OPHTH GEL | - | 2 | OPHTHALMIC AGENTS |
| ZITHROMAX POWDER PACK | - | 3 | MACROLIDES |
| ZITUVIMET XR TAB | - | NC | ANTIDIABETICS |
| ZITUVIO TAB | - | NC | ANTIDIABETICS |
| ZOCOR TAB 80MG | - | NC | ANTHYPERLIPIDEMICS |
| ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL | 2 | MISCELLANEOUS THERAPEUTIC CLASSES |
| ZOLINZA CAP | LMSP-PA-SF | 2 | ANTINEOPLASTICS |
| zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days) | QL | 3 | MIGRAINE PRODUCTS |
| zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 | MIGRAINE PRODUCTS |
| ZOLPAK KIT | - | NC | DERMATOLOGICALS |
| ZOLPIDEM CAP | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day) | QL | 1 | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| zolpidem tab (AMBIEN equiv) (QL= 1 tab/day) | QL | 1 | HYPNOTICS |
| zolpidem tartrate SL tab (INTERMEZZO equiv) | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| ZOLPIDEM TARTRATE SL TAB 1.75MG | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| ZOLPIDEM TARTRATE SL TAB 3.5MG | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| ZOLPIMIST SPRAY | - | NC | HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS |
| ZOMACTON INJ | - | EXC | ENDOCRINE AND METABOLIC AGENTS - MISC. |
| ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days) | QL | 3 | MIGRAINE PRODUCTS |
| ZONATUSS CAP 150MG | - | NC | COUGH/COLD/ALLERGY |
| ZONISADE SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 | ANTICONVULSANTS |
| zonisamide cap (ZONEGRAN equiv) | - | 1 | ANTICONVULSANTS |
| ZONTIVITY TAB (Restricted to Cardiology Specialist) | RS | 3 | HEMATOLOGICAL AGENTS - MISC. |
| ZORVOLEX CAP | - | NC | ANALGESICS - ANTI-INFLAMMATORY |
| ZORYVE CREAM (QL= 60 grams/30 days) | PA-QL | 2 | DERMATOLOGICALS |
| ZORYVE CREAM 0.05% | - | NC | DERMATOLOGICALS |
| ZORYVE CREAM 0.15% | - | NC | DERMATOLOGICALS |
| ZORYVE FOAM (QL= 60 grams/30 days) | PA-QL | 2 | DERMATOLOGICALS |
| ZOVIRAX CREAM | - | NC | DERMATOLOGICALS |

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary Cont.
 Alphabetical Index
 Last Updated 2/1/2026**

| Drug Name | Special Code | Tier | Category |
|--|---------------------|-------------|---|
| ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 | ANTICONVULSANTS |
| ZUBSOLV SL TAB | - | 2 | ANALGESICS - OPIOID |
| ZUNVEYL TAB | - | NC | PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. |
| ZUPLENZ SL FILM | - | NC | ANTIEMETICS |
| ZURAMPIC TAB | - | NC | GOUT AGENTS |
| ZURNAI INJ | - | 2 | ANTIDOTES AND SPECIFIC ANTAGONISTS |
| ZURZUVAE CAP 20MG, 25MG (QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 | ANTIDEPRESSANTS |
| ZURZUVAE CAP 30MG (QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 | ANTIDEPRESSANTS |
| ZYCLARA CREAM | - | NC | DERMATOLOGICALS |
| ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ZYFLO TAB | - | NC | ANTIASTHMATIC AND BRONCHODILATOR AGENTS |
| ZYKADIA TAB (QL= 3 tabs/day) | LMSP-PA-QL-SF | 2 | ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES |
| ZYLET OPHTH SUSP | - | NC | OPHTHALMIC AGENTS |
| ZYLET OPHTH SUSP 0.5-0.3% (QL= 5ml/fill (10ml bottle is Not Covered)) | QL | 2 | OPHTHALMIC AGENTS |
| ZYLOTROL-L KIT | - | NC | DERMATOLOGICALS |
| ZYMAXID OPHTH SOLN | - | 3 | OPHTHALMIC AGENTS |
| ZYMFENTRA INJ | - | NC | GASTROINTESTINAL AGENTS - MISC. |
| ZYPITAMAG TAB | - | NC | ANTIHYPERTENSIVES |
| ZYRTEC CAP | OTC | EXC | ANTIHISTAMINES |
| ZYRTEC CHILD CHEW ALLERGY | OTC | EXC | ANTIHISTAMINES |
| ZYRTEC CHILD CHEW TAB | OTC | EXC | ANTIHISTAMINES |
| ZYRTEC SYRUP | OTC | EXC | ANTIHISTAMINES |
| ZYRTEC TAB | OTC | EXC | ANTIHISTAMINES |
| ZYRTEC-D TAB | OTC | EXC | COUGH/COLD/ALLERGY |

DRAFT

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS | | |
| AMPHETAMINES | | |
| amphetamine/dextroamphetamine ER cap (ADDERALL XR equiv) | - | 1 |
| amphetamine/dextroamphetamine tab (ADDERALL equiv) | - | 1 |
| dextroamphetamine ER cap (DEXEDRINE equiv) | - | 1 |
| dextroamphetamine soln (PROCENTRA equiv) | - | 1 |
| dextroamphetamine tab (DEXEDRINE equiv) | - | 1 |
| lisdexamfetamine dimesylate cap (VYVANSE equiv) | - | 1 |
| lisdexamfetamine dimesylate chew tab (VYVANSE equiv) | - | 1 |
| VYVANSE CAP | - | 3 |
| VYVANSE CHEW TAB | - | 3 |
| ADZENYS ER SUSP | - | NC |
| ADZENYS XR ODT | - | NC |
| amphetamine er odt (ADZENYS XR equiv) | - | NC |
| AMPHETAMINE ER SUSP, DYANAVEL XR SUSP | - | NC |
| amphetamine tab (EVEKEO equiv) | - | NC |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 12.5mg (MYDAYIS equiv) | - | NC |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 25mg (MYDAYIS equiv) | - | NC |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 37.5mg (MYDAYIS equiv) | - | NC |
| amphetamine-dextroamphetamine 3-bead cap er 24hr 50mg (MYDAYIS equiv) | - | NC |
| dextroamphetamine sulfate tab 15mg (ZENZEDI equiv) | - | NC |
| dextroamphetamine sulfate tab 2.5mg (ZENZEDI equiv) | - | NC |
| dextroamphetamine sulfate tab 20mg (ZENZEDI equiv) | - | NC |
| dextroamphetamine sulfate tab 30mg (ZENZEDI equiv) | - | NC |
| dextroamphetamine sulfate tab 7.5mg (ZENZEDI equiv) | - | NC |
| DYANAVEL XR CHEW | - | NC |
| EVEKEO ODT | - | NC |
| methamphetamine hcl tab (METHAMPHETAMINE equiv) | - | NC |
| MYDAYIS CAP 12.5MG | - | NC |
| MYDAYIS CAP 25MG | - | NC |
| MYDAYIS CAP 37.5MG | - | NC |
| MYDAYIS CAP 50MG | - | NC |
| XELSTRYM PAD | - | NC |
| zenzedi tab 10mg (DEXEDRINE equiv) | - | NC |
| zenzedi tab 5mg (DEXEDRINE equiv) | - | NC |
| ANALECTICS | | |
| caffeine citrate soln (CAFCIT equiv) (Covered for members age 11 months and younger) | - | 1 |
| CAFCIT INJ | - | NC |
| ANOREXIANTS NON-AMPHETAMINE | | |
| ADIPEX-P TAB | - | EXC |
| benzphetamine tab | - | EXC |
| DIETHYLPROPION ER TAB | - | EXC |
| diethylpropion tab | - | EXC |
| PHENDIMETRAZINE ER TAB | - | EXC |
| phendimetrazine tab (BONTRIL PDM equiv) | - | EXC |
| phentermine cap (ADIPEX equiv) | - | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont. | | |
| phentermine hcl-topiramate cap er 24hr (QSYMIA equiv) | - | EXC |
| phentermine tab (ADIPEX equiv) | - | EXC |
| phentermine tab 8mg (ADIPEX equiv) | - | EXC |
| PLENITY CAP | - | EXC |
| QSYMIA CAP | - | EXC |
| ANTI-OBESITY AGENTS | | |
| CONTRAVE TAB | - | EXC |
| liraglutide (weight mngmt) soln pen-inj (SAXENDA equiv) | - | EXC |
| SAXENDA INJ | - | EXC |
| WEGOVY INJ | - | EXC |
| WEGOVY INJ 1.7MG/0.75ML | - | EXC |
| WEGOVY INJ 2.4MG/0.75ML | - | EXC |
| WEGOVY TAB | - | EXC |
| XENICAL CAP | - | EXC |
| ZEPBOUND INJ | - | EXC |
| ZEPBOUND VIAL INJ | - | EXC |
| ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD) AGENTS | | |
| atomoxetine cap (STRATTERA equiv) | - | 1 |
| clonidine ER tab (KAPVAY equiv) | - | 1 |
| guanfacine ER tab (INTUNIV equiv) | - | 1 |
| KAPVAY TAB | - | 3 |
| ONYDA XR SUSP | - | NC |
| QELBREE ER CAP | - | NC |
| DOPAMINE AND NOREPINEPHRINE REUPTAKE INHIBITORS (DNRIS) | | |
| SUNOSI TAB (QL= 1 tab/day) | PA-QL | 2 |
| HISTAMINE H3-RECEPTOR ANTAGONIST/INVERSE AGONISTS | | |
| WAKIX TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| STIMULANTS - MISC. | | |
| armodafinil tab (NUVIGIL equiv) (QL= 1 tab/day) | QL | 1 |
| dexmethylphenidate ER cap (FOCALIN XR equiv) | - | 1 |
| dexmethylphenidate tab (FOCALIN equiv) | - | 1 |
| methylphenidate CD cap (METADATE CD equiv) | - | 1 |
| methylphenidate chew tab (METHYLIN equiv) | - | 1 |
| methylphenidate ER cap (APTENSIO XR equiv) | - | 1 |
| methylphenidate ER cap (RITALIN LA equiv) | - | 1 |
| methylphenidate ER tab | - | 1 |
| methylphenidate soln (METHYLIN equiv) | - | 1 |
| methylphenidate tab (RITALIN equiv) | - | 1 |
| modafinil tab (PROVIGIL equiv) (QL= 2 tabs/day) | QL | 1 |
| CONCERTA TAB, RITALIN SR TAB | - | 3 |
| NUVIGIL TAB (QL= 1 tab/day) | QL | 3 |
| AZSTARYS CAP | - | NC |
| COTEMPLA XR ODT | - | NC |
| methylphenidate ER tab 72mg | - | NC |
| methylphenidate td patch (DAYTRANA equiv) | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS Cont. | | |
| QUILLICHEW ER TAB | - | NC |
| QUILLIVANT XR SUSP | - | NC |
| RELEXXII ER TAB | - | NC |

ALLERGENIC EXTRACTS/BIOLOGICALS MISC

ALLERGENIC EXTRACTS

| | | |
|--|-------|----|
| PALFORZIA POWDER PACK (Only available through Walgreens 888-347-3416) | LD-PA | 2 |
| PALFORZIA SPRINKLE CAP (Only available through Walgreens 888-347-3416) | LD-PA | 2 |
| ODACTRA SL TAB | PA | 3 |
| TRICHOPHYTON MENTAGROPHYTES SOLN | - | NC |

ALTERNATIVE MEDICINES

ALTERNATIVE MEDICINE - R'S

| | | |
|------------------|---|----|
| RESERVAPAK SYRUP | - | NC |
|------------------|---|----|

AMEBICIDES

AMEBICIDES

| | | |
|---|-------|---|
| SOLOSEC GRANULES PACKET (QL= 1 packet/fill) | PA-QL | 3 |
|---|-------|---|

AMINOGLYCOSIDES

AMINOGLYCOSIDES

| | | |
|---|----------|----|
| neomycin tab | - | 1 |
| tobramycin neb soln (TOBI equiv) (Restricted to Infectious Disease or Pulmonology Specialist) | LMSP-RS | 1 |
| ARIKAYCE SUSP (QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046) | LD-PA-QL | 2 |
| TOBI PODHALER (Only available through Walgreens 888-347-3416) | LD-PA | 3 |
| HUMATIN CAP | - | NC |
| KITABIS PAK NEB SOLN | - | NC |
| tobramycin neb soln (BETHKIS equiv) | - | NC |

ANALGESICS - ANTI-INFLAMMATORY

ANTIRHEUMATIC - ENZYME INHIBITORS

| | | |
|---------------------------------|------------|---|
| OLUMIANT TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| RINVOQ ER TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| RINVOQ ORAL SOLN (QL= 12ml/day) | LMSP-PA-QL | 2 |
| XELJANZ SOLN (QL= 10 ml/day) | LMSP-PA-QL | 2 |
| XELJANZ TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 |
| XELJANZ XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |

ANTIRHEUMATIC ANTIMETABOLITES

| | | |
|----------------|---|----|
| RHEUMATREX TAB | - | 3 |
| REDITREX INJ | - | NC |

ANTI-TNF-ALPHA - MONOCLONAL ANTIBODIES

| | | |
|---|------------|---|
| ADALIMUMAB FKJP KIT INJ 20MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT (YUFLYMA equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT (YUFLYMA equiv) (QL= 1 kit/fill; 1 fill/plan year) | LMSP-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANALGESICS - ANTI-INFLAMMATORY Cont. | | |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML (HULIO equiv) (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML (QL= 2 inj/28 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 |
| SIMPONI AUTO-INJECTOR 100MG (QL=1 inj/28 days) | LMSP-PA-QL | 2 |
| SIMPONI INJ 100MG (QL=1 inj/28 days) | LMSP-PA-QL | 2 |
| ABRILADA INJ | - | NC |
| ADALIMUMAB-ADAZ INJ | - | NC |
| ADALIMUMAB-ADAZ INJ (HYRIMOZ equiv) | - | NC |
| ADALIMUMAB-ADAZ INJ 10/0.1ML | - | NC |
| ADALIMUMAB-ADAZ PFS INJ (HYRIMOZ equiv) | - | NC |
| ADALIMUMAB-RYVK INJ (SIMLANDI equiv) | - | NC |
| CYLTEZO AUTO-INJECTOR KIT (adalimumab-adbm) | - | NC |
| CYLTEZO INJ (adalimumab-adbm) | - | NC |
| HADLIMA INJ (adalimumab-bwwd) | - | NC |
| HADLIMA PUSH INJ (adalimumab-bwwd) | - | NC |
| HULIO INJ (adalimumab-fkjp) | - | NC |
| HULIO KIT (adalimumab-fkjp) | - | NC |
| HUMIRA INJ 10MG | - | NC |
| HUMIRA INJ 20MG | - | NC |
| HUMIRA INJ 40MG | - | NC |
| HUMIRA INJ 80MG | - | NC |
| HUMIRA INJ CROHNS/UC/HIDRADENITIS STARTER PACK | - | NC |
| HUMIRA INJ PEDIATRIC CROHNS STARTER PACK | - | NC |
| HUMIRA INJ PEDIATRIC UC STARTER PACK | - | NC |
| HUMIRA INJ PSORIASIS/UVEITIS STARTER PACK | - | NC |
| HUMIRA PEN INJ 40MG | - | NC |
| HYRIMOZ INJ (adalimumab-adaz) | - | NC |
| HYRIMOZ PFS INJ (adalimumab-adaz) | - | NC |
| IDACIO INJ (adalimumab-aacf) | - | NC |
| SIMLANDI INJ, ADALIMUMAB-RYVK INJ (QUALLENT) | - | NC |
| SIMPONI AUTO-INJECTOR 50MG | - | NC |
| SIMPONI INJ 50MG | - | NC |
| YUFLYMA INJ KIT (adalimumab-aaty) | - | NC |
| YUFLYMA KIT (adalimumab-aaty) | - | NC |
| YUSIMRY INJ (adalimumab-aqvh) | - | NC |
| GOLD COMPOUNDS | | |
| AURANOFIN CAP, RIDAURA CAP | - | NC |
| INTERLEUKIN-1 BLOCKERS | | |
| ARCALYST INJ | - | NC |
| INTERLEUKIN-1 RECEPTOR ANTAGONIST (IL-1RA) | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|---|--------------------------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | Plan Exclusion | INF | Limited Distribution |
| PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| RS | Prior Authorization | QL | Restricted to Diagnosis |
| ST | Restricted to Specialist | SF | Smoking Cessation |
| | Step Therapy | VAC | RxCENTS |
| | | | ¢ |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANALGESICS - ANTI-INFLAMMATORY Cont. | | |
| KINERET INJ (QL= 1 inj/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| INTERLEUKIN-6 RECEPTOR INHIBITORS | | |
| KEVZARA INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| TYENNE INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| NONSTEROIDAL ANTI-INFLAMMATORY AGENTS (NSAIDS) | | |
| celecoxib cap (CELEBREX equiv) | - | 1 |
| diclofenac potassium tab (CATAFLAM equiv) | - | 1 |
| diclofenac sodium EC tab (VOLTAREN equiv) | - | 1 |
| diclofenac sodium XR tab (VOLTAREN XR equiv) | - | 1 |
| diclofenac/misoprostol DR tab (ARTHROTEC equiv) | - | 1 |
| etodolac cap (LODINE equiv) | - | 1 |
| etodolac ER tab (LODINE XL equiv) | - | 1 |
| etodolac tab | - | 1 |
| ibuprofen susp (Rx ONLY) (ADVIL, MOTRIN equiv) | - | 1 |
| ibuprofen tab | - | 1 |
| ibuprofen tab ((RX only)) | - | 1 |
| indomethacin cap (INDOCIN equiv) | - | 1 |
| indomethacin CR cap (INDOCIN SR equiv) | - | 1 |
| ketorolac inj 15mg/ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 |
| ketorolac inj 30mg/ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 |
| ketorolac inj 60mg/2ml (TORADOL equiv) (QL= 20ml/5 days) | QL | 1 |
| ketorolac tab (TORADOL equiv) (QL= 20 tabs/5 days) | QL | 1 |
| mefenamic acid cap (PONSTEL equiv) | - | 1 |
| meloxicam tab (MOBIC equiv) | - | 1 |
| nabumetone tab (RELAFEN equiv) | - | 1 |
| naproxen EC tab (NAPROSYN EC equiv) | - | 1 |
| naproxen sodium tab (ANAPROX equiv) | - | 1 |
| naproxen tab (NAPROSYN equiv) | - | 1 |
| oxaprozin tab (DAYPRO equiv) | - | 1 |
| piroxicam cap (FELDENE equiv) | - | 1 |
| sulindac tab (CLINORIL equiv) | - | 1 |
| CELEBREX CAP | - | 3 |
| IBUPROFEN TAB | - | EXC |
| ibuprofen-famotidine tab (DUEXIS equiv) | - | EXC |
| COXANTO CAP | - | NC |
| DICLOFENAC CAP | - | NC |
| diclofenac potassium cap (ZIPSOR equiv) | - | NC |
| diclofenac potassium tab 25mg (DICLOFENAC equiv) | - | NC |
| fenoprofen calcium cap (NALFON equiv) | - | NC |
| FENOPROFEN CAP, NAFLON CAP | - | NC |
| FENOPROFEN TAB | - | NC |
| FENOPRON CAP | - | NC |
| FLURBIPROFEN TAB | - | NC |
| flurbiprofen tab (ANSAID equiv) | - | NC |
| IBU 600-EZS KIT | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | MSP | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | QL | Restricted to Diagnosis |
| | | SF | SMKG |
| | | Limited to two 15 day fills per month for first 3 months | RxCENTS |
| | | VAC | ¢ |
| | | Vaccine Program | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANALGESICS - ANTI-INFLAMMATORY Cont. | | |
| INDOCIN SUPP | - | NC |
| INDOCIN SUSP | - | NC |
| INDOMETHACIN CAP, TIVORBEX CAP | - | NC |
| indomethacin suppository (INDOCIN equiv) | - | NC |
| indomethacin susp (INDOCIN equiv) | - | NC |
| INFLATHERM PAK | - | NC |
| KETOPROFEN CAP | - | NC |
| KETOPROFEN ER CAP | - | NC |
| KETOROLAC INJ | - | NC |
| ketorolac inj (TORADOL equiv) | - | NC |
| MECLOFENAMATE CAP | - | NC |
| meloxicam cap (VIVLODEX equiv) | - | NC |
| MELOXICAM COMFORT KIT | - | NC |
| MELOXICAM SUSP, ZYBIC SUSP | - | NC |
| NAFLON CAP | - | NC |
| NAPRELAN CR TAB | - | NC |
| NAPROSYN EC TAB 500MG | - | NC |
| naproxen EC tab 500mg (NAPROSYN EC equiv) | - | NC |
| naproxen sodium CR tab (NAPRELAN CR equiv) | - | NC |
| NAPROXEN SUSP | - | NC |
| naproxen susp (NAPROSYN equiv) | - | NC |
| naproxen/esomeprazole magnesium DR tab (VIMOVO equiv) | - | NC |
| ORUDIS CAP | - | NC |
| QMIIZ ODT TAB | - | NC |
| RELAFEN DS TAB | - | NC |
| SPRIX NASAL SPRAY | - | NC |
| TOLECTIN TAB | - | NC |
| TOLMETIN CAP | - | NC |
| TOLMETIN TAB, TOLECTIN TAB | - | NC |
| VIMOVO TAB | - | NC |
| VIVLODEX CAP | - | NC |
| VYSCOXIA SUSP | - | NC |
| YBUPHEN TAB | - | NC |
| ZIPSOR CAP | - | NC |
| ZORVOLEX CAP | - | NC |
| PHOSPHODIESTERASE 4 (PDE4) INHIBITORS | | |
| OTEZLA STARTER PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 |
| OTEZLA TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 |
| OTEZLA XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| OTEZLA/OTEZLA XR STARTER PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 |
| PYRIMIDINE SYNTHESIS INHIBITORS | | |
| leflunomide tab (ARAVA equiv) | - | 1 |
| SELECTIVE COSTIMULATION MODULATORS | | |
| ORENCIA CLICK INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| ORENCIA SC INJ 125MG/ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|--------------|---|--------------------------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSPP | Plan Exclusion | INF | Limited Distribution |
| PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| RS | Prior Authorization | QL | Restricted to Diagnosis |
| ST | Restricted to Specialist | SF | Restricted to Specialist |
| | Step Therapy | VAC | Smoking Cessation |
| | | | SMKG |
| | | | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANALGESICS - ANTI-INFLAMMATORY Cont. | | |
| ORENCIA SC INJ 50MG/0.4ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| ORENCIA SC INJ 87.5MG/0.7ML (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| SOLUBLE TUMOR NECROSIS FACTOR RECEPTOR AGENTS | | |
| ENBREL INJ 25MG (QL= 8 inj/28 days) | LMSP-PA-QL | 2 |
| ENBREL INJ 50MG (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| ENBREL MINI INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| ENBREL SURECLICK INJ 50MG (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| ANALGESICS - NONNARCOTIC | | |
| ANALGESIC COMBINATIONS | | |
| butalbital/acetaminophen/caffeine tab (FIORICET equiv) | - | 1 |
| ALLZITAL TAB | - | NC |
| butalbital/acetaminophen cap | - | NC |
| butalbital/acetaminophen/caffeine soln | - | NC |
| BUTALBITAL/ASPIRIN/CAFFEINE TAB | - | NC |
| DOLGIC PLUS TAB | - | NC |
| ESGIC TAB | - | NC |
| FIORICET CAP | - | NC |
| FIORINAL CAP | - | NC |
| VTOL SOLN | - | NC |
| ANALGESICS - SODIUM CHANNEL PAIN SIGNAL INHIBITORS | | |
| JOURNAVX TAB | - | EXC |
| SALICYLATES | | |
| aspirin chew tab 81mg (Covered for female members only) | OTC | \$0 |
| aspirin ec tab 81mg (Covered for female members only) | OTC | \$0 |
| difflunisal tab (DOLOBID equiv) | - | 1 |
| SALSALATE TAB | - | 1 |
| salsalate tab (DISALCID equiv) | - | 1 |
| ASPIRIN EC TAB 325MG | OTC | EXC |
| aspirin tab 325mg | OTC | EXC |
| DOLOBID TAB | - | NC |
| ANALGESICS - OPIOID | | |
| OPIOID AGONISTS | | |
| CODEINE SULFATE TAB | - | 1 |
| DISKETTS TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| fantanyl patch (DURAGESIC equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| HYDROCODONE BITARTRATE ER TAB (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 |
| hydrocodone bitartrate er tab (HYSINGLA equiv) (QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 |
| hydromorphone tab (DILAUDID equiv) | - | 1 |
| methadone soln (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| methadone tab (DOLOPHINE equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| methadose tab (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| morphine sulfate ER tab (MS CONTIN equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANALGESICS - OPIOID Cont. | | |
| MORPHINE SULFATE ORAL SOLN 100MG/5ML | - | 1 |
| MORPHINE SULFATE ORAL SOLN 10MG/5ML | - | 1 |
| morphine sulfate oral soln 10mg/5ml (MORPHINE SULFATE equiv) | - | 1 |
| morphine sulfate soln | - | 1 |
| MORPHINE SULFATE SOLN 20MG/5ML | - | 1 |
| MORPHINE SULFATE SUPP | - | 1 |
| MORPHINE SULFATE TAB | - | 1 |
| oxycodone cap (OXYIR equiv) | - | 1 |
| oxycodone conc (ROXICODONE equiv) | - | 1 |
| oxycodone soln (ROXICODONE equiv) | - | 1 |
| oxycodone tab (ROXICODONE equiv) | - | 1 |
| tramadol ER tab (ULTRAM ER equiv) (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| TRAMADOL HCL ER TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 1 |
| tramadol tab (ULTRAM equiv) | - | 1 |
| HYDROCODONE BITARTRATE ER CAP (QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 |
| NUCYNTA ER TAB (QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 |
| XTAMPZA ER CAP (QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 2 |
| METHADOSE CONC | ST | 3 |
| MS CONTIN TAB (Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | ST | 3 |
| NUCYNTA TAB | - | 3 |
| ABSTRAL SL TAB | - | NC |
| ACTIQ LOZENGE | - | NC |
| DSUVIA SL TAB | - | NC |
| FENTANYL BUCCAL TAB | - | NC |
| FENTANYL CITRATE LOLLIPOP | - | NC |
| fentanyl citrate lollipop (ACTIQ equiv) | - | NC |
| fentanyl patch 37.5mcg, 62.5mcg, 87.5mcg (FENTANYL equiv) | - | NC |
| FENTORA TAB | - | NC |
| hydromorphone ER tab (EXALGO TAB equiv) | - | NC |
| HYDROMORPHONE SUPP | - | NC |
| LAZANDA NASAL SPRAY | - | NC |
| levorphanol tab (LEVORPHANOL equiv) | - | NC |
| meperidine tab (DEMEROL equiv) | - | NC |
| MORPHABOND TAB | - | NC |
| MORPHINE SULFATE ER BEAD CAP | - | NC |
| OPANA TAB | - | NC |
| OXYCODONE TAB | - | NC |
| OXYCONTIN CR TAB | - | NC |
| OXYMORPHONE ER TAB | - | NC |
| oxymorphone tab (OPANA equiv) | - | NC |
| QDOLO SOLN, TRAMADOL SOLN | - | NC |
| ROXYBOND TAB | - | NC |
| RYBIX ODT | - | NC |
| SUBSYS SPRAY | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANALGESICS - OPIOID Cont. | | |
| TRAMADOL ER CAP | - | NC |
| TRAMADOL HCL TAB | - | NC |
| tramadol hcl tab 100mg | - | NC |
| OPIOID COMBINATIONS | | |
| acetaminophen/codeine tab (TYLENOL/CODEINE equiv) | - | 1 |
| hydrocodone/acetaminophen soln (HYCET, LORTAB equiv) | - | 1 |
| hydrocodone/acetaminophen soln 10-325 mg/15ml (HYCET equiv) | - | 1 |
| hydrocodone/acetaminophen tab (LORTAB equiv) | - | 1 |
| hydrocodone/ibuprofen tab (VICOPROFEN equiv) | - | 1 |
| OXYCODONE/ACETAMINOPHEN SOLN | - | 1 |
| oxycodone/acetaminophen tab (PERCOCET equiv) | - | 1 |
| tramadol/acetaminophen tab (ULTRACET equiv) | - | 1 |
| APAP/CODEINE SOLN | - | 2 |
| HYDROCODONE/IBUPROFEN TAB 10-200MG | - | 3 |
| LORTAB ELIXIR | - | 3 |
| ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE TAB | - | NC |
| APADAZ TAB | - | NC |
| FIORICET/CODEINE CAP | - | NC |
| FIORINAL/CODEINE CAP | - | NC |
| hydrocodone/acetaminophen tab 10mg-300mg (XODOL equiv) | - | NC |
| hydrocodone/acetaminophen tab 5mg-300mg (XODOL equiv) | - | NC |
| hydrocodone/acetaminophen tab 7.5mg-300mg (XODOL equiv) | - | NC |
| OXYCODONE/ACETAMINOPHEN SOLN 10-300MG/5ML, PROLATE SOLN 10-300MG/5ML | - | NC |
| OXYCODONE/ACETAMINOPHEN TAB 2.5-300MG | - | NC |
| PRIMLEV TAB 10-300MG | - | NC |
| PRIMLEV TAB 5-300MG | - | NC |
| PROLATE TAB 7.5-300MG | - | NC |
| SEGLENTIS TAB | - | NC |
| TREZIX CAP, ACETAMINOPHEN/CAFFEINE/DIHYDROCODEINE CAP | - | NC |
| VERDROCET TAB 2.5MG-325MG | - | NC |
| XODOL TAB 10MG-300MG | - | NC |
| XODOL TAB 5MG-300MG | - | NC |
| XODOL TAB 7.5MG-300MG | - | NC |
| OPIOID PARTIAL AGONISTS | | |
| buprenorphine patch (BUTRANS equiv) (QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency)) | QL-ST | 1 |
| buprenorphine SL tab (SUBUTEX equiv) | - | 1 |
| buprenorphine/naloxone sl film (SUBOXONE SL FILM equiv) | - | 1 |
| buprenorphine/naloxone SL tab (SUBOXONE equiv) | - | 1 |
| butorphanol nasal spray (STADOL equiv) (QL= 1 bottle/fill, 2 fills/30 days) | QL | 1 |
| pentazocine/naloxone tab (TALWIN NX equiv) | - | 1 |
| SUBLOCADE SOLN, BRIXADI SOLN | LMSP | 2 |
| ZUBSOLV SL TAB | - | 2 |
| BELBUCA FILM | - | NC |
| BUNAVAIL FILM | - | NC |
| buprenorphine hcl buccal film (BELBUCA equiv) | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|----------------------------------|--------------|------|
| ANALGESICS - OPIOID Cont. | | |
| SUBOXONE SL FILM | - | NC |

ANDROGENS-ANABOLIC

ANDROGENS

| | | |
|--|-------|----|
| danazol cap (DANOCRINE equiv) | - | 1 |
| testosterone cypionate inj (DEPO-TESTOSTERONE equiv) | - | 1 |
| testosterone gel 1% 25mg (ANDROGEL equiv) (QL= 1 packet/day) | PA-QL | 1 |
| testosterone gel 1% 50mg (ANDROGEL equiv) (QL= 2 packets/day) | PA-QL | 1 |
| testosterone gel 1% pump (VOGELXO GEL, ANDROGEL equiv) (QL= 4 bottles/30 days) | PA-QL | 1 |
| testosterone gel 1.62% 1.25gm (ANDROGEL equiv) (QL= 1 packet/day) | PA-QL | 1 |
| testosterone gel 1.62% 2.5gm (ANDROGEL equiv) (QL= 2 packets/day) | PA-QL | 1 |
| TESTOSTERONE GEL 20.25MG/1.25GM (QL= 1 packet/day) | PA-QL | 1 |
| TESTOSTERONE GEL PUMP 1% (QL= 4 bottles/30 days) | PA-QL | 1 |
| testosterone gel pump 1.62% (ANDROGEL equiv) (QL= 2 bottles/30 days) | PA-QL | 1 |
| testosterone soln (AXIRON equiv) (QL= 2 bottles/30 days) | PA-QL | 1 |
| TESTOSTERONE ENANTHATE INJ 200MG/ML (QL= 5ml/fill) | QL | 2 |
| TESTOSTERONE GEL 1% 25MG (QL= 1 packet/day) | PA-QL | 2 |
| VOGELXO GEL PUMP 1% (QL= 4 bottles/30 days) | PA-QL | 3 |
| FORTESTA GEL 2% | - | NC |
| KYZATREX CAP | - | NC |
| KYZATREX CAP, JATENZO CAP, TLANDO CAP | - | NC |
| METHITEST TAB | - | NC |
| methyltestosterone cap | - | NC |
| NATESTO GEL | - | NC |
| NATESTO NASAL GEL | - | NC |
| STRIANT FILM | - | NC |
| TESTOSTERONE GEL 10MG/ACT | - | NC |
| testosterone gel 2% (FORTESTA equiv) | - | NC |
| TESTOSTERONE GEL, VOGELXO GEL | - | NC |
| XYOSTED INJ | - | NC |

ANORECTAL AGENTS

INTRARECTAL STEROIDS

| | | |
|--|---|---|
| hydrocortisone enema (CORTENEMA equiv) | - | 1 |
| CORTIFOAM | - | 3 |

RECTAL COMBINATIONS

| | | |
|---|---|----|
| PROCTOFOAM HC FOAM | - | 2 |
| ANALPRAM-E KIT | - | 3 |
| LIDOCAINE/HYDROCORTISONE RECTAL CREAM KIT | - | NC |

RECTAL STEROIDS

| | | |
|---------------------------------------|---|---|
| hydrocortisone supp (ANUSOL HC equiv) | - | 1 |
| proctosol HC cream (ANUSOL HC equiv) | - | 1 |

ANORECTAL AND RELATED PRODUCTS

INTRARECTAL STEROIDS

| | | |
|---|----|---|
| budesonide rectal foam (UCERIS RECTAL FOAM equiv) | PA | 3 |
| UCERIS RECTAL FOAM | PA | 3 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to 15 day fills per month for first 3 months |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANORECTAL AND RELATED PRODUCTS Cont. | | |
| RECTAL COMBINATIONS | | |
| ANALPRAM HC CREAM 2.5-1% | - | 1 |
| HYDROCORTISONE ACETATE/PRAMOXINE CREAM | - | 1 |
| LIDOCAINE/HC CREAM | - | 1 |
| ANALPRAM HC CREAM 2.5-1% | - | 3 |
| ANALPRAM-HC CREAM | - | 3 |
| HYDROCORTISONE/PRAMOXINE SUPP | - | NC |
| RECTAL LOCAL ANESTHETICS | | |
| LIDOCAINE SUPP | - | NC |
| RECTAL STEROIDS | | |
| ANUCORT-HC SUPP 25MG | - | 1 |
| ANUCORT-HC SUPP 30MG | - | 1 |
| HYDROCORTISONE CREAM | - | 1 |
| PROCTOCORT SUPP | - | 3 |
| VASODILATING AGENTS | | |
| nitroglycerin oint (RECTIV equiv) | - | NC |
| RECTIV OINT | - | NC |
| ANTHELMINTICS | | |
| ANTHELMINTICS | | |
| ivermectin tab (STROMEKTOL equiv) | - | 1 |
| praziquantel tab (BILTRICIDE equiv) | - | 1 |
| BENZNIDAZOLE TAB (Restricted to Infectious Disease Specialist) | RS | 2 |
| BILTRICIDE TAB | - | 3 |
| albendazole tab (ALBENZA equiv) | - | NC |
| ALBENZA TAB | - | NC |
| EGATEN TAB | - | NC |
| EMVERM TAB | - | NC |
| IVERMECTIN TAB | - | NC |
| ANTIANGINAL AGENTS | | |
| ANTIANGINALS-OTHER | | |
| ranolazine tab (RANEXA equiv) | - | 1 |
| ASPRUZYO SPRINKLE GRANULES | - | NC |
| NITRATES | | |
| isosorbide dinitrate tab (ISORDIL equiv) | - | 1 |
| isosorbide dinitrate tab 40mg (ISORDIL equiv) | - | 1 |
| isosorbide mononitrate ER tab (IMDUR equiv) | - | 1 |
| isosorbide mononitrate tab (MONOKET equiv) | - | 1 |
| NITROGLYCERIN ER CAP | - | 1 |
| nitroglycerin lingual spray (NITROLINGUAL equiv) | - | 1 |
| nitroglycerin patch (NITRO-DUR equiv) | - | 1 |
| nitroglycerin SL tab (NITROSTAT equiv) | - | 1 |
| NITRO-BID OINT | - | 2 |
| ISOSORBIDE MONONITRATE TAB | - | 3 |
| NITRO-DUR PATCH 0.3MG/HR, 0.8MG/HR | - | 3 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Smoking Cessation |
| | Step Therapy | VAC | RxCENTS |
| | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class
Last Updated* 2/1/2026**

| DrugName | Special Code | Tier |
|---------------------------------|--------------|------|
| ANTIANGINAL AGENTS Cont. | | |
| NITROMIST SPRAY | - | 3 |
| GONITRO POWDER | - | NC |

ANTIANGXIETY AGENTS

ANTIANGXIETY AGENTS - MISC.

| | | |
|--|---|----|
| buspirone tab (BUSPAR equiv) | - | 1 |
| hydroxyzine pamoate cap (VISTARIL equiv) | - | 1 |
| hydroxyzine syrup (ATARAX equiv) | - | 1 |
| hydroxyzine tab (ATARAX equiv) | - | 1 |
| BUCAPSOL CAP | - | NC |
| meprobamate tab (MILTOWN equiv) | - | NC |

BENZODIAZEPINES

| | | |
|---|---|----|
| alprazolam ER tab (XANAX XR equiv) | - | 1 |
| alprazolam ODT (NIRAVAM equiv) | - | 1 |
| alprazolam tab (XANAX equiv) | - | 1 |
| chlordiazepoxide cap (LIBRIUM equiv) | - | 1 |
| clorazepate tab (TRANXENE-T equiv) | - | 1 |
| diazepam conc (VALIUM equiv) | - | 1 |
| diazepam oral soln 5mg/5ml (DIAZEPAM equiv) | - | 1 |
| diazepam tab (VALIUM equiv) | - | 1 |
| lorazepam conc (ATIVAN equiv) | - | 1 |
| lorazepam tab (ATIVAN equiv) | - | 1 |
| oxazepam cap (SERAX equiv) | - | 1 |
| LOREEV XR CAP | - | NC |

ANTIARRHYTHMICS

ANTIARRHYTHMICS TYPE I-A

| | | |
|----------------------------------|---|----|
| disopyramide cap (NORPACE equiv) | - | 1 |
| quinidine gluconate CR tab | - | 1 |
| quinidine sulfate tab | - | 1 |
| NORPACE CR CAP | - | 2 |
| QUINIDINE SULFATE TAB | - | NC |

ANTIARRHYTHMICS TYPE I-B

| | | |
|--------------------|---|---|
| mexiletine hcl cap | - | 1 |
|--------------------|---|---|

ANTIARRHYTHMICS TYPE I-C

| | | |
|---------------------------------------|---|---|
| flecainide tab (TAMBOCOR equiv) | - | 1 |
| propafenone ER cap (RYTHMOL SR equiv) | - | 1 |
| propafenone tab (RYTHMOL equiv) | - | 1 |

ANTIARRHYTHMICS TYPE III

| | | |
|----------------------------------|---|---|
| amiodarone tab (CORDARONE equiv) | - | 1 |
| dofetilide cap (TIKOSYN equiv) | - | 1 |
| MULTAQ TAB | - | 2 |

ANTIASTHMATIC AND BRONCHODILATOR AGENTS

ANTIASTHMATIC - MONOCLONAL ANTIBODIES

| | | |
|-------------------------------------|------------|---|
| FASENRA PEN INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 |
| NUCALA INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont. | | |
| TEZSPIRE INJ (QL= 1 pen/28 days) | LMSP-PA-QL | 2 |
| XOLAIR INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| XOLAIR INJ 150MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| XOLAIR INJ 300MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| XOLAIR SYRINGE (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| XOLAIR SYRINGE 150MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| XOLAIR SYRINGE 300MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| ANTI-INFLAMMATORY AGENTS | | |
| cromolyn neb soln (INTAL equiv) | - | NC |
| BRONCHODILATORS - ANTICHOLINERGICS | | |
| ipratropium neb soln (ATROVENT equiv) | - | 1 |
| ATROVENT HFA INHALER | - | 2 |
| INCRUSE ELLIPTA INHALER | - | 2 |
| SPIRIVA RESPIMAT INHALER 1.25MCG/ACT (QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL), or SPIRIVA HANDIHALER | QL-ST | 2 |
| SPIRIVA RESPIMAT INHALER 2.5MCG/ACT | - | NC |
| tiotropium bromide cap inhaler (SPIRIVA equiv) | - | NC |
| TUDORZA PRESSAIR INHALER | - | NC |
| YUPELRI SOLN | - | NC |
| LEUKOTRIENE MODULATORS | | |
| montelukast chew tab (SINGULAIR equiv) | - | 1 |
| montelukast granule pack (SINGULAIR equiv) | - | 1 |
| montelukast tab (SINGULAIR equiv) | - | 1 |
| zafirlukast tab (ACCOLATE equiv) | - | 1 |
| zileuton ER tab (ZYFLO CR equiv) | - | NC |
| ZYFLO TAB | - | NC |
| PHOSPHODIESTERASE 3 & 4 (PDE3 & PDE4) INHIBITORS | | |
| OHTUVAYRE SUSP (QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144) | LD-PA-QL | 2 |
| SELECTIVE PHOSPHODIESTERASE 4 (PDE4) INHIBITORS | | |
| roflumilast tab | - | 1 |
| DALIRESP TAB | - | 3 |
| STEROID INHALANTS | | |
| ARNUIITY ELLIPTA INHALER | - | 1 |
| ASMANEX HFA INHALER | - | 1 |
| ASMANEX INHALER | - | 1 |
| budesonide inh susp (PULMICORT equiv) | - | 1 |
| FLUTICASONE DISKUS INHALER | - | 1 |
| FLUTICASONE HFA INHALER | - | 1 |
| ALVESCO INHALER | - | 2 |
| QVAR REDIHALER | - | 2 |
| FLOVENT DISKUS INHALER | - | 3 |
| FLOVENT HFA INHALER | - | 3 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | generic = small letters | LD | BRANDS = CAPITAL LETTERS |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Limited Distribution |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Over-the-Counter |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Restricted to Diagnosis |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | Smoking Cessation |
| | | | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont. | | |
| ARMONAIR DIGITAL INHALER 113MCG/ACT | - | NC |
| ARMONAIR DIGITAL INHALER 232MCG/ACT | - | NC |
| ARMONAIR DIGITAL INHALER 55MCG/ACT | - | NC |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 100MCG/ACT | - | NC |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 200MCG/ACT | - | NC |
| FLUTICASONE FUROATE AEROSOL POWDER BREATH ACTIV 50MCG/ACT | - | NC |
| PULMICORT FLEXHALER | - | NC |
| SYMPATHOMIMETICS | | |
| albuterol HFA inhaler (PROAIR, PROVENTIL equiv) (QL= 2 inhalers/30 days) | QL | 1 |
| albuterol neb soln | - | 1 |
| ALBUTEROL NEBULIZER SOLN | - | 1 |
| albuterol sulfate syrup | - | 1 |
| albuterol sulfate tab | - | 1 |
| albuterol/ipratropium neb soln (DUONEB equiv) | - | 1 |
| arformoterol tartrate neb soln (BROVANA equiv) | - | 1 |
| budesonide/formoterol inhaler (SYMBICORT equiv) | - | 1 |
| fluticasone/salmeterol inhaler, wixela inhaler (ADVAIR equiv) | - | 1 |
| formoterol fumarate neb soln (PERFOROMIST equiv) | - | 1 |
| levalbuterol neb soln (XOPENEX equiv) | - | 1 |
| terbutaline sulfate tab (BRETHINE equiv) | - | 1 |
| VENTOLIN HFA INHALER (QL= 2 inhalers/30 days) | QL | 1 |
| ADVAIR HFA INHALER | - | 2 |
| ANORO ELLIPTA INHALER | - | 2 |
| BREO ELLIPTA INHALER | - | 2 |
| BREO ELLIPTA INHALER 50-25 MCG/ACT | - | 2 |
| BREZTRI AEROSPHERE INHALER | - | 2 |
| COMBIVENT RESPIMAT INHALER | - | 2 |
| DULERA INHALER | - | 2 |
| FLUTICASONE-SALMETEROL INHALER 115-21 MCG/ACT | - | 2 |
| FLUTICASONE-SALMETEROL INHALER 230-21 MCG/ACT | - | 2 |
| FLUTICASONE-SALMETEROL INHALER 45-21 MCG/ACT | - | 2 |
| FLUTICASONE-VILANTEROL INHALER 100-25 MCG/ACT | - | 2 |
| FLUTICASONE-VILANTEROL INHALER 200-25 MCG/ACT | - | 2 |
| STIOLTO INHALER | - | 2 |
| STRIVERDI RESPIMAT INHALER (QL= 1 inhaler/30 days) | QL | 2 |
| TRELEGY ELLIPTA INHALER | - | 2 |
| LEVALBUTEROL INHALER, XOPENEX HFA INHALER (QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA or an albuterol HFA product) | QL-ST | 3 |
| AIRDUO POWDER INHALER W/SENSOR | - | NC |
| AIRDUO RESPICLICK | - | NC |
| AIRSUPRA INH | - | NC |
| BEVESPI AEROSPHERE INHALER | - | NC |
| DUAKLIR INHALER | - | NC |
| SEREVENT DISKUS INHALER | - | NC |
| UMECLIDINIUM/VILANTEROL INHALER 62.5-25MCG/ACT | - | NC |

XANTHINES

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|--------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSPP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIASTHMATIC AND BRONCHODILATOR AGENTS Cont. | | |
| theophylline er tab (THEOPHYLLINE ER equiv) | - | 1 |
| theophylline ER tab (UNIPHYL equiv) | - | 1 |
| theophylline soln | - | 1 |
| ELIXOPHYLLIN ELIXIR | - | 2 |
| THEOPHYLLINE TAB ER | - | 2 |
| ANTICOAGULANTS | | |
| COUMARIN ANTICOAGULANTS | | |
| warfarin tab (COUMADIN equiv) | - | 1 |
| DIRECT FACTOR XA INHIBITORS | | |
| rivaroxaban for susp (XARELTO equiv) | - | 1 |
| rivaroxaban tab 2.5mg (XARELTO equiv) | - | 1 |
| ELIQUIS SPRINKLE CAP | - | 2 |
| ELIQUIS TAB FOR ORAL SUSP | - | 2 |
| ELIQUIS TAB, ELIQUIS STARTER PACK | - | 2 |
| XARELTO STARTER PACK | - | 2 |
| XARELTO SUSP | - | 2 |
| XARELTO TAB | - | 2 |
| SAVAYSA TAB | - | NC |
| HEPARINS AND HEPARINOID-LIKE AGENTS | | |
| enoxaparin inj (LOVENOX equiv) | - | 1 |
| fondaparinux inj (ARIXTRA equiv) | - | 1 |
| FRAGMIN INJ | - | 3 |
| THROMBIN INHIBITORS | | |
| dabigatran etexilate mesylate cap (PRADAXA equiv) | - | 1 |
| PRADAXA PELLETT PACK | - | NC |
| ANTICONVULSANTS | | |
| AMPA GLUTAMATE RECEPTOR ANTAGONISTS | | |
| FYCOMPA TAB | - | NC |
| FYCOMPA SUSP | - | NC |
| perampanel susp (FYCOMPA equiv) | - | NC |
| perampanel tab (FYCOMPA equiv) | - | NC |
| ANTICONVULSANTS - BENZODIAZEPINES | | |
| clobazam susp (ONFI equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| clobazam tab (ONFI equiv) | - | 1 |
| clonazepam ODT (KLONOPIN equiv) | - | 1 |
| clonazepam tab (KLONOPIN equiv) | - | 1 |
| diazepam rectal gel (QL= 4 doses/fill) | QL | 1 |
| DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL (QL= 4 doses/fill) | QL | 2 |
| DIAZEPAM GEL (QL= 4 doses/fill) | QL | 2 |
| DIASTAT ACDL GEL (QL= 4 doses/fill) | QL | 3 |
| NAYZILAM SPRAY (QL= 4 doses/fill) | QL | 3 |
| VALTOCO NASAL SPRAY (QL= 5 doses/fill) | QL | 3 |
| LIBERVANT FILM | - | NC |
| MIDAZOLAM INJ | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANTICONVULSANTS Cont. | | |
| ONFI TAB | - | NC |
| SYMPAZAN ORAL FILM | - | NC |
| ANTICONVULSANTS - MISC. | | |
| carbamazepine chew tab (TEGRETOL equiv) | - | 1 |
| carbamazepine ER cap (CARBATROL equiv) | - | 1 |
| carbamazepine ER tab (TEGRETOL XR equiv) | - | 1 |
| carbamazepine susp (TEGRETOL equiv) | - | 1 |
| carbamazepine tab (TEGRETOL equiv) | - | 1 |
| gabapentin cap (NEURONTIN equiv) (QL= 9 caps/day) | QL | 1 |
| gabapentin soln (NEURONTIN equiv) (QL= 72 mls/day) | QL | 1 |
| gabapentin tab 600mg (NEURONTIN equiv) (QL= 6 tabs/day) | QL | 1 |
| gabapentin tab 800mg (NEURONTIN equiv) (QL= 4.5 tabs/day) | QL | 1 |
| lacosamide oral solution (VIMPAT equiv) | - | 1 |
| lacosamide tab (VIMPAT equiv) | - | 1 |
| lamotrigine chew tab (LAMICTAL equiv) | - | 1 |
| lamotrigine ER tab (LAMICTAL XR equiv) | - | 1 |
| lamotrigine starter kit (LAMICTAL STARTER KIT equiv) | - | 1 |
| lamotrigine tab (LAMICTAL equiv) | - | 1 |
| levetiracetam ER tab (KEPPRA XR equiv) | - | 1 |
| levetiracetam soln (KEPPRA equiv) | - | 1 |
| levetiracetam tab (KEPPRA equiv) | - | 1 |
| oxcarbazepine susp (TRILEPTAL equiv) | - | 1 |
| oxcarbazepine tab (TRILEPTAL equiv) | - | 1 |
| pregabalin cap (LYRICA equiv) (QL= 3 caps/day) | QL | 1 |
| pregabalin cap 225mg (LYRICA equiv) (QL= 2 caps/day) | QL | 1 |
| pregabalin cap 300mg (LYRICA equiv) (QL= 2 caps/day) | QL | 1 |
| pregabalin soln (LYRICA equiv) (QL= 30ml/day) | QL | 1 |
| primidone tab (MYSOLINE equiv) | - | 1 |
| rufinamide susp (BANZEL equiv) | PA | 1 |
| rufinamide tab (BANZEL equiv) | PA | 1 |
| topiramate oral soln (EPRONTIA equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| topiramate sprinkle cap (TOPAMAX equiv) | - | 1 |
| topiramate tab (TOPAMAX equiv) | - | 1 |
| zonisamide cap (ZONEGRAN equiv) | - | 1 |
| DIACOMIT CAP (Only available through PantheRx Pharmacy 855-726-8479) | LD-PA | 2 |
| DIACOMIT POWDER PACK (Only available through PantheRx Pharmacy 855-726-8479) | LD-PA | 2 |
| EPIDIOLEX SOLN (Only available through Lumicera 855-847-3553) | LD-PA | 2 |
| FINTEPLA SOLN (QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 |
| ZTALMY SUSP (QL= 1100ml/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 |
| BANZEL SUSP | PA | 3 |
| EPRONTIA SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| LAMICTAL ODT KIT, LAMICTAL XR KIT | - | 3 |
| SUBVENITE SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| ZONISADE SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| APTiom TAB | - | NC |
| BANZEL TAB | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTICONVULSANTS Cont. | | |
| BRIVIACT INJ 50MG/5ML | - | NC |
| BRIVIACT SOLN 10MG/ML | - | NC |
| BRIVIACT TAB | - | NC |
| CARBAMAZEPINE CHEW TAB | - | NC |
| ELEPSIA XR TAB | - | NC |
| eslicarbazepine acetate tab (APTIOM equiv) | - | NC |
| GABARONE TAB | - | NC |
| lamotrigine ODT (LAMICTAL equiv) | - | NC |
| lamotrigine ODT kit (LAMICTAL equiv) | - | NC |
| MOTPOLY XR CAP | - | NC |
| oxcarbazepine er tab (OXTELLAR equiv) | - | NC |
| OXTELLAR XR TAB | - | NC |
| PRIMIDONE TAB | - | NC |
| QUDEXY XR CAP | - | NC |
| SPRITAM TAB | - | NC |
| topiramate ER cap (QUDEXY equiv) | - | NC |
| topiramate er cap (TROKENDI XR equiv) | - | NC |
| TROKENDI XR CAP | - | NC |
| VIMPAT SOLN | - | NC |
| VIMPAT TAB | - | NC |
| CARBAMATES | | |
| felbamate susp (FELBATOL equiv) | - | 1 |
| felbamate tab (FELBATOL equiv) | - | 1 |
| XCOPRI PAK 100-150MG (QL= 2 tabs/day) | QL | 2 |
| XCOPRI PAK 150-200MG (QL= 2 tabs/day) | QL | 2 |
| XCOPRI TAB 150MG, 200MG (QL= 2 tabs/day) | QL | 2 |
| XCOPRI TAB 25MG (QL= 1 tab/day) | QL | 2 |
| XCOPRI TAB 50MG, 100MG (QL= 1 tab/day) | QL | 2 |
| XCOPRI TITRATION PAK 12.5-25MG (QL= 1 tab/day) | QL | 2 |
| XCOPRI TITRATION PAK 150-200MG (QL= 1 tab/day) | QL | 2 |
| XCOPRI TITRATION PAK 50-100MG (QL= 1 tab/day) | QL | 2 |
| GABA MODULATORS | | |
| tiagabine tab (GABITRIL equiv) | - | 1 |
| vigabatrin powder pack (SABRIL POWDER equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 |
| vigabatrin tab (SABRIL equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 |
| vigadrone powder pack (Only available through PantheRx 855-726-8479) | LD-PA | 1 |
| SABRIL TAB | - | NC |
| VIGAFYDE SOLN | - | NC |
| HYDANTOINS | | |
| phenytoin cap (DILANTIN equiv) | - | 1 |
| phenytoin chew tab (DILANTIN equiv) | - | 1 |
| phenytoin susp (DILANTIN equiv) | - | 1 |
| DILANTIN CAP 30MG | - | 2 |
| SUCCINIMIDES | | |
| ethosuximide cap (ZARONTIN equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANTICONVULSANTS Cont. | | |
| ethosuximide soln (ZARONTIN equiv) | - | 1 |
| methsuximide cap (CELONTIN equiv) | - | 1 |
| VALPROIC ACID | | |
| divalproex ER tab (DEPAKOTE ER equiv) | - | 1 |
| divalproex sodium DR tab (DEPAKOTE equiv) | - | 1 |
| divalproex sprinkle cap (DEPAKOTE equiv) | - | 1 |
| valproic acid cap (DEPAKENE equiv) | - | 1 |
| valproic acid syrup (DEPAKENE equiv) | - | 1 |
| DEPACON INJ | - | NC |
| STAVZOR CAP | - | NC |
| valproate inj (DEPACON equiv) | - | NC |
| ANTIDEPRESSANTS | | |
| ALPHA-2 RECEPTOR ANTAGONISTS (TETRACYCLICS) | | |
| mirtazapine ODT (REMERON equiv) | - | 1 |
| mirtazapine tab (REMERON equiv) | - | 1 |
| ANTIDEPRESSANT COMBINATIONS | | |
| AUVELITY TAB | - | NC |
| ANTIDEPRESSANTS - MISC. | | |
| bupropion ER tab (WELLBUTRIN equiv) | - | 1 |
| bupropion tab (WELLBUTRIN equiv) | - | 1 |
| bupropion XL tab (WELLBUTRIN XL equiv) | - | 1 |
| APLENZIN TAB | - | NC |
| FORFIVO XL TAB | - | NC |
| GABA RECEPTOR MODULATOR - NEUROACTIVE STEROID | | |
| ZURZUVAE CAP 20MG, 25MG (QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 |
| ZURZUVAE CAP 30MG (QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 |
| MONOAMINE OXIDASE INHIBITORS (MAOIS) | | |
| PHENELZINE SULFATE TAB | - | 1 |
| phenelzine tab (NARDIL equiv) | - | 1 |
| tranylcypromine tab (PARNATE equiv) | - | 1 |
| MARPLAN TAB | - | 2 |
| EMSAM PATCH | - | 3 |
| NARDIL TAB 15MG | - | 3 |
| SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS) | | |
| citalopram soln (CELEXA equiv) | - | 1 |
| citalopram tab (CELEXA equiv) | - | 1 |
| escitalopram soln (LEXAPRO equiv) | - | 1 |
| escitalopram tab (LEXAPRO equiv) | - | 1 |
| fluoxetine cap (PROZAC equiv) | - | 1 |
| fluoxetine soln (PROZAC equiv) | - | 1 |
| fluoxetine tab (PROZAC equiv) | - | 1 |
| fluvoxamine ER cap (LUVOX CR equiv) (Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine) | ST | 1 |
| fluvoxamine tab (LUVOX equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|--------------|---|--------------------------------|--|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSPP | Lumicera Mandatory Specialty Pharmacy Program | INF | Infertility |
| PA | Prior Authorization | MSP | Mandatory Specialty Pharmacy Program |
| RS | Restricted to Specialist | QL | Quantity Limit |
| ST | Step Therapy | SF | Limited to two 15 day fills per month for first 3 months |
| | | VAC | Vaccine Program |
| | | LD | Limited Distribution |
| | | OTC | Over-the-Counter |
| | | RDX | Restricted to Diagnosis |
| | | SMKG | Smoking Cessation |
| | | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIDEPRESSANTS Cont. | | |
| nortriptyline oral soln (NORTRIPTYLINE equiv) | - | 1 |
| protriptyline tab (VIVACTIL equiv) | - | 1 |
| trimipramine cap (SURMONTIL equiv) | - | 1 |
| ANTIDIABETICS | | |
| ALPHA-GLUCOSIDASE INHIBITORS | | |
| acarbose tab (PRECOSE equiv) | - | 1 |
| miglitol tab (MIGLITOL equiv) | - | 1 |
| MIGLITOL TAB | - | 3 |
| ANTIDIABETIC - AMYLIN ANALOGS | | |
| SYMLINPEN INJ | - | NC |
| ANTIDIABETIC COMBINATIONS | | |
| glipizide/metformin tab (METAGLIP equiv) | - | 1 |
| glyburide/metformin tab (GLUCOVANCE equiv) | - | 1 |
| GLYXAMBI TAB (QL= 1 tab/day) | QL | 2 |
| JANUMET TAB (QL= 2 tabs/day) | QL | 2 |
| JANUMET XR TAB (QL= 2 tabs/day) | QL | 2 |
| JENTADUETO TAB (QL= 2 tabs/day) | QL | 2 |
| JENTADUETO XR TAB (QL= 2 tabs/day) | QL | 2 |
| SOLIQUA INJ (QL= 15ml/25 days) | QL | 2 |
| SYNJARDY TAB (QL= 2 tabs/day) | QL | 2 |
| SYNJARDY XR TAB 10-1000MG, 25-1000MG (QL= 1 tab/day) | QL | 2 |
| SYNJARDY XR TAB 5-1000MG, 12.5-1000MG (QL= 2 tabs/day) | QL | 2 |
| TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG (QL= 1 tab/day) | QL | 2 |
| TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG (QL= 2 tabs/day) | QL | 2 |
| XIGDUO XR TAB (QL= 2 tabs/day) | QL | 2 |
| XIGDUO XR TAB 10-1000MG (QL= 1 tab/day) | QL | 2 |
| XIGDUO XR TAB 2.5-1000MG, 5-1000MG (QL= 2 tabs/day) | QL | 2 |
| XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG (QL= 1 tab/day) | QL | 2 |
| XULTOPHY INJ (QL= 15ml/30 days) | QL | 2 |
| ACTOPLUS MET TAB | - | NC |
| ALOGLIPTIN/METFORMIN TAB, KAZANO TAB | - | NC |
| ALOGLIPTIN/PIOGLITAZONE TAB, OSENI TAB | - | NC |
| ALOGLIPTIN-METFORMIN TAB | - | NC |
| ALOGLIPTIN-PIOGILTAZONE TAB | - | NC |
| DAPAGLIFLOZIN PROP-METFORMIN HCL 10-1000MG | - | NC |
| DAPAGLIFLOZIN PROP-METFORMIN HCL 5-1000MG | - | NC |
| DUETACT TAB | - | NC |
| INVOKAMET TAB | - | NC |
| INVOKAMET XR TAB | - | NC |
| KOMBIGLYZE XR TAB | - | NC |
| pioglitazone/glimepiride tab (DUETACT equiv) | - | NC |
| pioglitazone/metformin tab (ACTOPLUS MET equiv) | - | NC |
| PRANDIMET TAB | - | NC |
| QTERN TAB | - | NC |
| saxagliptin-metformin hcl tab er 24hr (KOMBIGLYZE equiv) | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIDIABETICS Cont. | | |
| SEGLUROMET TAB | - | NC |
| SITAGLIPTIN/METFORMIN TAB | - | NC |
| STEGLUJAN TAB | - | NC |
| ZITUVIMET XR TAB | - | NC |
| BIGUANIDES | | |
| metformin ER tab (GLUCOPHAGE XR equiv) | - | 1 |
| metformin soln (RIOMET equiv) | - | 1 |
| metformin tab (GLUCOPHAGE equiv) | - | 1 |
| FORTAMET TAB | - | NC |
| GLUMETZA TAB 1000MG | - | NC |
| GLUMETZA TAB 500MG | - | NC |
| metformin ER osmotic tab (FORTAMET equiv) | - | NC |
| metformin ER osmotic tab (GLUMETZA equiv) | - | NC |
| METFORMIN TAB | - | NC |
| DIABETIC OTHER | | |
| diazoxide susp (PROGLYCEM equiv) | - | 1 |
| glucagon (rdna) for inj kit (QL= 2 inj/fill) | QL | 1 |
| BAQSIMI NASAL POWDER (QL= 2 inhalations/fill) | QL | 2 |
| GLUCAGON EMR INJ (QL= 2 inj/fill) | QL | 2 |
| GLUCAGON INJ KIT (QL= 2 inj/fill) | QL | 2 |
| GVOKE INJ (QL= 2 inj/fill) | QL | 2 |
| GVOKE INJ KIT (QL= 2 inj/fill) | QL | 2 |
| GVOKE PFS INJ (QL= 2 inj/fill) | QL | 2 |
| mifepristone tab (KORLYM equiv) (QL= 4 tabs/day) | LMSP-PA-QL | 2 |
| ZEGALOGUE INJ (QL= 2 inj/fill) | QL | 2 |
| KORLYM TAB | - | NC |
| DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS | | |
| JANUVIA TAB (QL= 1 tab/day) | QL-¢ | 2 |
| TRADJENTA TAB (QL= 1 tab/day) | QL | 2 |
| ALOGLIPTIN TAB | - | NC |
| ALOGLIPTIN TAB, NESINA TAB | - | NC |
| BRYNOVIN SOLN | - | NC |
| ONGLYZA TAB | - | NC |
| saxagliptin hcl tab (ONGLYZA equiv) | - | NC |
| ZITUVIO TAB | - | NC |
| DOPAMINE RECEPTOR AGONISTS - ANTIDIABETIC | | |
| CYCLOSET TAB | - | 3 |
| INCRETIN MIMETIC AGENTS | | |
| liraglutide soln pen-injector (VICTOZA equiv) (QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 1 |
| MOUNJARO INJ (QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 |
| OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 |
| TRULICITY INJ (QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 |
| VICTOZA INJ | - | NC |
| INCRETIN MIMETIC AGENTS (GLP-1 RECEPTOR AGONISTS) | | |
| OZEMPIC INJ (QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIDIABETICS Cont. | | |
| RYBELSUS TAB (QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11)) | QL-RDX | 2 |
| BYDUREON BCISE AUTO INJ | - | NC |
| BYDUREON INJ | - | NC |
| BYDUREON PEN INJ | - | NC |
| EXENATIDE INJ (BYETTA INJ EQUIV) | - | NC |
| TANZEUM INJ | - | NC |
| INSULIN | | |
| INSULIN LISPRO INJ (HUMALOG equiv) | - | 1 |
| HUMALOG JR KWIKPEN INJ | - | 2 |
| HUMALOG KWIKPEN INJ | - | 2 |
| HUMALOG MIX INJ | - | 2 |
| HUMALOG MIX KWIKPEN, INSULIN LISPRO MIX KWIKPEN | - | 2 |
| HUMALOG PEN INJ | - | 2 |
| HUMALOG TEMPO PEN | - | 2 |
| HUMULIN MIX INJ | OTC | 2 |
| HUMULIN MIX PEN INJ | OTC | 2 |
| HUMULIN N INJ | OTC | 2 |
| HUMULIN N PEN INJ | OTC | 2 |
| HUMULIN R INJ | OTC | 2 |
| HUMULIN R INJ U-500 | - | 2 |
| HUMULIN R U-500 KWIKPEN INJ | - | 2 |
| INSULIN GLARGINE SOLN PEN-INJ | - | 2 |
| INSULIN LISPRO JR KWIKPEN INJ | - | 2 |
| INSULIN LISPRO KWIKPEN INJ | - | 2 |
| LANTUS INJ | - | 2 |
| LANTUS SOLOSTAR INJ | - | 2 |
| LEVEMIR FLEXTOUCH INJ | - | 2 |
| LEVEMIR INJ | - | 2 |
| LYUMJEV INJ | - | 2 |
| LYUMJEV KWIKPEN INJ | - | 2 |
| LYUMJEV TEMPO PEN | - | 2 |
| SEMGLEE INJ, INSULIN GLARGINE-YFGN INJ | - | 2 |
| SEMGLEE PEN, INSULIN GLARGINE-YFGN PEN | - | 2 |
| TOUJEO MAX SOLOSTAR INJ | - | 2 |
| TOUJEO SOLOSTAR INJ | - | 2 |
| TRESIBA FLEXTOUCH INJ | - | 2 |
| TRESIBA INJ | - | 2 |
| ADMELOG INJ, HUMALOG INJ | - | NC |
| ADMELOG SOLOSTAR, HUMALOG TEMPO PEN | - | NC |
| APIDRA INJ | - | NC |
| APIDRA SOLOSTAR INJ | - | NC |
| BASAGLAR INJ, INSULIN GLARGINE SOLOSTAR INJ | - | NC |
| DEGLUDEC FLEXTOUCH INJ | - | NC |
| DEGLUDEC INJ | - | NC |
| FIASP FLEXTOUCH INJ | - | NC |
| FIASP INJ | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | |
|--------------|--|--------------------------------|-------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | LD | BRANDS = CAPITAL LETTERS |
| LMSPP | NC/3P = Not Covered, Third Party Reviewer | INF | OTC | Limited Distribution |
| PA | Plan Exclusion | MSP | RDX | Over-the-Counter |
| RS | Lumicera Mandatory Specialty Pharmacy Program | QL | SMKG | Restricted to Diagnosis |
| ST | Prior Authorization | SF | ¢ | Smoking Cessation |
| | Restricted to Specialist | VAC | | RxCENTS |
| | Step Therapy | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIDIABETICS Cont. | | |
| FIASP PENFILL INJ, FIASP PUMP CARTRIDGE | - | NC |
| INSULIN ASPART FLEXPEN INJ (NOVOLOG equiv) | - | NC |
| INSULIN ASPART INJ | - | NC |
| INSULIN ASPART MIX FLEXPEN INJ (NOVOLOG equiv) | - | NC |
| INSULIN ASPART MIX INJ (NOVOLOG equiv) | - | NC |
| INSULIN ASPART PENFILL INJ | - | NC |
| INSULIN GLARGINE INJ | - | NC |
| INSULIN GLARGINE-YFGN (SINGLE PEN) | - | NC |
| INSULIN GLARGINE-YFGN PEN (CIVICA) 100UNIT/ML | - | NC |
| KIRSTY INJ | - | NC |
| LYUMJEV TEMPO PEN INJ | - | NC |
| MERILOG INJ | - | NC |
| MERILOG SOLOSTAR INJ | - | NC |
| NOVOLIN 70/30 FLEXPEN INJ | OTC | NC |
| NOVOLIN 70/30 FLEXPEN RELION INJ | OTC | NC |
| NOVOLIN 70/30 INJ | OTC | NC |
| NOVOLIN 70/30 RELION INJ | OTC | NC |
| NOVOLIN N FLEXPEN INJ | OTC | NC |
| NOVOLIN N INJ | OTC | NC |
| NOVOLIN N RELION 100UNIT/ML | OTC | NC |
| NOVOLIN R FLEXPEN INJ | OTC | NC |
| NOVOLIN R INJ | OTC | NC |
| NOVOLIN R RELION INJ | OTC | NC |
| NOVOLOG FLEXPEN INJ | - | NC |
| NOVOLOG FLEXPEN RELION INJ | - | NC |
| NOVOLOG INJ | - | NC |
| NOVOLOG MIX FLEXPEN INJ | - | NC |
| NOVOLOG MIX INJ | - | NC |
| NOVOLOG PENFILL INJ | - | NC |
| REZVOGLAR INJ | - | NC |
| SEMGLEE INJ (SINGLE PEN) | - | NC |
| SEMGLEE SOLN | - | NC |
| INSULIN SENSITIZING AGENTS | | |
| pioglitazone tab (ACTOS equiv) | - | 1 |
| MEGLITINIDE ANALOGUES | | |
| nateglinide tab (STARLIX equiv) | - | 1 |
| repaglinide tab (PRANDIN equiv) | - | 1 |
| SODIUM-GLUCOSE CO-TRANSPORTER 2 (SGLT2) INHIBITORS | | |
| FARXIGA TAB (QL= 1 tab/day) | QL | 2 |
| JARDIANCE TAB (QL= 1 tab/day) | QL | 2 |
| BEXAGLIFLOZIN | - | NC |
| DAPAGLIFLOZIN PROPRANEDIOL TAB 10MG | - | NC |
| DAPAGLIFLOZIN PROPRANEDIOL TAB 5MG | - | NC |
| INVOKANA TAB | - | NC |
| STEGLATRO TAB | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---------------------------------------|--------------|------|
| ANTIDIABETICS Cont. | | |
| SULFONYLUREAS | | |
| glimepiride tab (AMARYL equiv) | - | 1 |
| glipizide ER tab (GLUCOTROL XL equiv) | - | 1 |
| glipizide tab (GLUCOTROL equiv) | - | 1 |
| GLYBURID MCR TAB | - | 1 |
| glyburide tab (MICRONASE equiv) | - | 1 |
| GLIMEPIRIDE TAB | - | NC |
| GLIPIZIDE TAB 2.5MG | - | NC |

ANTIDIARRHEAL/PROBIOTIC AGENTS

| ANTIPERISTALTIC AGENTS | | |
|--|-----|----|
| OPIUM TINCTURE | - | 1 |
| DIPHENOXYLATE/ATROPINE LIQUID | - | 3 |
| loperamide hcl soln (LOPERAMIDE equiv) | OTC | NC |

ANTIDIARRHEALS

| ANTIDIARRHEAL - CHLORIDE CHANNEL ANTAGONISTS | | |
|---|---|----|
| MYTESI TAB | - | NC |

| ANTIDIARRHEAL AGENTS - MISC. | | |
|-------------------------------------|---|----|
| REZYST CHEW TAB | - | NC |
| VSL #3 CAP | - | NC |

| ANTIDIARRHEAL COMBINATIONS | | |
|-----------------------------------|---|----|
| EVIVO LIQUID | - | NC |

| ANTIPERISTALTIC AGENTS | | |
|--|---|----|
| diphenoxylate/atropine tab (LOMOTIL equiv) | - | 1 |
| loperamide cap (IMODIUM equiv) | - | NC |
| PAREGORIC TINCTURE | - | NC |

ANTIDOTES

| ANTIDOTES | | |
|------------------|---|----|
| VISTOGARD PAK | - | NC |

| ANTIDOTES - CHELATING AGENTS | | |
|---|-------|---|
| CHEMET CAP | - | 2 |
| FERRIPROX SOLN (Only available through Ferriprox Total Care 866-758-7071) | LD-PA | 2 |

| OPIOID ANTAGONISTS | | |
|------------------------------|------|----|
| naltrexone tab (REVIA equiv) | - | 1 |
| VIVITROL INJ | LMSP | 2 |
| EVZIO INJ | - | NC |

ANTIDOTES AND SPECIFIC ANTAGONISTS

| ANTIDOTES - CHELATING AGENTS | | |
|--|-------|----|
| deferasirox granules packet (JADENU equiv) | LMSP | 1 |
| deferasirox tab (JADENU equiv) | LMSP | 1 |
| deferasirox tab for oral susp (EXJADE equiv) | LMSP | 1 |
| deferiprone tab (FERRIPROX equiv) (Only available through Lumicera 855-847-3553) | LD-PA | 1 |
| JADENU SPRINKLE | - | NC |

ANTIDOTES AND SPECIFIC ANTAGONISTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|---|--|------------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIDOTES AND SPECIFIC ANTAGONISTS Cont. | | |
| CETYLEV TAB | - | NC |
| OPIOID ANTAGONISTS | | |
| naloxone hcl nasal spray (NARCAN equiv) | OTC | 1 |
| naloxone inj | - | 1 |
| naloxone prefilled inj | - | 1 |
| NARCAN NASAL SPRAY | OTC | 1 |
| RIVIVE, REXTOVY SPRAY | OTC | 1 |
| KLOXXADO NASAL SPRAY | - | 2 |
| NALOXONE PREFILLED INJ (QL= 2 inj/fill) | QL | 2 |
| OPVEE NASAL SPRAY | - | 2 |
| ZIMHI SOLN | - | 2 |
| ZURNAI INJ | - | 2 |
| EVZIO INJ | - | NC |
| ANTIEMETICS | | |
| 5-HT3 RECEPTOR ANTAGONISTS | | |
| granisetron tab (KYTRIL equiv) (QL= 14 tabs/fill) | QL | 1 |
| ondansetron ODT (ZOFTRAN equiv) | - | 1 |
| ondansetron soln (ZOFTRAN equiv) | - | 1 |
| ondansetron tab (ZOFTRAN equiv) | - | 1 |
| ANZEMET TAB (QL= 9 tabs/fill) | QL | 3 |
| SANCUSO PATCH (QL= 4 patches/fill) | QL | 3 |
| ONDANSETRON TAB | - | NC |
| ONDANSETRON TAB ODT | - | NC |
| SUSTOL INJ | - | NC |
| ZUPLENZ SL FILM | - | NC |
| ANTIEMETICS - ANTICHOLINERGIC | | |
| meclizine tab (ANTIVERT equiv) (Rx Only) | - | 1 |
| scopolamine patch (TRANSDERM-SCOP equiv) | - | 1 |
| trimethobenzamide cap (TIGAN equiv) | - | 1 |
| TIGAN INJ | - | 3 |
| TRANSDERM-SCOP PATCH | - | 3 |
| meclizine chew tab (BONINE equiv) | OTC | EXC |
| meclizine hcl tab (ANTIVERT equiv) | - | NC |
| ANTIEMETICS - MISCELLANEOUS | | |
| dronabinol cap (MARINOL equiv) | PA | 1 |
| AKYNZEO CAP (QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist) | QL-RS | 2 |
| doxylamine/pyridoxine dr tab (DICLEGIS equiv) | - | NC |
| SYNDROS SOLN | - | NC |
| SUBSTANCE P/NEUROKININ 1 (NK1) RECEPTOR ANTAGONISTS | | |
| aprepitant cap (EMEND equiv) (QL= 3 caps/fill) | QL | 1 |
| aprepitant pak (EMEND equiv) (QL= 3 caps/fill) | QL | 1 |
| VARUBI TAB (QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist) | QL-RS | 2 |
| EMEND SUSP | - | NC |

ANTIFUNGALS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIFUNGALS Cont. | | |
| ANTIFUNGAL - GLUCAN SYNTHESIS INHIBITORS (ECHINOCANDINS) | | |
| BREXAFEMME TAB | - | NC |
| ANTIFUNGALS | | |
| flucytosine cap (ANCOBON equiv) | - | 1 |
| griseofulvin micro tab (GRIFULVIN V equiv) | - | 1 |
| griseofulvin susp (GRIFULVIN equiv) | - | 1 |
| griseofulvin tab (GRIS-PEG equiv) | - | 1 |
| nystatin tab | - | 1 |
| terbinafine tab (LAMISIL equiv) | - | 1 |
| FULVICIN P/G TAB | - | NC |
| FULVICIN P/G TAB, GRISEOFULVIN ULTRA MICRO TAB | - | NC |
| IMIDAZOLE-RELATED ANTIFUNGALS | | |
| fluconazole susp (DIFLUCAN equiv) | - | 1 |
| fluconazole tab (DIFLUCAN equiv) | - | 1 |
| itraconazole cap (SPORANOX equiv) | - | 1 |
| itraconazole soln (SPORANOX equiv) | PA | 1 |
| ketoconazole tab (NIZORAL equiv) | - | 1 |
| posaconazole DR tab (NOXAFIL equiv) | - | 1 |
| posaconazole susp (NOXAFIL equiv) | - | 1 |
| voriconazole susp (VFEND equiv) | - | 1 |
| voriconazole tab (VFEND equiv) | - | 1 |
| NOXAFIL PAK | - | 3 |
| SPORANOX SOLN | PA | 3 |
| VFEND SUSP | - | 3 |
| CRESEMBA CAP | - | NC |
| NOXAFIL TAB | - | NC |
| TOLSURA CAP | - | NC |
| VIVJOA CAP | - | NC |
| ANTIHISTAMINES | | |
| ANTIHISTAMINES - ALKYLAMINES | | |
| CORPHENA ORAL SOLN, RYCLORA ORAL SOLN | - | NC |
| MICLARA LIQUID | OTC | NC |
| ANTIHISTAMINES - ETHANOLAMINES | | |
| CARBINOXAMINE SOLN | - | 1 |
| carbinoxamine tab (PALGIC equiv) | - | 1 |
| diphenhydramine inj (BENADRYL equiv) | - | 1 |
| carbinoxamine maleate tab 6mg | - | NC |
| CARBZAH SOLN 4MG/5ML | - | NC |
| CLEMASTINE SYRUP | - | NC |
| CLEMASTINE TAB | - | NC |
| CLEMASTINE TAB, CLEMASZ TAB | - | NC |
| KARBINAL ER SUSP | - | NC |
| ANTIHISTAMINES - NON-SEDATING | | |
| ALLEGRA ODT | OTC | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | Mandatory Specialty Pharmacy Program | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | Quantity Limit | Restricted to Diagnosis |
| | | SF | SMKG |
| | | Limited to two 15 day fills per month for first 3 months | Smoking Cessation |
| | | VAC | ¢ |
| | | Vaccine Program | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--------------------------------------|---------------------|-------------|
| ANTIHISTAMINES Cont. | | |
| ALLEGRA TAB | OTC | EXC |
| cetirizine cap (ZYRTEC equiv) | OTC | EXC |
| cetirizine chew tab (ZYRTEC equiv) | OTC | EXC |
| cetirizine syrup (ZYRTEC equiv) | OTC | EXC |
| cetirizine tab (ZYRTEC equiv) | OTC | EXC |
| CLARINEX SYRUP | - | EXC |
| CLARINEX TAB | - | EXC |
| CLARITIN CAP | OTC | EXC |
| CLARITIN CHEW TAB | OTC | EXC |
| CLARITIN REDITAB | OTC | EXC |
| CLARITIN SYRUP | OTC | EXC |
| CLARITIN TAB | OTC | EXC |
| DESLORATADINE ODT | - | EXC |
| DESLORATADINE SOLN | - | EXC |
| desloratadine tab (CLARINEX equiv) | - | EXC |
| fexofenadine susp (ALLEGRA equiv) | OTC | EXC |
| fexofenadine tab (ALLEGRA equiv) | OTC | EXC |
| levocetirizine soln (XYZAL equiv) | - | EXC |
| levocetirizine tab (XYZAL equiv) | - | EXC |
| loratadine cap (CLARITIN equiv) | OTC | EXC |
| loratadine chew tab (CLARITIN equiv) | OTC | EXC |
| loratadine ODT (CLARITIN equiv) | OTC | EXC |
| loratadine syrup (CLARITIN equiv) | OTC | EXC |
| loratadine tab (CLARITIN equiv) | OTC | EXC |
| XYZAL SOLN | - | EXC |
| XYZAL TAB | - | EXC |
| ZYRTEC CAP | OTC | EXC |
| ZYRTEC CHILD CHEW ALLERGY | OTC | EXC |
| ZYRTEC CHILD CHEW TAB | OTC | EXC |
| ZYRTEC SYRUP | OTC | EXC |
| ZYRTEC TAB | OTC | EXC |

DRAFT

ANTIHISTAMINES - PHENOTHIAZINES

| | | |
|-------------------------------------|---|---|
| promethazine supp (PHENERGAN equiv) | - | 1 |
| promethazine syrup | - | 1 |
| promethazine tab (PHENERGAN equiv) | - | 1 |
| PROMETHEGAN SUPP | - | 1 |

ANTIHISTAMINES - PIPERIDINES

| | | |
|----------------------|---|---|
| cyproheptadine syrup | - | 1 |
| cyproheptadine tab | - | 1 |

ANTHYPERLIPIDEMICS

ADENOSINE TRIPHOSPHATE-CITRATE LYASE (ACL) INHIBITORS

| | | |
|---|-------|---|
| NEXLETOL TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 |
|---|-------|---|

ANTHYPERLIPIDEMICS - COMBINATIONS

| | | |
|--|----|---|
| ezetimibe/simvastatin tab (VYTORIN equiv) (QL= 1 tab/day (10-80mg is Not Covered)) | QL | 1 |
|--|----|---|

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIHYPERTENSIVES Cont. | | |
| NEXLIZET TAB (QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 |
| EZETIMIBE/ATORVASTATIN TAB | - | NC |
| ezetimibe/simvastatin tab 10-80mg (VYTORIN equiv) (This strength excluded from coverage) | - | NC |
| OMEGA-3 RX PAK COMPLETE | - | NC |
| ROSZET TAB | - | NC |
| ROSZET TAB, EZETIMIBE/ROSUVASTATIN TAB | - | NC |
| ANTIHYPERTENSIVES - MISC. | | |
| icosapent ethyl cap (VASCEPA equiv) (QL= 4 caps/day) | QL | 1 |
| omega-3-acid ethyl esters cap (LOVAZA equiv) | - | 1 |
| KYNAMRO INJ | - | NC |
| BILE ACID SEQUESTRANTS | | |
| cholestyramine lite powder (QUESTRAN LITE equiv) | - | 1 |
| cholestyramine lite powder pack (QUESTRAN LITE equiv) | - | 1 |
| cholestyramine powder (QUESTRAN equiv) | - | 1 |
| cholestyramine powder pack (QUESTRAN equiv) | - | 1 |
| colesevelam pack (WELCHOL equiv) | - | 1 |
| colesevelam tab (WELCHOL equiv) | - | 1 |
| colestipol granule (COLESTID equiv) | - | 1 |
| colestipol powder packet (COLESTID equiv) | - | 1 |
| colestipol tab (COLESTID equiv) | - | 1 |
| WELCHOL PACK | - | 3 |
| WELCHOL TAB | - | 3 |
| FIBRIC ACID DERIVATIVES | | |
| fenofibrate cap 67mg, 134mg, 200mg (LOFIBRA equiv) | - | 1 |
| fenofibrate tab 48mg, 54mg, 145mg, 160mg (TRICOR equiv) | - | 1 |
| fenofibric acid DR cap (TRILIPIX equiv) | - | 1 |
| gemfibrozil tab (LOPID equiv) | - | 1 |
| FENOFIBRIC TAB | - | 3 |
| FENOFIBRIC TAB, FIBRICOR TAB | - | 3 |
| ANTARA CAP, FENOFIBRATE MICRONIZED CAP | - | NC |
| ANTARA CAP, LOFIBRA CAP | - | NC |
| fenofibrate cap 43mg, 130mg (ANTARA equiv) | - | NC |
| FENOFIBRATE CAP, LIPOFEN CAP | - | NC |
| FENOFIBRATE CAP, LIPOFEN CAP 50MG, 150MG | - | NC |
| fenofibrate tab 40mg, 120mg (FENOGLIDE equiv) | - | NC |
| TRIGLIDE TAB | - | NC |
| TRILIPIX CAP | - | NC |
| HMG COA REDUCTASE INHIBITORS | | |
| atorvastatin tab (LIPITOR equiv) | - | \$0 |
| lovastatin tab (MEVACOR equiv) | - | \$0 |
| pravastatin tab (PRAVACHOL equiv) | - | \$0 |
| rosuvastatin tab (CRESTOR equiv) | - | \$0 |
| simvastatin tab (ZOCOR equiv) (80mg is Not Covered) | - | \$0 |
| fluvastatin cap (LESCOL equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | MSP | Restricted to Diagnosis |
| | Restricted to Specialist | QL | Restricted to Diagnosis |
| | Step Therapy | SF | Smoking Cessation |
| | | VAC | RxCENTS |
| | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIHYPERTENSIVES Cont. | | |
| fluvastatin ER tab (LESCOL XL equiv) | - | 1 |
| pitavastatin calcium tab (LIVALO equiv) | - | 1 |
| ATORVALIQ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| CRESTOR TAB | - | 3 |
| EZALLOR SPRINKLE CAP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| FLOLIPID SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| LIVALO TAB | - | 3 |
| ADVICOR TAB | - | NC |
| ALTOPREV TAB | - | NC |
| SIMCOR TAB | - | NC |
| simvastatin tab 80mg (ZOCOR equiv) | - | NC |
| ZOCOR TAB 80MG | - | NC |
| ZYPITAMAG TAB | - | NC |
| INTESTINAL CHOLESTEROL ABSORPTION INHIBITORS | | |
| ezetimibe tab (ZETIA equiv) | - | 1 |
| ZETIA TAB | - | NC |
| MICROSOMAL TRIGLYCERIDE TRANSFER PROTEIN (MTP) INHIBITORS | | |
| JUXTAPID CAP | - | NC |
| NICOTINIC ACID DERIVATIVES | | |
| niacin ER tab (NIASPAN equiv) | - | 1 |
| NIASPAN ER TAB | - | 3 |
| NIACOR TAB | - | NC |
| PROPROTEIN CONVERTASE SUBTILISIN/KEXIN TYPE 9 INHIBITORS | | |
| REPATHA INJ (QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 |
| REPATHA PUSHTRONEX INJ (QL= 1 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin) | QL-ST | 2 |
| ANTIHYPERTENSIVES | | |
| ACE INHIBITORS | | |
| benazepril tab (LOTENSIN equiv) | - | 1 |
| captopril tab (CAPOTEN equiv) | - | 1 |
| enalapril maleate oral soln (EPANED equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| enalapril tab (VASOTEC equiv) | - | 1 |
| fosinopril tab (MONOPRIL equiv) | - | 1 |
| lisinopril tab (PRINIVIL/ZESTRIL equiv) | - | 1 |
| moexipril tab (UNIVASC equiv) | - | 1 |
| PERINDOPRIL TAB | - | 1 |
| perindopril tab (ACEON equiv) | - | 1 |
| quinapril tab (ACCUPRIL equiv) | - | 1 |
| ramipril cap (ALTACE equiv) | - | 1 |
| trandolapril tab (MAVIK equiv) | - | 1 |
| QBRELIS SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| AGENTS FOR PHEOCHROMOCYTOMA | | |
| phenoxybenzamine cap (DIBENZYLININE equiv) | - | 1 |
| DEMSEER CAP | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANTIHYPERTENSIVES Cont. | | |
| metyrosine cap (DEMSEER equiv) | - | NC |
| ANGIOTENSIN II RECEPTOR ANTAGONISTS | | |
| candesartan tab (ATACAND equiv) | - | 1 |
| irbesartan tab (AVAPRO equiv) | - | 1 |
| losartan tab (COZAAR equiv) | - | 1 |
| olmesartan tab (BENICAR equiv) | - | 1 |
| telmisartan tab (MICARDIS equiv) | - | 1 |
| valsartan tab (DIOVAN equiv) | - | 1 |
| ARBLI SUSP (QL= 330mL/30 days; Prior Authorization required for members age 9 years and older) | PA-QL | 3 |
| EDARBI TAB | - | NC |
| valsartan oral soln (VALSARTAN equiv) | - | NC |
| ANTIADRENERGIC ANTIHYPERTENSIVES | | |
| clonidine patch (CATAPRES-TTS equiv) | - | 1 |
| clonidine tab (CATAPRES equiv) | - | 1 |
| doxazosin tab (CARDURA equiv) | - | 1 |
| guanfacine IR tab (TENEX equiv) | - | 1 |
| methyldopa tab (ALDOMET equiv) | - | 1 |
| prazosin cap (MINIPRESS equiv) | - | 1 |
| terazosin cap (HYTRIN equiv) | - | 1 |
| CATAPRES-TTS PATCH | - | 3 |
| METHYLDOPA TAB | - | 3 |
| JAVADIN SOLN | - | NC |
| NEXICLON XR TAB | - | NC |
| TEZRULY SOLN | - | NC |
| ANTIHYPERTENSIVE COMBINATIONS | | |
| amlodipine/benazepril cap (LOTREL equiv) | - | 1 |
| amlodipine/olmesartan tab (AZOR equiv) | - | 1 |
| amlodipine/valsartan tab (EXFORGE equiv) | - | 1 |
| atenolol/chlorthalidone tab (TENORETIC equiv) | - | 1 |
| benazepril/hydrochlorothiazide tab (LOTENSIN HCT equiv) | - | 1 |
| bisoprolol/hydrochlorothiazide tab (ZIAC equiv) | - | 1 |
| enalapril/hydrochlorothiazide tab (VASERETIC equiv) | - | 1 |
| fosinopril/hydrochlorothiazide tab (MONOPRIL HCT equiv) | - | 1 |
| irbesartan/hydrochlorothiazide tab (AVALIDE equiv) | - | 1 |
| lisinopril/hydrochlorothiazide tab (ZESTORETIC equiv) | - | 1 |
| losartan/hydrochlorothiazide tab (HYZAAR equiv) | - | 1 |
| metoprolol/hydrochlorothiazide tab (LOPRESSOR HCT equiv) | - | 1 |
| olmesartan/hydrochlorothiazide tab (BENICAR HCT equiv) | - | 1 |
| valsartan/hydrochlorothiazide tab (DIOVAN HCT equiv) | - | 1 |
| TEKTURNA HCT TAB | - | 3 |
| amlodipine/valsartan/hydrochlorothiazide tab (EXFORGE HCT equiv) | - | NC |
| BYVALSON TAB | - | NC |
| candesartan/hydrochlorothiazide tab (ATACAND HCT equiv) | - | NC |
| DUTOPROL TAB | - | NC |
| EDARBYCLOR TAB | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|---|--|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSPLumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PAPrior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SFLimited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Category/Class
Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANTIHYPERTENSIVES Cont. | | |
| MICARDIS HCT TAB | - | NC |
| olmesartan/amlodipine/hydrochlorothiazide tab (TRIBENZOR equiv) | - | NC |
| PRESTALIA TAB | - | NC |
| QUINAPRIL/HCTZ TAB | - | NC |
| quinapril/hydrochlorothiazide tab (ACCURETIC equiv) | - | NC |
| TELMISARTAN/AMLODIPINE TAB | - | NC |
| telmisartan/amlodipine tab (TWYNSTA equiv) | - | NC |
| telmisartan/hydrochlorothiazide tab (MICARDIS HCT equiv) | - | NC |
| TRANDOLAPRIL/VERAPAMIL ER TAB | - | NC |
| TRIBENZOR TAB | - | NC |
| ANTIHYPERTENSIVES - MISC. | | |
| VECAMYL TAB | - | NC |
| DIRECT RENIN INHIBITORS | | |
| aliskiren tab (TEKURNA equiv) | - | 1 |
| ENDOTHELIN RECEPTOR ANTAGONISTS | | |
| TRYVIO TAB | - | EXC |
| SELECTIVE ALDOSTERONE RECEPTOR ANTAGONISTS (SARAS) | | |
| eplerenone tab (INSPRA equiv) | - | 1 |
| VASODILATORS | | |
| hydralazine tab (APRESOLINE equiv) | - | 1 |
| minoxidil tab (LONITEN equiv) | - | 1 |
| ANTI-INFECTIVE AGENTS - MISC. | | |
| ANTI-INFECTIVE AGENTS - MISC. | | |
| metronidazole tab (FLAGYL equiv) | - | 1 |
| pentamidine neb soln (NEBUPENT equiv) | - | 1 |
| tinidazole tab (TINDAMAX equiv) | - | 1 |
| TRIMETHOPRIM TAB | - | 1 |
| trimethoprim tab (PROLOPRIM equiv) | - | 1 |
| XIFAXAN TAB 550MG (QL= 60 tabs/30 days) | QL | 2 |
| FIRST METRONIDAZOLE SUSP | - | 3 |
| LIKMEZ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| PRIMSOL SOLN | - | 3 |
| XIFAXAN TAB 200MG (QL= 9 tabs/3 days) | QL | 3 |
| AEMCOLO TAB | - | NC |
| IMPAVIDO CAP | - | NC |
| metronidazole cap (FLAGYL equiv) | - | NC |
| METRONIDAZOLE TAB | - | NC |
| ANTI-INFECTIVE MISC. - COMBINATIONS | | |
| smz/tmp (DS) tab (BACTRIM DS equiv) | - | 1 |
| smz/tmp susp (BACTRIM, SEPTRA equiv) | - | 1 |
| HYOPHEN TAB | - | NC |
| UTA CAP | - | NC |
| ANTIPROTOZOAL AGENTS | | |
| atovaquone susp (MEPRON equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANTI-INFECTIVE AGENTS - MISC. Cont. | | |
| nitazoxanide tab (ALINIA equiv) (QL= 6 tabs/3 days) | PA-QL | 1 |
| LAMPIT TAB (Restricted to Infectious Disease Specialist) | RS | 2 |
| GLYCOPEPTIDES | | |
| FIRVANQ SOLN 25MG/ML | - | 1 |
| FIRVANQ SOLN 50MG/ML | - | 1 |
| vancomycin cap (VANCOCIN equiv) (QL= 56 caps/fill) | QL | 1 |
| VANCOCIN CAP (QL= 56 caps/fill) | QL | 3 |
| vancomycin hcl soln (VANCOMYCIN equiv) | - | NC |
| VANCOMYCIN ORAL SOLN | - | NC |
| VANCOMYCIN SOLN | - | NC |
| LEPROSTATICS | | |
| dapsone tab | - | 1 |
| LINCOSAMIDES | | |
| clindamycin cap (CLEOCIN equiv) | - | 1 |
| clindamycin soln (CLEOCIN equiv) | - | 1 |
| MONOBACTAMS | | |
| CAYSTON INH SOLN (Restricted to Infectious Disease or Pulmonology Specialist; Only available through Walgreens 888-347-3416) | LD-RS | 2 |
| OXAZOLIDINONES | | |
| linezolid susp (ZYVOX equiv) (Restricted to Infectious Disease Specialist) | RS | 1 |
| linezolid tab (ZYVOX equiv) (Restricted to Infectious Disease Specialist) | RS | 1 |
| SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist) | QL-RS | 2 |
| SIVEXTRO TAB (QL= 6 tabs/fill; Restricted to Infectious Disease Specialist) | QL-RS | 2 |
| PENEMS | | |
| ORLYNVAH TAB | - | EXC |
| PLEUROMUTILINS | | |
| XENLETA TAB (QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist) | QL-RS | 2 |
| POLYMYXINS | | |
| colistimethate inj (COLY-MYCIN M equiv) | - | NC |
| URINARY ANTI-INFECTIVES | | |
| fosfomycin tromethamine powder pack (MONUROL equiv) | - | 1 |
| METHENAM MAN TAB | - | 1 |
| methenamine hippurate tab (HIPREX equiv) | - | 1 |
| methenamine mandelate tab | - | 1 |
| nitrofurantoin macrocrystals cap (MACRODANTIN equiv) | - | 1 |
| nitrofurantoin monohydrate cap (MACROBID equiv) | - | 1 |
| nitrofurantoin susp (FURADANTIN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| MONUROL GRANULE PACK | - | 3 |
| BLUJEP A TAB | - | EXC |
| nitrofurantoin macrocrystals cap 25mg (MACRODANTIN equiv) | - | NC |
| NITROFURANTOIN SUSP | - | NC |

ANTIMALARIALS

| ANTIMALARIAL COMBINATIONS | Special Code | Tier |
|---|---------------------|-------------|
| atovaquone/proguanil tab (MALARONE equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANTIMALARIALS Cont. | | |
| PYRIMETHAMINE/LEUCOVORIN CAP | - | NC |
| ANTIMALARIALS | | |
| CHLOROQUINE TAB | - | 1 |
| chloroquine tab (ARALEN equiv) | - | 1 |
| hydroxychloroquine tab (PLAQUENIL equiv) | - | 1 |
| mefloquine tab (LARIAM equiv) | - | 1 |
| primaquine tab (PRIMAQUINE equiv) | - | 1 |
| pyrimethamine tab (DARAPRIM equiv) (QL= 3 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 |
| KRINTAFEL TAB | - | 2 |
| ARAKODA TAB | - | 3 |
| QUALAQUIN CAP | - | NC |
| quinine sulfate cap (QUALAQUIN equiv) | - | NC |
| SOVUNA TAB | - | NC |
| ANTIMYASTHENIC/CHOLINERGIC AGENTS | | |
| ANTIMYASTHENIC/CHOLINERGIC AGENTS | | |
| pyridostigmine CR tab (MESTINON equiv) | - | 1 |
| pyridostigmine tab (MESTINON equiv) | - | 1 |
| pyridostigmine soln (MESTINON equiv) | - | 1 |
| FIRDAPSE TAB (Only available through AnovoRx 844-288-5007) | LD-PA | 2 |
| PYRIDOSTIGMINE TAB 30MG | - | NC |
| ANTIMYCOBACTERIAL AGENTS | | |
| ANTIMYCOBACTERIAL AGENTS | | |
| ethambutol tab (MYAMBUTOL equiv) | - | 1 |
| isoniazid tab | - | 1 |
| pyrazinamide tab | - | 1 |
| rifabutin cap (MYCOBUTIN equiv) | - | 1 |
| rifampin cap (RIFADIN equiv) | - | 1 |
| PRETOMANID TAB (QL= 1 tab/day; Restricted to Infectious Disease Specialist) | QL-RS | 2 |
| PRIFTIN TAB | - | 2 |
| isoniazid syrup (ISONIAZID equiv) | - | 3 |
| CYCLOSERINE CAP | - | NC |
| SIRTURO TAB | - | NC |
| TRECATOR TAB | - | NC |
| ANTINEOPLASTICS | | |
| ALKYLATING AGENTS | | |
| MYLERAN TAB | LMSP | 2 |
| ANTIMETABOLITES | | |
| mercaptapurine tab (PURINETHOL equiv) | - | 1 |
| methotrexate tab (Trexall equiv) | - | 1 |
| TABLOID TAB | - | 2 |
| TREXALL TAB | - | NC |
| ANTINEOPLASTIC ENZYME INHIBITORS | | |
| ZOLINZA CAP | LMSP-PA-SF | 2 |
| ANTINEOPLASTICS MISC. | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------|------|
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont. | | |
| VIZIMPRO TAB (QL= 1 tab/day) | MSP-PA-QL-SF | 2 |
| LAZCLUZE TAB | - | NC |
| TARCEVA TAB | - | NC |
| ANTINEOPLASTIC - HEDGEHOG PATHWAY INHIBITORS | | |
| ERIVEDGE CAP (QL= 1 cap/day) | LMSP-PA-QL-SF | 2 |
| ODOMZO CAP (QL= 1 cap/day) | LMSP-PA-QL-SF | 2 |
| DAURISMO TAB | - | NC |
| ANTINEOPLASTIC - HORMONAL AND RELATED AGENTS | | |
| anastrozole tab (ARIMIDEX equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 |
| exemestane tab (AROMASIN equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 |
| tamoxifen tab (NOLVADEX equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 |
| abiraterone tab 250mg (ZYTIGA equiv) (QL= 4 tabs/day) | LMSP-QL | 1 |
| bicalutamide tab (CASODEX equiv) | - | 1 |
| flutamide cap (EULEXIN equiv) | - | 1 |
| letrozole tab (FEMARA equiv) | - | 1 |
| megestrol susp (MEGACE equiv) | - | 1 |
| megestrol tab (MEGACE equiv) | - | 1 |
| nilutamide tab (NILANDRON equiv) | LMSP | 1 |
| toremifene tab (FARESTON equiv) | - | 1 |
| ERLEADA TAB (QL= 4 tabs/day) | LMSP-PA-QL | 2 |
| ERLEADA TAB 240MG (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| EULEXIN CAP | - | 2 |
| FLUTAMIDE CAP | - | 2 |
| LYSODREN TAB (Only available through Walgreens 888-347-3416) | LD | 2 |
| NUBEQA TAB (QL= 4 tabs/day) | MSP-PA-QL-SF | 2 |
| ORGOVYX TAB (QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| ORSERDU TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| ORSERDU TAB 345MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| INLURIYO TAB | - | EXC |
| leuprolide inj (LUPRON equiv) | INF | EXC |
| abiraterone acetate tab 500mg (ZYTIGA equiv) | - | NC |
| AKEEGA TAB | - | NC |
| HYDROXYPROGESTERONE CAPROATE INJ | - | NC |
| XTANDI CAP | - | NC |
| XTANDI TAB 40MG | - | NC |
| XTANDI TAB 80MG | - | NC |
| YONSA TAB | - | NC |
| ANTINEOPLASTIC - HYPOXIA-INDUCIBLE FACTOR INHIBITORS | | |
| WELIREG TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| ANTINEOPLASTIC - IMMUNOMODULATORS | | |
| POMALYST CAP (QL= 21 caps/28 days) | MSP-PA-QL | 2 |
| ANTINEOPLASTIC - MENIN INHIBITORS | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | Quantity Limit | RDX |
| | Step Therapy | SF | Restricted to Diagnosis |
| | | Limited to two 15 day fills per month for first 3 months | SMKG |
| | | VAC | Smoking Cessation |
| | | | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont. | | |
| REVUFORJ TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| REVUFORJ TAB 110MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| REVUFORJ TAB 25MG (QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| KOMZIFTI CAP | - | EXC |
| ANTINEOPLASTIC - PDGFR-ALPHA INHIBITORS | | |
| AYVAKIT TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| ANTINEOPLASTIC - PROTEASE ACTIVATORS | | |
| MODEYSO CAP | - | EXC |
| ANTINEOPLASTIC - XPO1 INHIBITORS | | |
| XPOVIO PAK (QL= 32 tabs/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| ANTINEOPLASTIC COMBINATIONS | | |
| AVMAPKI FAKZYNJA CO-PACK (QL= 1 pack/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| INQOVI TAB (QL= 5 tabs/28 days) | MSP-PA-QL | 2 |
| KISQALI PAK (QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 |
| LONSURF TAB | MSP-PA | 2 |
| ANTINEOPLASTIC ENZYME INHIBITORS | | |
| dasatinib tab (SPRYCEL equiv) | LMSP-PA | 1 |
| everolimus tab (AFINITOR equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 |
| everolimus tab for oral susp (AFINITOR DISPERZ equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 |
| imatinib tab (GLEEVEC equiv) | LMSP | 1 |
| lapatinib ditosylate tab (TYKERB equiv) | LMSP-PA | 1 |
| nilotinib hcl cap (TASIGNA equiv) | LMSP-PA | 1 |
| pazopanib tab (VOTRIENT equiv) (QL= 4 tabs/day) | LMSP-PA-QL | 1 |
| sorafenib tosylate tab (NEXAVAR equiv) | LMSP-PA | 1 |
| sunitinib malate cap (SUTENT equiv) (QL= 1 cap/day) | LMSP-PA-QL | 1 |
| ALECENSA CAP (QL= 8 caps/day) | LMSP-PA-QL | 2 |
| ALUNBRIG TAB 30MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| ALUNBRIG TAB 90MG, 180MG (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| AUGTYRO CAP (QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| AUGTYRO CAP 160MG (QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| BALVERSA TAB 3MG (QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 |
| BALVERSA TAB 4MG (QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 |
| BALVERSA TAB 5MG (QL= 1 tab/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL-SF | 2 |
| BOSULIF CAP | MSP-PA | 2 |
| BOSULIF TAB | MSP-PA-SF | 2 |
| BRAFTOVI CAP 75MG (QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| BRUKINSA CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 |
| BRUKINSA TAB (QL= 2 tabs/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 |
| CABOMETYX TAB (QL= 1 tab/day) | MSP-PA-QL-SF | 2 |
| CALQUENCE TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| CAPRELSA TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| CAPRELSA TAB 300MG (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| COMETRIQ KIT (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 |
| COPIKTRA CAP (QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont. | | |
| COTELLIC TAB (QL= 3 tabs/day) | LMSP-PA-QL | 2 |
| GAVRETO CAP (QL= 4 caps/day; Only available through Lumicera 855-847-3553) | LD-PA-QL-SF | 2 |
| GOMEKLI CAP (QL= 84 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| GOMEKLI CAP 1MG (QL= 168 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| GOMEKLI TAB FOR ORAL SUSP (QL= 168 tabs/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| IBTROZI CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| ICLUSIG TAB (QL= 1 tab/day; Only available through AcariaHealth 800-511-5144) | LD-PA-QL-SF | 2 |
| IDHIFA TAB (QL= 1 tab/day) | MSP-PA-QL | 2 |
| IMBRUVICA CAP 140MG (QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| IMBRUVICA CAP 70MG (QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| IMBRUVICA SUSP (QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| IMBRUVICA TAB 420MG (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| JAKAFI TAB (QL= 2 tabs/day) | MSP-PA-QL-SF | 2 |
| JAYPIRCA TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 |
| KISQALI TAB (QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828) | LD-PA-QL | 2 |
| KOSELUGO CAP (QL= 4 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| KOSELUGO CAP 10MG (QL= 8 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| KOSELUGO SPRINKLE CAP (QL= 12 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| KOSELUGO SPRINKLE CAP 5MG (QL= 20 caps/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| KRAZATI TAB (QL= 6 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| LORBRENA TAB 100MG (QL= 1 tab/day) | MSP-PA-QL-SF | 2 |
| LORBRENA TAB 25MG (QL= 3 tabs/day) | MSP-PA-QL-SF | 2 |
| LUMAKRAS TAB (QL= 8 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| LUMAKRAS TAB 240MG (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| LUMAKRAS TAB 320MG (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| LYNPARZA TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| LYTGOBI THERAPY PACK (QL= 5 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| MEKINIST SOLN | LMSP-PA | 2 |
| MEKINIST TAB 0.5MG (QL= 3 tabs/day) | LMSP-PA-QL | 2 |
| MEKINIST TAB 2MG (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| MEKTOVI TAB (QL= 6 tabs/day) | MSP-PA-QL | 2 |
| NERLYNX TAB (QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL-SF | 2 |
| NINLARO CAP (Only available through Diplomat 877-977-9118, Walgreens 888-347-3416, Walmart Specialty 877-453-4566) | LD-PA | 2 |
| OGSIVEO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| OGSIVEO TAB 50MG (QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| OJEMDA SUSP (QL= 96ml/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL-SF | 2 |
| OJEMDA TAB (QL= 24 tabs/28 days; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| OJJAARA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| PEMAZYRE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| PIQRAY TAB (Only available through Biologics 800-850-4306) | LD-PA-SF | 2 |
| QINLOCK TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| RETEVMO CAP (QL= 2 caps/day) | LMSP-PA-QL-SF | 2 |
| RETEVMO CAP 40MG (QL= 3 caps/day) | LMSP-PA-QL-SF | 2 |
| RETEVMO TAB (QL= 2 tabs/day) | LMSP-PA-QL-SF | 2 |
| RETEVMO TAB 40MG (QL= 3 tabs/day) | LMSP-PA-QL-SF | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | |
|-------------|---|--------------------------------|-------------------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | LD | BRANDS = CAPITAL LETTERS |
| LMSP | Plan Exclusion | INF | Limited Distribution | |
| PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter | |
| RS | Prior Authorization | QL | Restricted to Diagnosis | |
| ST | Restricted to Specialist | SF | Restricted to Diagnosis | |
| | Step Therapy | VAC | Smoking Cessation | |
| | | | SMKG | RxCENTS |
| | | | ¢ | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont. | | |
| REZLIDHIA CAP (QL= 2 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| ROMVIMZA CAP (QL= 8 caps/28 days; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| ROZLYTREK CAP (QL= 3 caps/day) | LMSP-PA-QL | 2 |
| ROZLYTREK PAK (QL= 6 packs/day) | LMSP-PA-QL | 2 |
| RUBRACA TAB (QL= 4 tabs/day; Only available through Optum 877-445-6874) | LD-PA-QL-SF | 2 |
| RYDAPT CAP (QL= 56 caps/28 days) | LMSP-PA-QL | 2 |
| SCSEMBLIX TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| SCSEMBLIX TAB 100 MG (QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| STIVARGA TAB (QL= 4 tabs/day) | MSP-PA-QL-SF | 2 |
| TABRECTA TAB (QL= 4 tabs/day) | LMSP-PA-QL-SF | 2 |
| TAFINLAR CAP (QL= 4 caps/day) | LMSP-PA-QL | 2 |
| TAFINLAR TAB | LMSP-PA | 2 |
| TALZENNA CAP 0.25MG (QL= 3 caps/day) | MSP-PA-QL-SF | 2 |
| TALZENNA CAP 0.5MG, 0.75MG, 1MG (QL= 1 cap/day) | MSP-PA-QL-SF | 2 |
| TAZVERIK TAB (QL= 8 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| TEPMETKO TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| TIBSOVO TAB (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| TRUQAP TAB (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| TRUQAP THERAPY PACK (QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| TURALIO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| VANFLYTA TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| VANFLYTA TAB 26.5MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| VERZENIO TAB (QL= 2 tabs/day) | LMSP-PA-QL | 2 |
| VITRAKVI CAP 100MG (QL= 2 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 |
| VITRAKVI CAP 25MG (QL= 6 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 |
| VITRAKVI SOLN (QL= 10ml/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 |
| VONJO CAP (QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| VORANIGO TAB (QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| VORANIGO TAB 10MG (QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306) | LD-PA-QL | 2 |
| XALKORI CAP (QL= 2 caps/day) | MSP-PA-QL-SF | 2 |
| XALKORI SPRINKLE CAP (QL= 4 caps/day) | MSP-PA-QL-SF | 2 |
| XOSPATA TAB (QL= 3 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL-SF | 2 |
| ZEJULA TAB (QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118) | LD-PA-QL | 2 |
| ZELBORAF TAB (QL= 8 tabs/day) | LMSP-PA-QL | 2 |
| ZYDELIG TAB (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 |
| ZYKADIA TAB (QL= 3 tabs/day) | LMSP-PA-QL-SF | 2 |
| FOTIVDA CAP (QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 3 |
| ENSACOVE CAP | - | EXC |
| HYRNUO TAB | - | EXC |
| NILOTINB TAR CAP | - | EXC |
| AFINITOR DISPERZ TAB | - | NC |
| AFINITOR TAB | - | NC |
| ALUNBRIG PAK | - | NC |
| DANZITEN TAB | - | NC |
| IBRANCE CAP | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | Mandatory Specialty Pharmacy Program | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | Quantity Limit | Restricted to Diagnosis |
| | | SF | SMKG |
| | | Limited to two 15 day fills per month for first 3 months | Smoking Cessation |
| | | VAC | ¢ |
| | | Vaccine Program | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ANTINEOPLASTICS AND ADJUNCTIVE THERAPIES Cont. | | |
| IBRANCE TAB | - | NC |
| IMBRUVICA TAB 140MG | - | NC |
| IMBRUVICA TAB 280MG | - | NC |
| IMKELDI SOLUTION | - | NC |
| INREBIC CAP | - | NC |
| ITOVEBI TAB | - | NC |
| PAZOPANIB TAB 400MG | - | NC |
| PHYRAGO TAB | - | NC |
| SPRYCEL TAB | - | NC |
| SUTENT CAP | - | NC |
| TALZENNA CAP 0.1MG | - | NC |
| TALZENNA CAP 0.35MG | - | NC |
| TASIGNA CAP | - | NC |
| TYKERB TAB | - | NC |
| VOTRIENT TAB | - | NC |
| ANTINEOPLASTICS MISC. | | |
| bexarotene cap (TARGRETIN equiv) (QL= 10 caps/day) | LMSP-QL | 1 |
| BESREMI INJ (QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633) | LD-PA-QL | 2 |
| SYLATRON INJ | - | NC |
| CHEMOTHERAPY RESCUE/ANTIDOTE/PROTECTIVE AGENTS | | |
| mesna tab (MESNEX equiv) | LMSP | 1 |
| IWILFIN TAB (QL= 8 tabs/day; Only available through CurantHealth 866-437-8040) | LD-PA-QL-SF | 2 |
| LEUCOVORIN CA TAB | - | NC |
| MESNEX TAB | - | NC |
| MITOTIC INHIBITORS | | |
| ETOPOSIDE CAP | LMSP | 1 |
| ANTIPARKINSON AGENTS | | |
| ANTIPARKINSON ADJUVANTS | | |
| carbidopa tab (LODOSYN equiv) | - | 1 |
| ANTIPARKINSON ANTICHOLINERGICS | | |
| benztropine tab | - | 1 |
| trihexyphenidyl tab (ARTANE equiv) | - | 1 |
| ANTIPARKINSON COMT INHIBITORS | | |
| entacapone tab (COMTAN equiv) | - | 1 |
| tolcapone tab (TASMAR equiv) | - | 1 |
| ANTIPARKINSON DOPAMINERGICS | | |
| amantadine cap (SYMMETREL equiv) | - | 1 |
| amantadine tab | - | 1 |
| bromocriptine cap (PARLODEL equiv) | - | 1 |
| bromocriptine tab (PARLODEL equiv) | - | 1 |
| carbidopa/levodopa ER tab (SINEMET CR equiv) | - | 1 |
| carbidopa/levodopa ODT (PARCOPA equiv) | - | 1 |
| carbidopa/levodopa tab (SINEMET equiv) | - | 1 |
| pramipexole ER tab (MIRAPEX ER equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ANTIPARKINSON AGENTS Cont. | | |
| pramipexole tab (MIRAPEX equiv) | - | 1 |
| ropinirole ER tab (REQUIP XL equiv) | - | 1 |
| ropinirole tab (REQUIP equiv) | - | 1 |
| CARBIDOPA/LEVODOPA/ENTACAPONE TAB (STALEVO equiv) | - | 2 |
| NEUPRO PATCH | - | 3 |
| CREXONT CAP | - | NC |
| DUOPA ENTERAL SUSP | - | NC |
| GOCOVRI CAP | - | NC |
| ANTIPARKINSON MONOAMINE OXIDASE INHIBITORS | | |
| rasagiline tab (AZILECT equiv) | - | 1 |
| selegiline cap (ELDEPRYL equiv) | - | 1 |
| selegiline tab (ELDEPRYL equiv) | - | 1 |
| XADAGO TAB (QL= 1 tab/day) | PA-QL | 3 |
| ZELAPAR ODT | - | NC |
| ANTIPARKINSON AND RELATED THERAPY AGENTS | | |
| ANTIPARKINSON ANTICHOLINERGICS | | |
| trihexyphenidyl elixir (ARTANE equiv) | - | 1 |
| TRIHEXYPHENIDYL SOLN | - | 1 |
| ANTIPARKINSON COMT INHIBITORS | | |
| ONGENTYS CAP (QL= 1 tab/day, 30 tabs per fill) | PA-QL | 3 |
| ANTIPARKINSON DOPAMINERGICS | | |
| amantadine soln (AMANTADINE equiv) | - | 1 |
| carbidopa-levodopa-entacapone tab (STALEVO equiv) | - | 1 |
| INBRIJA INH POWDER (QL= 10 caps/day) | PA-QL | 3 |
| APOKYN INJ | - | NC |
| apomorphine inj (APOKYN equiv) | - | NC |
| CARBIDOPA/LEVODOPA CAP, RYTARY CAP | - | NC |
| DHIVY TAB | - | NC |
| KYNMOBI FILM | - | NC |
| KYNMOBI TITRATION KIT | - | NC |
| ONAPGO INJ | - | NC |
| OSMOLEX ER TAB | - | NC |
| VYALEV INJ | - | NC |
| ANTIPSYCHOTICS/ANTIMANIC AGENTS | | |
| ANTIMANIC AGENTS | | |
| lithium carbonate cap (ESKALITH ER equiv) | - | 1 |
| lithium carbonate ER tab (LITHOBID equiv) | - | 1 |
| lithium carbonate tab | - | 1 |
| lithium oral solution (LITHIUM equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| ANTIPSYCHOTICS - MISC. | | |
| lurasidone hcl tab (LATUDA equiv) | - | 1 |
| ziprasidone cap (GEODON equiv) | - | 1 |
| EQUETRO CAP | - | 2 |
| LATUDA TAB | - | 3 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont. | | |
| CAPLYTA CAP | - | NC |
| NUPLAZID CAP | - | NC |
| NUPLAZID TAB | - | NC |
| VRAYLAR CAP | - | NC |
| VRAYLAR PACK | - | NC |
| BENZISOXAZOLES | | |
| paliperidone ER tab (INVEGA equiv) | - | 1 |
| risperidone ODT (RISPERDAL M equiv) | - | 1 |
| risperidone soln (RISPERDAL equiv) | - | 1 |
| risperidone tab (RISPERDAL equiv) | - | 1 |
| RISPERIDONE ODT | - | 2 |
| FANAPT TAB | - | NC |
| FANAPT TITRATION PACK | - | NC |
| FANAPT TITRATION PACK 1MG/2MG/6MG/8MG | - | NC |
| BUTYROPHENONES | | |
| haloperidol lactate conc (HALDOL equiv) | - | 1 |
| haloperidol tab (HALDOL equiv) | - | 1 |
| DIBENZAPINES | | |
| asenapine maleate SL tab (SAPHRIS equiv) (QL= 2 tabs/day) | QL | 1 |
| clozapine tab (CLOZARIL equiv) | - | 1 |
| loxapine cap (LOXITANE equiv) | - | 1 |
| olanzapine ODT (ZYPREXA equiv) | - | 1 |
| olanzapine tab (ZYPREXA equiv) | - | 1 |
| quetiapine tab (SEROQUEL equiv) | - | 1 |
| quetiapine XR tab (SEROQUEL XR equiv) | - | 1 |
| ADASUVE INHALER | - | NC |
| clozapine odt tab (CLOZAPINE, FAZACLO equiv) | - | NC |
| CLOZAPINE ODT, FAZACLO ODT | - | NC |
| QUETIAPINE TAB | - | NC |
| SECUADO PATCH | - | NC |
| VERSACLOZ SUSP | - | NC |
| DIHYDROINDOLONES | | |
| MOLINDONE TAB | - | NC |
| MUSCARINIC AGENTS | | |
| COBENFY CAP | - | NC |
| COBENFY CAP STARTER PACK | - | NC |
| PHENOTHIAZINES | | |
| chlorpromazine tab (THORAZINE equiv) | - | 1 |
| fluphenazine tab (PROLIXIN equiv) | - | 1 |
| perphenazine tab (TRILAFON equiv) | - | 1 |
| prochlorperazine supp (COMPAZINE equiv) | - | 1 |
| prochlorperazine tab (COMPAZINE equiv) | - | 1 |
| thioridazine hcl tab (THIORIDAZINE equiv) | - | 1 |
| trifluoperazine tab (STELAZINE equiv) | - | 1 |
| CHLORPROMAZINE CONC | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTIPSYCHOTICS/ANTIMANIC AGENTS Cont. | | |
| chlorpromazine hcl conc | - | NC |
| QUINOLINONE DERIVATIVES | | |
| aripiprazole soln (ABILIFY equiv) | - | 1 |
| aripiprazole tab (ABILIFY equiv) | - | 1 |
| ABILIFY MYCITE PACK | - | NC |
| ABILIFY MYCITE TAB | - | NC |
| aripiprazole ODT (ABILIFY equiv) | - | NC |
| OPIPZA FILM | - | NC |
| REXULTI TAB | - | NC |
| THIOXANTHENES | | |
| thiothixene cap (NAVANE equiv) | - | 1 |
| ANTISEPTICS & DISINFECTANTS | | |
| ANTISEPTICS & DISINFECTANTS | | |
| HYLAMEND GEL FIRST AID | - | NC |
| IODINE ANTISEPTICS | | |
| IODOFLEX PAD | - | NC |
| ANTIVIRALS | | |
| ANTIRETROVIRALS | | |
| APRETUDE SUSP (QL= 7 inj/year) | PA-QL | \$0 |
| DESCOVY TAB | PA | \$0 |
| emtricitabine/tenofovir disoproxil fumarate tab (TRUVADA equiv) | - | \$0 |
| YEZTUGO INJ (QL= 2 inj/180 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | \$0 |
| YEZTUGO TAB (QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | \$0 |
| abacavir soln (ZIAGEN equiv) | - | 1 |
| abacavir tab (ZIAGEN equiv) | - | 1 |
| abacavir/lamivudine tab (EPZICOM equiv) | - | 1 |
| abacavir/lamivudine/zidovudine tab (TRIZIVIR equiv) | - | 1 |
| atazanavir cap (REYATAZ equiv) | - | 1 |
| darunavir tab | - | 1 |
| EFAVIRENZ CAP | - | 1 |
| efavirenz tab (SUSTIVA equiv) | - | 1 |
| efavirenz/emtricitabine/tenofovir df tab (ATRIPLA equiv) | - | 1 |
| efavirenz/lamivudine/tenofovir df (lo) tab (SYMFI (LO) equiv) | - | 1 |
| EFAVIRENZ/LAMIVUDINE/TENOFOVIR TAB | - | 1 |
| emtricitabine cap (EMTRIVA equiv) | - | 1 |
| emtricitabine-rilpivirine-tenofovir df tab (COMPLERA equiv) | - | 1 |
| etravirine tab (INTELENCE equiv) | - | 1 |
| fosamprenavir tab (LEXIVA equiv) | - | 1 |
| lamivudine soln (EPIVIR equiv) | - | 1 |
| lamivudine tab (EPIVIR equiv) | - | 1 |
| lamivudine/zidovudine tab (COMBIVIR equiv) | - | 1 |
| lopinavir/ritonavir soln (KALETRA equiv) | - | 1 |
| lopinavir/ritonavir tab (KALETRA equiv) | - | 1 |
| maraviroc tab (SELZENTRY equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | generic = small letters | | BRANDS = CAPITAL LETTERS | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIVIRALS Cont. | | |
| NEVIRAPINE ER TAB | - | 1 |
| nevirapine ER tab (VIRAMUNE XR equiv) | - | 1 |
| NEVIRAPINE SUSP | - | 1 |
| nevirapine tab (VIRAMUNE equiv) | - | 1 |
| ritonavir tab (NORVIR equiv) | - | 1 |
| STAVUDINE CAP | - | 1 |
| stavudine cap (ZERIT equiv) | - | 1 |
| tenofovir disoproxil fumarate tab (VIREAD equiv) | - | 1 |
| zidovudine cap (RETROVIR equiv) | - | 1 |
| zidovudine syrup (RETROVIR equiv) | - | 1 |
| zidovudine tab (RETROVIR equiv) | - | 1 |
| APTIVUS CAP | - | 2 |
| BIKTARVY TAB | - | 2 |
| CABENUVA IM SUSP (QL= 1 kit/30 days) | LMSP-QL | 2 |
| CABENUVA SUSP 600MG-900MG/3ML (QL= 1 kit/30 days) | LMSP-QL | 2 |
| CIMDUO TAB | - | 2 |
| CRIXIVAN CAP | - | 2 |
| DELSTRIGO TAB | - | 2 |
| DOVATO TAB | - | 2 |
| EDURANT PED TAB | - | 2 |
| EDURANT TAB | - | 2 |
| EMTRIVA SOLN | - | 2 |
| EVOTAZ TAB | - | 2 |
| GENVOYA TAB | - | 2 |
| INTELENCE TAB | - | 2 |
| INVIRASE TAB | - | 2 |
| ISENTRESS (HD) TAB | - | 2 |
| ISENTRESS CHEW TAB | - | 2 |
| ISENTRESS POWDER PACK | - | 2 |
| JULUCA TAB | - | 2 |
| LEXIVA SUSP | - | 2 |
| NORVIR CAP | - | 2 |
| NORVIR POWDER PACK | - | 2 |
| NORVIR SOLN | - | 2 |
| ODEFSEY TAB | - | 2 |
| PIFELTRO TAB | - | 2 |
| PREZCOBIX TAB | - | 2 |
| PREZISTA SUSP | - | 2 |
| PREZISTA TAB | - | 2 |
| REYATAZ POWDER PACK | - | 2 |
| RUKOBIA ER TAB (Restricted to Infectious Disease Specialist) | RS | 2 |
| SELZENTRY SOLN | - | 2 |
| SELZENTRY TAB | - | 2 |
| STRIBILD TAB | - | 2 |
| SUNLENCA INJ (QL= 2 vials/26 weeks; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIVIRALS Cont. | | |
| SUNLENCA TAB (QL= 4 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 |
| SUNLENCA TAB 300MG (QL= 5 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828) | LD-QL-RS | 2 |
| SYMTUZA TAB | - | 2 |
| TIVICAY PD TAB | - | 2 |
| TIVICAY TAB | - | 2 |
| TRIUMEQ PD TAB | - | 2 |
| TRIUMEQ TAB | - | 2 |
| TRIZIVIR TAB | - | 2 |
| TYBOST TAB | - | 2 |
| VIRACEPT TAB | - | 2 |
| VIREAD TAB | - | 2 |
| COMPLERA TAB | - | 3 |
| EMTRIVA CAP | - | 3 |
| KALETRA SOLN | - | 3 |
| KALETRA TAB | - | 3 |
| PREZISTA TAB | - | 3 |
| SELZENTRY TAB | - | 3 |
| SUSTIVA TAB | - | 3 |
| SYMFI (LO) TAB | - | 3 |
| ATRIPLA TAB | - | NC |
| FUZEON INJ | - | NC |
| TRUVADA TAB | - | NC |
| ANTIVIRAL COMBINATIONS | | |
| PAXLOVID PAK (QL= 11 tabs/90 days) | QL | 2 |
| PAXLOVID TAB 150-100MG (QL= 20 tabs/90 days) | QL | 2 |
| PAXLOVID TAB 300-100MG (QL= 30 tabs/90 days) | QL | 2 |
| CMV AGENTS | | |
| valganciclovir soln (VALCYTE equiv) | - | 1 |
| valganciclovir tab (VALCYTE equiv) | - | 1 |
| LIVTENCITY TAB (QL= 4 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| PREVYMIS PAK (QL= 4 packets/day; Limit 800 packets/365 days) | LMSP-PA-QL | 2 |
| PREVYMIS TAB (QL= 1 tab/day; Limit 200 tabs/365 days) | LMSP-PA-QL | 2 |
| HEPATITIS AGENTS | | |
| adefovir dipivoxil tab (HEPSERA equiv) | - | 1 |
| entecavir tab (BARACLUDE equiv) (QL= 1 tab/day) | QL | 1 |
| lamivudine tab 100mg (EPIVIR HBV equiv) | - | 1 |
| RIBAVIRIN CAP | LMSP | 1 |
| ribavirin cap (REBETOL equiv) | LMSP | 1 |
| RIBAVIRIN TAB | LMSP | 1 |
| EPIVIR HBV SOLN | - | 2 |
| LEDIPASVIR/SOFOSBUVIR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| MAVYRET PAK (QL= 5 packs/day) | LMSP-PA-QL | 2 |
| MAVYRET TAB (QL= 3 tabs/day) | LMSP-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ANTIVIRALS Cont. | | |
| PEGASYS INJ | LMSP | 2 |
| SOFOSBUVIR/VELPATASVIR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| VEMLIDY TAB | - | 2 |
| VOSEVI TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| BARACLUDE SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| EPCLUSA PAK | - | NC |
| EPCLUSA TAB | - | NC |
| HARVONI PELLETT PAK | - | NC |
| HARVONI TAB | - | NC |
| SOVALDI PELLETT PAK | - | NC |
| SOVALDI TAB | - | NC |
| ZEPATIER TAB | - | NC |
| HERPES AGENTS | | |
| acyclovir cap (ZOVIRAX equiv) | - | 1 |
| acyclovir susp (ZOVIRAX equiv) | - | 1 |
| acyclovir tab (ZOVIRAX equiv) | - | 1 |
| famciclovir tab (FAMVIR equiv) | - | 1 |
| valacyclovir tab (VALTRESX equiv) | - | 1 |
| SITAVIG TAB | - | NC |
| INFLUENZA AGENTS | | |
| oseltamivir cap (TAMIFLU equiv) (QL= 10 caps/fill) | QL | 1 |
| oseltamivir cap 30mg (TAMIFLU equiv) (QL= 20 caps/fill) | QL | 1 |
| oseltamivir susp (TAMIFLU equiv) (QL= 250ml/fill) | QL | 1 |
| RELENZA DISKHALER (QL= 1 inhaler/fill) | QL | 2 |
| RIMANTADINE TAB | - | 3 |
| XOFLUZA TAB (QL= 1 tab/fill) | QL | 3 |
| MISC. ANTIVIRALS | | |
| LAGEVRIO CAP (EUA) (QL= 40 caps/fill) | QL | \$0 |
| LAGEVRIO CAP 200MG (QL= 40 caps/fill) | QL | 2 |
| RESPIRATORY SYNCYTIAL VIRUS (RSV) AGENTS | | |
| ribavirin inh soln (VIRAZOLE equiv) | - | NC |
| ASSORTED CLASSES | | |
| CHELATING AGENTS | | |
| D-PENAMINE TAB | - | 2 |
| IMMUNOMODULATORS | | |
| THALOMID CAP | MSP | 2 |
| IMMUNOSUPPRESSIVE AGENTS | | |
| azathioprine tab (IMURAN equiv) | - | 1 |
| cyclosporine cap (SANDIMMUNE equiv) | - | 1 |
| cyclosporine modified cap (NEORAL equiv) | - | 1 |
| cyclosporine modified soln (NEORAL equiv) | - | 1 |
| mycophenolate DR tab (MYFORTIC equiv) | - | 1 |
| mycophenolate mofetil cap (CELLCEPT equiv) | - | 1 |
| mycophenolate mofetil susp (CELLCEPT SUSP equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ASSORTED CLASSES Cont. | | |
| mycophenolate mofetil tab (CELLCEPT equiv) | - | 1 |
| sirolimus tab (RAPAMUNE equiv) | - | 1 |
| tacrolimus cap (PROGRAF equiv) | - | 1 |
| SANDIMMUNE SOLN 100MG/ML | - | 2 |
| ENVARBUS XR TAB | - | NC |
| POTASSIUM REMOVING RESINS | | |
| sodium polystyrene powder (KAYEXALATE equiv) | - | 1 |
| sodium polystyrene susp (SPS equiv) | - | 1 |
| VELTASSA POWDER (QL= 1 packet/day) | PA-QL | 2 |
| BETA BLOCKERS | | |
| ALPHA-BETA BLOCKERS | | |
| carvedilol tab (COREG equiv) | - | 1 |
| labetalol tab (NORMODYNE equiv) | - | 1 |
| carvedilol phosphate ER cap (COREG CR equiv) | - | NC |
| LABETALOL TAB | - | NC |
| BETA BLOCKERS CARDIO-SELECTIVE | | |
| acebutolol cap (SECTRAL equiv) | - | 1 |
| atenolol tab (TENORMIN equiv) | - | 1 |
| betaxolol tab (KERLONE equiv) | - | 1 |
| bisoprolol tab (ZEBETA equiv) | - | 1 |
| metoprolol ER tab (TOPROL XL equiv) | - | 1 |
| metoprolol tab (LOPRESSOR equiv) | - | 1 |
| nebivolol hcl tab (BYSTOLIC equiv) | - | 1 |
| LOPRESSOR SOLN (QL= 45ml/day; Prior Authorization required for members age 9 years and older) | PA-QL | 3 |
| BISOPROLOL FUMARATE TAB | - | NC |
| KAPSPARGO CAP | - | NC |
| METOPROLOL TARTRATE TAB | - | NC |
| BETA BLOCKERS NON-SELECTIVE | | |
| nadolol tab (CORGARD equiv) | - | 1 |
| pindolol tab (VISKEN equiv) | - | 1 |
| propranolol ER cap (INDERAL LA equiv) | - | 1 |
| PROPRANOLOL SOLN | - | 1 |
| PROPRANOLOL SOLN 20MG/5ML | - | 1 |
| propranolol tab (INDERAL equiv) | - | 1 |
| sotalol AF tab (BETAPACE AF equiv) | - | 1 |
| sotalol tab (BETAPACE equiv) | - | 1 |
| TIMOLOL MALEATE TAB | - | 1 |
| timolol maleate tab (BLOCADREN equiv) | - | 1 |
| SOTYLIZE SOLN 5MG/ML (Prior Authorization required for members age 9 years and older) | PA | 3 |
| HEMANGEOL SOLN | - | NC |
| INDERAL XL CAP, INNOPRAN XL CAP | - | NC |
| SOTYLIZE SOLN | - | NC |

BIOLOGICALS MISC

ALLERGENIC EXTRACTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

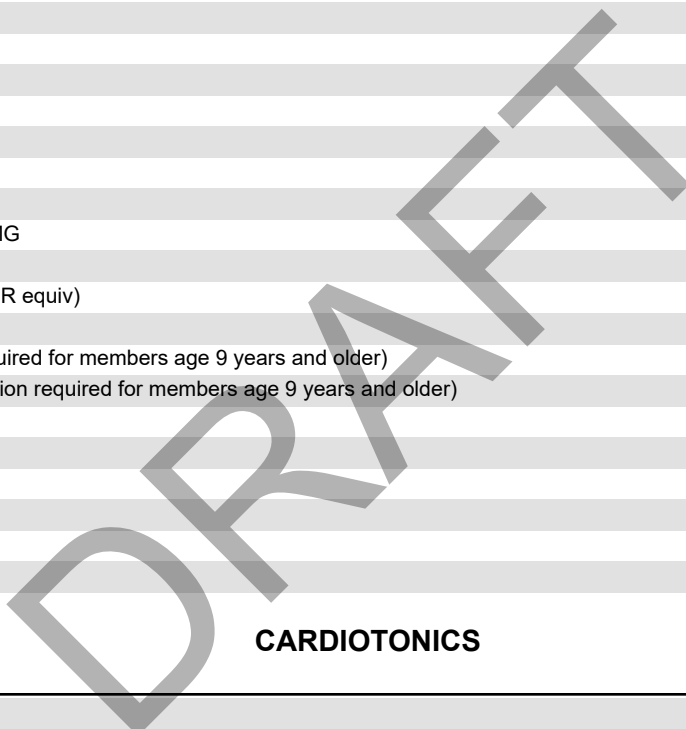
| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| BIOLOGICALS MISC Cont. | | |
| GRASTEK SL TAB | - | NC |
| ORALAIR SL TAB | - | NC |
| RAGWITEK SL TAB | - | NC |
| CALCIUM CHANNEL BLOCKERS | | |
| CALCIUM CHANNEL BLOCKER COMBINATIONS | | |
| CONSENSI TAB | - | NC |
| CALCIUM CHANNEL BLOCKERS | | |
| amlodipine tab (NORVASC equiv) | - | 1 |
| diltiazem ER cap (CARDIZEM CD equiv) | - | 1 |
| diltiazem ER cap (CARDIZEM SR equiv) | - | 1 |
| diltiazem ER cap (DILACOR XR equiv) | - | 1 |
| diltiazem ER cap (TIAZAC equiv) | - | 1 |
| diltiazem ER tab (CARDIZEM LA equiv) | - | 1 |
| diltiazem tab (CARDIZEM equiv) | - | 1 |
| felodipine ER tab (PLENDIL equiv) | - | 1 |
| isradipine cap (DYNACIRC equiv) | - | 1 |
| nicardipine cap (CARDENE equiv) | - | 1 |
| nifedipine cap (PROCARDIA equiv) | - | 1 |
| nifedipine ER tab (ADALAT CC equiv) | - | 1 |
| nimodipine cap (NIMOTOP equiv) | - | 1 |
| nisoldipine ER tab (SULAR equiv) | - | 1 |
| NISOLDIPINE ER TAB 20MG, 30MG, 40MG | - | 1 |
| verapamil SR cap (VERELAN equiv) | - | 1 |
| verapamil SR tab (CALAN SR, ISOPTIN SR equiv) | - | 1 |
| verapamil tab (CALAN equiv) | - | 1 |
| KATERZIA SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| NORLIQVA ORAL SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| VERELAN CAP | - | 3 |
| CARDAMYST NASAL SPRAY | - | EXC |
| CONJUPRI TAB, LEVAMLODIPINE TAB | - | NC |
| NYMALIZE SOLN | - | NC |
| SDAMLO SOLN | - | NC |
| VERAPAMIL CR CAP, VERELAN CAP | - | NC |
| VERAPAMIL ER CAP | - | NC |
| CARDIOTONICS | | |
| CARDIAC GLYCOSIDES | | |
| digoxin soln (LANOXIN equiv) | - | 1 |
| DIGOXIN SOLN 0.05MG/ML | - | 1 |
| digoxin tab (LANOXIN equiv) | - | 1 |
| digoxin tab 62.5mcg (LANOXIN equiv) | - | NC |
| LANOXIN INJ | - | NC |
| LANOXIN TAB 62.5MCG | - | NC |
| CARDIOVASCULAR AGENTS - MISC. | | |
| CARDIAC MYOSIN INHIBITORS | | |



Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| CARDIOVASCULAR AGENTS - MISC. Cont. | | |
| CAMZYOS CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 |
| MYQORZO TAB | - | EXC |
| CARDIOVASCULAR AGENTS MISC. - COMBINATIONS | | |
| sacubitril-valsartan tab (ENTRESTO equiv) (QL= 2 tabs/day) | QL | 1 |
| amlodipine/atorvastatin tab (CADUET equiv) | - | NC |
| BIDIL TAB | - | NC |
| ENTRESTO CAP | - | NC |
| isosorbide dinitrate/hydralazine hcl tab (BIDIL equiv) | - | NC |
| OPSYNVI TAB | - | NC |
| CARDIOVASCULAR ANTI-INFLAMMATORY/IMMUNE MODULATORS | | |
| LODOCO TAB | - | NC |
| CARDIOVASCULAR SODIUM-GLUCOSE CO-TRANSPORTER 2 INHIBITORS | | |
| INPEFA TAB | - | NC |
| IMPOTENCE AGENTS | | |
| tadalafil tab 2.5mg, 5mg (CIALIS equiv) (QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap) | QL-ST | 1 |
| avanafil tab (STENDRA equiv) | - | EXC |
| CAVERJECT INJ | - | EXC |
| CIALIS TAB | - | EXC |
| CIALIS TAB 2.5MG, 5MG | - | EXC |
| EDEX INJ | - | EXC |
| LEVITRA TAB | - | EXC |
| sildenafil tab (VIAGRA equiv) | - | EXC |
| STAXYN ODT | - | EXC |
| STENDRA TAB | - | EXC |
| tadalafil tab (CIALIS equiv) | - | EXC |
| vardeafil ODT (STAXYN equiv) | - | EXC |
| vardeafil tab (LEVITRA equiv) | - | EXC |
| VIAGRA TAB | - | EXC |
| PERIPHERAL VASODILATORS | | |
| ISOXSUPRINE TAB | - | 1 |
| PROSTAGLANDIN VASODILATORS | | |
| TYVASO DPI POWDER (QL= 4 cartridges/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG (QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO DPI POWDER TITRATION KIT 16-32-48MCG (QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO DPI POWDER TITRATION KIT 16-32MCG (QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TYVASO INH SOLN 0.6 MG/ML (QL= 1 ampule/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| YUTREPIA CAP (QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767) | LD-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | Mandatory Specialty Pharmacy Program | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | Quantity Limit | Restricted to Diagnosis |
| | | SF | SMKG |
| | | Limited to two 15 day fills per month for first 3 months | Smoking Cessation |
| | | VAC | ¢ |
| | | Vaccine Program | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| CARDIOVASCULAR AGENTS - MISC. Cont. | | |
| ORENITRAM TAB | PA | Non-EHB |
| ORENITRAM TAB MONTH PAK | - | Non-EHB |
| VENTAVIS INH SOLN (QL= 9 ampules/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| PULMONARY HYPERTENSION - ACTIVIN SIGNALING INHIBITOR | | |
| WINREVAIR INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 |
| PULMONARY HYPERTENSION - ENDOTHELIN RECEPTOR ANTAGONISTS | | |
| ambrisentan tab (LETAIRIS equiv) (QL= 1 tab/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 1 |
| bosentan tab (TRACLEER equiv) (QL= 2 tabs/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 1 |
| bosentan tab for oral susp (TRACLEER equiv) (QL= 4 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 1 |
| OPSUMIT TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TRACLEER TAB | - | NC |
| PULMONARY HYPERTENSION - PHOSPHODIESTERASE INHIBITORS | | |
| sildenafil susp (REVATIO equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| sildenafil tab 20mg (REVATIO equiv) | PA | 1 |
| tadalafil tab (PAH) (ADCIRCA equiv) | PA | 1 |
| TADLIQ SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| ADCIRCA TAB | - | NC |
| LIQREV SUSP | - | NC |
| PULMONARY HYPERTENSION - PROSTACYCLIN RECEPTOR AGONIST | | |
| UPTRAVI TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| UPTRAVI INJ | - | NC |
| PULMONARY HYPERTENSION - SOL GUANYLATE CYCLASE STIMULATOR | | |
| ADEMPAS TAB (QL= 3 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| SINUS NODE INHIBITORS | | |
| ivabradine hcl tab (CORLANOR equiv) | - | 1 |
| CORLANOR SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| CORLANOR TAB | - | 3 |
| TRANSTHYRETIN STABILIZERS | | |
| ATTRUBY PACK (QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 |
| VYNDAMAX CAP (QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 |
| VYNDAQEL CAP (QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 |
| VASOACTIVE SOLUBLE GUANYLATE CYCLASE STIMULATOR (SGC) | | |
| VERQUVO TAB (QL= 1 tab/day; Restricted to Cardiology Specialist) | QL-RS | 2 |
| CEPHALOSPORINS | | |
| CEPHALOSPORINS - 1ST GENERATION | | |
| cefadroxil cap (DURICEF equiv) | - | 1 |
| cefadroxil susp (DURICEF equiv) | - | 1 |
| cefadroxil tab (DURICEF equiv) | - | 1 |
| cephalexin cap (KEFLEX equiv) | - | 1 |
| cephalexin susp (KEFLEX equiv) | - | 1 |
| CEFADROXIL TAB | - | 2 |
| cephalexin cap 750mg (KEFLEX equiv) | - | NC |
| cephalexin tab | - | NC |
| KEFLEX CAP 750MG | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| CEPHALOSPORINS Cont. | | |
| CEPHALOSPORINS - 2ND GENERATION | | |
| CEFACLOR CAP | - | 1 |
| cefaclor cap (CECLOR equiv) | - | 1 |
| cefprozil susp (CEFZIL equiv) | - | 1 |
| cefprozil tab (CEFZIL equiv) | - | 1 |
| cefuroxime tab (CEFTIN equiv) | - | 1 |
| CEFACLOR ER TAB | - | 3 |
| CEFACLOR SUSP | - | 3 |
| CEPHALOSPORINS - 3RD GENERATION | | |
| cefdinir cap (OMNICEF equiv) | - | 1 |
| cefdinir susp (OMNICEF equiv) | - | 1 |
| cefixime cap (SUPRAX equiv) | - | 1 |
| cefixime susp (SUPRAX equiv) | - | 1 |
| CEFPODOXIME PROXETIL SUSP | - | 1 |
| cefpodoxime proxetil tab (VANTIN equiv) | - | 1 |
| SUPRAX CAP | - | 3 |
| SUPRAX CHEW TAB | - | 3 |
| SUPRAX SUSP 500MG/5ML | - | 3 |
| CEFIXIME TAB | - | NC |
| CONTRACEPTIVES | | |
| COMBINATION CONTRACEPTIVES - ORAL | | |
| amethyst tab (LYBREL equiv) | - | \$0 |
| ARANELLE TAB | - | \$0 |
| ashlyna tab, daysee tab (SEASONALE, SEASONIQUE equiv) | - | \$0 |
| AVERI TAB | - | \$0 |
| cryselle tab | - | \$0 |
| drospirenone/ethinyl estradiol/levomefolate tab (BEYAZ equiv) | - | \$0 |
| enpresse tab (TRI-LEVELLEN equiv) | - | \$0 |
| FEMLYV TAB | - | \$0 |
| gianvi tab, ocella tab (YASMIN, YAZ equiv) | - | \$0 |
| isibloom tab, enskyce tab, apri tab (DESOGEN equiv) | - | \$0 |
| kelnor tab (DEMULEN equiv) | - | \$0 |
| layolis FE tab, wymzya FE tab (FEMCON FE equiv) | - | \$0 |
| norethindrone acetate/ethinyl estradiol FE chew tab (MINASTRIN equiv) | - | \$0 |
| norethindrone acetate/ethinyl estradiol tab (LOESTRIN equiv) | - | \$0 |
| norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv) | - | \$0 |
| nortrel 7/7/7 tab, pirmella 7/7/7 tab (TRI-NORINYL equiv) | - | \$0 |
| nortrel tab (OVCON 35 equiv) | - | \$0 |
| SAFYRAL TAB | - | \$0 |
| sprintec 28 tab (ORTHO-CYCLEN equiv) | - | \$0 |
| tri-legest tab (ESTROSTEP FE equiv) | - | \$0 |
| tri-sprintec tab (ORTHO TRI-CYCLEN (LO) equiv) | - | \$0 |
| TYBLUME TAB | - | \$0 |
| VELIVET PAK | - | \$0 |
| velivet tab (CYCLESSA equiv) | - | \$0 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| CONTRACEPTIVES Cont. | | |
| vienva tab, lessina tab, kurvelo tab (ALESSE equiv) | - | \$0 |
| viorele tab, kariva tab (MIRCETTE equiv) | - | \$0 |
| loestrin 21 tab | - | 1 |
| loestrin tab | - | 1 |
| norethindrone ace-ethinyl estradiol-fe cap (TAYTULLA equiv) | - | 1 |
| norethindrone/ethinyl estradiol FE tab (LOESTRIN FE equiv) | - | 1 |
| BALCOLTRA TAB | - | 3 |
| BEYAZ TAB | - | 3 |
| levonorgestrel-ethinyl estradiol-fe tab (BALCOLTRA equiv) | - | 3 |
| LO LOESTRIN TAB | - | 3 |
| NATAZIA TAB | - | 3 |
| NEXTSTELLIS TAB | - | 3 |
| FALESSA KIT | - | NC |
| COMBINATION CONTRACEPTIVES - TRANSDERMAL | | |
| zafemy patch (XULANE equiv) | - | \$0 |
| TWIRLA PATCH | - | 3 |
| COMBINATION CONTRACEPTIVES - VAGINAL | | |
| eluryng vaginal ring (NUVARING equiv) | - | \$0 |
| ANNOVERA RING (QL= 1 ring/year) | QL | 3 |
| NUVARING | - | 3 |
| COPPER CONTRACEPTIVES - IUD | | |
| MIDUELLA, PARAGARD IUD | - | \$0 |
| EMERGENCY CONTRACEPTIVES | | |
| ELLA TAB | - | \$0 |
| levonorgestrel tab (PLAN B equiv) | OTC | \$0 |
| PLAN B TAB | OTC | 3 |
| PROGESTIN CONTRACEPTIVES - IMPLANTS | | |
| NEXPLANON IMPLANT | - | \$0 |
| PROGESTIN CONTRACEPTIVES - INJECTABLE | | |
| DEPO-PROVERA SC INJ 104MG (QL= 1 inj/90 days) | QL | \$0 |
| medroxyprogesterone inj (DEPO-PROVERA equiv) (QL= 1 inj/90 days) | QL | \$0 |
| DEPO-PROVERA INJ | QL | 3 |
| PROGESTIN CONTRACEPTIVES - IUD | | |
| MIRENA IUD | - | \$0 |
| PROGESTIN CONTRACEPTIVES - ORAL | | |
| norethindrone tab (NORA-QD equiv) | - | \$0 |
| OPILL TAB | OTC | \$0 |
| SLYND TAB | - | 3 |
| CORTICOSTEROIDS | | |
| GLUCOCORTICOSTEROIDS | | |
| budesonide ER tab (UCERIS equiv) (QL=1 tab/day) | PA-QL | 1 |
| budesonide SR cap (ENTOCORT EC equiv) | - | 1 |
| DEXAMETHASONE CONC | - | 1 |
| dexamethasone elixir | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| CORTICOSTEROIDS Cont. | | |
| DEXAMETHASONE PHOSPHATE INJ | - | 1 |
| dexamethasone sodium phosphate inj | - | 1 |
| DEXAMETHASONE SOLN | - | 1 |
| dexamethasone tab (DECADRON equiv) | - | 1 |
| hydrocortisone tab (CORTEF equiv) | - | 1 |
| methylprednisolone acetate inj (DEPO-MEDROL equiv) | - | 1 |
| methylprednisolone dose pack (MEDROL equiv) | - | 1 |
| methylprednisolone tab (MEDROL equiv) | - | 1 |
| methylprednisolone sod succinate inj (SOLU-MEDROL equiv) | - | 1 |
| prednisolone ODT (ORAPRED equiv) | - | 1 |
| prednisolone soln | - | 1 |
| prednisolone soln (PEDIAPRED equiv) | - | 1 |
| prednisone pack | - | 1 |
| prednisone tab (DELTASONE equiv) | - | 1 |
| triamcinolone acetonide inj (KENALOG equiv) | - | 1 |
| CORTISONE ACETATE TAB | - | 2 |
| hydrocortisone succinate inj 100mg (SOLU-CORTEF equiv) (QL= 2 vials/fill) | QL | 2 |
| PREDNISONE SOLN | - | 2 |
| SOLU-CORTEF INJ (QL= 1 vial/fill) | QL | 2 |
| SOLU-CORTEF INJ 100MG (QL= 2 vials/fill) | QL | 2 |
| SOLU-MEDROL INJ 2GM | - | 2 |
| ALKINDI SPRINKLE CAP 0.5MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 |
| ALKINDI SPRINKLE CAP 1MG (QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 |
| DEPO-MEDROL INJ | - | 3 |
| DEPO-MEDROL INJ, METHYLPREDNISOLONE ACE INJ | - | 3 |
| KENALOG INJ, TRIAMCINOLONE ACE INJ | - | 3 |
| KHINDIVI SOLN (QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older) | LD-PA-QL | 3 |
| MILLIPRED TAB | - | 3 |
| ORAPRED ODT TAB, PREDNISOLONE ODT TAB | - | 3 |
| PREDNISOLONE SOLN | - | 3 |
| prednisolone tab (MILLIPRED equiv) | - | 3 |
| PREDNISONE PACK | - | 3 |
| SOLU-MEDROL PF INJ | - | 3 |
| AGAMREE SUSP | - | NC |
| ALKINDI SPRINKLE CAP | - | NC |
| deflazacort susp (EMFLAZA equiv) | - | NC |
| deflazacort tab (EMFLAZA equiv) | - | NC |
| dexamethasone pak (DEXPAK equiv) | - | NC |
| DEXAMETHASONE TAB | - | NC |
| DEXPAK TAB | - | NC |
| DXEVO 11-DAY PAK | - | NC |
| EMFLAZA SUSP | - | NC |
| EMFLAZA TAB | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | | | generic = small letters | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| CORTICOSTEROIDS Cont. | | |
| EOHILIA SUSP | - | NC |
| FLO-PRED SUSP | - | NC |
| LIDOLOG KIT | - | NC |
| MILLIPRED DP PAK | - | NC |
| ORTIKOS ER CAP | - | NC |
| PREDNISON DR TAB | - | NC |
| PREDNISON/DIPHENHYDRAMINE KIT | - | NC |
| RAYOS TAB | - | NC |
| TARPEYO CAP | - | NC |
| MINERALOCORTICIDS | | |
| fludrocortisone tab (FLORINEF equiv) | - | 1 |
| COUGH/COLD/ALLERGY | | |
| ANTITUSSIVES | | |
| benzonatate cap (TESSALON equiv) | - | 1 |
| hydrocodone/homatropine syrup (HYCODAN equiv) | - | 1 |
| tussigon tab (HYCODAN equiv) | - | 1 |
| HYCODAN SYRUP | - | 3 |
| BENZONATATE CAP 150MG | - | NC |
| benzonatate cap 150mg (ZONATUSS equiv) | - | NC |
| ZONATUSS CAP 150MG | - | NC |
| COUGH/COLD/ALLERGY COMBINATIONS | | |
| guaifenesin-DM oral liquid (ROBITUSSIN equiv) | - | 1 |
| HYD POL/CPM SUSP (QL= 120ml/fill; 2 fills/30 days) | QL | 1 |
| hydrocodone/chlorpheniramine CR susp (TUSSIONEX equiv) (QL= 120ml/fill; 2 fills/30 days) | QL | 1 |
| promethazine DM syrup | - | 1 |
| PROMETHAZINE VC SYRUP | - | 1 |
| promethazine VC syrup (PHENERGAN VC equiv) | - | 1 |
| PROMETHAZINE VC/CODEINE SYRUP | - | 1 |
| promethazine VC/codeine syrup (PHENERGAN VC/CODEINE equiv) | - | 1 |
| promethazine/codeine syrup (PHENERGAN/CODEINE equiv) | - | 1 |
| INTENSE COUGH LIQUID | - | 3 |
| ALLEGRA-D 12-HOUR TAB | OTC | EXC |
| ALLEGRA-D 24-HOUR TAB | OTC | EXC |
| ALLEGRA-D TAB | OTC | EXC |
| BROVEX PEB LIQUID | OTC | EXC |
| cetirizine/pseudoephedrine 12-hour tab (ZYRTEC equiv) | OTC | EXC |
| CLARINEX-D TAB | - | EXC |
| CLARITIN-D TAB | OTC | EXC |
| feofenadine/pseudoephedrine 12-hour tab (ALLEGRA-D 12 hour equiv) | OTC | EXC |
| feofenadine/pseudoephedrine 24-hour tab (ALLEGRA-D equiv) | OTC | EXC |
| guaifenesin/codeine syrup (TUSSI-ORGANIDIN-S equiv) | OTC | EXC |
| lohist liquid | OTC | EXC |
| loratadine/pseudoephedrine 12-hour tab (CLARITIN-D equiv) | OTC | EXC |
| loratadine/pseudoephedrine 24-hour tab (CLARITIN-D equiv) | OTC | EXC |
| SEMPREX-D CAP | - | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | Mandatory Specialty Pharmacy Program | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | Quantity Limit | Restricted to Diagnosis |
| | | SF | SMKG |
| | | Limited to two 15 day fills per month for first 3 months | Smoking Cessation |
| | | VAC | ¢ |
| | | Vaccine Program | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| COUGH/COLD/ALLERGY Cont. | | |
| ZYRTEC-D TAB | OTC | EXC |
| DURAVENT PE TAB | - | NC |
| HYCOFENIX SOLN | - | NC |
| MUCINEX LIQUID | - | NC |
| POLY-TUSSIN DM SYRUP | - | NC |
| TUSSICAPS | - | NC |
| TUXARIN ER TAB | - | NC |
| TUZISTRA XR SUSP | - | NC |
| EXPECTORANTS | | |
| POTASSIUM IODIDE ORAL SOLN | - | 1 |
| SSKI ORAL SOLN | - | 3 |
| GUAIFENESEN SYRUP | - | NC |
| MUCINEX TAB | - | NC |
| MISC. RESPIRATORY INHALANTS | | |
| NEBUSAL NEB SOLN | - | 2 |
| HYPER-SAL NEB SOLN 7% | - | 3 |
| MUCOLYTICS | | |
| acetylcysteine soln (MUCOMYST equiv) | - | 1 |
| DERMATOLOGICALS | | |
| ACNE PRODUCTS | | |
| adapalene cream (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| adapalene gel (DIFFERIN equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| adapalene/benzoyl peroxide gel 0.1-2.5% (EPIDUO equiv) | - | 1 |
| adapalene/benzoyl peroxide gel 0.3-2.5% (EPIDUO FORTE equiv) | - | 1 |
| amnesteem cap, claravis cap, isotretinoin cap, myorisan cap, zenatane cap (ACCUTANE equiv) | - | 1 |
| AVAR CLEANSE LIQ 10-5% | - | 1 |
| AVAR-E EMOLL CREAM | - | 1 |
| benzoyl peroxide cream | OTC | 1 |
| benzoyl peroxide gel | - | 1 |
| benzoyl peroxide liquid | - | 1 |
| clindamycin gel (CLEOCIN GEL equiv) | - | 1 |
| clindamycin lotion (CLEOCIN- T equiv) | - | 1 |
| clindamycin topical soln (CLEOCIN-T equiv) | - | 1 |
| clindamycin/benzoyl peroxide gel (BENZACLIN equiv) | - | 1 |
| clindamycin/benzoyl peroxide gel (DUAC GEL equiv) | - | 1 |
| erythromycin pad | - | 1 |
| erythromycin soln | - | 1 |
| erythromycin/benzoyl peroxide gel | - | 1 |
| SOD SUL/SULF LIQ 9-4.5% | - | 1 |
| SOD SUL/SULF SUSP 10-5% | - | 1 |
| SOD SUL/SULF SUSP 8-4% | - | 1 |
| sodium sulfacetamide lotion (KLARON equiv) | - | 1 |
| sodium sulfacetamide/sulfur cleanser 10-5% (SUMAXIN equiv) | - | 1 |
| sodium sulfacetamide/sulfur cleanser 9-4.5% (SUMADAN WASH equiv) | - | 1 |
| SODIUM SULFACETAMIDE/SULFUR CREAM 10-2% | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|---|--------------------------------|--|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | INF | Infertility |
| PA | Prior Authorization | MSP | Mandatory Specialty Pharmacy Program |
| RS | Restricted to Specialist | QL | Quantity Limit |
| ST | Step Therapy | SF | Limited to two 15 day fills per month for first 3 months |
| | | VAC | Vaccine Program |
| | | LD | Limited Distribution |
| | | OTC | Over-the-Counter |
| | | RDX | Restricted to Diagnosis |
| | | SMKG | Smoking Cessation |
| | | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| sodium sulfacetamide/sulfur emulsion (ROSULA equiv) | - | 1 |
| sodium sulfacetamide/sulfur foam (CLARIFOAM EF equiv) | - | 1 |
| sodium sulfacetamide/sulfur lotion (SULFACET R equiv) | - | 1 |
| sulfacetamide sodium/sulfur cream 10-2% (AVAR-E LS equiv) | - | 1 |
| sulfacetamide sodium/sulfur cream 10-5% (PLEXION SCT equiv) | - | 1 |
| SULFACETAMIDE SODIUM/SULFUR CREAM 9.8-9.8% | - | 1 |
| tretinoin cream (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| tretinoin gel (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| tretinoin gel (RETIN-A GEL equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| tretinoin gel 0.08% (RETIN-A MICRO equiv) (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| TRETINOIN MICROSPHERE GEL 0.04% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| TRETINOIN MICROSPHERE GEL 0.1% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| TRETINOIN MICROSPHERE GEL PUMP 0.04% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| TRETINOIN MICROSPHERE GEL PUMP 0.1% (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 1 |
| ADAPALENE/BENZOYL PEROXIDE/CLINDAMYCIN GEL | - | 2 |
| ADAPALENE/BENZOYL PEROXIDE/NIACINAMIDE GEL | - | 2 |
| ALTRENO LOTION (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 |
| AZELAIC ACID/NIACINAMIDE CREAM | - | 2 |
| BENZIQLS GEL | - | 2 |
| BENZOYL PEROXIDE/CLINDAMYCIN/NIACINAMIDE/TRETINOIN GEL | - | 2 |
| CLINDAMYCIN PHOSPHATE/NIACINAMIDE GEL | - | 2 |
| CLINDAMYCIN/BENZOYL PEROXIDE/NIACINAMIDE GEL | - | 2 |
| CLINDAMYCIN/NIACINAMIDE LOTION | - | 2 |
| CLINDAMYCIN/NIACINAMIDE/SPIRONOLACTONE/TRETINOIN GEL | - | 2 |
| CLINDAMYCIN/NIACINAMIDE/TRETINOIN CREAM | - | 2 |
| DAPSONE/NIACINAMIDE GEL | - | 2 |
| DAPSONE/NIACINAMIDE/SPIRONOLACTONE GEL | - | 2 |
| ERY PAD | - | 2 |
| NIACINAMIDE/SPIRONOLACTONE GEL | - | 2 |
| NIACINAMIDE/SPIRONOLACTONE/TRETINOIN GEL (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 |
| NIACINAMIDE/SULFACETAMIDE CREAM | - | 2 |
| NIACINAMIDE/TAZAROTENE CREAM (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 |
| NIACINAMIDE/TRETINOIN CREAM (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 |
| NIACINAMIDE/TRETINOIN GEL (Acne Only - Prior Authorization required for members age 35 years and older) | PA | 2 |
| RIAX FOAM | - | 2 |
| SALICYLIC ACID/SULFACETAMIDE SUSP | - | 2 |
| BENZAFLIN GEL | - | 3 |
| BENZAMYCIN GEL | - | 3 |
| BENZOYL PEROXIDE CLOTH | - | 3 |
| BENZOYL PEROXIDE CREAM | OTC | 3 |
| CLEOCIN-T LOTION | - | 3 |
| EPIDUO FORTE GEL 0.3-2.5% | - | 3 |
| EPIDUO GEL 0.1-2.5% | - | 3 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| DERMATOLOGICALS Cont. | | |
| KLARON LOTION | - | 3 |
| SODIUM SULFACETAMIDE/SULFUR SUSP | - | 3 |
| SUMADAN WASH 9-4.5% | - | 3 |
| ABSORICA CAP | - | NC |
| ABSORICA LD CAP | - | NC |
| ACZONE GEL | - | NC |
| ADAPALENE SOLN | - | NC |
| ADAPALENE LOTION (DIFFERIN equiv) | - | NC |
| ADAPALENE PAD | - | NC |
| ADAPALENE/BENZOYL PEROXIDE PAD | - | NC |
| ADVANCED ACNE WASH | - | NC |
| AKLIEF CREAM | - | NC |
| AMZEEQ FOAM | - | NC |
| ARAZLO LOTION | - | NC |
| AVAR AEROSOL FOAM | - | NC |
| AVAR PAD | - | NC |
| AVAR-E LS CREAM 10-2% | - | NC |
| AZELEX CREAM | - | NC |
| BENZOYL PEROXIDE LOTION | - | NC |
| BENZOYL PEROXIDE WASH | - | NC |
| BENZOYL PEROXIDE/HYDROCORTISONE LOTION | - | NC |
| BP 10-1 EMU | - | NC |
| CLEOCIN-T GEL | - | NC |
| CLINDACIN KIT | - | NC |
| clindamycin foam (EVOCLIN equiv) | - | NC |
| clindamycin pad (CLEOCIN-T equiv) | - | NC |
| clindamycin phosphate-benzoyl peroxide gel 1.2-3.75% (ONEXTON equiv) | - | NC |
| clindamycin/tretinoin gel (ZIANA equiv) | - | NC |
| CLINDAVIX KIT | - | NC |
| dapsone gel (ACZONE equiv) | - | NC |
| DIFFERIN LOTION | - | NC |
| EPSOLAY CREAM | - | NC |
| ERYTHROMYCIN GEL | - | NC |
| EVOCLIN FOAM | - | NC |
| FABIOR AEROSOL FOAM | - | NC |
| isotretinoin cap 25mg (ABSORICA equiv) | - | NC |
| isotretinoin cap 35mg (ABSORICA equiv) | - | NC |
| NUCARACLINPA KIT | - | NC |
| NUCARARXPAK KIT | - | NC |
| ONEXTON GEL 1.2-3.75% | - | NC |
| PLEXION CREAM 9.8-4.8% | - | NC |
| RETIN-A MICRO GEL 0.04%, 0.1% | - | NC |
| RETIN-A MICRO GEL 0.08%, 0.06% | - | NC |
| RETIN-A MICRO GEL, RETIN-A MICRO GEL PUMP | - | NC |
| SODIUM SULFACETAMIDE/SULFUR EMULSION | - | NC |
| SODIUM SULFACETAMIDE/SULFUR LOTION | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Category/Class
Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| DERMATOLOGICALS Cont. | | |
| sodium sulfacetamide/sulfur pad (PLEXION CLEANSING CLOTH equiv) | - | NC |
| SODIUM SULFACETAMIDE/SULFUR WASH | - | NC |
| sodium sulfacetamide/sulfur wash (SUMAXIN WASH equiv) | - | NC |
| sodium sulfacetamide/sunscreen kit (SUMADEN XLT equiv) | - | NC |
| SUMADAN KIT, SUMAXIN KIT | - | NC |
| SUMADEN XLT KIT | - | NC |
| SUMAXIN WASH | - | NC |
| TRETIN-X CREAM | - | NC |
| TWYNEO CREAM | - | NC |
| WINLEVI CREAM | - | NC |
| ZIANA GEL | - | NC |
| AGENTS FOR EXTERNAL GENITAL AND PERIANAL WARTS | | |
| VEREGEN OINT | - | NC |
| AGENTS FOR WRINKLES/LIPOATROPHY/OTHER AESTHETIC USES | | |
| AVAGE CREAM | - | EXC |
| RENOVA CREAM | - | EXC |
| KYBELLA INJ | - | NC |
| ANALGESICS - TOPICAL | | |
| BACLOFEN CREAM COMPOUND KIT | - | NC |
| TRAMADOL COMPOUND KIT | - | NC |
| ANTIBIOTICS - TOPICAL | | |
| gentamicin sulfate cream | - | 1 |
| gentamicin sulfate oint | - | 1 |
| mupirocin oint (BACTROBAN OINT equiv) | - | 1 |
| CENTANY OINT | - | 3 |
| ALTABAX OINT | - | NC |
| BACTROBAN CREAM | - | NC |
| mupirocin cream (BACTROBAN CREAM equiv) | - | NC |
| NEO-SYNALAR CREAM | - | NC |
| XEPI CREAM | - | NC |
| ANTIFUNGALS - TOPICAL | | |
| ciclopirox cream (LOPROX CREAM equiv) | - | 1 |
| ciclopirox gel (LOPROX GEL equiv) | - | 1 |
| ciclopirox nail soln (PENLAC equiv) | - | 1 |
| ciclopirox shampoo (LOPROX SHAMPOO equiv) | - | 1 |
| ciclopirox topical susp (LOPROX SUSP equiv) | - | 1 |
| clotrimazole/betamethasone cream (LORTRISONE CREAM equiv) | - | 1 |
| econazole cream (SPECTAZOLE equiv) | - | 1 |
| HC/IODOQUIN CREAM | - | 1 |
| iodoquinol/hydrocortisone cream 1% (VYTONE equiv) | - | 1 |
| ketoconazole cream (NIZORAL CREAM equiv) | - | 1 |
| ketoconazole shampoo (NIZORAL equiv) | - | 1 |
| naftifine cream (NAFTIN equiv) | - | 1 |
| nystatin cream (MYCOSTATIN CREAM equiv) | - | 1 |
| nystatin oint | - | 1 |

DRAFT

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| DERMATOLOGICALS Cont. | | |
| nystatin topical powder | - | 1 |
| nystatin/triamcinolone cream | - | 1 |
| nystatin/triamcinolone oint | - | 1 |
| oxiconazole nitrate cream (OXISTAT equiv) | - | 1 |
| ERTACZO CREAM | - | 3 |
| EXELDERM CREAM, SULCONAZOLE CREAM | - | 3 |
| EXELDERM SOLN | - | 3 |
| EXELDERM SOLN, SULCONAZOLE SOLN | - | 3 |
| LOTRIMIN AF CREAM | - | 3 |
| LULICONAZOLE CREAM, LUZU CREAM | - | 3 |
| MENTAX CREAM | - | 3 |
| NAFTIFINE CREAM | - | 3 |
| OXISTAT CREAM | - | 3 |
| OXISTAT LOTION | - | 3 |
| XOLEGEL | - | 3 |
| clotrimazole cream (LOTRIMIN AF equiv) | OTC | EXC |
| ALCORTIN A GEL (iodoquinol/hydrocortisone/aloe polysaccharide gel equiv) | - | NC |
| ALOQUIN GEL | - | NC |
| CICLODAN KIT | - | NC |
| CLOTTRIMAZOLE/BETAMETHASONE LOTION | - | NC |
| clotrimazole/betamethasone lotion (LOTRISONE equiv) | - | NC |
| ECONASIL KIT | - | NC |
| ECONAZOLE NITRATE FOAM, ECOZA FOAM | - | NC |
| ECOZA FOAM | - | NC |
| HIXDEFRIMA SOLN | - | NC |
| IDOQUINOL/HC ALOE GEL | - | NC |
| iodoquinol/hydrocortisone cream 1.9-1% (VYTONE equiv) | - | NC |
| IDOQUINOL-HYDROCORTISONE CREAM | - | NC |
| JUBLIA SOLN | - | NC |
| KERYDIN SOLN | - | NC |
| naftifine hcl gel 2% (NAFTIN equiv) | - | NC |
| NAFTIN GEL 2% | - | NC |
| ONYCHO-MED KIT | - | NC |
| PEDIZOLPAK THERAPY PACK | - | NC |
| PENLAC SOLN | - | NC |
| tavorole soln (KERYDIN equiv) | - | NC |
| VYTONE CREAM 1.9-1% | - | NC |
| ZOLPAK KIT | - | NC |

DRAFT

ANTI-INFLAMMATORY AGENTS - TOPICAL

| | | |
|--|-----|-----|
| diclofenac gel 1% (VOLTAREN equiv) (QL= 5 tubes/fill; Rx Only) | QL | 1 |
| diclofenac soln 1.5% (PENNSAID equiv) (QL= 3 bottles/fill) | QL | 1 |
| VOLTAREN GEL | OTC | EXC |
| DICLOFENAC PATCH, FLECTOR PATCH | - | NC |
| diclofenac sodium gel kit (VENNGEL equiv) | - | NC |
| diclofenac sodium soln 2% (PENNSAID equiv) | - | NC |
| DICLONA GEL | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| DERMATOLOGICALS Cont. | | |
| DICLOTREX PAK | - | NC |
| GABAPENTIN/NAPROXEN CREAM COMPOUND KIT | - | NC |
| LEXTOL PAK | - | NC |
| LICART PATCH | - | NC |
| NAPROXEN CREAM COMPOUND KIT | - | NC |
| PENNSAID SOLN | - | NC |
| PROFINAC PAK | - | NC |
| REXAPHENAC CREAM | - | NC |
| VENNGEL ONE KIT | - | NC |
| VOPAC 5 CREAM | - | NC |
| VOPAC CREAM | - | NC |
| VOPAC GB CREAM | - | NC |
| XRYLIX PAK | - | NC |
| ANTINEOPLASTIC OR PREMALIGNANT LESION AGENTS - TOPICAL | | |
| bexarotene gel (TARGRETIN equiv) (QL= 60 grams/30 days) | LMSP-PA-QL | 1 |
| diclofenac gel (SOLARAZE equiv) (QL= 300gm/30 days) | PA-QL | 1 |
| fluorouracil cream (EFUDEX CREAM equiv) | - | 1 |
| fluorouracil soln (FLUOROURACIL equiv) | - | 1 |
| FLUOROURACIL SOLN | - | 2 |
| VALCHLOR GEL (QL= 4 tubes/30 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| FLUOROURACIL CREAM 0.5% | - | 3 |
| CARAC CREAM | - | NC |
| FLUORAC CREAM | - | NC |
| KLISYRI OINT | - | NC |
| ROAOXIA GEL | - | NC |
| SOLARAVIX PAK | - | NC |
| TARGRETIN GEL | - | NC |
| ANTIPRURITICS - TOPICAL | | |
| doxepin hcl cream | - | NC |
| ANTIPSORIATICS | | |
| acitretin cap (SORIATANE equiv) | - | 1 |
| calcipotriene cream (DOVONEX CREAM equiv) | - | 1 |
| calcipotriene oint | - | 1 |
| CALCIPOTRIENE SOLN | - | 1 |
| calcipotriene soln (DOVONEX SOLN equiv) | - | 1 |
| methoxsalen cap (OXSORALEN ULTRA equiv) | - | 1 |
| tazarotene cream 0.05% (TAZORAC equiv) | - | 1 |
| tazarotene cream 0.1% (TAZORAC equiv) | - | 1 |
| BIMZELX INJ (QL= 1 mL/28 days) | LMSP-PA-QL | 2 |
| BIMZELX INJ 320MG/2ML (QL= 2 mL/56 days) | LMSP-PA-QL | 2 |
| BIMZELX SYRINGE (QL= 1 mL/28 days) | LMSP-PA-QL | 2 |
| BIMZELX SYRINGE 320MG/2ML (QL= 2 mL/56 days) | LMSP-PA-QL | 2 |
| METHOXSALEN CAP | - | 2 |
| SKYRIZI INJ 150MG/ML (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| SPEVIGO INJ (QL= 2ml/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| STEQEYMA INJ (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| STEQEYMA INJ 90MG (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| TALTZ INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| TALTZ INJ 20MG/0.25ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| TALTZ INJ 40 MG/0.5ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| TREMFYA INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 |
| USTEKINUMAB-AEKN 45MG/0.5ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 |
| USTEKINUMAB-AEKN 90MG/ML (QL= 1 inj/84 days; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 |
| YESINTEK INJ (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| YESINTEK SYRINGE (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| YESINTEK SYRINGE 90MG (QL= 1 inj/84 days) | LMSP-PA-QL | 2 |
| CALCITRIOL OINT | - | 3 |
| calcipotriene cream (TRIONEX equiv) | - | NC |
| CALCIPOTRIENE FOAM | - | NC |
| CALCIPOTRIENE FOAM, SORILUX FOAM | - | NC |
| CALSODORE PAK | - | NC |
| COSENTYX INJ (1-PACK) | - | NC |
| COSENTYX INJ (2-PACK) | - | NC |
| COSENTYX INJ 300MG/2ML | - | NC |
| COSENTYX UNO INJ | - | NC |
| IMULDOSA SYRINGE | - | NC |
| OTULFI INJ | - | NC |
| OTULFI, USTEKINUMAB-AAUZ SYRINGE | - | NC |
| PYZCHIVA INJ | - | NC |
| SELARSDI INJ | - | NC |
| SILIQ INJ | - | NC |
| SOTYKTU TAB | - | NC |
| STARJEMZA INJ | - | NC |
| STARJEMZA PFS INJ | - | NC |
| STELARA INJ | - | NC |
| tazarotene gel (TAZORAC equiv) | - | NC |
| TRIONEX PAK | - | NC |
| USTEKINUMAB INJ 45/0.5ML | - | NC |
| USTEKINUMAB INJ 90MG/ML | - | NC |
| VECTICAL OINT | - | NC |
| VTAMA CREAM | - | NC |
| WEZLANA INJ | - | NC |
| WEZLANA SYRINGE | - | NC |

DRAFT

ANTISEBORRHEIC PRODUCTS

| | | |
|---|---|---|
| SELENIUM SUL SHA | - | 1 |
| SELENIUM SUL SHA 2% | - | 1 |
| SELENIUM SULFIDE LOTION | - | 1 |
| selenium sulfide lotion 2.5% (SELSUN equiv) | - | 1 |
| selenium sulfide shampoo (SELSEB equiv) | - | 1 |
| selenium sulfide shampoo 2.3% (SELRX equiv) | - | 1 |
| SODIUM SULFA LIQ WASH | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| sodium sulfacetamide wash (OVACE WASH equiv) | - | 1 |
| OVACE PLUS CREAM | - | 3 |
| OVACE PLUS LIQ WASH 10% | - | 3 |
| OVACE PLUS LOTION | - | 3 |
| OVACE PLUS FOAM | - | 3 |
| ESKATA SOLN | - | NC |
| OVACE PLUS SHAMPOO | - | NC |
| PROMISEB CREAM | - | NC |
| sodium sulfacetamide shampoo (OVACE equiv) | - | NC |
| SODIUM SULFACETAMIDE WASH, OVACE PLUS GEL WASH | - | NC |
| ANTIVIRALS - TOPICAL | | |
| acyclovir oint (ZOVIRAX OINT equiv) | - | 1 |
| ZELSUVMI GEL (QL= 1 carton/fill, 2 fills/365 days) | PA-QL | 2 |
| acyclovir cream (ZOVIRAX equiv) | - | NC |
| DENAVIR CREAM | - | NC |
| penciclovir cream (DENAVIR equiv) | - | NC |
| XERESE CREAM | - | NC |
| ZOVIRAX CREAM | - | NC |
| BURN PRODUCTS | | |
| silver sulfadiazine cream (SILVADENE CREAM equiv) | - | 1 |
| SULFAMYLON CREAM | - | 2 |
| MAFENIDE ACETATE SOLN PACK | - | NC |
| CORTICOSTEROIDS - TOPICAL | | |
| alclometasone cream (ACLOVATE equiv) | - | 1 |
| ALCLOMETASONE OINT | - | 1 |
| alclometasone oint (ACLOVATE OINT equiv) | - | 1 |
| BETAMETH VALERATE LOTION | - | 1 |
| betamethasone augmented cream (DIPROLENE AF CREAM equiv) | - | 1 |
| betamethasone augmented lotion (DIPROLENE LOTION equiv) | - | 1 |
| betamethasone augmented oint (DIPROLENE OINT equiv) | - | 1 |
| betamethasone dipropionate cream (DIPROSONE CREAM equiv) | - | 1 |
| betamethasone dipropionate lotion | - | 1 |
| betamethasone dipropionate oint (DIPROSONE OINT equiv) | - | 1 |
| betamethasone valerate cream | - | 1 |
| betamethasone valerate lotion | - | 1 |
| betamethasone valerate oint | - | 1 |
| clobetasol foam (OLUX equiv) | - | 1 |
| clobetasol lotion (CLOBEX equiv) | - | 1 |
| clobetasol propionate cream (TEMOVATE equiv) | - | 1 |
| clobetasol propionate emollient cream (TEMOVATE E equiv) | - | 1 |
| clobetasol propionate gel (TEMOVATE GEL equiv) | - | 1 |
| clobetasol propionate oint (TEMOVATE equiv) | - | 1 |
| clobetasol propionate soln (TEMOVATE equiv) | - | 1 |
| clobetasol shampoo (CLOBEX equiv) | - | 1 |
| clobetasol spray (CLOBEX equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| DERMATOLOGICALS Cont. | | |
| desonide cream (DESOWEN equiv) | - | 1 |
| desonide oint (DESOWEN equiv) | - | 1 |
| desoximetasone cream (TOPICORT CREAM equiv) | - | 1 |
| desoximetasone oint (TOPICORT equiv) | - | 1 |
| fluocinolone acetonide cream | - | 1 |
| fluocinolone acetonide oil | - | 1 |
| fluocinolone acetonide oint | - | 1 |
| fluocinolone acetonide soln | - | 1 |
| fluocinonide cream 0.05% (LIDEX equiv) | - | 1 |
| fluocinonide cream 0.1% (VANOS CREAM equiv) | - | 1 |
| fluocinonide emollient cream | - | 1 |
| fluocinonide gel | - | 1 |
| fluocinonide oint | - | 1 |
| fluocinonide soln | - | 1 |
| fluticasone propionate cream (CUTIVATE equiv) | - | 1 |
| fluticasone propionate oint (CUTIVATE equiv) | - | 1 |
| halobetasol propionate cream (ULTRAVATE equiv) | - | 1 |
| halobetasol propionate oint (ULTRAVATE equiv) | - | 1 |
| HC PRAMOXINE CREAM 1-2.5% | - | 1 |
| hydrocortisone cream (PROCTOCORT equiv) | - | 1 |
| hydrocortisone lotion (HYTONE equiv) | - | 1 |
| HYDROCORTISONE LOTION 2.5% | - | 1 |
| hydrocortisone oint | - | 1 |
| hydrocortisone pramoxine cream (PRAMOSONE equiv) | - | 1 |
| mometasone cream (ELOCON equiv) | - | 1 |
| mometasone oint (ELOCON equiv) | - | 1 |
| mometasone soln (ELOCON equiv) | - | 1 |
| triamcinolone cream | - | 1 |
| TRIAMCINOLONE LOTION | - | 1 |
| triamcinolone oint | - | 1 |
| BETAMETHASONE AUGMENTED GEL | - | 2 |
| EPIFOAM AEROSOL | - | 2 |
| PREDNICARBATE OIN | - | 2 |
| TOPICORT OINT | - | 3 |
| TRIAMVEX KIT | - | EXC |
| ALA-SCALP LOTION | - | NC |
| AMCINONIDE CREAM 0.1% | - | NC |
| AMCINONIDE LOTION | - | NC |
| AMCINONIDE OINTMENT | - | NC |
| APEXICON E CREAM (PSORCON E equiv) | - | NC |
| BESER KIT 0.05% | - | NC |
| betamethasone augmented gel | - | NC |
| betamethasone valerate foam (LUXIQ equiv) | - | NC |
| BRYHALI LOTION | - | NC |
| calcipotriene/betamethasone dipropionate susp | - | NC |
| calcipotriene/betamethasone oint (TACLONEX equiv) | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| CAPEX SHAMPOO | - | NC |
| clobetasol E foam (OLUX E equiv) | - | NC |
| CLOBETASOL PROPIONATE CREAM, IMPOYZ CREAM | - | NC |
| CLOBETAVIX KIT | - | NC |
| CLOCORTOLONE CREAM | - | NC |
| clocortolone pivalate cream | - | NC |
| CLODERM CREAM | - | NC |
| CORDRAN CREAM 0.025% | - | NC |
| CORDRAN OINTMENT | - | NC |
| CORDRAN TAPE | - | NC |
| CUTIVATE LOTION | - | NC |
| DERMACINRX KIT | - | NC |
| DESONATE GEL | - | NC |
| desonide gel | - | NC |
| desonide lotion (DESOWEN equiv) | - | NC |
| DESOWEN CREAM | - | NC |
| DESOWEN CREAM KIT | - | NC |
| DESOWEN LOTION | - | NC |
| DESOWEN LOTION KIT | - | NC |
| DESOWEN OINT | - | NC |
| DESOWEN OINT KIT | - | NC |
| desoximetasone cream 0.05% (TOPICORT equiv) | - | NC |
| DESOXIMETASONE GEL | - | NC |
| desoximetasone oint 0.05% (TOPICORT equiv) | - | NC |
| DIFLORASONE CREAM | - | NC |
| DIFLORASONE CREAM, PSORCON CREAM | - | NC |
| diflorasone oint | - | NC |
| DUOBRII LOTION | - | NC |
| ENSTILAR FOAM | - | NC |
| FLUOPAR KIT | - | NC |
| FLUOVIX PAK | - | NC |
| FLURANDRENOL LOTION | - | NC |
| flurandrenolide cream (CORDRAN equiv) | - | NC |
| flurandrenolide oint (CORDRAN equiv) | - | NC |
| FLUTICASONE LOTION | - | NC |
| fluticasone propionate lotion (CUTIVATE equiv) | - | NC |
| halcinonide cream (HALOG equiv) | - | NC |
| HALCINONIDE SOLN | - | NC |
| halcinonide soln (HALOG equiv) | - | NC |
| HALOBETASOL AER | - | NC |
| halobetasol propionate foam (LEXETTE equiv) | - | NC |
| HALOG CREAM | - | NC |
| HALOG OINT | - | NC |
| HALOG SOLN | - | NC |
| halonate pac kit (ULTRAVATE KIT equiv) | - | NC |
| HC BUTYRATE CREAM | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| DERMATOLOGICALS Cont. | | |
| HC BUTYRATE SOLN | - | NC |
| HC/PRAMOXINE CREAM 1-2.35% | - | NC |
| HC-LIDOCAINE CREAM | - | NC |
| hydrocortisone butyrate cream (LOCOID equiv) | - | NC |
| HYDROCORTISONE BUTYRATE LIPO CREAM | - | NC |
| hydrocortisone butyrate lipocream (LOCOID equiv) | - | NC |
| HYDROCORTISONE BUTYRATE OINT | - | NC |
| hydrocortisone butyrate oint (LOCOID equiv) | - | NC |
| hydrocortisone butyrate soln (LOCOID equiv) | - | NC |
| hydrocortisone lotion (LOCOID equiv) | - | NC |
| hydrocortisone lotion 2% (ALA SCALP equiv) | - | NC |
| HYDROCORTISONE PAK | - | NC |
| hydrocortisone valerate cream (WESTCORT equiv) | - | NC |
| hydrocortisone valerate oint (WESTCORT equiv) | - | NC |
| HYDROXYM GEL | - | NC |
| IMPEKLO LOTION | - | NC |
| IMPOYZ CREAM | - | NC |
| LOCOID CREAM | - | NC |
| LOCOID LIPOCREAM | - | NC |
| LOCOID OINT | - | NC |
| LOCOID SOLN | - | NC |
| LUXIQ FOAM | - | NC |
| MEXPAROX HC CREAM | - | NC |
| MICORT-HC CREAM | - | NC |
| NOVACORT GEL | - | NC |
| OLUX E FOAM | - | NC |
| PANDEL CREAM | - | NC |
| paramox hc gel (NOVACORT GEL equiv) | - | NC |
| PRAMOSONE CREAM 1-1% | - | NC |
| PRAMOSONE LOTION | - | NC |
| PRAMOSONE OINT | - | NC |
| QUINIXIL PAK | - | NC |
| SERNIVO SPRAY | - | NC |
| SILALITE PAK MIS | - | NC |
| TASOPROL CREAM KIT | - | NC |
| TEXACORT SOLN | - | NC |
| TOPICORT CREAM 0.05% | - | NC |
| TOPICORT GEL | - | NC |
| TOVET KIT | - | NC |
| triamcinolone acetonide oint (TRIANEX equiv) | - | NC |
| TRIAMCINOLONE SPRAY | - | NC |
| triamcinolone spray (KENALOG equiv) | - | NC |
| TRIANEX OINT | - | NC |
| TRILOCICLO KIT | - | NC |
| ULTRAVATE LOTION | - | NC |
| ULTRAVATE PAC KIT | - | NC |

DRAFT

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| DERMATOLOGICALS Cont. | | |
| VANOS CREAM | - | NC |
| VERDESO FOAM | - | NC |
| WESTCORT OINT | - | NC |
| WYNZORA CREAM | - | NC |
| ECZEMA AGENTS | | |
| ADBRY INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ADBRY INJ (QL= 4 inj/28 days) | LMSP-PA-QL | 2 |
| CIBINQO TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| DUPIXENT INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| DUPIXENT PEN INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| EBGLYSS INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| EBGLYSS PEN INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| OPZELURA CREAM (QL= 12 tubes/year) | PA-QL | 3 |
| ANZUPGO CREAM | - | EXC |
| EMOLLIENT/KERATOLYTIC AGENTS | | |
| CARMOL LOTION | - | NC |
| KERAFOAM | - | NC |
| KERALAC CREAM | - | NC |
| UMECTA EMULSION | - | NC |
| UMECTA PD EMULSION | - | NC |
| UMECTA SUSP | - | NC |
| URAMAXIN CREAM | - | NC |
| URAMAXIN GEL | - | NC |
| urea cream | - | NC |
| urea emulsion | - | NC |
| urea gel (URAMAXIN equiv) | - | NC |
| UREA LOT | - | NC |
| UREA NAIL KIT | - | NC |
| UREA SUSP | - | NC |
| urea susp 40% (UMECTA equiv) | - | NC |
| EMOLLIENTS | | |
| ammonium lactate cream (LAC-HYDRIN equiv) (Rx Only) | - | 1 |
| ammonium lactate lotion (LAC-HYDRIN equiv) (Rx Only) | - | 1 |
| NEOSALUS LOTION | - | 3 |
| HYLINATE LOTION | - | NC |
| ENZYMES - TOPICAL | | |
| SANTYL OINT (QL= 90gm/30 days) | QL | 2 |
| vasolex oint (XENADERM equiv) | - | NC |
| XENADERM OINT | - | NC |
| HAIR GROWTH AGENTS | | |
| LITFULO CAP (QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 |
| bimatoprost ophth soln | - | EXC |
| finasteride tab (PROPECIA equiv) | - | EXC |
| LEQSELVI TAB | - | EXC |
| minoxidil soln (ROGAINE equiv) | OTC | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | QL | Over-the-Counter |
| | Restricted to Specialist | QL | Restricted to Diagnosis |
| | Step Therapy | SF | SMKG |
| | | SF | Smoking Cessation |
| | | VAC | ¢ |
| | | VAC | RxCENTS |
| | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| PROPECIA TAB | - | EXC |
| ROGAINE SOLN | OTC | EXC |
| HAIR REDUCTION AGENTS | | |
| VANIQA CREAM | - | EXC |
| IMMUNOMODULATING AGENTS - SYSTEMIC | | |
| NEMLUVIO INJ (QL= 1 inj/56 days) | LMSP-PA-QL | 2 |
| IMMUNOMODULATING AGENTS - TOPICAL | | |
| imiquimod cream (ALDARA equiv) | - | 1 |
| IMIQUIMOD CREAM 3.75% | - | NC |
| imiquimod cream 3.75% (IMIQUIMOD equiv) | - | NC |
| ZYCLARA CREAM | - | NC |
| IMMUNOSUPPRESSIVE AGENTS - TOPICAL | | |
| pimecrolimus cream (ELIDEL equiv) (Covered for members age 2 years and older) | - | 1 |
| tacrolimus oint (PROTOPIC OINT equiv) | - | 1 |
| HYFTOR GEL (QL= 10 grams/30 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | 2 |
| OXIANUJO CREAM | - | NC |
| KERATOLYTIC/ANTIMITOTIC AGENTS | | |
| PODOFILOX SOLN | - | 1 |
| podofilox soln (CONDYLOX equiv) | - | 1 |
| PODOCON SOLN | - | 2 |
| CONDYLOX GEL | - | 3 |
| podofilox gel (CONDYLOX equiv) | - | 3 |
| SALEX SHAMPOO | - | 3 |
| ATRIX SYSTEM KIT | - | NC |
| GEAMETDRAY GEL | - | NC |
| METDRAY GEL | - | NC |
| SALEX LOTION KIT | - | NC |
| SALICATE LIQUID | - | NC |
| SALICYLIC AC SOLN ER, XALIX SOLN | - | NC |
| salicylic acid cream (CERAVE PSORIASIS equiv) | - | NC |
| SALIMEZ FORTE CREAM | - | NC |
| UREA/SALICYLIC CREAM | - | NC |
| LOCAL ANESTHETICS - TOPICAL | | |
| lidocaine cream 3% (LIDAMANTLE equiv) | - | 1 |
| lidocaine gel (GLYDO equiv) | - | 1 |
| lidocaine oint (QL= 107gm/30 days) | QL | 1 |
| lidocaine patch (QL= 3 patches/day) | QL | 1 |
| lidocaine patch 5% (LIDODERM equiv) (QL= 3 patches/day) | QL | 1 |
| lidocaine soln (XYLOCAINE equiv) | - | 1 |
| lidocaine/prilocaine cream (EMLA equiv) | - | 1 |
| ADAZIN CREAM | - | NC |
| ANASTIA LOTION | - | NC |
| APRIZIO PAK KIT | - | NC |
| capsaicin/menthol topical patch (SINELEE equiv) | - | NC |
| DERMALID PAK | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| DERMATOLOGICALS Cont. | | |
| GEN7T LOTION | - | NC |
| GEN7T PAD 3.5% | - | NC |
| GEN7T PLUS LOTION | - | NC |
| GEN7T PLUS PAD | - | NC |
| L.E.T. GEL | - | NC |
| LIDO/MENTHOL SPRAY | - | NC |
| LIDO/RAC/TET GEL | - | NC |
| LIDOCAINE CREAM | - | NC |
| lidocaine cream 3.88% (LIDOTRAL CREAM equiv) | - | NC |
| lidocaine gel (XYLOCAINE equiv) | - | NC |
| lidocaine hcl cream 4.12% | - | NC |
| lidocaine lotion | - | NC |
| lidocaine oint/transparent dressing kit | - | NC |
| lidocaine patch 3.5% (GEN7T equiv) | OTC | NC |
| LIDOCIN GEL | - | NC |
| LIDO-EP-TETR SOLN | - | NC |
| LIDOSTREAM KIT | - | NC |
| LIDOTRAL CREAM (lidocaine cream equiv) | - | NC |
| LIDOTREX GEL | - | NC |
| LIDOVEX CREAM | - | NC |
| MEDI-PATCH W/LIDOCAINE PATCH | - | NC |
| MENTHOREAL10 THERAPY PACK | - | NC |
| MICROVIX LP PAK | - | NC |
| NENDRUX GEL | - | NC |
| nulido pad (NULIDO equiv) | - | NC |
| NUVAKAAN II KIT | - | NC |
| PLIAGLIS CREAM | - | NC |
| PLIAGLIS KIT | - | NC |
| PROZENA PAD | - | NC |
| SILVERA PAD | - | NC |
| SOLAICE PATCH | - | NC |
| SYNVEXIA TC CREAM | - | NC |
| WPR PLUS | - | NC |
| ZILACAINE PAK | - | NC |
| ZYLOTROL-L KIT | - | NC |
| MISC. DERMATOLOGICAL PRODUCTS | | |
| NEOSALUS FOAM | - | NC |
| NEOSALUS LOTION | - | NC |
| MISC. TOPICAL | | |
| DRYSOL SOLN | - | 1 |
| DERMACINRX CREAM | - | NC |
| HYCLODEX SOLN | - | NC |
| QBREXZA PAD | - | NC |
| SOFDRA GEL | - | NC |
| PHOSPHODIESTERASE 4 (PDE4) INHIBITORS - TOPICAL | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| DERMATOLOGICALS Cont. | | |
| ZORYVE CREAM (QL= 60 grams/30 days) | PA-QL | 2 |
| ZORYVE FOAM (QL= 60 grams/30 days) | PA-QL | 2 |
| EUCRISA OINT | - | NC |
| ZORYVE CREAM 0.05% | - | NC |
| ZORYVE CREAM 0.15% | - | NC |
| PIGMENTING-DEPIGMENTING AGENTS | | |
| BLANCHE CREAM | - | EXC |
| DY-O-DERM SOLN | OTC | EXC |
| hydroquinone cream (LUSTRA equiv) | - | EXC |
| LUSTRA CREAM | - | EXC |
| METHOXSALEN CRYSTALS | - | EXC |
| METHOXSALEN POWDER | - | EXC |
| TRI-LUMA CREAM | - | EXC |
| VITADYE LOTION | OTC | EXC |
| ROSACEA AGENTS | | |
| azelaic acid gel (FINACEA equiv) | - | 1 |
| metronidazole cream (METROCREAM equiv) | - | 1 |
| metronidazole gel (METROGEL equiv) | - | 1 |
| metronidazole gel 0.75% (METROGEL equiv) | - | 1 |
| metronidazole lotion (METROLOTION equiv) | - | 1 |
| FINACEA FOAM | - | 2 |
| FINACEA GEL | - | 3 |
| METROCREAM | - | 3 |
| METROGEL 1% | - | 3 |
| METROLOTION | - | 3 |
| brimonidine tartrate gel (MIRVASO equiv) | - | EXC |
| MIRVASO GEL | - | EXC |
| RHOFADE CREAM | - | EXC |
| doxycycline (rosacea) cap delayed release (ORACEA equiv) | - | NC |
| EMROSI CAP | - | NC |
| IVERMECTIN CREAM | - | NC |
| ivermectin cream (SOOLANTRA equiv) | - | NC |
| NORITATE CREAM | - | NC |
| ORACEA CAP | - | NC |
| ROSADAN KIT | - | NC |
| SOOLANTRA CREAM | - | NC |
| ZILXI FOAM | - | NC |
| SCABICIDES & PEDICULICIDES | | |
| LINDANE SHAMPOO | - | 1 |
| malathion lotion (OVIDE equiv) (QL= 2 bottles/fill) | QL | 1 |
| permethrin cream (ELIMITE CREAM equiv) | - | 1 |
| SPINOSAD SUSP (QL= 1 bottle/fill) | QL | 2 |
| NATROBA SUSP (QL= 1 bottle/fill) | QL | 3 |
| NATROBA SUSP 0.90% (QL= 1 bottle/fill) | QL | 3 |
| CROTAN LOTION | - | NC |



Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|--------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSPP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| DIURETICS Cont. | | |
| POTASSIUM SPARING DIURETICS | | |
| amiloride tab (MIDAMOR equiv) | - | 1 |
| spironolactone susp (CAROSPIR equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| spironolactone tab (ALDACTONE equiv) | - | 1 |
| triamterene cap (DYRENIUM equiv) | - | 1 |
| DYRENIUM CAP | - | 3 |
| THIAZIDES AND THIAZIDE-LIKE DIURETICS | | |
| chlorthalidone tab | - | 1 |
| hydrochlorothiazide cap (MICROZIDE equiv) | - | 1 |
| hydrochlorothiazide tab (HYDRODIURIL equiv) | - | 1 |
| indapamide tab (LOZOL equiv) | - | 1 |
| metolazone tab (ZAROXOLYN equiv) | - | 1 |
| DIURIL SUSP | - | 2 |
| INZIRQO SUSP (Prior Authorization required for members age 9 years and older) | PA | 3 |
| THALITONE TAB | - | NC |
| ENDOCRINE AND METABOLIC AGENTS - MISC. | | |
| ADRENAL STEROID INHIBITORS | | |
| ISTURISA TAB (QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 |
| RECORLEV TAB | - | NC |
| BONE DENSITY REGULATORS | | |
| alendronate sodium oral soln (FOSAMAX equiv) | - | 1 |
| alendronate tab (FOSAMAX equiv) | - | 1 |
| calcitonin nasal spray (MIACALCIN equiv) | - | 1 |
| ibandronate tab 150mg (BONIVA equiv) (QL= 1 tab/30 days) | QL | 1 |
| risedronate DR tab (ATELVIA equiv) (Step Therapy requires trial of alendronate) | ST | 1 |
| risedronate tab (ACTONEL equiv) | - | 1 |
| teriparatide (recombinant) soln pen-inj (FORTEO equiv) | LMSP | 1 |
| ALENDRONATE TAB 40MG | - | 2 |
| TYMLOS INJ | LMSP | 2 |
| BINOSTO TAB | - | NC |
| BONSITY INJ | - | NC |
| calcitonin inj (MIACALCIN equiv) | - | NC |
| FORTEO INJ | - | NC |
| FOSAMAX+D TAB | - | NC |
| CORTICOTROPIN | | |
| ACTHAR GEL INJ (QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 |
| ACTHAR GEL AUTO-INJECTOR | - | NC |
| CORTROPHIN INJ | - | NC |
| CORTROPHIN INJ GEL | - | NC |
| CORTICOTROPIN-RELEASING FACTOR (CRF) RECEPTOR ANTAGONISTS | | |
| CRENESSITY CAP (QL= 2 caps/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| CRENESSITY SOLN (QL= 2ml/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| FERTILITY REGULATORS | | |
| clomiphene citrate tab (CLOMID equiv) | INF | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | OTC |
| ST | Prior Authorization | Quantity Limit | Over-the-Counter |
| | Restricted to Specialist | QL | RDX |
| | Step Therapy | SF | Restricted to Diagnosis |
| | | Limited to two 15 day fills per month for first 3 months | SMKG |
| | | VAC | Smoking Cessation |
| | | Vaccine Program | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Category/Class

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| ENDOCRINE AND METABOLIC AGENTS - MISC. Cont. | | |
| CLOMIPHENE TAB | INF | EXC |
| FOLLISTIM AQ INJ | INF | EXC |
| GONAL-F RFF INJ | INF | EXC |
| GONAL-F RFF INJ, GONAL-F INJ | INF | EXC |
| MENOPUR INJ | INF | EXC |
| OVIDREL INJ | INF | EXC |
| PREGNYL INJ, NOVAREL INJ | INF | EXC |
| GNRH/LHRH ANTAGONISTS | | |
| ORLISSA TAB 150MG (QL= 1 tab/day) | PA-QL | 2 |
| ORLISSA TAB 200MG (QL= 2 tabs/day) | PA-QL | 2 |
| cetorelix acetate for inj kit (CETROTIDE equiv) | INF | EXC |
| CETROTIDE KIT | INF | EXC |
| GANIRELIX AC INJ | INF | EXC |
| ganirelix ac inj (GANIRELIX equiv) | INF | EXC |
| GROWTH HORMONE RECEPTOR ANTAGONISTS | | |
| SOMAVERT INJ (Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA | 2 |
| GROWTH HORMONE RELEASING HORMONES (GHRH) | | |
| EGRIFTA INJ | - | EXC |
| EGRIFTA WR KIT | - | EXC |
| GROWTH HORMONES | | |
| GENOTROPIN INJ | - | EXC |
| GENOTROPIN INJ 5MG | - | EXC |
| HUMATROPE INJ, ZOMACTON INJ | - | EXC |
| NGENLA INJ | - | EXC |
| NORDITROPIN INJ, NUTROPIN AQ INJ | - | EXC |
| OMNITROPE INJ | - | EXC |
| SAIZEN INJ, SEROSTIM INJ, ZORBTIVE INJ | - | EXC |
| SKYTROFA INJ | - | EXC |
| SOGROYA INJ | - | EXC |
| ZOMACTON INJ | - | EXC |
| HORMONE RECEPTOR MODULATORS | | |
| raloxifene tab (EVISTA equiv) (\$0 copay for female members only age 35 years and older; All other members covered at generic copay) | - | \$0 |
| OSPHENA TAB | - | NC |
| INSULIN-LIKE GROWTH FACTORS (SOMATOMEDINS) | | |
| INCRELEX INJ (Only available through AnovoRx 844-288-5007) | LD | 2 |
| LHRH/GNRH AGONIST ANALOG PITUITARY SUPPRESSANTS | | |
| SYNAREL NASAL SOLN | - | 2 |
| MENOPAUSAL SYMPTOMS SUPPRESSANTS | | |
| VEOZAH TAB (QL= 1 tab/day) | PA-QL | 3 |
| LYNKUET CAP | - | EXC |
| METABOLIC MODIFIERS | | |
| calcitriol cap (ROCALTROL equiv) | - | 1 |
| calcitriol soln (ROCALTROL equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | generic = small letters | LD | BRANDS = CAPITAL LETTERS |
| LMSP | Plan Exclusion | MSP | Infertility | OTC | Limited Distribution |
| PA | Lumicera Mandatory Specialty Pharmacy Program | QL | Mandatory Specialty Pharmacy Program | RDX | Over-the-Counter |
| RS | Prior Authorization | SF | Quantity Limit | SMKG | Restricted to Diagnosis |
| ST | Restricted to Specialist | VAC | Limited to two 15 day fills per month for first 3 months | ¢ | Smoking Cessation |
| | Step Therapy | | Vaccine Program | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| ENDOCRINE AND METABOLIC AGENTS - MISC. Cont. | | |
| carglumic acid tab (CARBAGLU equiv) (Only available through AnovoRx 844-288-5007) | LD-PA | 1 |
| cinacalcet tab (SENSIPAR equiv) | - | 1 |
| DOXERCALCIFEROL CAP | - | 1 |
| doxercalciferol cap (HECTOROL equiv) | - | 1 |
| levocarnitine soln (CARNITOR equiv) | - | 1 |
| levocarnitine tab (CARNITOR equiv) | - | 1 |
| nitisinone cap (ORFADIN equiv) | LMSP-PA | 1 |
| paricalcitol cap (ZEMPLAR equiv) | - | 1 |
| sapropterin dihydrochloride powder packet (KUVAN equiv) | LMSP-PA | 1 |
| sapropterin dihydrochloride soluble tab (KUVAN equiv) | LMSP-PA | 1 |
| sodium phenylbutyrate powder (BUPHENYL equiv) | - | 1 |
| sodium phenylbutyrate tab (BUPHENYL equiv) | - | 1 |
| CYSTADANE POWDER (Only available through AnovoRx 844-288-5007) | LD | 2 |
| GALAFOLD CAP (QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL | 2 |
| IMCIVREE INJ (QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| PALYNZIQ INJ (QL= 1 inj/day; Only available through Accredo 800-803-2523) | LD-PA-QL-SF | 2 |
| PHEBURANE ORAL PELLETS (Only available through Accredo 800-803-2523) | LD | 2 |
| TRYNGOLZA INJ (QL= 1 inj/28 days; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| VYKAT XR TAB (QL= 4 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 |
| VYKAT XR TAB 150MG (QL= 3 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 |
| VYKAT XR TAB 75MG (QL= 7 tabs/day; Only available through PantherRx 855-726-8479) | LD-PA-QL | 2 |
| YORVIPATH INJ (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 |
| YORVIPATH INJ 294MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 |
| YORVIPATH INJ 420MCG (QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 2 |
| SENSIPAR TAB | - | 3 |
| XPHOZAH TAB (QL= 2 tabs/day) | MSP-PA-QL | 3 |
| FORZINITY INJ | - | EXC |
| REDEMPLO PFS INJ | - | EXC |
| SEPHIENCE POWDER | - | EXC |
| betaine powder for oral solution (CYSTADANE equiv) | - | NC |
| CALCITRIOL INJ | - | NC |
| CARBAGLU TAB | - | NC |
| CITRULLINE EASY TAB | - | NC |
| glycerol phenylbutyrate liquid (RAVICTI equiv) | - | NC |
| HARLIKU TAB | - | NC |
| KUVAN POWDER PACK | - | NC |
| KUVAN TAB | - | NC |
| MYALEPT INJ | - | NC |
| NITYR TAB | - | NC |
| OLPRUVA PACK | - | NC |
| ORFADIN CAP | - | NC |
| ORFADIN SUSP | - | NC |
| RAVICTI LIQUID | - | NC |
| RAYALDEE CAP | - | NC |
| XURIDEN POWDER | - | NC |
| STRENSIQ INJ (Only available through PantherRx Pharmacy 855-726-8479) | LD-PA | Non-EHB |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | | | generic = small letters | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ENDOCRINE AND METABOLIC AGENTS - MISC. Cont. | | |
| MINERALOCORTICOID RECEPTOR ANTAGONISTS | | |
| KERENDIA TAB (QL= 1 tab/day) | PA-QL | 2 |
| NATRIURETIC PEPTIDES | | |
| VOXZOGO INJ (QL= 1 vial/day; Only available through Accredo 888-773-7376) | LD-PA-QL | 2 |
| POSTERIOR PITUITARY HORMONES | | |
| desmopressin acetate nasal spray (DDAVP equiv) | - | 1 |
| desmopressin acetate tab (DDAVP equiv) | - | 1 |
| DESMOPRESSIN NASAL SPRAY | - | 1 |
| STIMATE NASAL SOLN | - | 2 |
| NOCDURNA SL TAB | - | NC |
| NOCTIVA EMULSION SPRAY | - | NC |
| PROGESTERONE RECEPTOR ANTAGONISTS | | |
| mifepristone tab 200mg (MIFIPREX equiv) | - | 1 |
| PROLACTIN INHIBITORS | | |
| cabergoline tab (DOSTINEX equiv) | - | 1 |
| SOMATOSTATIC AGENTS | | |
| octreotide inj (SANDOSTATIN equiv) | LMSP | 1 |
| OCTREOTIDE INJ 100MCG | LMSP | 1 |
| SIGNIFOR INJ (QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007) | LD-PA-QL | 2 |
| PALSONIFY TAB | - | EXC |
| BYNFEZIA PEN INJ | - | NC |
| MYCAPSSA CAP | - | NC |
| VASOPRESSIN RECEPTOR ANTAGONISTS | | |
| tolvaptan tab (SAMSCA, JYNARQUE equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 |
| tolvaptan tab therapy pack (JYNARQUE equiv) (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | 1 |
| JYNARQUE PAK | - | NC |
| TOLVAPTAN TAB | - | NC |
| ESTROGENS | | |
| ESTROGEN COMBINATIONS | | |
| COVARYX HS TAB | - | 1 |
| esterified estrogens/methyltestosterone tab (ESTRATEST equiv) | - | 1 |
| estradiol/norethindrone tab (ACTIVEVELLA equiv) | - | 1 |
| jinteli tab (FEMHRT equiv) | - | 1 |
| COMBIPATCH | - | 2 |
| MYFEMBREE TAB (QL= 1 tab/day) | PA-QL | 2 |
| ORIAHNN CAP (QL= 2 caps/day) | PA-QL | 2 |
| PREMPHASE TAB, PREMPRO TAB | - | 2 |
| PREFEST TAB | - | 3 |
| ANGELIQ TAB | - | NC |
| BIJUVA CAP | - | NC |
| CLIMARA PRO PATCH | - | NC |
| ESTROGENS | | |
| estradiol patch (CLIMARA equiv) | - | 1 |
| estradiol patch (VIVELLE-DOT, MINIVELLE equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ESTROGENS Cont. | | |
| estradiol tab (ESTRACE equiv) | - | 1 |
| estradiol valerate inj (DELESTROGEN equiv) (QL= 5ml/fill) | QL | 1 |
| estrogens, conjugated tab (PREMARIN equiv) | - | 1 |
| PREMARIN TAB | - | 2 |
| ALORA PATCH | - | 3 |
| MENEST TAB | - | 3 |
| DEPO-ESTRADIOL IM | - | NC |
| DIVIGEL GEL | - | NC |
| DIVIGEL GEL, ELESTRIN GEL | - | NC |
| estradiol td gel (DIVIGEL equiv) | - | NC |
| EVAMIST SPRAY | - | NC |
| MENOSTAR PATCH | - | NC |
| FLUOROQUINOLONES | | |
| ciprofloxacin susp (CIPRO equiv) | - | 1 |
| ciprofloxacin tab (CIPRO equiv) | - | 1 |
| levofloxacin soln (LEVAQUIN equiv) | - | 1 |
| levofloxacin tab (LEVAQUIN equiv) | - | 1 |
| moxifloxacin tab (AVELOX equiv) | - | 1 |
| OFLOXACIN TAB | - | 1 |
| BAXDELA TAB (QL= 2 tabs/day; Restricted to Infectious Disease Specialist) | QL-RS | 2 |
| CIPRO SUSP | - | 3 |
| CIPROFLOXACIN 100MG TAB | - | 3 |
| FACTIVE TAB | - | NC |
| PROQUIN XR TAB | - | NC |
| GASTROINTESTINAL AGENTS - MISC. | | |
| 5-HT4 RECEPTOR AGONISTS | | |
| prucalopride succinate tab (MOTTEGRITY equiv) (QL= 1 tab/day) | PA-QL | 1 |
| MOTTEGRITY TAB (QL= 1 tab/day) | PA-QL | 3 |
| AGENTS FOR CHRONIC IDIOPATHIC CONSTIPATION (CIC) | | |
| TRULANCE TAB (QL= 1 tab/day) | PA-QL | 2 |
| BILE ACID SYNTHESIS DISORDER AGENTS | | |
| CHOLBAM CAP (Only available through Dohmen LSS 844-246-5226) | LD-PA | 2 |
| CHENODAL TAB, CTEXLI TAB | - | NC |
| GALLSTONE SOLUBILIZING AGENTS | | |
| ursodiol cap (ACTIGALL equiv) | - | 1 |
| ursodiol tab (URSO (FORTE) equiv) | - | 1 |
| CHENODAL TAB, CTEXLI TAB | - | NC |
| RELTONE CAP | - | NC |
| URSODIOL CAP | - | NC |
| GASTROINTESTINAL ANTIALLERGY AGENTS | | |
| cromolyn conc (GASTROCROM equiv) | - | 1 |
| GASTROINTESTINAL CHLORIDE CHANNEL ACTIVATORS | | |
| lubiprostone cap (AMITIZA equiv) (QL= 2 caps/day) | QL | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| GASTROINTESTINAL AGENTS - MISC. Cont. | | |
| AMITIZA CAP (QL= 2 caps/day) | QL | 3 |
| GASTROINTESTINAL STIMULANTS | | |
| metoclopramide soln (REGLAN equiv) | - | 1 |
| metoclopramide tab (REGLAN equiv) | - | 1 |
| GIMOTI NASAL SPRAY | - | NC |
| METZOZOLV ODT | - | NC |
| HEPATOTROPICS | | |
| REZDIFFRA TAB (QL= 1 tab/day; Only available through Optum 877-445-6874) | LD-PA-QL | 2 |
| ILEAL BILE ACID TRANSPORTER (IBAT) INHIBITORS | | |
| BYLVAY CAP 1200MCG (QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| BYLVAY CAP 400MCG (QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| BYLVAY SPRINKLE CAP 200MCG (QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| BYLVAY SPRINKLE CAP 600MCG (QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| LIVMARLI SOLN (QL= 90ml/30 days; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 |
| LIVMARLI SOLN 19MG/ML (QL= 60mL/30 days; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 |
| LIVMARLI TAB (QL= 2 tabs/day; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 |
| LIVMARLI TAB 30MG (QL= 1 tab/day; Only available through Eversana 866-849-4481) | LD-PA-QL | 2 |
| INFLAMMATORY BOWEL AGENTS | | |
| balsalazide cap (COLAZAL equiv) | - | 1 |
| mesalamine DR cap (DELZICOL equiv) | - | 1 |
| mesalamine DR tab (LIALDA equiv) | - | 1 |
| mesalamine enema (ROWASA equiv) | - | 1 |
| mesalamine ER cap (APRISO equiv) | - | 1 |
| mesalamine supp (CANASA equiv) | - | 1 |
| mesalamine tab (ASACOL equiv) | - | 1 |
| sulfasalazine EC tab (AZULFIDINE equiv) | - | 1 |
| sulfasalazine tab (AZULFIDINE equiv) | - | 1 |
| CIMZIA INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| CIMZIA INJ 200MG/ML (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| ENTYVIO SC INJ (QL= 2 inj/28 days) | LMSP-PA-QL | 2 |
| SKYRIZI INJ 180 MG/1.2ML (QL= 1 inj/56 days) | LMSP-PA-QL | 2 |
| SKYRIZI INJ 360MG/2.4ML (QL= 1 inj/56 days) | LMSP-PA-QL | 2 |
| TREMFYA INDUCTION INJ 200MG/ML (QL= 2 inj/28 days; 6 inj/year) | LMSP-PA-QL | 2 |
| TREMFYA INJ 200MG/2ML (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| DIPENTUM CAP | - | 3 |
| APRISO CAP | - | NC |
| ASACOL HD TAB | - | NC |
| ASACOL HD TAB, MESALAMINE TAB | - | NC |
| DELZICOL CAP | - | NC |
| mesalamine ER cap (PENTASA CR equiv) | - | NC |
| OMVOH INJ | - | NC |
| PENTASA CR CAP | - | NC |
| PENTASA CR CAP 500MG | - | NC |
| ROWASA KIT | - | NC |
| VELSIPITY TAB | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Category/Class

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|---------|
| GASTROINTESTINAL AGENTS - MISC. Cont. | | |
| ZYMFENTRA INJ | - | NC |
| INTESTINAL ACIDIFIERS | | |
| lactulose soln | - | \$0 |
| IRRITABLE BOWEL SYNDROME (IBS) AGENTS | | |
| alosetron tab (LOTROXEX equiv) | - | 1 |
| LINZESS CAP (QL= 1 cap/day) | PA-QL | 3 |
| IBSRELA TAB | - | NC |
| VIBERZI TAB | - | NC |
| LIVE FECAL MICROBIOTA | | |
| VOWST CAP (QL= 12 caps/fill; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 |
| PERIPHERAL OPIOID RECEPTOR ANTAGONISTS | | |
| MOVANTIK TAB (QL= 1 tab/day) | PA-QL | 2 |
| SYMPROIC TAB (QL= 1 tab/day) | PA-QL | 2 |
| alvimopan cap (ENTEREG equiv) | - | NC |
| ENTEREG CAP | - | NC |
| RELISTOR INJ | - | NC |
| RELISTOR INJ KIT | - | NC |
| RELISTOR TAB | - | NC |
| PEROXISOME PROLIFERATOR-ACTIVATED RECEPTOR (PPAR) AGONISTS | | |
| IQIRVO TAB (QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416) | LD-PA-QL | 3 |
| LIVDELZI CAP (QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479) | LD-PA-QL | 3 |
| PHOSPHATE BINDER AGENTS | | |
| calcium acetate cap (PHOSLO equiv) | - | 1 |
| lanthanum carbonate chew tab (FOSRENOL equiv) | - | 1 |
| sevelamer powder pak (RENVELA equiv) | - | 1 |
| sevelamer tab (RENVELA TAB equiv) | - | 1 |
| FOSRENOL POWDER PACK | - | 2 |
| AURYXIA TAB | - | 3 |
| FOSRENOL CHEW TAB | - | 3 |
| RENVELA TAB | - | 3 |
| FERRIC CITRATE TAB | - | NC |
| RENAGEL TAB 800MG | - | NC |
| sevelamer hydrochloride tab (RENAGEL equiv) | - | NC |
| VELPHORO CHEW TAB | - | NC |
| SHORT BOWEL SYNDROME (SBS) AGENTS | | |
| GATTEX KIT | PA | Non-EHB |
| TRYPTOPHAN HYDROXYLASE INHIBITORS | | |
| XERMELO TAB | - | NC |
| GENERAL ANESTHETICS | | |
| ANESTHETICS - MISC. | | |
| KETAMINE HCL TROCHES | - | NC |
| GENITOURINARY AGENTS - MISCELLANEOUS | | |
| ALKALINIZERS | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Smoking Cessation |
| | Step Therapy | VAC | RxCENTS |
| | | | ¢ |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|---------|
| GENITOURINARY AGENTS - MISCELLANEOUS Cont. | | |
| CYTRA K CRYSTALS | - | 1 |
| CYTRA-3 SYRUP | - | 1 |
| K CITRATE SOLN CITR ACD | - | 1 |
| K/NA CITRATE SOL CITR ACD | - | 1 |
| ORACIT SOLN | - | 1 |
| potassium citrate CR tab (UROKIT-K TAB equiv) | - | 1 |
| potassium citrate/citric acid powder pack (POLYCITRA equiv) | - | 1 |
| sodium citrate/citric acid soln (BICITRA equiv) | - | 1 |
| CYSTINOSIS AGENTS | | |
| CYSTAGON CAP (Only available through CVS Specialty 800-238-7828) | LD | 2 |
| PROCYSBI CAP | - | NC |
| PROCYSBI GRANULES PACKET | - | NC |
| HYPEROXALURIA AGENTS | | |
| RIVFLOZA INJ (QL= 1 inj/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 |
| RIVFLOZA INJ 160MG (QL= 1 inj/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 |
| RIVFLOZA VIAL (QL= 2 vials/30 days; Only available through Orsini 800-410-8575) | LD-PA-QL | Non-EHB |
| IGA NEPHROPATHY (IGAN) AGENTS | | |
| FILSPARI TAB (QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CVS Specialty 800-378-0695) | LD-PA-QL | 2 |
| VANRAFIA TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405) | LD-PA-QL | 2 |
| VOYXACT INJ | - | EXC |
| INTERSTITIAL CYSTITIS AGENTS | | |
| ELMIRON CAP | - | NC |
| PENTOSAN CAP | - | NC |
| PROSTATIC HYPERTROPHY AGENTS | | |
| alfuzosin SR tab (UROXATRAL equiv) | - | 1 |
| dutasteride cap (AVODART equiv) | - | 1 |
| finasteride tab (PROSCAR equiv) | - | 1 |
| silodosin cap (RAPAFLO equiv) | - | 1 |
| tamsulosin cap (FLOMAX equiv) | - | 1 |
| CARDURA XL TAB | - | NC |
| dutasteride/tamsulosin cap (JALYN equiv) | - | NC |
| ENTADFI CAP | - | NC |
| URINARY ANALGESICS | | |
| PHENAZOPYRIDINE TAB | - | 1 |
| phenazopyridine tab (PYRIDIDIUM equiv) | - | 1 |
| PYRIDIDIUM TAB 100MG | - | 3 |
| PYRIDIDIUM TAB 200MG | - | 3 |
| URINARY STONE AGENTS | | |
| tiopronin tab (THIOLA equiv) | LMSP-PA | 1 |
| tiopronin tab delayed release (THIOLA EC equiv) | LMSP-PA | 2 |
| LITHOSTAT TAB | - | 3 |
| THIOLA EC TAB | - | NC |

GOUT AGENTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|----------|--------------|------|
|----------|--------------|------|

GOUT AGENTS Cont.

GOUT AGENT COMBINATIONS

| | | |
|---|---|----|
| colchicine/probenecid tab (COL-BENEMID equiv) | - | 1 |
| DUZALLO TAB | - | NC |

GOUT AGENTS

| | | |
|--|----|----|
| allopurinol tab (ZYLOPRIM equiv) | - | 1 |
| colchicine tab (COLCRYS equiv) | - | 1 |
| febuxostat tab (ULORIC equiv) (Step Therapy requires trial of allopurinol) | ST | 1 |
| GLOPERBA SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| allopurinol tab 200mg | - | NC |
| colchicine cap (MITIGARE equiv) | - | NC |
| COLCRYS TAB | - | NC |
| ULORIC TAB | - | NC |
| ZURAMPIC TAB | - | NC |

URICOSURICS

| | | |
|--------------------------------|---|---|
| probenecid tab (BENEMID equiv) | - | 1 |
|--------------------------------|---|---|

HEMATOLOGICAL AGENTS - MISC.

ANTIHEMOPHILIC PRODUCTS

| | | |
|--|---------|-----|
| ADVATE, KOVALTRY INJ | LMSP-PA | 2 |
| AFSTYLA KIT | LMSP-PA | 2 |
| ALHEMO INJ | LMSP-PA | 2 |
| ALPHANATE, HUMATE-P INJ | LMSP-PA | 2 |
| ALPHANINE SD INJ | LMSP-PA | 2 |
| ALPROLIX INJ | LMSP-PA | 2 |
| ALTUVIIIIO INJ | LMSP-PA | 2 |
| BENEFIX INJ | LMSP-PA | 2 |
| COAGADEX INJ (Only available through CVS/Caremark 800-237-2767 or OptionCare 877-686-2622) | LD-PA | 2 |
| CORIFACT KIT | LMSP-PA | 2 |
| ELOCTATE INJ | LMSP-PA | 2 |
| ESPEROCT INJ | LMSP-PA | 2 |
| FIBRYGA, RIASTAP INJ | LMSP-PA | 2 |
| HEMLIBRA INJ | LMSP-PA | 2 |
| HEMOFIL M, KOATE INJ | LMSP-PA | 2 |
| JIVI INJ | LMSP-PA | 2 |
| NOVOEIGHT INJ | LMSP-PA | 2 |
| NOVOSEVEN RT INJ | LMSP-PA | 2 |
| NUWIQ INJ | LMSP-PA | 2 |
| NUWIQ KIT | LMSP-PA | 2 |
| PROFILNINE INJ | LMSP-PA | 2 |
| RECOMBINATE INJ | LMSP-PA | 2 |
| RIXUBIS INJ | LMSP-PA | 2 |
| SEVENFACT INJ | LMSP-PA | 2 |
| VONVENDI INJ | LMSP-PA | 2 |
| WILATE INJ | LMSP-PA | 2 |
| XYNTHA INJ | LMSP-PA | 2 |
| QFITLIA INJ | - | EXC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to two 15 day fills per month for first 3 months |
| | Step Therapy | VAC | Smoking Cessation |
| | | | SMKG |
| | | | Smoking Cessation |
| | | | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|---------|
| HEMATOLOGICAL AGENTS - MISC. Cont. | | |
| ADYNOVATE INJ | - | NC |
| FEIBA INJ | - | NC |
| HYMPAVZI INJ | - | NC |
| IDELVION INJ | - | NC |
| IXINITY INJ | - | NC |
| KOGENATE FS INJ | - | NC |
| OBIZUR INJ | - | NC |
| REBINYN INJ | - | NC |
| TRETTEN INJ | - | NC |
| BRADYKININ B2 RECEPTOR ANTAGONISTS | | |
| icatibant inj (FIRAZYR equiv) | LMSP-PA | 1 |
| FIRAZYR INJ | - | NC |
| COMPLEMENT INHIBITORS | | |
| BERINERT INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 |
| EMPAVELI INJ (QL= 160ml/28 days; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| RUCONEST INJ (Only available through Accredo 800-803-2523) | LD-PA | 2 |
| TAVNEOS CAP (QL= 6 caps/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| VOYDEYA TAB (QL= 6 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| VOYDEYA TAB THERAPY PACK (QL= 6 tabs/day; Only available through Onco360 877-662-6633) | LD-PA-QL | 2 |
| ZILBRYSQ INJ (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| ZILBRYSQ INJ 23MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| ZILBRYSQ INJ 32.4MG (QL= 1 inj/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| FABHALTA CAP | - | NC |
| CINRYZE INJ (QL= 16 vials/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| HAEGARDA INJ (Only available through Accredo 800-803-2523) | LD-PA | Non-EHB |
| HEMATOLOGIC - TYROSINE KINASE INHIBITORS | | |
| WAYRILZ TAB | - | EXC |
| TAVALISSE TAB | - | NC |
| HEMATORHEOLOGIC AGENTS | | |
| pentoxifylline ER tab (TRENTAL equiv) | - | 1 |
| PLASMA FACTOR XIII INHIBITORS | | |
| ANDEMBRY INJ | - | EXC |
| PLASMA KALLIKREIN INHIBITORS | | |
| EKTERLY TAB | - | EXC |
| ORLADEYO CAP | - | NC |
| TAKHZYRO INJ (QL= 2 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| TAKHZYRO INJ 150MG/ML (QL= 2 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| PLATELET AGGREGATION INHIBITORS | | |
| anagrelide cap (AGRYLIN equiv) | - | 1 |
| aspirin/dipyridamole cap (AGGRENOX equiv) | - | 1 |
| cilostazol tab (PLETAL equiv) | - | 1 |
| clopidogrel tab 75mg (PLAVIX equiv) | - | 1 |
| dipyridamole tab (PERSANTINE equiv) | - | 1 |
| prasugrel tab (EFFIENT equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|---|--------------------------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | Plan Exclusion | INF | Limited Distribution |
| PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| RS | Prior Authorization | QL | Restricted to Diagonser |
| ST | Restricted to Specialist | SF | Smoking Cessation |
| | Step Therapy | VAC | RxCENTS |
| | | | ¢ |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| HEMATOLOGICAL AGENTS - MISC. Cont. | | |
| ticagrelor tab (BRILINTA equiv) | - | 1 |
| CABLIVI INJ KIT (QL= 1 vial/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| ZONTIVITY TAB (Restricted to Cardiology Specialist) | RS | 3 |
| ASPIRIN/OMEPRAZOLE ER TAB | - | NC |
| CLOPIDOGREL THERAPY PACK | - | NC |
| PLAVIX TAB 300MG | - | NC |
| YOSPRALA TAB | - | NC |
| PYRUVATE KINASE ACTIVATORS | | |
| PYRUKYND TAB (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| PYRUKYND TAPER PACK (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| AQVESME TAB 100MG | - | NC |

HEMATOPOIETIC AGENTS

AGENTS FOR GAUCHER DISEASE

| | | |
|---|------------|----|
| miglustat cap (ZAVESCA equiv) (QL= 3 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 1 |
| CERDELGA CAP (QL= 2 caps/day) | LMSP-PA-QL | 2 |
| ZAVESCA CAP | - | NC |

AGENTS FOR SICKLE CELL ANEMIA

| | | |
|-------------|---|----|
| DROXIA CAP | - | 2 |
| OXBRYTA TAB | - | NC |
| SIKLOS TAB | - | NC |

AGENTS FOR SICKLE CELL DISEASE

| | | |
|---|------------|----|
| l-glutamine powder packet (ENDARI equiv) (QL= 6 packets/day) | LMSP-PA-QL | 1 |
| XROMI SOLN (Prior Authorization required for members age 9 years and older) | PA | 3 |
| ENDARI POWDER PACKET | - | NC |
| OXBRYTA TAB FOR ORAL SUSP | - | NC |

COBALAMINS

| | | |
|---|---|---|
| cyanocobalamin inj | - | 1 |
| cyanocobalamin nasal spray 500 mcg/0.1ml (NASCOBAL equiv) | - | 1 |
| NASCOBAL SPRAY | - | 3 |

FOLIC ACID/FOLATES

| | | |
|--|-----|-----|
| folic acid tab 1mg (\$0 copay for female members only; All other members covered at generic copay) | - | \$0 |
| folic acid tab 400mcg (Covered for female members only) | OTC | \$0 |
| folic acid tab 800mcg (Covered for female members only) | OTC | \$0 |

HEMATOPOIETIC GROWTH FACTORS

| | | |
|---|------------|---|
| eltrombopag olamine powder pack for susp (PROMACTA equiv) (QL= 1 packet/day) | LMSP-PA-QL | 1 |
| eltrombopag olamine tab (PROMACTA equiv) (QL= 1 tab/day) | LMSP-PA-QL | 1 |
| eltrombopag olamine tab 50MG (PROMACTA equiv) (QL= 2 tabs/day) | LMSP-PA-QL | 1 |
| eltrombopag olamine tab 75MG (PROMACTA equiv) (QL= 2 tabs/day) | LMSP-PA-QL | 1 |
| DOPTELET SPRINKLE CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| DOPTELET TAB (QL= 2 tabs/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| FULPHILA INJ | LMSP | 2 |
| NIVESTYM INJ | LMSP | 2 |
| NYVEPRIA INJ | LMSP | 2 |
| RETACRIT INJ | - | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Category/Class

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|------------------------------------|--------------|------|
| HEMATOPOIETIC AGENTS Cont. | | |
| ZARXIO INJ | LMSP | 2 |
| ALVAIZ TAB | - | NC |
| ARANESP INJ | - | NC |
| FYLNETRA INJ | - | NC |
| GRANIX INJ | - | NC |
| JESDUVROQ TAB | - | NC |
| LEUKINE INJ | - | NC |
| MULPLETA TAB | - | NC |
| NEULASTA INJ | - | NC |
| NEUPOGEN INJ | - | NC |
| NYPOZI INJ | - | NC |
| PROCRIT INJ | - | NC |
| PROMACTA POWDER | - | NC |
| PROMACTA TAB 12.5MG, 25MG | - | NC |
| RELEUKO INJ | - | NC |
| RELEUKO PREFILLED SYRINGE INJ | - | NC |
| STIMUFEND INJ | - | NC |
| UDENYCA INJ | - | NC |
| VAFSEO TAB | - | NC |
| ZIEXTENZO INJ | - | NC |
| HEMATOPOIETIC MIXTURES | | |
| FEROTRINSIC CAP | - | 1 |
| ferrex 150 forte cap | - | 1 |
| MULTIGEN FOLIC TAB | - | 1 |
| MULTIGEN PLUS TAB | - | 1 |
| MULTIGEN TAB | - | 1 |
| POLY-IRON CAP 150 FORTE | - | 1 |
| NEPHRON FA TAB | - | 2 |
| ICAR-C PLUS TAB 100-250-0.025-1 MG | - | 3 |
| BENTIVITE TAB | - | NC |
| BIFERARX TAB | - | NC |
| B-SERENE PAD | - | NC |
| CORVITA 150 TAB | - | NC |
| CYFOLEX CAP | - | NC |
| FEONYX TAB | - | NC |
| FERIVA 21/7 TAB | - | NC |
| FERRO-PLEX TAB | - | NC |
| folbee tab (FOLGARD RX equiv) | - | NC |
| FOLGARD RX TAB | - | NC |
| FOLITE TAB | - | NC |
| FOLVITE-FE TAB | - | NC |
| OVEEZA CAP | - | NC |
| PUREFOLIX TAB | - | NC |
| IRON | | |
| ACCRUFER CAP | - | NC |

DRAFT

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| HEMATOPOIETIC AGENTS Cont. | | |
| ferrous sulfate elixir | OTC | NC |
| FERROUS SULFATE LIQUID | OTC | NC |
| ferrous sulfate soln | OTC | NC |
| ferrous sulfate SR tab | OTC | NC |
| ferrous sulfate tab | OTC | NC |
| IRON TAB | OTC | NC |
| STEM CELL MOBILIZERS | | |
| XOLREMDI CAP (QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |

HEMOSTATICS

HEMOSTATICS - SYSTEMIC

| | | |
|---------------------------------------|---|---|
| aminocaproic acid soln (AMICAR equiv) | - | 1 |
| aminocaproic acid tab (AMICAR equiv) | - | 1 |
| tranexamic acid tab (LYSTEDA equiv) | - | 1 |

HYPNOTICS

NON-BARBITURATE HYPNOTICS

| | | |
|---|----|---|
| zolpidem tab (AMBIEN equiv) (QL= 1 tab/day) | QL | 1 |
|---|----|---|

OREXIN RECEPTOR ANTAGONISTS

| | | |
|--------------|---|----|
| BELSOMRA TAB | - | NC |
|--------------|---|----|

HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS

BARBITURATE HYPNOTICS

| | | |
|----------------------|---|---|
| phenobarbital elixir | - | 1 |
| PHENOBARBITAL ELXIR | - | 1 |
| phenobarbital tab | - | 1 |

HYPNOTICS - TRICYCLIC AGENTS

| | | |
|-----------------------------|---|----|
| doxepin tab (SILENOR equiv) | - | NC |
|-----------------------------|---|----|

NON-BARBITURATE HYPNOTICS

| | | |
|--|----|----|
| estazolam tab (PROSOM equiv) | - | 1 |
| eszopiclone tab (LUNESTA equiv) (QL= 1 tab/day) | QL | 1 |
| midazolam inj (MIDAZOLAM equiv) (Restricted to Neurology Specialist) | RS | 1 |
| temazepam cap 15mg (RESTORIL equiv) | - | 1 |
| temazepam cap 22.5mg (RESTORIL equiv) | - | 1 |
| temazepam cap 30mg (RESTORIL equiv) | - | 1 |
| temazepam cap 7.5mg (RESTORIL equiv) | - | 1 |
| triazolam tab (HALCION equiv) | - | 1 |
| zaleplon cap (SONATA equiv) (QL= 1 cap/day) | QL | 1 |
| zolpidem ER tab (AMBIEN CR equiv) (QL= 1 tab/day) | QL | 1 |
| EDLUAR SL TAB | - | NC |
| FLURAZEPAM CAP | - | NC |
| INTERMEZZO SL TAB | - | NC |
| QUAZEPAM TAB | - | NC |
| ZOLPIDEM CAP | - | NC |
| zolpidem tartrate SL tab (INTERMEZZO equiv) | - | NC |
| ZOLPIDEM TARTRATE SL TAB 1.75MG | - | NC |
| ZOLPIDEM TARTRATE SL TAB 3.5MG | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| HYPNOTICS/SEDATIVES/SLEEP DISORDER AGENTS Cont. | | |
| ZOLPIMIST SPRAY | - | NC |
| OREXIN RECEPTOR ANTAGONISTS | | |
| DAYVIGO TAB (QL= 1 tab/day) | PA-QL | 3 |
| QUVIVIQ TAB | - | NC |
| SELECTIVE MELATONIN RECEPTOR AGONISTS | | |
| ramelteon tab (ROZEREM equiv) (QL= 1 tab/day) | QL | 1 |
| HETLIOZ CAP | - | NC |
| HETLIOZ SUSP | - | NC |
| tasimelteon cap (HETLIOZ equiv) | - | NC |
| LAXATIVES | | |
| LAXATIVE COMBINATIONS | | |
| GAVILYTE-C SOLN (\$0 copay for members age 45-75 years; all other members covered at preferred brand copay; Limited to 2 fills/calendar year) | QL | \$0 |
| peg 3350 soln (100 gram Moviprep equiv) (MOVIPREP equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 |
| peg 3350/electrolytes soln (COLYTE equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 |
| peg 3350/electrolytes soln (NULYTELY equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 |
| sodium/magnesium/potassium soln (SUPREP equiv) (\$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year) | QL | \$0 |
| SUFLAVE SOLN (QL= 2 fills/calendar year) | QL | 2 |
| GOLYTELY SOLN (Limited to 2 fills/calendar year) | QL | 3 |
| CLENPIQ SOLN | - | NC |
| MOVIPREP SOLN | - | NC |
| PEG-PREP KIT | - | NC |
| PLENVU SOLN | - | NC |
| SUPREP BOWEL PREP PACK | - | NC |
| SUTAB TAB | - | NC |
| LAXATIVES - MISCELLANEOUS | | |
| lactulose soln | - | \$0 |
| polyethylene glycol 3350 powder (MIRALAX equiv) | OTC | \$0 |
| polyethylene glycol packet (MIRALAX equiv) | OTC | \$0 |
| MIRALAX PACKET | OTC | EXC |
| MIRALAX POWDER | OTC | EXC |
| GIALAX KIT | - | NC |
| lactulose oral crystal packet | - | NC |
| LACTULOSE PACK 10MG | - | NC |
| LACTULOSE PAK 10GM | - | NC |
| SALINE LAXATIVES | | |
| magnesium citrate soln | OTC | \$0 |
| magnesium hydroxide | OTC | \$0 |
| sodium phosphates enema | OTC | \$0 |
| OSMOPREP TAB | - | NC |
| STIMULANT LAXATIVES | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to 15 day fills per month for first 3 months |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|------------------------|--------------|------|
| LAXATIVES Cont. | | |
| bisacodyl supp | OTC | \$0 |
| bisacodyl tab | OTC | \$0 |
| senna cap | OTC | \$0 |
| senna chew tab | OTC | \$0 |
| senna tab | OTC | \$0 |

LOCAL ANESTHETICS-PARENTERAL

| LOCAL ANESTHETIC COMBINATIONS | Special Code | Tier |
|-------------------------------------|--------------|------|
| ROPIVICAINE/CLONIDINE/KETOROLAC INJ | - | NC |

MACROLIDES

| AZITHROMYCIN | Special Code | Tier |
|---|--------------|------|
| azithromycin susp (ZITHROMAX equiv) | - | 1 |
| azithromycin tab (ZITHROMAX equiv) | - | 1 |
| ZITHROMAX POWDER PACK | - | 3 |
| CLARITHROMYCIN | | |
| clarithromycin ER tab (BIAXIN XL equiv) | - | 1 |
| clarithromycin tab (BIAXIN equiv) | - | 1 |
| CLARITHROMYC SUSP | - | 2 |
| ERYTHROMYCINS | | |
| E.E.S. TAB | - | 1 |
| erythromycin DR cap (ERYC equiv) | - | 1 |
| erythromycin ethylsuccinate susp (ERYPED equiv) | - | 1 |
| erythromycin ethylsuccinate tab (E.E.S. equiv) | - | 1 |
| erythromycin tab (ERY-TAB equiv) | - | 1 |
| erythromycin tab (ERYTHROMYCIN equiv) (all forms except PCE) | - | 1 |
| ERYTHROMYCIN CAP DR | - | 2 |
| ERYTHROMYCIN EC CAP | - | 2 |
| FIDAXOMICIN | | |
| fidaxomicin tab (DIFICID equiv) (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 1 |
| DIFICID SUSP (QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 2 |
| DIFICID TAB (QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution) | QL-ST | 2 |

MEDICAL DEVICES AND SUPPLIES

| CONTRACEPTIVES | Special Code | Tier |
|--------------------------------------|--------------|------|
| CERVICAL CAP | - | \$0 |
| DIAPHRAGM | - | \$0 |
| FEMALE CONDOMS (QL= 12 condoms/fill) | OTC-QL | \$0 |
| MALE CONDOMS (QL= 12 condoms/fill) | OTC-QL | \$0 |
| DIABETIC SUPPLIES | | |
| ACCU-CHEK GUIDE CARE METER | OTC | \$0 |
| ACCU-CHEK GUIDE ME KIT | OTC | \$0 |
| FREESTYLE FREEDOM LITE METER | OTC | \$0 |
| FREESTYLE LITE METER | OTC | \$0 |
| FREESTYLE PRECISION NEO METER | OTC | \$0 |
| PRECISION XTRA METER | OTC | \$0 |
| CALIBRATION LIQUID | OTC | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSF Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| MEDICAL DEVICES AND SUPPLIES Cont. | | |
| ALCOHOL SWABS | OTC | 1 |
| ORAL HYGIENE PRODUCTS | | |
| HURRISEAL MIS SNAP | - | NC |
| PARENTERAL THERAPY SUPPLIES | | |
| B-D INSULIN SYRINGE | --OTC | 1 |
| B-D PEN NEEDLE | OTC | 1 |
| EMBECTA INSULIN SYRINGE | --OTC | 1 |
| EMBECTA PEN NEEDLE | OTC | 1 |
| NOVOFINE PEN NEEDLE | OTC | 1 |
| NOVOTWIST PEN NEEDLE | OTC | 1 |
| NOVOTWIST/NOVOFINE PEN NEEDLE | OTC | 1 |
| CEQR SIMPLICITY | - | NC |
| INPEN INSULIN INJECTION DEVICE | - | NC |
| INSULIN SYRINGE | OTC | NC |
| PEN NEEDLE | OTC | NC |
| RESPIRATORY THERAPY SUPPLIES | | |
| PEAK FLOW METER | OTC | 1 |
| AEROCHAMBER | OTC | 2 |
| MIGRAINE PRODUCTS | | |
| CALCITONIN GENE-RELATED PEPTIDE (CGRP) RECEPTOR ANTAG | | |
| UBRELVY TAB (QL= 10 tabs/30 days, 6 fills/year) | PA-QL | 2 |
| ZAVZPRET NASAL SPRAY (QL= 6 units/fill; 60 units/365 days) | PA-QL | 2 |
| NURTEC ODT | - | NC |
| QULIPTA TAB | - | NC |
| MIGRAINE COMBINATIONS | | |
| ACETAMINOPHEN/ISOMETHEPTENE/DICHLORAL CAP | - | NC |
| acetaminophen/isometheptene/dichloral cap (MIDRIN equiv) | - | NC |
| ERGOTAMINE/CAFFEINE TAB | - | NC |
| ergotamine/caffeine tab (CAFERGOT equiv) | - | NC |
| MIGERGOT SUPP | - | NC |
| PRODRIN TAB | - | NC |
| SUMANSETRON PAK | - | NC |
| sumatriptan/naproxen tab (TREXIMET equiv) | - | NC |
| SYMBRAVO TAB | - | NC |
| TREXIMET TAB | - | NC |
| MIGRAINE PRODUCTS | | |
| BREKIYA INJ | - | NC |
| dihydroergotamine mesylate inj (D.H.E. equiv) | - | NC |
| dihydroergotamine mesylate nasal spray (MIGRANAL equiv) | - | NC |
| ERGOMAR SL TAB | - | NC |
| MIGRANAL SPRAY | - | NC |
| TRUDHESA NASAL SPRAY | - | NC |
| MIGRAINE PRODUCTS - MONOCLONAL ANTIBODIES | | |
| AIMOVIG INJ (QL= 1 pack/28 days) | PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| MIGRAINE PRODUCTS Cont. | | |
| AJOVY INJ (QL= 1 pack/28 days) | PA-QL | 2 |
| EMGALITY INJ (QL= 1 inj/28 days) | PA-QL | 2 |
| EMGALITY INJ 100MG/ML (QL= 3 inj/fill, 6 fills/year) | PA-QL | 2 |
| MIGRAINE PRODUCTS - NSAIDS | | |
| CAMBIA POWDER | - | NC |
| diclofenac potassium (migraine) packet (CAMBIA equiv) | - | NC |
| ELYXYB SOLN | - | NC |
| SEROTONIN AGONISTS | | |
| eletriptan tab (RELPAX equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 |
| naratriptan tab (AMERGE equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 |
| rizatriptan ODT (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days) | QL | 1 |
| rizatriptan tab (MAXALT equiv) (QL= 12 tabs/fill, 3 fills/60 days) | QL | 1 |
| SUMATRIPTAN INJ (QL= 4 inj/fill, 2 fills/30 days) | QL | 1 |
| sumatriptan inj (IMITREX equiv) (QL= 4 inj/fill, 2 fills/30 days) | QL | 1 |
| sumatriptan nasal spray (IMITREX, SUMATRIPTAN equiv) (QL= 6 sprays/fill, 2 fills/30 days) | QL | 1 |
| sumatriptan tab (IMITREX equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 |
| sumatriptan vial inj (IMITREX equiv) (QL= 5 inj/fill, 2 fills/30 days) | QL | 1 |
| zolmitriptan nasal spray (ZOLMITRIPTAN, ZOMIG equiv) (QL= 6 sprays/fill, 2 fills/30 days) | QL | 1 |
| zolmitriptan ODT (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 |
| zolmitriptan tab (ZOMIG equiv) (QL= 9 tabs/fill, 2 fills/30 days) | QL | 1 |
| REYVOW TAB (QL= 8 tabs/30 days, 6 fills/year) | PA-QL | 2 |
| IMITREX INJ (QL= 4 inj/fill, 2 fills/30 days) | QL | 3 |
| IMITREX INJ 4MG/0.5ML (QL= 4 inj/fill, 2 fills/30 days) | QL | 3 |
| ZOLMITRIPTAN SPRAY (QL= 6 sprays/fill, 2 fills/30 days) | QL | 3 |
| ZOMIG SPRAY (QL= 6 sprays/fill, 2 fills/30 days) | QL | 3 |
| almotriptan tab (AXERT equiv) | - | NC |
| ALSUMA INJ, ZEMBRACE SYMTOUCH INJ | - | NC |
| AXERT TAB | - | NC |
| FROVA TAB | - | NC |
| frovatriptan tab (FROVA equiv) | - | NC |
| ONZETRA XSAIL | - | NC |
| SUMAVEL DOSEPRO INJ | - | NC |
| TOSYMRA SOLN | - | NC |
| ZECUITY PAD | - | NC |
| MINERALS & ELECTROLYTES | | |
| FLUORIDE | | |
| FLORIVA DROPS | - | \$0 |
| FLUORABON SOLN (\$0 copay for members age 5 years and younger; All other members covered at preferred brand copay) | - | \$0 |
| FLUORIDE CHW 0.25MG (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 |
| sodium fluoride chew tab (LURIDE equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 |
| sodium fluoride soln (LURIDE equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 |
| SODIUM FLUORIDE TAB (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| MINERALS & ELECTROLYTES Cont. | | |
| PHOSPHATE | | |
| PHOSPHA 250 NEUTRAL TAB | - | 1 |
| K-PHOS TAB | - | 2 |
| PHOSPHO-TRIN K500 TAB | - | 2 |
| K-PHOS NEUTRAL TAB 155-852-130MG | - | 3 |
| POTASSIUM | | |
| EFFER-K TAB | - | 1 |
| K-TAB | - | 1 |
| potassium bicarbonate effer tab (K-LYTE equiv) | - | 1 |
| potassium chloride ER cap (MICRO-K equiv) | - | 1 |
| potassium chloride ER tab (K-TAB equiv) | - | 1 |
| potassium chloride micro tab (K-DUR equiv) | - | 1 |
| potassium chloride powder packet (KLOR-CON equiv) | - | 1 |
| potassium chloride soln | - | 1 |
| POTASSIUM CHLORIDE TAB ER | - | 1 |
| POKONZA POWDER | - | NC |
| ZINC | | |
| zinc gluconate tab | OTC | 1 |
| GALZIN CAP | - | NC |

MISCELLANEOUS THERAPEUTIC CLASSES

| | | |
|---|------------|-----|
| CHELATING AGENTS | | |
| penicillamine tab (DEPEN TITRATAB equiv) | - | 1 |
| trientine cap (SYPRINE equiv) | LMSP-PA | 1 |
| CUVRIOR TAB | - | NC |
| penicillamine cap (CUPRIMINE equiv) | - | NC |
| TRIENTINE CAP | - | NC |
| IMMUNOMODULATORS | | |
| lenalidomide cap (REVLIMID equiv) (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416) | LD-QL-RS | 1 |
| JOENJA TAB (QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| REZUROCK TAB (QL= 1 tab/day; Only available through Lumicera 855-847-3553) | LD-PA-QL | 2 |
| VYVGART HYTRULO INJ (QL= 4 inj/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| REVLIMID CAP (QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416) | LD-QL-RS | 3 |
| RHAPSIDO TAB | - | EXC |
| IMMUNOSUPPRESSIVE AGENTS | | |
| everolimus tab (ZORTRESS equiv) | PA | 1 |
| sirolimus soln (RAPAMUNE equiv) | - | 1 |
| ENSPRYNG INJ (QL= 1 inj/28 days) | LMSP-PA-QL | 2 |
| LUPKYNIS CAP (QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 3 |
| ASTAGRAF XL CAP | - | NC |
| azathioprine tab 100mg (AZASAN equiv) | - | NC |
| azathioprine tab 75mg (AZASAN equiv) | - | NC |
| MYHIBBIN SUSP | - | NC |
| PROGRAF PACKET | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| MISCELLANEOUS THERAPEUTIC CLASSES Cont. | | |
| PIK3CA-RELATED OVERGROWTH SPECTRUM (PROS) AGENTS | | |
| VIJOICE GRANULES PACKET (QL= 1 packet/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 |
| VIJOICE TAB (QL= 1 tab/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 |
| VIJOICE TAB 250MG (QL= 2 tabs/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 3 |
| POTASSIUM REMOVING AGENTS | | |
| LOKELMA PAK (QL= 1 packet/day) | PA-QL | 2 |
| VELTASSA POWDER 1GM (QL= 4 packets/day) | PA-QL | 2 |
| LOKELMA PAK 10GM | - | NC |
| LOKELMA PAK 5GM | - | NC |
| SPS | - | NC |
| PROGERIA TREATMENT AGENTS | | |
| ZOKINVY CAP (QL= 4 caps/day; Only available through CVS Specialty 800-237-2767) | LD-PA-QL | 2 |
| SYSTEMIC LUPUS ERYTHEMATOSUS AGENTS | | |
| BENLYSTA AUTO-INJECTOR (QL= 4 inj/28 day) | LMSP-PA-QL | 2 |
| BENLYSTA INJ (QL= 4 inj/28 day) | LMSP-PA-QL | 2 |
| MOUTH/THROAT/DENTAL AGENTS | | |
| ANESTHETICS TOPICAL ORAL | | |
| lidocaine viscous soln (XYLOCAINE HCL (MOUTH-THROAT) equiv) | - | 1 |
| FIRST MOUTHWASH BLM | - | 3 |
| LIDOCAINE ORAL SOLN | - | NC |
| ANTI-INFECTIVES - THROAT | | |
| clotrimazole troches (MYCELEX TROCHES equiv) | - | 1 |
| nystatin susp | - | 1 |
| NYSTATIN SUSP | - | NC |
| ORAVIG TAB | - | NC |
| ANTISEPTICS - MOUTH/THROAT | | |
| chlorhexidine gluconate soln (PERIDEX equiv) | - | 1 |
| DENTAL PRODUCTS | | |
| DENTA 5000 CREAM PLUS (\$0 copay for members age 5 years and younger; All other members covered at preferred brand copay) | - | \$0 |
| sodium fluoride cream (PREVIDENT equiv) (\$0 copay for members age 5 years and younger; All other members covered at generic copay) | - | \$0 |
| FLUORIDEX SENSITIVITY PASTE | - | 1 |
| SODIUM FLUORIDE GEL | - | 1 |
| SODIUM FLUORIDE PASTE | - | 1 |
| SODIUM FLUORIDE SOLN | - | 1 |
| PREVIDENT 5000 PASTE 1.1% | - | 2 |
| PREVIDENT GEL | - | 2 |
| PREVIDENT SOLN 0.2% | - | 2 |
| FRAICHE 5000 SENSITIVE GEL | - | NC |
| STEROIDS - MOUTH/THROAT | | |
| triamcinolone in orabase paste (KENALOG/ORABASE equiv) | - | 1 |
| THROAT PRODUCTS - MISC. | | |
| cevimeline cap (EVOXAC equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|-----------------------------------|---------------------|-------------|
| MULTIVITAMINS Cont. | | |
| PRENATAL VITAMINS (NON-PREFERRED) | - | 3 |
| VITAFOL STRIPS | - | 3 |
| AZESCHEW TAB 13-1MG | - | NC |
| AZESCO TAB | - | NC |
| CITRANATAL CAP MEDLEY | - | NC |
| JENLIVA CAP | - | NC |
| MATERVIA CAP | - | NC |
| MATRONEX TAB 27-1 MG | - | NC |
| MULTI-MAC TAB | - | NC |
| PREGEN DHA CAP | - | NC |
| PREGENNA TAB | - | NC |
| PRENARA CAP | - | NC |
| PRENATE MAX TAB | - | NC |
| PRENATOL-M TAB 27-1.2MG | - | NC |
| PRENATRIX TAB | - | NC |
| PRENATRYL TAB | - | NC |

MUSCULOSKELETAL THERAPY AGENTS

CENTRAL MUSCLE RELAXANTS

| | | |
|---|----|----|
| baclofen oral soln 10mg/5ml (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| baclofen oral soln 5mg/5ml (Prior Authorization required for members age 9 years and older) | PA | 1 |
| baclofen susp (BACLOFEN equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| baclofen tab (BACLOFEN equiv) | - | 1 |
| carisoprodol tab (SOMA equiv) | - | 1 |
| chlorzoxazone tab 500mg | - | 1 |
| cyclobenzaprine tab (FLEXERIL equiv) | - | 1 |
| metaxalone tab (SKELAXIN equiv) | - | 1 |
| methocarbamol tab (ROBAXIN equiv) | - | 1 |
| orphenadrine citrate ER tab (NORFLEX equiv) | - | 1 |
| tizanidine cap (ZANAFLEX equiv) | - | 1 |
| tizanidine tab (ZANAFLEX equiv) | - | 1 |
| BACLOFEN ORAL SOLN 10MG/5ML (Prior Authorization required for members age 9 years and older) | PA | 3 |
| BACLOFEN ORAL SOLN 5 MG/5ML (Prior Authorization required for members age 9 years and older) | PA | 3 |
| LYVISPAH GRANULE PACKET (Prior Authorization required for members age 9 years and older) | PA | 3 |
| baclofen tab 15mg | - | NC |
| carisoprodol tab 250mg (SOMA equiv) | - | NC |
| chlorzoxazone tab | - | NC |
| CHLORZOXAZONE TAB 250MG, LORZONE TAB | - | NC |
| CYCLOBENZAPRINE COMPOUND KIT | - | NC |
| cyclobenzaprine ER cap (AMRIX equiv) | - | NC |
| METAXALONE TAB | - | NC |
| methocarbamol tab 1000mg (ROBAXIN equiv) | - | NC |
| SOMA TAB 250MG | - | NC |
| ZANAFLEX CAP | - | NC |

DIRECT MUSCLE RELAXANTS

| | | |
|---------------------------------|---|---|
| dantrolene cap (DANTRIUM equiv) | - | 1 |
|---------------------------------|---|---|

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|---------|
| NASAL AGENTS - SYSTEMIC AND TOPICAL Cont. | | |
| epinephrine hcl nasal soln (ADRENALIN equiv) | - | NC |
| NEUROMUSCULAR AGENTS | | |
| ALS AGENTS | | |
| riluzole tab (RILUTEK equiv) | - | 1 |
| RADICAVA ORS STARTER KIT (QL= 70ml/365 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| RADICAVA ORS SUSP (QL= 50mL/28 days; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| TIGLUTIK SUSP | - | NC |
| FRIEDRICH'S ATAXIA AGENTS | | |
| SKYCLARYS CAP (QL= 3 caps/day; Only available through Biologics 800-850-4306) | LD-PA-QL | 2 |
| MUSCULAR DYSTROPHY AGENTS | | |
| DUVYZAT ORAL SUSP | - | NC |
| RETT SYNDROME AGENTS | | |
| DAYBUE STIX POWDER | - | NC |
| DAYBUE SOLN (QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007) | LD-PA-QL | Non-EHB |
| SPINAL MUSCULAR ATROPHY AGENTS (SMA) | | |
| EVRYSDI SOLN (QL= 6.67ml/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| EVRYSDI TAB (QL= 1 tab/day; Only available through Accredo 800-803-2523) | LD-PA-QL | Non-EHB |
| NUTRIENTS | | |
| LIPIDS | | |
| DOJOLVI ORAL LIQUID | - | NC |
| OPHTHALMIC AGENTS | | |
| ARTIFICIAL TEARS AND LUBRICANTS | | |
| LACRISERT OPHTH INSERT | - | NC |
| BETA-BLOCKERS - OPHTHALMIC | | |
| BETAXOLOL OPHTH SOLN | - | 1 |
| betaxolol ophth soln (BETOPTIC-S equiv) | - | 1 |
| brimonidine/timolol ophth soln (COMBIGAN equiv) | - | 1 |
| CARTEOLOL OPHTH SOLN | - | 1 |
| carteolol ophth soln (OCUPRESS equiv) | - | 1 |
| dorzolamide/timolol (pf) ophth soln (COSOPT equiv) | - | 1 |
| LEVOBUNOLOL OPHTH SOLN | - | 1 |
| levobunolol ophth soln (BETAGAN equiv) | - | 1 |
| timolol maleate (pf) ophth soln 0.5% (TIMOPTIC equiv) | - | 1 |
| timolol maleate ophth gel (TIMOPTIC-XE equiv) | - | 1 |
| timolol maleate ophth soln (TIMOPTIC equiv) | - | 1 |
| timolol maleate ophth soln 0.5% (ISTALOL equiv) | - | 1 |
| timolol maleate preservative free ophth soln 0.25% (TIMOPTIC equiv) | - | 1 |
| timolol ophth soln (BETIMOL equiv) | - | 1 |
| BETIMOL OPHTH SOLN 0.25% | - | 2 |
| BETOPTIC-S OPHTH SOLN | - | 2 |
| DORZOLAMIDE/TIMOLOL OPHTH SOLN | - | 2 |
| ISTALOL OPHTH SOLN | - | 2 |
| CHOLINERGIC AGONISTS | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| OPHTHALMIC AGENTS Cont. | | |
| TYRVAYA NASAL SPRAY (QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist) | QL-RS | 2 |
| CYCLOPLEGIC MYDRIATICS | | |
| ALTAFRIN OPHTH SOLN | - | 1 |
| atropine ophth oint | - | 1 |
| atropine ophth soln (ISOPTO ATROPINE equiv) | - | 1 |
| ATROPINE SUL SOLN 1% OPHTH | - | 1 |
| ATROPINE SULFATE OPHTH OINT | - | 1 |
| cyclopentolate ophth soln (CYCLOGYL equiv) | - | 1 |
| phenylephrine ophth soln (MYDFRIN equiv) | - | 1 |
| tropicamide ophth soln (MYDRIACYL equiv) | - | 1 |
| CYCLOMYDRIL OPHTH SOLN | - | 2 |
| HOMATROPINE OPHTH SOLN | - | 2 |
| CYCLOGYL OPHTH SOLN | - | 3 |
| MYDCOMBI OPHTH SOLN | - | NC |
| TROPICAMIDE/CYCLOPENT/KETOROLAC/PE OPHTH SOLN | - | NC |
| MIOTICS | | |
| pilocarpine ophth soln (ISOPTO CARPINE equiv) | - | 1 |
| VIZZ OPHTH SOLN | - | EXC |
| PHOSPHOLINE OPHTH SOLN | - | NC |
| pilocarpine hcl ophth soln 1.25% (VUIITY equiv) | - | NC |
| QLOSI OPHTH SOLN, VUIITY OPHTH SOLN | - | NC |
| VUIITY OPHTH SOLN 1.25% | - | NC |
| OPHTHALMIC ADRENERGIC AGENTS | | |
| apraclonidine ophth soln (IOPIDINE equiv) | - | 1 |
| brimonidine ophth soln 0.15% (ALPHAGAN P 0.15% equiv) | - | 1 |
| brimonidine ophth soln 0.2% | - | 1 |
| brimonidine tartrate ophth soln 0.1% (ALPHAGAN equiv) | - | 1 |
| APRACLONIDINE OPHTH SOLN | - | 2 |
| IOPIDINE OPHTH SOLN | - | 2 |
| SIMBRINZA OPHTH SUSP | - | 2 |
| OPHTHALMIC ANTI-INFECTIVES | | |
| BACIT/POLYMY OPHTH OINT | - | 1 |
| bacitracin/neomycin/polymyxin b ophth oint (NEOSPORIN equiv) | - | 1 |
| bacitracin/polymyxin b ophth oint (POLYSPORIN equiv) | - | 1 |
| ciprofloxacin ophth soln (CILOXAN equiv) | - | 1 |
| erythromycin ophth oint | - | 1 |
| gatifloxacin ophth soln (ZYMAXID equiv) | - | 1 |
| GENTAK OPHTH OINT | - | 1 |
| gentamicin ophth soln (GARAMYCIN equiv) | - | 1 |
| levofloxacin ophth soln (QUIXIN equiv) | - | 1 |
| LEVOFLOXACIN OPHTH SOLN 0.5% | - | 1 |
| moxifloxacin ophth soln (VIGAMOX OPHTH SOLN equiv) | - | 1 |
| NEO/BAC/POLY OPHTH OINT | - | 1 |
| NEOMYCIN/POLYMIXIN/GRAMICIDIN OPHTH SOLN | - | 1 |
| ofloxacin ophth soln (OCUFLOX equiv) | - | 1 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|---|--------------------------------|--|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | INF | Infertility |
| PA | Prior Authorization | MSP | Mandatory Specialty Pharmacy Program |
| RS | Restricted to Specialist | QL | Quantity Limit |
| ST | Step Therapy | SF | Limited to two 15 day fills per month for first 3 months |
| | | VAC | Vaccine Program |
| | | LD | Limited Distribution |
| | | OTC | Over-the-Counter |
| | | RDX | Restricted to Diagnosis |
| | | SMKG | Smoking Cessation |
| | | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| OPHTHALMIC AGENTS Cont. | | |
| fluorometholone ophth soln (FML LIQUIFILM equiv) | - | 1 |
| loteprednol etabonate ophth gel (LOTEMAX equiv) | - | 1 |
| loteprednol ophth susp (LOTEMAX, ALREX equiv) | - | 1 |
| NEO/POLY/BAC/HC OPHTH OINT | - | 1 |
| neomycin/polymyxin/dexamethasone ophth oint (MAXITROL equiv) | - | 1 |
| neomycin/polymyxin/dexamethasone ophth soln (MAXITROL equiv) | - | 1 |
| prednisolone acetate ophth susp (PRED FORTE equiv) | - | 1 |
| PREDNISOLONE OPHTH SUSP | - | 1 |
| PREDNISOLONE SODIUM PHOSPHATE OPHTH SOLN | - | 1 |
| sulfacetamide sodium/prednisolone ophth soln (VASOCIDIN equiv) | - | 1 |
| tobramycin/dexamethasone ophth soln (TOBRADEX equiv) | - | 1 |
| ALREX OPHTH SUSP | - | 2 |
| BLEPHAMIDE OPHTH SOLN | - | 2 |
| LOTEMAX OPHTH OINT | - | 2 |
| MAXIDEX OPHTH SOLN | - | 2 |
| NEOMYCIN/POLYMYXIN/HYDROCORTISONE OPHTH SOLN | - | 2 |
| PRED MILD OPHTH SOLN | - | 2 |
| PRED-G OPHTH SOLN | - | 2 |
| TOBRADEX OPHTH OINT | - | 2 |
| ZYLET OPHTH SUSP 0.5-0.3% (QL= 5ml/fill (10ml bottle is Not Covered)) | QL | 2 |
| ALREX OPHTH SUSP 0.2% | - | 3 |
| BLEPHAMIDE S.O.P. OPHTH OINT | - | 3 |
| FLAREX OPHTH SUSP | - | 3 |
| FML FORTE OPHTH SUSP | - | 3 |
| FML S.O.P. OPHTH OINT | - | 3 |
| PRED FORTE OPHTH SUSP | - | 3 |
| TOBRADEX ST OPHTH SUSP | - | 3 |
| CLOBETASOL OPHTH SUSP | - | NC |
| DEXTENZA OPHTH INSERT | - | NC |
| EYSUVIS OPHTH SUSP | - | NC |
| INVELTYS OPHTH SUSP | - | NC |
| KLARITY-B DROPS | - | NC |
| KLARITY-L DROPS | - | NC |
| LOTEMAX SM GEL 0.38% | - | NC |
| loteprednol etabonate-tobramycin ophth susp (ZYLET equiv) | - | NC |
| PREDNISOLONE/MOXIFLOXACIN OPHTH SOLN | - | NC |
| PREDNISOLONE/MOXIFLOXACIN OPHTH SUSP | - | NC |
| PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SOLN | - | NC |
| PREDNISOLONE/MOXIFLOXACIN/BROMFENAC OPHTH SUSP | - | NC |
| PREDNISOLONE/MOXIFLOXACIN/KETOROLAC OPHTH SOLN | - | NC |
| PREDNISOLONE/MOXIFLOXACIN/NEPAFENAC OPHTH SUSP | - | NC |
| PREDNISOLONE/NEPAFENAC OPHTH SUSP | - | NC |
| ZYLET OPHTH SUSP | - | NC |
| OPHTHALMIC SURGICAL AIDS | | |
| DUOVISC KIT | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|-------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer Plan Exclusion | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class
Last Updated* 2/1/2026**

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| OPHTHALMIC AGENTS Cont. | | |
| XELPROS OPHTH EMULSION | - | NC |
| ZIOPTAN OPHTH SOLN | - | NC |
| OTIC AGENTS | | |
| OTIC AGENTS - MISCELLANEOUS | | |
| acetic acid otic soln (VOSOL equiv) | - | 1 |
| OTIC ANTI-INFECTIVES | | |
| ciprofloxacin hcl otic soln (CETRAXAL equiv) | - | 1 |
| ofloxacin otic soln (FLOXIN equiv) | - | 1 |
| OTIC COMBINATIONS | | |
| ciprofloxacin/dexamethasone otic susp (CIPRODEX equiv) | - | 1 |
| ciprofloxacin-hydrocortisone otic susp (CIPRO HC equiv) | - | 1 |
| neomycin/polymixin/hydrocortisone otic soln (CORTISPORIN equiv) | - | 1 |
| neomycin/polymixin/hydrocortisone otic susp (CORTISPORIN equiv) | - | 1 |
| COLY-MYCIN S OTIC SUSP | - | 2 |
| CIPRO HC OTIC SUSP | - | 3 |
| antipyrine/benzocaine otic soln (AURALGAN equiv) | - | NC |
| CORTANE-B OTIC SOLN | - | NC |
| CORTIC-ND DROPS | - | NC |
| otomax-HC otic soln (CORTANE-B equiv) | - | NC |
| OTOVEL OTIC SOLN, CIPROFLOXACIN/FLUOCINOLONE OTIC SOLN | - | NC |
| OTIC STEROIDS | | |
| acetic acid/hydrocortisone otic soln (VOSOL HC equiv) | - | 1 |
| fluocinolone otic oil (DERMOTIC equiv) | - | 1 |
| OXYTOCICS | | |
| ABORTIFACIENTS/AGENTS FOR CERVICAL RIPENING | | |
| MPM PAK | - | NC |
| OXYTOCICS | | |
| methylergonovine tab (METHERGINE equiv) (QL= 28 tabs/fill, 1 fill/365 days) | QL | 1 |
| PASSIVE IMMUNIZING AGENTS | | |
| IMMUNE SERUMS | | |
| HIZENTRA INJ | MSP-PA | 2 |
| CUVITRU INJ | - | NC |
| PASSIVE IMMUNIZING AGENTS - COMBINATIONS | | |
| HYQVIA INJ | MSP-PA | 2 |
| PASSIVE IMMUNIZING AND TREATMENT AGENTS | | |
| CYSTIC FIBROSIS AGENTS | | |
| TRIKAFTA THERAPY PACK (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| IMMUNE SERUMS | | |
| HIZENTRA INJ | MSP-PA | 2 |
| XEMBIFY INJ (Only available through Diplomat Pharmacy 877-977-9118) | LD-PA | 2 |
| CUTAQUIG INJ | - | NC |
| MONOCLONAL ANTIBODIES | | |
| BEYFORTUS INJ | VAC | \$0 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|---|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | Infertility | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | Quantity Limit | RDX |
| | Step Therapy | Limited to two 15 day fills per month for first 3 months | Restricted to Diagnosis |
| | | VAC | SMKG |
| | | | Smoking Cessation |
| | | | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| PASSIVE IMMUNIZING AND TREATMENT AGENTS Cont. | | |
| ENFLONIA INJ | VAC | \$0 |

PENICILLINS

AMIDINOPENICILLINS

| | | |
|-----------|---|-----|
| PIVYA TAB | - | EXC |
|-----------|---|-----|

AMINOPENICILLINS

| | | |
|-----------------------------------|---|----|
| amoxicillin cap (TRIMOX equiv) | - | 1 |
| AMOXICILLIN CHEW TAB | - | 1 |
| amoxicillin susp (TRIMOX equiv) | - | 1 |
| amoxicillin tab (AMOXIL equiv) | - | 1 |
| ampicillin cap (AMPICILLIN equiv) | - | 1 |
| MOXATAG TAB | - | NC |
| MOXATAG TAB 775MG | - | NC |

NATURAL PENICILLINS

| | | |
|-----------------------------------|---|---|
| penicillin vk tab (VEETIDS equiv) | - | 1 |
|-----------------------------------|---|---|

PENICILLIN COMBINATIONS

| | | |
|--|---|---|
| amoxicillin/clavulanate susp (AUGMENTIN ES equiv) | - | 1 |
| amoxicillin/clavulanate tab (AUGMENTIN equiv) | - | 1 |
| amoxicillin/k clavulanate er tab (AMOXICILLIN/CLAVULANATE equiv) | - | 1 |
| AMOXICILLIN/CLAVULANATE CHEW TAB | - | 2 |

PENICILLINASE-RESISTANT PENICILLINS

| | | |
|-----------------------------------|---|---|
| dicloxacillin cap (DYNAPEN equiv) | - | 1 |
|-----------------------------------|---|---|

PHARMACEUTICAL ADJUVANTS

LIQUID VEHICLES

| | | |
|----------------|---|----|
| TRICHOSOL SOLN | - | NC |
|----------------|---|----|

SEMI SOLID VEHICLES

| | | |
|-----------------------------------|---|----|
| POLYETHYLENE GLYCOL 8000 GRANULES | - | 2 |
| VERSAPENN AL GEL ANHYDROU | - | NC |

PROGESTINS

PROGESTINS

| | | |
|---|---|---|
| medroxyprogesterone tab (PROVERA equiv) | - | 1 |
| megestrol ES susp (MEGACE ES equiv) | - | 1 |
| MEGESTROL SUSP | - | 1 |
| norethindrone tab (AYGESTIN equiv) | - | 1 |
| progesterone cap (PROMETRIUM equiv) | - | 1 |
| progesterone oil inj | - | 1 |

PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC.

AGENTS FOR CHEMICAL DEPENDENCY

| | | |
|--|-------|----|
| acamprosate calcium DR tab (CAMPRAL equiv) | - | 1 |
| disulfiram tab (ANTABUSE equiv) | - | 1 |
| lofexidine hcl tab (LUCEMYRA equiv) (QL= 96 tabs/7 days) | PA-QL | 1 |
| LUCEMYRA TAB (QL= 96 tabs/7 days) | PA-QL | 3 |
| disulfiram tab 500mg | - | NC |

ANTI-CATAPLECTIC AGENTS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont. | | |
| LUMRYZ PACK (QL= 1 pack/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| LUMRYZ STARTER PACK (QL= 1 packet/day; Only available through Accredo 800-803-2523) | LD-PA-QL | 2 |
| SODIUM OXYBATE SOLN (QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3688) | LD-PA-QL | 2 |
| XYREM SOLN | - | NC |
| XYWAV SOLN | - | NC |
| ANTIDEMENTIA AGENTS | | |
| donepezil ODT (ARICEPT equiv) (QL= 1 tab/day) | QL | 1 |
| donepezil tab (ARICEPT equiv) (QL= 2 tabs/day) | QL | 1 |
| donepezil tab 23mg (ARICEPT equiv) (QL= 1 tab/day) | QL | 1 |
| galantamine ER cap (RAZADYNE ER equiv) | - | 1 |
| GALANTAMINE SOLN | - | 1 |
| galantamine tab (RAZADYNE equiv) | - | 1 |
| memantine ER cap (NAMENDA XR equiv) | - | 1 |
| memantine soln (NAMENDA equiv) | - | 1 |
| memantine tab (NAMENDA equiv) | - | 1 |
| MEMANTINE TITRATION PAK | - | 1 |
| rivastigmine cap (EXELON equiv) | - | 1 |
| rivastigmine patch (EXELON equiv) | - | 1 |
| LEQEMBI IQLK INJ (QL= 4 inj/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | 2 |
| NAMENDA XR TITRATION PAK | - | 2 |
| ADLARITY PATCH | - | NC |
| memantine hcl-donepezil hcl 24hr er cap (NAMZARIC equiv) | - | NC |
| NAMZARIC CAP | - | NC |
| NAMZARIC STARTER PACK | - | NC |
| ZUNVEYL TAB | - | NC |
| COMBINATION PSYCHOTHERAPEUTICS | | |
| olanzapine/fluoxetine cap (SYMBYAX equiv) | - | 1 |
| PERPHENAZINE/ AMITRIPTYLINE TAB | - | 1 |
| CHLORDIAZEPOXIDE/AMITRIPTYLINE TAB | - | NC |
| DULOXICAINE PACK | - | NC |
| LYBALVI TAB | - | NC |
| FIBROMYALGIA AGENTS | | |
| SAVELLA PAK | - | 2 |
| SAVELLA TAB (QL= 2 tabs/day) | QL | 2 |
| TONMYA SUB | - | NC |
| HYPOACTIVE SEXUAL DESIRE DISORDER (HSDD) AGENTS | | |
| ADDYI TAB | - | EXC |
| VYLEESI INJ | - | EXC |
| MOVEMENT DISORDER DRUG THERAPY | | |
| tetrabenazine tab (XENAZINE equiv) | LMSP | 1 |
| AUSTEDO TAB (QL= 4 tabs/day) | LMSP-PA-QL | 2 |
| AUSTEDO XR TAB (QL= 1 tab/day) | LMSP-PA-QL | 2 |
| AUSTEDO XR TAB TITRATION KIT (QL= 1 pack/28 days) | LMSP-PA-QL | 2 |
| AUSTEDO XR TITRATION PACK (QL= 1 pack/28 days) | LMSP-PA-QL | 2 |
| INGREZZA CAP (QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | | | |
|-------------|---|------------|--|-------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | INF | Infertility | LD | Limited Distribution |
| LMSP | Lumicera Mandatory Specialty Pharmacy Program | MSP | Mandatory Specialty Pharmacy Program | OTC | Over-the-Counter |
| PA | Prior Authorization | QL | Quantity Limit | RDX | Restricted to Diagnosis |
| RS | Restricted to Specialist | SF | Limited to two 15 day fills per month for first 3 months | SMKG | Smoking Cessation |
| ST | Step Therapy | VAC | Vaccine Program | ¢ | RxCENTS |
| | | | generic = small letters | | BRANDS = CAPITAL LETTERS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont. | | |
| INGREZZA PACK 40-80MG (QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479) | LD-PA-QL | 2 |
| INGREZZA SPRINKLE CAP (QL= 1 cap/day; Only available through PantheRx 855-726-8479) | LD-PA-QL | 2 |
| AUSTEDO TITRATION PACK | - | NC |
| XENAZINE TAB | - | NC |
| MULTIPLE SCLEROSIS AGENTS | | |
| cladribine tab therapy pack (MAVENCLAD equiv) | LMSP | 1 |
| dalfampridine ER tab (AMPYRA equiv) (QL= 2 tabs/day; Restricted to Neurology Specialist) | LMSP-QL-RS | 1 |
| dimethyl fumarate DR cap (TECFIDERA equiv) | LMSP | 1 |
| dimethyl fumarate DR starter pack (TECFIDERA STARTER PACK equiv) | LMSP | 1 |
| fingolimod hcl cap 0.5mg (GILENYA equiv) | LMSP | 1 |
| glatiramer inj (COPAXONE equiv) | LMSP | 1 |
| teriflunomide tab (AUBAGIO equiv) | LMSP | 1 |
| AVONEX INJ | LMSP | 2 |
| BETASERON INJ | LMSP | 2 |
| GILENYA CAP 0.25MG | LMSP | 2 |
| KESIMPTA INJ | LMSP | 2 |
| MAVENCLAD THERAPY PAK | LMSP | 2 |
| MAYZENT TAB | LMSP | 2 |
| MAYZENT TAB STARTER PACK | LMSP | 2 |
| PLEGRIDY INJ | LMSP | 2 |
| PLEGRIDY PEN INJ | LMSP | 2 |
| REBIF INJ | LMSP | 2 |
| ZEPOSIA CAP (QL= 1 cap/day) | LMSP-PA-QL | 2 |
| ZEPOSIA STARTER PACK (QL= 1 cap/day) | LMSP-PA-QL | 2 |
| AUBAGIO TAB | - | NC |
| BAFIERTAM CAP | - | NC |
| EXTAVIA INJ | - | NC |
| GILENYA CAP 0.5MG | - | NC |
| PONVORY TAB | - | NC |
| PONVORY TAB STARTER PACK | - | NC |
| TASCENSO ODT TAB | - | NC |
| TECFIDERA CAP | - | NC |
| TECFIDERA STARTER PACK | - | NC |
| VUMERITY CAP | - | NC |
| ZINBRYTA INJ | - | NC |
| POSTHERPETIC NEURALGIA (PHN)/NEUROPATHIC PAIN AGENTS | | |
| gabapentin (once-daily) tab (GRALISE equiv) | - | NC |
| GRALISE TAB | - | NC |
| LIDOTIN PAK | - | NC |
| pregabalin ER tab (LYRICA CR equiv) | - | NC |
| PREMENSTRUAL DYSPHORIC DISORDER (PMDD) AGENTS | | |
| FLUOXETINE CAP (PMDD) | - | NC |
| SARAFEM TAB | - | NC |
| PSEUDOBULBAR AFFECT (PBA) AGENTS | | |
| NUEDEXTA CAP (QL= 2 caps/day) | PA-QL | 2 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to Diagnosis |
| | Step Therapy | VAC | Smoking Cessation |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|---------|
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. Cont. | | |
| PSYCHOTHERAPEUTIC AND NEUROLOGICAL AGENTS - MISC. | | |
| AQNEURSA PACKET FOR SUSPENSION (QL= 4 packets/day; Only available through CurantHealth 866-437-8040) | LD-PA-QL | 2 |
| PIMOZIDE TAB | - | 2 |
| ERGOLOID MESYLATES TAB | - | NC |
| MIPLYFFA CAP | - | NC |
| RESTLESS LEG SYNDROME (RLS) AGENTS | | |
| HORIZANT TAB | - | NC |
| SMOKING DETERRENENTS | | |
| bupropion SR tab (ZYBAN equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| nicotine gum (NICORETTE equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 |
| NICOTINE KIT | OTC-QL-SMKG | \$0 |
| nicotine lozenge (COMMIT equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 |
| nicotine patch (NICODERM equiv) (Limited to 180 days/plan year) | OTC-QL-SMKG | \$0 |
| NICOTROL INHALER (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| NICOTROL NASAL SPRAY (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| VARENICLINE TAB (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| varenicline tartrate tab (VARENICLINE equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| varenicline tartrate tab starter pack (VARENICLINE PAK equiv) (Limited to 180 days/plan year) | QL-SMKG | \$0 |
| CHANTIX STARTER PACK | SMKG | NC |
| TRANSTHYRETIN AMYLOIDOSIS AGENTS | | |
| WAINUA INJ (QL= 1 inj/28 days; Only available through Orsini 800-410-8575) | LD-PA-QL | 2 |
| VASOMOTOR SYMPTOM AGENTS | | |
| BRISDELLE CAP | - | NC |
| paroxetine cap (BRISDELLE equiv) | - | NC |
| RESPIRATORY AGENTS - MISC. | | |
| CYSTIC FIBROSIS AGENTS | | |
| PULMOZYME INH SOLN | LMSP | 2 |
| BRONCHITOL CAP | - | NC |
| ALYFTREK TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| ALYFTREK TAB 4-20-50MG (QL= 3 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| KALYDECO PAK (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| KALYDECO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| ORKAMBI GRANULES PACKET (QL= 2 packets/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| ORKAMBI TAB (QL= 4 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| SYMDEKO TAB (QL= 2 tabs/day; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| TRIKAFTA TAB (QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416) | LD-PA-QL | Non-EHB |
| PULMONARY FIBROSIS AGENTS | | |
| pirfenidone cap (ESBRIET equiv) (QL= 9 caps/day) | LMSP-PA-QL | 1 |
| pirfenidone tab 267mg (ESBRIET equiv) (QL= 9 tabs/day) | LMSP-PA-QL | 1 |
| pirfenidone tab 801mg (ESBRIET equiv) (QL= 3 tabs/day) | LMSP-PA-QL | 1 |
| OFEV CAP (QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416) | LD-PA-QL-SF | 2 |
| JASCAYD TAB | - | EXC |
| PIRFENIDONE TAB | - | NC |
| RESPIRATORY AGENTS - MISC. | | |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|---|--------------------------------|---------------------------------|
| EXC | NC = Not Covered NC/3P = Not Covered, Third Party Reviewer | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | Plan Exclusion | INF | Limited Distribution |
| PA | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| RS | Prior Authorization | QL | Restricted to Diagnosis |
| ST | Restricted to Specialist | SF | Smoking Cessation |
| | Step Therapy | VAC | RxCENTS |
| | | | ¢ |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|--------------|------|
| RESPIRATORY AGENTS - MISC. Cont. | | |
| BRINSUPRI TAB | - | EXC |
| TETRACYCLINES | | |
| AMINOMETHYLCYCLINES | | |
| NUZYRA TAB | - | NC |
| TETRACYCLINES | | |
| demeclocycline tab (DECLOMYCIN equiv) | - | 1 |
| doxycycline hyclate cap (VIBRAMYCIN equiv) | - | 1 |
| doxycycline hyclate tab (VIBRATAB equiv) | - | 1 |
| doxycycline monohydrate cap 50mg, 100mg (MONODOX equiv) | - | 1 |
| doxycycline monohydrate tab (ADOXA equiv) | - | 1 |
| doxycycline susp (VIBRAMYCIN equiv) | - | 1 |
| minocycline cap (MINOCIN equiv) | - | 1 |
| minocycline tab (DYNACIN equiv) | - | 1 |
| tetracycline cap | - | 1 |
| ACTICLATE TAB 75MG, 150MG | - | NC |
| DORYX MPC TAB | - | NC |
| doxycycline hyclate DR tab (DORYX equiv) | - | NC |
| doxycycline hyclate tab (TARGADOX equiv) | - | NC |
| doxycycline hyclate tab 75mg, 150mg | - | NC |
| doxycycline hyclate tab 75mg, 150mg (ACTICLATE equiv) | - | NC |
| doxycycline monohydrate cap 150mg (MONODOX equiv) | - | NC |
| doxycycline monohydrate cap 75mg (MONODOX equiv) | - | NC |
| doxycycline monohydrate tab 150mg (ADOXA equiv) | - | NC |
| MINOCYCLINE ER CAP | - | NC |
| minocycline ER tab (SOLODYN equiv) | - | NC |
| MINOLIRA TAB | - | NC |
| SEYSARA TAB | - | NC |
| TETRACYCLINE TAB | - | NC |
| THYROID AGENTS | | |
| ANTITHYROID AGENTS | | |
| methimazole tab (TAPAZOLE equiv) | - | 1 |
| propylthiouracil tab | - | 1 |
| SODIUM IODIDE I-131 SOLN | - | NC |
| THYROID HORMONES | | |
| ARMOUR THYROID TAB, NATURE THROID TAB | - | 1 |
| levothyroxine tab (SYNTHROID equiv) | - | 1 |
| liothyronine tab (CYTOMEL equiv) | - | 1 |
| np thyroid tab (ARMOUR THYROID, NATURE THROID equiv) | - | 1 |
| TIROSINT-SOL (QL= 1ml/day; Prior Authorization required for members age 9 years and older) | PA-QL | 3 |
| ERMEZA SOLN 150 MCG/5ML | - | NC |
| LEVOTHYROXINE INJ | - | NC |
| LEVOTHYROXINE INJ 100MCG/ML | - | NC |
| THYQUIDITY SOLN | - | NC |
| TIROSINT CAP | - | NC |

TOXOIDS

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| TOXOID COMBINATIONS | | |
| ADACEL/BOOSTRIX INJ | VAC | \$0 |
| DAPTACEL INJ, INFANRIX INJ | VAC | \$0 |
| DIPHTHERIA/TETANUS TOXOID (PEDIATRIC) INJ | VAC | \$0 |
| KINRIX INJ, QUADRACEL DTAP-IPV INJ | VAC | \$0 |
| KINRIX PREF SYRINGE, QUADRACEL PREF SYRINGE | VAC | \$0 |
| PEDIARIX INJ | VAC | \$0 |
| PENTACEL INJ | VAC | \$0 |
| TETANUS/DIPHTHERIA TOXOID INJ | VAC | \$0 |
| VAXELIS INJ | VAC | \$0 |

ULCER DRUGS

| DrugName | Special Code | Tier |
|---|--------------|------|
| ANTISPASMODICS | | |
| chlordiazepoxide/clidinium cap (LIBRAX equiv) | - | 1 |
| dicyclomine cap (BENTYL equiv) | - | 1 |
| dicyclomine soln (BENTYL equiv) | - | 1 |
| dicyclomine tab (BENTYL equiv) | - | 1 |
| glycopyrrolate tab (ROBINUL equiv) | - | 1 |
| hyoscyamine sulfate CR tab (LEVVID equiv) | - | 1 |
| hyoscyamine sulfate ODT (ANASPAZ equiv) | - | 1 |
| hyoscyamine sulfate SL tab (LEVSIN equiv) | - | 1 |
| hyoscyamine sulfate soln (LEVSIN equiv) | - | 1 |
| hyoscyamine tab (LEVSIN equiv) | - | 1 |
| methscopolamine tab (PAMINE equiv) | - | 1 |
| BELLADONNA ALKALOID/OPIUM SUPP | - | 2 |
| b-donna tab (DONNATAL equiv) | - | NC |
| GLYCATO TAB, GLYCOPYRROLATE TAB | - | NC |

| DrugName | Special Code | Tier |
|--|--------------|------|
| H-2 ANTAGONISTS | | |
| cimetidine soln (CIMETIDINE equiv) | - | 1 |
| cimetidine tab (TAGAMET equiv) (Rx Only) | - | 1 |
| famotidine susp (PEPCID equiv) | - | 1 |
| famotidine tab (PEPCID equiv) (Rx Only) | - | 1 |
| nizatidine cap (AXID equiv) | - | 1 |
| PEPCID TAB (Rx Only) | - | 3 |
| TAGAMET TAB | - | 3 |

| DrugName | Special Code | Tier |
|---------------------------------|--------------|------|
| MISC. ANTI-ULCER | | |
| sucralfate tab (CARAFATE equiv) | - | 1 |

| DrugName | Special Code | Tier |
|--------------------------------------|--------------|------|
| PROTON PUMP INHIBITORS | | |
| esomeprazole cap (NEXIUM equiv) | OTC | 1 |
| lansoprazole cap (PREVACID equiv) | OTC | 1 |
| omeprazole DR cap (PRILOSEC equiv) | - | 1 |
| pantoprazole EC tab (PROTONIX equiv) | - | 1 |
| rabeprazole EC tab (ACIPHEX equiv) | - | 1 |
| ACIPHEX SPRINKLE CAP | - | NC |
| ACIPHEX TAB | - | NC |
| ESOMEPRAZOLE-EZS KIT | - | NC |
| FIRST OMEPRAZOLE SUSP | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | MSF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | QL | Over-the-Counter |
| ST | Prior Authorization | SF | Restricted to Diagnosis |
| | Restricted to Specialist | VAC | Smoking Cessation |
| | Step Therapy | | RxCENTS |
| | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|--|---------------------|-------------|
| ULCER DRUGS Cont. | | |
| LANSOPRAZOLE SUSP | - | NC |
| PREVACID CAP | - | NC |
| PROTONIX EC TAB | - | NC |
| ULCER DRUGS - PROSTAGLANDINS | | |
| misoprostol tab (CYTOTEC equiv) | - | 1 |
| ULCER THERAPY COMBINATIONS | | |
| omeprazole/sodium bicarbonate cap (ZEGERID equiv) | - | NC |
| omeprazole/sodium bicarbonate powder pack (ZEGERID equiv) | - | NC |
| ZEGERID POWDER PACK | - | NC |
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS | | |
| ANTISPASMODICS | | |
| CHLORDIAZEPOXIDE/CLIDINIUM CAP | - | 1 |
| glycopyrrolate oral soln (CUVPOSA equiv) | - | 1 |
| HYOSCYAMINE ELXIR | - | 1 |
| HYOSCYAMINE SULFATE ER TAB | - | 1 |
| HYOSCYAMINE SULFATE SL TAB | - | 1 |
| HYOSCYAMINE TAB | - | 1 |
| LEVBID ER TAB 0.375MG | - | 3 |
| LEVSIN SL TAB 0.125MG | - | 3 |
| LEVSIN TAB 0.125MG | - | 3 |
| DARTISLA ODT TAB | - | NC |
| DICYCLOMINE TAB | - | NC |
| DONNATAL ELIXIR, PB-BELLADONNA ELIXIR | - | NC |
| DONNATAL TAB | - | NC |
| GLYCATE TAB | - | NC |
| HYOSCYAMINE INJ | - | NC |
| H-2 ANTAGONISTS | | |
| NIZATIDINE CAP | - | 1 |
| RANITIDINE TAB | - | NC |
| MISC. ANTI-ULCER | | |
| sucralfate susp (CARAFATE equiv) | - | 1 |
| PROTON PUMP INHIBITORS | | |
| esomeprazole DR granule pack (NEXIUM equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| lansoprazole odt (PREVACID SOLUTAB equiv) (Prior Authorization required for members age 9 years and older) | PA | 1 |
| omeprazole magnesium DR tab 20mg (PRILOSEC equiv) | OTC | 1 |
| omeprazole tab | OTC | 1 |
| NEXIUM 24HR TAB | OTC | 3 |
| DEXILANT DR CAP | - | NC |
| dexlansoprazole DR cap (DEXILANT equiv) | - | NC |
| FIRST PANTOPRAZOLE SUSP | - | NC |
| NEXIUM GRANULE PACK | - | NC |
| pantoprazole sodium packet (PROTONIX equiv) | - | NC |
| PREVACID SOLUTAB | - | NC |
| PROTONIX PAK | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---------------------------------|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | MSF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | QL | Over-the-Counter |
| ST | Prior Authorization | SF | Restricted to Diagnostics |
| | Restricted to Specialist | VAC | Smoking Cessation |
| | Step Therapy | | RxCENTS |
| | | | |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|--------------|------|
| ULCER DRUGS/ANTISPASMODICS/ANTICHOLINERGICS Cont. | | |
| VOQUEZNA TAB | - | NC |
| ULCER THERAPY COMBINATIONS | | |
| bismuth/metro/tetra cap (PYLERA equiv) | - | NC |
| HELIDAC PACK | - | NC |
| KONVOMEK SUSP | - | NC |
| lansoprazole/amoxicillin/clarithromycin kit (PREVPAC equiv) | - | NC |
| LANSOPRAZOLE/AMOXICILLIN/CLARITHROMYCIN KIT | - | NC |
| PYLERA CAP | - | NC |
| TALICIA CAP | - | NC |
| VOQUEZNA DUAL PAK | - | NC |
| VOQUEZNA TRIP PAK | - | NC |
| URINARY ANTI-INFECTIVES | | |
| URINARY ANTI-INFECTIVE COMBINATIONS | | |
| PROSED DS TAB | - | NC |
| URINARY ANTISPASMODICS | | |
| URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLIN) (NEW) | | |
| tropium chloride SR cap (SANCTURA XR equiv) | - | 1 |
| URINARY ANTISPASMODIC - ANTIMUSCARINICS (ANTICHOLINERGIC) | | |
| darifenacin SR tab (ENABLEX equiv) | - | 1 |
| fesoterodine fumarate ER tab (TOVIAZ equiv) | - | 1 |
| oxybutynin ER tab (DITROPAN XL equiv) | - | 1 |
| oxybutynin syrup | - | 1 |
| oxybutynin tab (DITROPAN equiv) | - | 1 |
| solifenacin tab (VESICARE equiv) | - | 1 |
| tolterodine SR cap (DETROL LA equiv) | - | 1 |
| tolterodine tab (DETROL equiv) | - | 1 |
| tropium tab (SANCTURA equiv) | - | 1 |
| TOVIAZ TAB | - | 3 |
| OXYBUTYNIN TAB | - | NC |
| VESICARE LS SUSP | - | NC |
| URINARY ANTISPASMODICS - BETA-3 ADRENERGIC AGONISTS | | |
| mirabegron tab er (MYRBETRIQ equiv) | - | 1 |
| MYRBETRIQ TAB | - | 3 |
| GEMTESA TAB | - | NC |
| MYRBETRIQ SUSP | - | NC |
| URINARY ANTISPASMODICS - CHOLINERGIC AGONISTS | | |
| bethanechol tab (URECHOLINE equiv) | - | 1 |
| URINARY ANTISPASMODICS - DIRECT MUSCLE RELAXANTS (NEW) | | |
| flavoxate tab (URISPAS equiv) | - | NC |

VACCINES

BACTERIAL VACCINES

| | | |
|-------------------------|-----|-----|
| ACTHIB INJ, HIBERIX INJ | VAC | \$0 |
| BEXSERO INJ | VAC | \$0 |
| CAPVAXIVE INJ | VAC | \$0 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|-----------------------|--------------|------|
| VACCINES Cont. | | |
| MENACTRA INJ | VAC | \$0 |
| MENQUADFI INJ | VAC | \$0 |
| MENVEO INJ | VAC | \$0 |
| PEDVAXHIB INJ | VAC | \$0 |
| PENBRAYA INJ | VAC | \$0 |
| PENMENVY INJ | VAC | \$0 |
| PNEUMOVAX INJ | VAC | \$0 |
| PREVNAR 20 INJ | VAC | \$0 |
| TRUMENBA INJ | VAC | \$0 |
| VAXNEUVANCE INJ | VAC | \$0 |
| BCG INJ | VAC | EXC |
| TYPHIM VI INJ | VAC | EXC |
| VAXCHORA SUSP | VAC | EXC |
| VIVOTIF CAP | VAC | EXC |

VIRAL VACCINES

| | | |
|--|--------|-----|
| ABRYSCO INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 |
| AFLURIA INJ, FLUZONE INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| AREXVY INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 |
| COMIRNATY INJ (QL= 1 dose/17 days) | QL-VAC | \$0 |
| COMIRNATY INJ 30MCG/0.3ML (QL= 1 dose/17 days) | QL-VAC | \$0 |
| COVID-19 VACCINE INJ 5-11Y (PFIZER) (QL= 1 dose/17 days) | QL-VAC | \$0 |
| COVID-19 VACCINE INJ 6M-11Y (MODERNA) (QL= 1 dose/24 days) | QL-VAC | \$0 |
| COVID-19 VACCINE INJ 6M-4Y (PFIZER) (QL= 1 dose/17 days) | QL-VAC | \$0 |
| DENGVAXIA SUSP | VAC | \$0 |
| ENGERIX-B INJ, RECOMBIVAX-HB INJ | VAC | \$0 |
| FLUAD INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| FLUBLOK INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| FLUCELVAX INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| FLULAVAL INJ, FLUARIX INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| FLUMIST NASAL (QL= 1 dose/28 days) | QL-VAC | \$0 |
| FLUZONE HIGH DOSE PF INJ (QL= 1 inj/28 days) | QL-VAC | \$0 |
| GARDASIL 9 INJ | VAC | \$0 |
| HAVRIX INJ, VAQTA INJ | VAC | \$0 |
| HEPLISAV-B INJ | VAC | \$0 |
| IPOLE INJ | VAC | \$0 |
| JYNNEOS INJ | VAC | \$0 |
| M-M-R II INJ | VAC | \$0 |
| MNEXSPIKE INJ 10MCG/0.2ML (QL= 1 dose/24 days) | QL-VAC | \$0 |
| MRESVIA INJ (QL= 1 dose/lifetime) | QL-VAC | \$0 |
| NOVAVAX INJ (QL= 1 dose/24 days) | QL-VAC | \$0 |
| PREHEVBRIO SUSP | VAC | \$0 |
| PRIORIX INJ | VAC | \$0 |
| PROQUAD INJ | VAC | \$0 |
| ROTARIX SUSP | VAC | \$0 |
| ROTATEQ INJ | VAC | \$0 |
| SHINGRIX INJ (Covered for members age 19 years and older) | VAC | \$0 |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | |
|--|---|---------------------------------|
| NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| NC/3P = Not Covered, Third Party Reviewer | | |
| EXC Plan Exclusion | INF Infertility | LD Limited Distribution |
| LMSP Lumicera Mandatory Specialty Pharmacy Program | MSP Mandatory Specialty Pharmacy Program | OTC Over-the-Counter |
| PA Prior Authorization | QL Quantity Limit | RDX Restricted to Diagnosis |
| RS Restricted to Specialist | SF Limited to two 15 day fills per month for first 3 months | SMKG Smoking Cessation |
| ST Step Therapy | VAC Vaccine Program | ¢ RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary
Category/Class**

Last Updated* 2/1/2026

| DrugName | Special Code | Tier |
|---|---------------------|-------------|
| VACCINES Cont. | | |
| SPIKEVAX INJ (QL= 1 dose/24 days) | QL-VAC | \$0 |
| SPIKEVAX INJ 50MCG/0.5ML (QL= 1 dose/24 days) | QL-VAC | \$0 |
| TWINRIX INJ | VAC | \$0 |
| VARIVAX INJ | VAC | \$0 |
| IMOVAX INJ | VAC | EXC |
| IXCHIQ INJ | - | EXC |
| IXIARO INJ | VAC | EXC |
| RABAVERT INJ | VAC | EXC |
| TICOVAC INJ | VAC | EXC |
| VIMKUNYA INJ | VAC | EXC |
| YF-VAX INJ | VAC | EXC |

VAGINAL AND RELATED PRODUCTS

VAGINAL ANTI-INFECTIVES

| | | |
|---|----|---|
| CLINDESSE VAGINAL CREAM (QL= 1 applicator/fill) | QL | 2 |
| XACIATO GEL (QL= 1 applicator/fill) | QL | 2 |

VAGINAL CONTRACEPTIVE - PH MODULATORS

| | | |
|-----------------------------|----|-----|
| PHEXXI GEL (QL= 1 box/fill) | QL | \$0 |
|-----------------------------|----|-----|

VAGINAL PROGESTINS

| | | |
|--|----|---|
| progesterone vaginal insert (ENDOMETRIN equiv) | PA | 1 |
| ENDOMETRIN SUPP | PA | 2 |

VAGINAL PRODUCTS

MISCELLANEOUS VAGINAL PRODUCTS

| | | |
|----------------|---|----|
| FEM PH GEL | - | 3 |
| INTRAROSA SUPP | - | NC |

SPERMICIDES

| | | |
|--------------------|-----|-----|
| CONTRACEPTIVE FOAM | OTC | \$0 |
| CONTRACEPTIVE GEL | OTC | \$0 |
| CONTRACEPTIVE SUPP | OTC | \$0 |
| TODAY SPONGE | OTC | \$0 |

VAGINAL ANTI-INFECTIVES

| | | |
|--|----|---|
| clindamycin vaginal cream (CLEOCIN equiv) (QL=1 tube/fill) | QL | 1 |
| metronidazole vaginal gel (METROGEL equiv) | - | 1 |
| terconazole cream (TERAZOL equiv) | - | 1 |
| TERCONAZOLE CREAM 0.8% | - | 1 |
| terconazole supp (TERAZOL equiv) | - | 1 |
| CLEOCIN VAGINAL SUPP (QL= 3 suppositories/fill) | QL | 3 |

VAGINAL ESTROGENS

| | | |
|--|----|----|
| estradiol cream (ESTRACE equiv) | - | 1 |
| estradiol vaginal tab, yuvafem vaginal tab (VAGIFEM equiv) (QL= 8 tabs/28 days, 18 tabs on first fill) | QL | 1 |
| ESTRING (3 copays per Rx) | - | 2 |
| PREMARIN VAGINAL CREAM | - | 2 |
| ESTRACE VAGINAL CREAM | - | 3 |
| FEMRING (3 copays per Rx) | - | 3 |
| IMVEXXY SUPP | - | NC |

Note: Unless otherwise specifically noted, all strengths and forms of products listed in the formulary are covered.

| | | | |
|-------------|--|--------------------------------|---|
| EXC | NC = Not Covered | generic = small letters | BRANDS = CAPITAL LETTERS |
| LMSP | NC/3P = Not Covered, Third Party Reviewer | INF | LD |
| PA | Plan Exclusion | INF | Limited Distribution |
| RS | Lumicera Mandatory Specialty Pharmacy Program | MSP | Over-the-Counter |
| ST | Prior Authorization | QL | Restricted to Diagnosis |
| | Restricted to Specialist | SF | Restricted to two 15 day fills per month for first 3 months |
| | Step Therapy | VAC | Smoking Cessation |
| | | | ¢ |
| | | | RxCENTS |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Prior Authorization Drug List
Last Updated* 2/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---|--|
| ACTHAR GEL INJ | 2 |
| ACTIMMUNE INJ | Non-EHB |
| ADALIMUMAB FKJP KIT INJ 20MG/0.4ML | 2 |
| ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT | 2 |
| ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT | 2 |
| ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT | 2 |
| ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT | 2 |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT | 2 |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML | 2 |
| ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML | 2 |
| ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML | 2 |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML | 2 |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML | 2 |
| adapalene cream | 1 |
| adapalene gel | 1 |
| ADBRY INJ | 2 |
| ADEMPAS TAB | 2 |
| ADVATE, KOVALTRY INJ | 2 |
| AFSTYLA KIT | 2 |
| AIMOVIG INJ | 2 |
| AJOVY INJ | 2 |
| ALECENSA CAP | 2 |
| ALHEMO INJ | 2 |
| ALKINDI SPRINKLE CAP 0.5MG | 3 |
| ALKINDI SPRINKLE CAP 1MG | 3 |
| ALPHANATE, HUMATE-P INJ | 2 |
| ALPHANINE SD INJ | 2 |
| ALPROLIX INJ | 2 |
| ALTRENO LOTION | 2 |
| ALTUVIIIIO INJ | 2 |
| ALUNBRIG TAB 30MG | 2 |
| ALUNBRIG TAB 90MG, 180MG | 2 |
| ALYFTREK TAB | Non-EHB |
| ALYFTREK TAB 4-20-50MG | Non-EHB |
| ambrisentan tab | 1 |
| APRETUDE SUSP | \$0 |
| AQNEURSA PACKET FOR SUSPENSION | 2 |
| ARBLI SUSP | 3 |
| ARIKAYCE SUSP | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|------------------------------|--|
| ATORVALIQ SUSP | 3 |
| ATTRUBY PACK | 2 |
| AUGTYRO CAP | 2 |
| AUGTYRO CAP 160MG | 2 |
| AUSTEDO TAB | 2 |
| AUSTEDO XR TAB | 2 |
| AUSTEDO XR TAB TITRATION KIT | 2 |
| AUSTEDO XR TITRATION PACK | 2 |
| AVMAPKI FAKZYNJA CO-PACK | 2 |
| AYVAKIT TAB | 2 |
| BACLOFEN ORAL SOLN 10MG/5ML | 3 |
| BACLOFEN ORAL SOLN 5 MG/5ML | 3 |
| baclofen oral soln 5mg/5ml | 1 |
| baclofen susp | 1 |
| BALVERSA TAB 3MG | 2 |
| BALVERSA TAB 4MG | 2 |
| BALVERSA TAB 5MG | 2 |
| BANZEL SUSP | 3 |
| BARACLUDE SOLN | 3 |
| BENEFIX INJ | 2 |
| BENLYSTA AUTO-INJECTOR | 2 |
| BENLYSTA INJ | 2 |
| BERINERT INJ | 2 |
| BESREMI INJ | 2 |
| bexarotene gel | 1 |
| BIMZELX INJ | 2 |
| BIMZELX INJ 320MG/2ML | 2 |
| BIMZELX SYRINGE | 2 |
| BIMZELX SYRINGE 320MG/2ML | 2 |
| bosentan tab | 1 |
| bosentan tab for oral susp | 1 |
| BOSULIF CAP | 2 |
| BOSULIF TAB | 2 |
| BRAFTOVI CAP 75MG | 2 |
| BRUKINSA CAP | 2 |
| BRUKINSA TAB | 2 |
| budesonide ER tab | 1 |
| budesonide rectal foam | 3 |
| BYLVAY CAP 1200MCG | 2 |
| BYLVAY CAP 400MCG | 2 |
| BYLVAY SPRINKLE CAP 200MCG | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|--|--|
| BYLVAY SPRINKLE CAP 600MCG | 2 |
| CABLIVI INJ KIT | 2 |
| CABOMETYX TAB | 2 |
| CALQUENCE TAB | 2 |
| CAMZYOS CAP | 2 |
| CAPRELSA TAB | 2 |
| CAPRELSA TAB 300MG | 2 |
| carglumic acid tab | 1 |
| CERDELGA CAP | 2 |
| CHOLBAM CAP | 2 |
| CIBINQO TAB | 2 |
| CIMZIA INJ | 2 |
| CIMZIA INJ 200MG/ML | 2 |
| CINRYZE INJ | Non-EHB |
| clobazam susp | 1 |
| COAGADEX INJ | 2 |
| COMETRIQ KIT | 2 |
| COPIKTRA CAP | 2 |
| CORIFACT KIT | 2 |
| CORLANOR SOLN | 3 |
| COTELLIC TAB | 2 |
| CRENESSITY CAP | 2 |
| CRENESSITY SOLN | 2 |
| CRINONE GEL | 2 |
| dasatinib tab | 1 |
| DAYBUE SOLN | Non-EHB |
| DAYVIGO TAB | 3 |
| deferiprone tab | 1 |
| DESCOVY TAB | \$0 |
| DIACOMIT CAP | 2 |
| DIACOMIT POWDER PACK | 2 |
| diclofenac gel | 1 |
| DOPTELET SPRINKLE CAP | 2 |
| DOPTELET TAB | 2 |
| dronabinol cap | 1 |
| DUPIXENT INJ | 2 |
| DUPIXENT PEN INJ | 2 |
| EBGLYSS INJ | 2 |
| EBGLYSS PEN INJ | 2 |
| ELOCTATE INJ | 2 |
| eltrombopag olamine powder pack for susp | 1 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
 Prior Authorization Drug List
 Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---------------------------------|--|
| eltrombopag olamine tab | 1 |
| eltrombopag olamine tab 50MG | 1 |
| eltrombopag olamine tab 75MG | 1 |
| EMGALITY INJ | 2 |
| EMGALITY INJ 100MG/ML | 2 |
| EMPAVELI INJ | 2 |
| enalapril maleate oral soln | 1 |
| ENBREL INJ 25MG | 2 |
| ENBREL INJ 50MG | 2 |
| ENBREL MINI INJ | 2 |
| ENBREL SURECLICK INJ 50MG | 2 |
| ENDOMETRIN INSERT | 2 |
| ENDOMETRIN SUPP | 2 |
| ENSPRYNG INJ | 2 |
| ENTYVIO SC INJ | 2 |
| EPIDIOLEX SOLN | 2 |
| EPRONTIA SOLN | 3 |
| ERIVEDGE CAP | 2 |
| ERLEADA TAB | 2 |
| ERLEADA TAB 240MG | 2 |
| erlotinib tab | 1 |
| erlotinib tab 25mg | 1 |
| esomeprazole DR granule pack | 1 |
| ESPEROCT INJ | 2 |
| everolimus tab | 1 |
| everolimus tab (ZORTRESS equiv) | 1 |
| everolimus tab for oral susp | 1 |
| EVRYSDI SOLN | Non-EHB |
| EVRYSDI TAB | Non-EHB |
| EZALLOR SPRINKLE CAP | 3 |
| FASENRA PEN INJ | 2 |
| FERRIPROX SOLN | 2 |
| FIBRYGA, RIASTAP INJ | 2 |
| FILSPARI TAB | 2 |
| FINTEPLA SOLN | 2 |
| FIRDAPSE TAB | 2 |
| FLOLIPID SUSP | 3 |
| FOTIVDA CAP | 3 |
| FRUZAQLA CAP 1MG | 2 |
| FRUZAQLA CAP 5MG | 2 |
| GALAFOLD CAP | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---------------------------|--|
| GATTEX KIT | Non-EHB |
| GAVRETO CAP | 2 |
| gefitinib tab | 1 |
| GILOTRIF TAB | 2 |
| GLOPERBA SOLN | 3 |
| GOMEKLI CAP | 2 |
| GOMEKLI CAP 1MG | 2 |
| GOMEKLI TAB FOR ORAL SUSP | 2 |
| HAEGARDA INJ | Non-EHB |
| HEMLIBRA INJ | 2 |
| HEMOFIL M, KOATE INJ | 2 |
| HIZENTRA INJ | 2 |
| HYCAMTIN CAP | 2 |
| HYFTOR GEL | 2 |
| HYQVIA INJ | 2 |
| IBTROZI CAP | 2 |
| icatibant inj | 1 |
| ICLUSIG TAB | 2 |
| IDHIFA TAB | 2 |
| IMBRUVICA CAP 140MG | 2 |
| IMBRUVICA CAP 70MG | 2 |
| IMBRUVICA SUSP | 2 |
| IMBRUVICA TAB 420MG | 2 |
| IMCIVREE INJ | 2 |
| INBRIJA INH POWDER | 3 |
| INGREZZA CAP | 2 |
| INGREZZA PACK 40-80MG | 2 |
| INGREZZA SPRINKLE CAP | 2 |
| INLYTA TAB | 2 |
| INLYTA TAB 1MG | 2 |
| INQOVI TAB | 2 |
| INZIRQO SUSP | 3 |
| IQIRVO TAB | 3 |
| ISTURISA TAB | 2 |
| itraconazole soln | 1 |
| IWILFIN TAB | 2 |
| JAKAFI TAB | 2 |
| JAYPIRCA TAB | 2 |
| JIVI INJ | 2 |
| JOENJA TAB | 2 |
| JYLAMVO SOLN, XATMEP SOLN | 3 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---------------------------|--|
| KALYDECO PAK | Non-EHB |
| KALYDECO TAB | Non-EHB |
| KATERZIA SUSP | 3 |
| KERENDIA TAB | 2 |
| KEVZARA INJ | 2 |
| KHINDIVI SOLN | 3 |
| KINERET INJ | 2 |
| KISQALI PAK | 2 |
| KISQALI TAB | 2 |
| KOSELUGO CAP | 2 |
| KOSELUGO CAP 10MG | 2 |
| KOSELUGO SPRINKLE CAP | 2 |
| KOSELUGO SPRINKLE CAP 5MG | 2 |
| KRAZATI TAB | 2 |
| lansoprazole odt | 1 |
| lapatinib ditosylate tab | 1 |
| LEDIPASVIR/SOFOSBUVIR TAB | 2 |
| LENVIMA CAP | 2 |
| LEQEMBI IQLK INJ | 2 |
| l-glutamine powder packet | 1 |
| LIKMEZ SUSP | 3 |
| LINZESS CAP | 3 |
| LITFULO CAP | 2 |
| lithium oral solution | 1 |
| LIVDELZI CAP | 3 |
| LIVMARLI SOLN | 2 |
| LIVMARLI SOLN 19MG/ML | 2 |
| LIVMARLI TAB | 2 |
| LIVMARLI TAB 30MG | 2 |
| LIVTENCITY TAB | 2 |
| lofexidine hcl tab | 1 |
| LOKELMA PAK | 2 |
| LONSURF TAB | 2 |
| LOPRESSOR SOLN | 3 |
| LORBRENA TAB 100MG | 2 |
| LORBRENA TAB 25MG | 2 |
| LUCEMYRA TAB | 3 |
| LUMAKRAS TAB | 2 |
| LUMAKRAS TAB 240MG | 2 |
| LUMAKRAS TAB 320MG | 2 |
| LUMRYZ PACK | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|--|--|
| LUMRYZ STARTER PACK | 2 |
| LUPKYNIS CAP | 3 |
| LYNPARZA TAB | 2 |
| LYTGOBI THERAPY PACK | 2 |
| LYVISPAH GRANULE PACKET | 3 |
| MAVYRET PAK | 2 |
| MAVYRET TAB | 2 |
| MEKINIST SOLN | 2 |
| MEKINIST TAB 0.5MG | 2 |
| MEKINIST TAB 2MG | 2 |
| MEKTOVI TAB | 2 |
| mercaptopurine susp | 1 |
| mifepristone tab | 2 |
| miglustat cap | 1 |
| MOTEGRITY TAB | 3 |
| MOVANTIK TAB | 2 |
| MYFEMBREE TAB | 2 |
| NEMLUVIO INJ | 2 |
| NERLYNX TAB | 2 |
| NIACINAMIDE/SPIRONOLACTONE/TRETINOIN GEL | 2 |
| NIACINAMIDE/TAZAROTENE CREAM | 2 |
| NIACINAMIDE/TRETINOIN CREAM | 2 |
| NIACINAMIDE/TRETINOIN GEL | 2 |
| nilotinib hcl cap | 1 |
| NINLARO CAP | 2 |
| nitazoxanide tab | 1 |
| nitisinone cap | 1 |
| nitrofurantoin susp | 1 |
| NORLIQVA ORAL SOLN | 3 |
| NOVOEIGHT INJ | 2 |
| NOVOSEVEN RT INJ | 2 |
| NUBEQA TAB | 2 |
| NUCALA INJ | 2 |
| NUEDEXTA CAP | 2 |
| NUWIQ INJ | 2 |
| NUWIQ KIT | 2 |
| ODACTRA SL TAB | 3 |
| ODOMZO CAP | 2 |
| OFEV CAP | 2 |
| OGSIVEO TAB | 2 |
| OGSIVEO TAB 50MG | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|-------------------------------|--|
| OHTUVAYRE SUSP | 2 |
| OJEMDA SUSP | 2 |
| OJEMDA TAB | 2 |
| OJJAARA TAB | 2 |
| OLUMIANT TAB | 2 |
| ONGENTYS CAP | 3 |
| OPSUMIT TAB | 2 |
| OPZELURA CREAM | 3 |
| ORENCIA CLICK INJ | 2 |
| ORENCIA SC INJ 125MG/ML | 2 |
| ORENCIA SC INJ 50MG/0.4ML | 2 |
| ORENCIA SC INJ 87.5MG/0.7ML | 2 |
| ORENITRAM TAB | Non-EHB |
| ORGOVYX TAB | 2 |
| ORIAHNN CAP | 2 |
| ORILISSA TAB 150MG | 2 |
| ORILISSA TAB 200MG | 2 |
| ORKAMBI GRANULES PACKET | Non-EHB |
| ORKAMBI TAB | Non-EHB |
| ORSERDU TAB | 2 |
| ORSERDU TAB 345MG | 2 |
| OTEZLA STARTER PACK | 2 |
| OTEZLA TAB | 2 |
| OTEZLA XR TAB | 2 |
| OTEZLA/OTEZLA XR STARTER PACK | 2 |
| OXERVATE OPHTH SOLN | 2 |
| PALFORZIA POWDER PACK | 2 |
| PALFORZIA SPRINKLE CAP | 2 |
| PALYNZIQ INJ | 2 |
| pazopanib tab | 1 |
| PEMAZYRE TAB | 2 |
| PIQRAY TAB | 2 |
| pirfenidone cap | 1 |
| pirfenidone tab 267mg | 1 |
| pirfenidone tab 801mg | 1 |
| POMALYST CAP | 2 |
| PREVYMIS PAK | 2 |
| PREVYMIS TAB | 2 |
| PROFILNINE INJ | 2 |
| PROGESTERONE SUPP | 3 |
| progesterone vaginal insert | 1 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---|--|
| prucalopride succinate tab | 1 |
| pyrimethamine tab | 1 |
| PYRUKYND TAB | 2 |
| PYRUKYND TAPER PACK | 2 |
| QBRELIS SOLN | 3 |
| QINLOCK TAB | 2 |
| RADICAVA ORS STARTER KIT | 2 |
| RADICAVA ORS SUSP | 2 |
| RECOMBINATE INJ | 2 |
| RETEVMO CAP | 2 |
| RETEVMO CAP 40MG | 2 |
| RETEVMO TAB | 2 |
| RETEVMO TAB 40MG | 2 |
| REVUFORJ TAB | 2 |
| REVUFORJ TAB 110MG | 2 |
| REVUFORJ TAB 25MG | 2 |
| REYVOW TAB | 2 |
| REZDIFFRA TAB | 2 |
| REZLIDHIA CAP | 2 |
| REZUROCK TAB | 2 |
| RINVOQ ER TAB | 2 |
| RINVOQ ORAL SOLN | 2 |
| RIVFLOZA INJ | 2 |
| RIVFLOZA INJ 160MG | 2 |
| RIVFLOZA VIAL | Non-EHB |
| RIXUBIS INJ | 2 |
| ROMVIMZA CAP | 2 |
| ROZLYTREK CAP | 2 |
| ROZLYTREK PAK | 2 |
| RUBRACA TAB | 2 |
| RUCONEST INJ | 2 |
| rufinamide susp | 1 |
| rufinamide tab | 1 |
| RYDAPT CAP | 2 |
| sapropterin dihydrochloride powder packet | 1 |
| sapropterin dihydrochloride soluble tab | 1 |
| SCSEMBLIX TAB | 2 |
| SCSEMBLIX TAB 100 MG | 2 |
| SEVENFACT INJ | 2 |
| SIGNIFOR INJ | 2 |
| sildenafil susp | 1 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|-----------------------------|--|
| sildenafil tab 20mg | 1 |
| SIMPONI AUTO-INJECTOR 100MG | 2 |
| SIMPONI INJ 100MG | 2 |
| SKYCLARYS CAP | 2 |
| SKYRIZI INJ 150MG/ML | 2 |
| SKYRIZI INJ 180 MG/1.2ML | 2 |
| SKYRIZI INJ 360MG/2.4ML | 2 |
| SODIUM OXYBATE SOLN | 2 |
| SOFOSBUVIR/VELPATASVIR TAB | 2 |
| SOHONOS CAP 1.5MG | 2 |
| SOHONOS CAP 10MG | 2 |
| SOHONOS CAP 1MG | 2 |
| SOHONOS CAP 2.5MG | 2 |
| SOHONOS CAP 5MG | 2 |
| SOLOSEC GRANULES PACKET | 3 |
| SOMAVERT INJ | 2 |
| sorafenib tosylate tab | 1 |
| SOTYLIZE SOLN 5MG/ML | 3 |
| SPEVIGO INJ | 2 |
| spironolactone susp | 1 |
| SPORANOX SOLN | 3 |
| STEQEYMA INJ | 2 |
| STEQEYMA INJ 90MG | 2 |
| STIVARGA TAB | 2 |
| STRENSIQ INJ | Non-EHB |
| SUBVENITE SUSP | 3 |
| sunitinib malate cap | 1 |
| SUNOSI TAB | 2 |
| SYMDEKO TAB | Non-EHB |
| SYMPROIC TAB | 2 |
| TABRECTA TAB | 2 |
| tadalafil tab (PAH) | 1 |
| TADLIQ SUSP | 3 |
| TAFINLAR CAP | 2 |
| TAFINLAR TAB | 2 |
| TAGRISSO TAB | 2 |
| TAKHZYRO INJ | Non-EHB |
| TAKHZYRO INJ 150MG/ML | Non-EHB |
| TALTZ INJ | 2 |
| TALTZ INJ 20MG/0.25ML | 2 |
| TALTZ INJ 40 MG/0.5ML | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|--------------------------------------|--|
| TALZENNA CAP 0.25MG | 2 |
| TALZENNA CAP 0.5MG, 0.75MG, 1MG | 2 |
| TAVNEOS CAP | 2 |
| TAZVERIK TAB | 2 |
| TEPMETKO TAB | 2 |
| testosterone gel 1% 25mg | 1 |
| testosterone gel 1% 50mg | 1 |
| testosterone gel 1% pump | 1 |
| testosterone gel 1.62% 1.25gm | 1 |
| testosterone gel 1.62% 2.5gm | 1 |
| TESTOSTERONE GEL 20.25MG/1.25GM | 1 |
| TESTOSTERONE GEL PUMP 1% | 1 |
| testosterone gel pump 1.62% | 1 |
| testosterone soln | 1 |
| TEZSPIRE INJ | 2 |
| TIBSOVO TAB | 2 |
| tiopronin tab | 1 |
| tiopronin tab delayed release | 2 |
| TIROSINT-SOL | 3 |
| TOBI PODHALER | 3 |
| tolvaptan tab | 1 |
| tolvaptan tab therapy pack | 1 |
| topiramate oral soln | 1 |
| TREMFYA INDUCTION INJ 200MG/ML | 2 |
| TREMFYA INJ | 2 |
| TREMFYA INJ 200MG/2ML | 2 |
| tretinoin cream | 1 |
| tretinoin gel | 1 |
| tretinoin gel 0.08% | 1 |
| TRETINOIN MICROSPHERE GEL 0.04% | 1 |
| TRETINOIN MICROSPHERE GEL 0.1% | 1 |
| TRETINOIN MICROSPHERE GEL PUMP 0.04% | 1 |
| TRETINOIN MICROSPHERE GEL PUMP 0.1% | 1 |
| trientine cap | 1 |
| TRIKAFTA TAB | Non-EHB |
| TRIKAFTA THERAPY PACK | Non-EHB |
| TRULANCE TAB | 2 |
| TRUQAP TAB | 2 |
| TRUQAP THERAPY PACK | 2 |
| TRYNGOLZA INJ | 2 |
| TUKYSA TAB | 2 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|---|--|
| TURALIO CAP | 2 |
| TYENNE INJ | 2 |
| TYVASO DPI POWDER | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG | 2 |
| TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG | 2 |
| TYVASO DPI POWDER TITRATION KIT 16-32-48MCG | 2 |
| TYVASO DPI POWDER TITRATION KIT 16-32MCG | 2 |
| TYVASO INH SOLN 0.6 MG/ML | 2 |
| UBRELVY TAB | 2 |
| UCERIS RECTAL FOAM | 3 |
| UPTRAVI TAB | 2 |
| USTEKINUMAB-AEKN 45MG/0.5ML | 2 |
| USTEKINUMAB-AEKN 90MG/ML | 2 |
| VALCHLOR GEL | 2 |
| VANFLYTA TAB | 2 |
| VANFLYTA TAB 26.5MG | 2 |
| VANRAFIA TAB | 2 |
| VELTASSA POWDER | 2 |
| VELTASSA POWDER 1GM | 2 |
| VENCLEXTA STARTER PACK | 2 |
| VENCLEXTA TAB | 2 |
| VENTAVIS INH SOLN | Non-EHB |
| VEOZAH TAB | 3 |
| VERZENIO TAB | 2 |
| vigabatrin powder pack | 1 |
| vigabatrin tab | 1 |
| vigadrone powder pack | 1 |
| VIJOICE GRANULES PACKET | 3 |
| VIJOICE TAB | 3 |
| VIJOICE TAB 250MG | 3 |
| VITRAKVI CAP 100MG | 2 |
| VITRAKVI CAP 25MG | 2 |
| VITRAKVI SOLN | 2 |
| VIZIMPRO TAB | 2 |
| VOGELXO GEL PUMP 1% | 3 |
| VONJO CAP | 2 |
| VONVENDI INJ | 2 |
| VORANIGO TAB | 2 |
| VORANIGO TAB 10MG | 2 |
| VOSEVI TAB | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|--------------------------|--|
| VOWST CAP | 2 |
| VOXZOGO INJ | 2 |
| VOYDEYA TAB | 2 |
| VOYDEYA TAB THERAPY PACK | 2 |
| VYKAT XR TAB | 2 |
| VYKAT XR TAB 150MG | 2 |
| VYKAT XR TAB 75MG | 2 |
| VYNDAMAX CAP | 2 |
| VYNDAQEL CAP | 2 |
| VYVGART HYTRULO INJ | 2 |
| WAINUA INJ | 2 |
| WAKIX TAB | 2 |
| WELIREG TAB | 2 |
| WILATE INJ | 2 |
| WINREVAIR INJ | 2 |
| XADAGO TAB | 3 |
| XALKORI CAP | 2 |
| XALKORI SPRINKLE CAP | 2 |
| XELJANZ SOLN | 2 |
| XELJANZ TAB | 2 |
| XELJANZ XR TAB | 2 |
| XEMBIFY INJ | 2 |
| XOLAIR INJ | 2 |
| XOLAIR INJ 150MG/ML | 2 |
| XOLAIR INJ 300MG/2ML | 2 |
| XOLAIR SYRINGE | 2 |
| XOLAIR SYRINGE 150MG/ML | 2 |
| XOLAIR SYRINGE 300MG/2ML | 2 |
| XOLREMDI CAP | 2 |
| XOSPATA TAB | 2 |
| XPHOZAH TAB | 3 |
| XPOVIO PAK | 2 |
| XROMI SOLN | 3 |
| XYNTHA INJ | 2 |
| YESINTEK INJ | 2 |
| YESINTEK SYRINGE | 2 |
| YESINTEK SYRINGE 90MG | 2 |
| YEZTUGO INJ | \$0 |
| YEZTUGO TAB | \$0 |
| YORVIPATH INJ | 2 |
| YORVIPATH INJ 294MCG | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

**Navitus Key Traditional Formulary cont.
Prior Authorization Drug List
Last Updated* 2/1/2026**

Some products on the Formulary are only covered with a prior authorization approval. Drug products requiring prior authorization are listed below. The pharmacy will also alert members if the medication prescribed requires prior authorization. Please call Customer Service if you have further questions regarding prior authorizations.

| Drug Name | Tier # for Drug Copay (if prior auth is approved) |
|-------------------------|--|
| YORVIPATH INJ 420MCG | 2 |
| YUTREPIA CAP | 2 |
| ZAVZPRET NASAL SPRAY | 2 |
| ZEJULA TAB | 2 |
| ZELBORAF TAB | 2 |
| ZELSUVMI GEL | 2 |
| ZEPOSIA CAP | 2 |
| ZEPOSIA STARTER PACK | 2 |
| ZILBRYSQ INJ | 2 |
| ZILBRYSQ INJ 23MG | 2 |
| ZILBRYSQ INJ 32.4MG | 2 |
| ZOKINVY CAP | 2 |
| ZOLINZA CAP | 2 |
| ZONISADE SUSP | 3 |
| ZORYVE CREAM | 2 |
| ZORYVE FOAM | 2 |
| ZTALMY SUSP | 2 |
| ZURZUVAE CAP 20MG, 25MG | 2 |
| ZURZUVAE CAP 30MG | 2 |
| ZYDELIG TAB | 2 |
| ZYKADIA TAB | 2 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Last Updated* 2/1/2026
RxCents (Cost Savings Enabled by Tablet Splitting)

Tablet splitting helps control prescription drug benefit costs and can provide significant savings for members. Participation in the program is voluntary. Through this program, members pay up to one-half of their usual copayment on a select group of prescription drugs. Drugs included in this program are based on the following criteria:

- The drug product is on the formulary.
- The drug product is recognized as an appropriate product to split by the Pharmacy & Therapeutics Committee.
- The drug is flat priced (i.e. various strengths of the medication must be comparably priced).
- The medication must have once-daily dosing.

An example of the savings that can be realized through this program is illustrated below:

| | Product & Strength | Quantity | Member Copay | Member Annual Savings |
|--------------------------|--------------------|----------|--------------|-----------------------|
| Without Tablet Splitting | Drug A 40 mg tab | 30 | \$15.00 | |
| With Tablet Splitting | Drug A 80 mg tab | 15 | \$7.50 | \$90 |

As the example illustrates, tablet splitting allows members to receive the same dose in a fewer number of tablets; thus, the overall

RxCents Program Medications

JANUVIA TAB

TRINTELLIX TAB

DRAFT

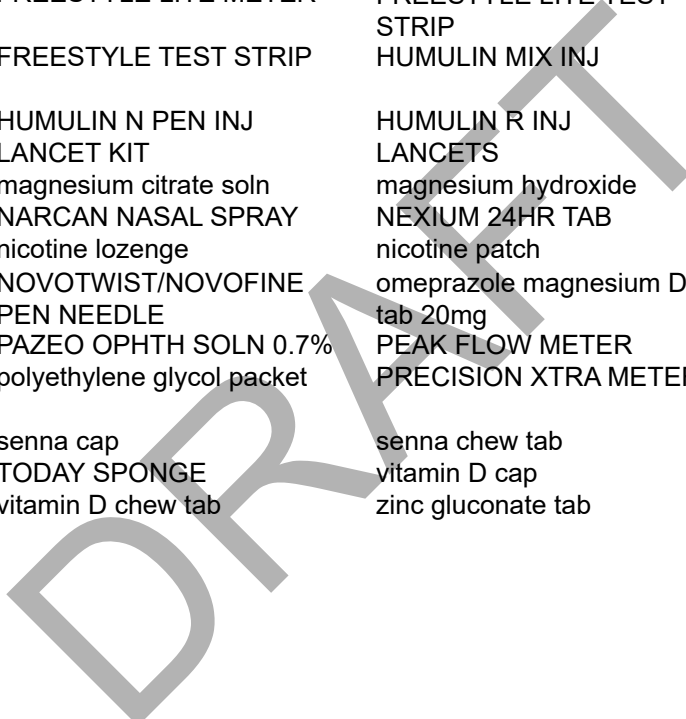
Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Last Updated* 2/1/2026
Over-the-Counter (OTC)

• The following OTC drugs are a covered benefit with a prescription

Over-the-Counter (OTC) Medications

| | | | |
|------------------------------------|-------------------------------|----------------------------------|-------------------------------|
| ACCU-CHEK GUIDE CARE METER | ACCU-CHEK GUIDE ME KIT | ACCU-CHEK GUIDE TEST STRIP | AEROCHAMBER |
| ALCOHOL SWABS | aspirin chew tab 81mg | aspirin ec tab 81mg | B-D INSULIN SYRINGE |
| B-D PEN NEEDLE | BENZOYL PEROXIDE CREAM | bisacodyl supp | bisacodyl tab |
| CALIBRATION LIQUID | CLINISTIX TEST STRIP | CONTRACEPTIVE FOAM | CONTRACEPTIVE GEL |
| CONTRACEPTIVE SUPP | EMBECTA INSULIN SYRINGE | EMBECTA PEN NEEDLE | esomeprazole cap |
| FEMALE CONDOMS | folic acid tab 400mcg | folic acid tab 800mcg | FREESTYLE FREEDOM LITE METER |
| FREESTYLE INSULINX TEST STRIP | FREESTYLE LITE METER | FREESTYLE LITE TEST STRIP | FREESTYLE PRECISION NEO METER |
| FREESTYLE PRECISION NEO TEST STRIP | FREESTYLE TEST STRIP | HUMULIN MIX INJ | HUMULIN MIX PEN INJ |
| HUMULIN N INJ | HUMULIN N PEN INJ | HUMULIN R INJ | KETO-DIASTIX TEST STRIP |
| KETOSTIX | LANCET KIT | LANCETS | lansoprazole cap |
| levonorgestrel tab | magnesium citrate soln | magnesium hydroxide | MALE CONDOMS |
| naloxone hcl nasal spray | NARCAN NASAL SPRAY | NEXIUM 24HR TAB | nicotine gum |
| NICOTINE KIT | nicotine lozenge | nicotine patch | NOVOFINE PEN NEEDLE |
| NOVOTWIST PEN NEEDLE | NOVOTWIST/NOVOFINE PEN NEEDLE | omeprazole magnesium DR tab 20mg | omeprazole tab |
| OPILL TAB | PAZEO OPHTH SOLN 0.7% | PEAK FLOW METER | PLAN B TAB |
| polyethylene glycol 3350 powder | polyethylene glycol packet | PRECISION XTRA METER | PRECISION XTRA TEST STRIP |
| RIVIVE, REXTOVY SPRAY | senna cap | senna chew tab | senna tab |
| sodium phosphates enema | TODAY SPONGE | vitamin D cap | vitamin D cap 1000unit |
| vitamin D cap 400unit | vitamin D chew tab | zinc gluconate tab | |



Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Last Updated* 2/1/2026
Mandatory Specialty Pharmacy (MSP)

- Navitus utilizes a specialty pharmacy, experienced in handling specialty drugs, to coordinate personalized support for members impacted by chronic illnesses and complex diseases.
- Specialty drugs are only available for a one month supply due to their high cost and use.
- The following drugs are required to be filled through a Specialty Pharmacy provider.

Mandatory Specialty Pharmacy (MSP) Medications

| | | | |
|--|--|--|--|
| abiraterone tab 250mg | ACTHAR GEL INJ | ACTIMMUNE INJ | ADALIMUMAB FKJP KIT INJ 20MG/0.4ML |
| ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT | ADALIMUMAB-AATY 40 MG/0.4 ML PEN (1 PEN) KIT | ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT | ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT |
| ADALIMUMAB-AATY 80 MG/0.8 ML PEN (1 PEN) KIT | ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT | ADALIMUMAB-FKJP AUTO-INJECTOR KIT | ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML |
| ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML | ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML | ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEV/ 80MG/0.8ML | ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEV/ 40MG/0.4ML |
| ADBRY INJ | ADEMPAS TAB | ADVATE, KOVALTRY INJ | AFSTYLA KIT |
| ALECENSA CAP | ALFERON-N INJ | ALHEMO INJ | ALKINDI SPRINKLE CAP 0.5MG |
| ALKINDI SPRINKLE CAP 1MG | ALPHANATE, HUMATE-P INJ | ALPHANINE SD INJ | ALPROLIX INJ |
| ALTUVIIIIO INJ | ALUNBRIG TAB 30MG | ALUNBRIG TAB 90MG, 180MG | ALYFTREK TAB |
| ALYFTREK TAB 4-20-50MG | ambrisentan tab | AQNEURSA PACKET FOR SUSPENSION | ARIKAYCE SUSP |
| ATTRUBY PACK | AUGTYRO CAP | AUGTYRO CAP 160MG | AUSTEDO TAB |
| AUSTEDO XR TAB | AUSTEDO XR TAB TITRATION KIT | AUSTEDO XR TITRATION PACK | AVMAPKI FAKZYNJA CO-PACK |
| AVONEX INJ | AYVAKIT TAB | BALVERSA TAB 3MG | BALVERSA TAB 4MG |
| BALVERSA TAB 5MG | BENEFIX INJ | BENLYSTA AUTO-INJECTOI | BENLYSTA INJ |
| BERINERT INJ | BESREMI INJ | BETASERON INJ | bexarotene cap |
| bexarotene gel | BIMZELX INJ | BIMZELX INJ 320MG/2ML | BIMZELX SYRINGE |
| BIMZELX SYRINGE 320MG/2ML | bosentan tab | bosentan tab for oral susp | BOSULIF CAP |
| BOSULIF TAB | BRAFTOVI CAP 75MG | BRUKINSA CAP | BRUKINSA TAB |
| BYLVAY CAP 1200MCG | BYLVAY CAP 400MCG | BYLVAY SPRINKLE CAP 200MCG | BYLVAY SPRINKLE CAP 600MCG |
| CABENUVA IM SUSP | CABENUVA SUSP 600MG-900MG/3ML | CABLIVI INJ KIT | CABOMETYX TAB |
| CALQUENCE TAB | CAMZYOS CAP | capecitabine tab | CAPRELSA TAB |
| CAPRELSA TAB 300MG | carglumic acid tab | CAYSTON INH SOLN | CERDELGA CAP |
| CHOLBAM CAP | CIBINQO TAB | CIMZIA INJ | CIMZIA INJ 200MG/ML |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

| | | | |
|-----------------------------|------------------------------|-------------------------------|--|
| CINRYZE INJ | cladribine tab therapy pack | COAGADEX INJ | COMETRIQ KIT |
| COPIKTRA CAP | CORIFACT KIT | COTELLIC TAB | CRENESSITY CAP |
| CRENESSITY SOLN | CYSTADANE POWDER | CYSTADROPS SOLN | CYSTAGON CAP |
| CYSTARAN OPTH SOLN | dalfampridine ER tab | dasatinib tab | DAYBUE SOLN |
| deferasirox granules packet | deferasirox tab | deferasirox tab for oral susp | deferiprone tab |
| DIACOMIT CAP | DIACOMIT POWDER PACK | dimethyl fumarate DR cap | dimethyl fumarate DR starter pack |
| DOPTELET SPRINKLE CAP | DOPTELET TAB | DUPIXENT INJ | DUPIXENT PEN INJ |
| EBGLYSS INJ | EBGLYSS PEN INJ | ELOCTATE INJ | eltrombopag olamine powder pack for susp |
| eltrombopag olamine tab | eltrombopag olamine tab 50MG | eltrombopag olamine tab 75MG | EMPAVELI INJ |
| ENBREL INJ 25MG | ENBREL INJ 50MG | ENBREL MINI INJ | ENBREL SURECLICK INJ 50MG |
| ENSPRYNG INJ | ENTYVIO SC INJ | EPIDIOLEX SOLN | ERIVEDGE CAP |
| ERLEADA TAB | ERLEADA TAB 240MG | erlotinib tab | erlotinib tab 25mg |
| ESPEROCT INJ | ETOPOSIDE CAP | everolimus tab | everolimus tab for oral susp |
| EVRYSDI SOLN | EVRYSDI TAB | FASENRA PEN INJ | FERRIPROX SOLN |
| FIBRYGA, RIASTAP INJ | FILSPARI TAB | fingolimod hcl cap 0.5mg | FINTEPLA SOLN |
| FIRDAPSE TAB | FOTIVDA CAP | FRUZAQLA CAP 1MG | FRUZAQLA CAP 5MG |
| FULPHILA INJ | FUROSCIX KIT | GALAFOLD CAP | GAVRETO CAP |
| gefitinib tab | GILENYA CAP 0.25MG | GILOTRIF TAB | glatiramer inj |
| GOMEKLI CAP | GOMEKLI CAP 1MG | GOMEKLI TAB FOR ORAL SUSP | HAEGARDA INJ |
| HEMLIBRA INJ | HEMOPIL M, KOATE INJ | HIZENTRA INJ | HYCANTIN CAP |
| HYFTOR GEL | HYQVIA INJ | IBTROZI CAP | icatibant inj |
| ICLUSIG TAB | IDHIFA TAB | imatinib tab | IMBRUVICA CAP 140MG |
| IMBRUVICA CAP 70MG | IMBRUVICA SUSP | IMBRUVICA TAB 420MG | IMCIVREE INJ |
| INCRELEX INJ | INGREZZA CAP | INGREZZA PACK 40-80MG | INGREZZA SPRINKLE CAP |
| INLYTA TAB | INLYTA TAB 1MG | INQOVI TAB | INTRON-A INJ |
| IQIRVO TAB | ISTURISA TAB | IWILFIN TAB | JAKAFI TAB |
| JAYPIRCA TAB | JIVI INJ | JOENJA TAB | KALYDECO PAK |
| KALYDECO TAB | KESIMPTA INJ | KEVZARA INJ | KHINDIVI SOLN |
| KINERET INJ | KISQALI PAK | KISQALI TAB | KOSELUGO CAP |
| KOSELUGO CAP 10MG | KOSELUGO SPRINKLE CAP | KOSELUGO SPRINKLE CAP 5MG | KRAZATI TAB |
| lapatinib ditosylate tab | LEDIPASVIR/SOFOSBUVIR TAB | lenalidomide cap | LENVIMA CAP |
| LEQEMBI IQLK INJ | l-glutamine powder packet | LITFULO CAP | LIVDELZI CAP |
| LIVMARLI SOLN | LIVMARLI SOLN 19MG/ML | LIVMARLI TAB | LIVMARLI TAB 30MG |
| LIVTENCITY TAB | LONSURF TAB | LORBRENA TAB 100MG | LORBRENA TAB 25MG |
| LUMAKRAS TAB | LUMAKRAS TAB 240MG | LUMAKRAS TAB 320MG | LUMRYZ PACK |
| LUMRYZ STARTER PACK | LUPKYNIS CAP | LYNPARZA TAB | LYSODREN TAB |
| LYTGOBI THERAPY PACK | MAVENCLAD THERAPY PAK | MAVYRET PAK | MAVYRET TAB |
| MAYZENT TAB | MAYZENT TAB STARTER PACK | MEKINIST SOLN | MEKINIST TAB 0.5MG |
| MEKINIST TAB 2MG | MEKTOVI TAB | mesna tab | mifepristone tab |
| miglustat cap | MYLERAN TAB | NEMLUVIO INJ | NERLYNX TAB |
| nilotinib hcl cap | nilutamide tab | NINLARO CAP | nitisinone cap |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

| | | | |
|-----------------------------------|--|--|------------------------------------|
| NIVESTYM INJ | NOVOEIGHT INJ | NOVOSEVEN RT INJ | NUBEQA TAB |
| NUCALA INJ | NUWIQ INJ | NUWIQ KIT | NYVEPRIA INJ |
| octreotide inj | OCTREOTIDE INJ 100MCG | ODOMZO CAP | OFEV CAP |
| OGSIVEO TAB | OGSIVEO TAB 50MG | OHTUVAYRE SUSP | OJEMDA SUSP |
| OJEMDA TAB | OJJAARA TAB | OLUMIANT TAB | OPSUMIT TAB |
| ORENCIA CLICK INJ | ORENCIA SC INJ 125MG/MI | ORENCIA SC INJ 50MG/0.4ML | ORENCIA SC INJ 87.5MG/0.7ML |
| ORGOVYX TAB | ORKAMBI GRANULES PACKET | ORKAMBI TAB | ORSERDU TAB |
| ORSERDU TAB 345MG | OTEZLA STARTER PACK | OTEZLA TAB | OTEZLA XR TAB |
| OTEZLA/OTEZLA XR STARTER PACK | OXERVATE OPHTH SOLN | PALFORZIA POWDER PACK | PALFORZIA SPRINKLE CAF |
| PALYNZIQ INJ | pazopanib tab | PEGASYS INJ | PEMAZYRE TAB |
| PHEBURANE ORAL PELLETS | PIQRAY TAB | pirfenidone cap | pirfenidone tab 267mg |
| pirfenidone tab 801mg | PLEGRIDY INJ | PLEGRIDY PEN INJ | POMALYST CAP |
| PREVYMIS PAK | PREVYMIS TAB | PROFILNINE INJ | PULMOZYME INH SOLN |
| pyrimethamine tab | PYRUKYND TAB | PYRUKYND TAPER PACK | QINLOCK TAB |
| RADICAVA ORS STARTER KIT | RADICAVA ORS SUSP | REBIF INJ | RECOMBIMATE INJ |
| RETEVMO CAP | RETEVMO CAP 40MG | RETEVMO TAB | RETEVMO TAB 40MG |
| REVLIMID CAP | REVUFORJ TAB | REVUFORJ TAB 110MG | REVUFORJ TAB 25MG |
| REZDIFFRA TAB | REZLIDHIA CAP | REZUROCK TAB | ribavirin cap |
| RIBAVIRIN TAB | RINVOQ ER TAB | RINVOQ ORAL SOLN | RIVFLOZA INJ |
| RIVFLOZA INJ 160MG | RIVFLOZA VIAL | RIXUBIS INJ | ROMVIMZA CAP |
| ROZLYTREK CAP | ROZLYTREK PAK | RUBRACA TAB | RUCONEST INJ |
| RYDAPT CAP | sapropterin dihydrochloride powder packet | sapropterin dihydrochloride soluble tab | SCSEMBLIX TAB |
| SCSEMBLIX TAB 100 MG | SEVENFACT INJ | SIGNIFOR INJ | SIMPONI AUTO-INJECTOR 100MG |
| SIMPONI INJ 100MG | SKYCLARYS CAP | SKYRIZI INJ 150MG/ML | SKYRIZI INJ 180 MG/1.2ML |
| SKYRIZI INJ 360MG/2.4ML | SODIUM OXYBATE SOLN | SOFOSBUVIR/VELPATASVI R TAB | SOHONOS CAP 1.5MG |
| SOHONOS CAP 10MG | SOHONOS CAP 1MG | SOHONOS CAP 2.5MG | SOHONOS CAP 5MG |
| SOMAVERT INJ | sorafenib tosylate tab | SPEVIGO INJ | STEQEYMA INJ |
| STEQEYMA INJ 90MG | STIVARGA TAB | STRENSIQ INJ | SUBLOCADE SOLN, BRIXADI SOLN |
| sunitinib malate cap | SUNLENCA INJ | SUNLENCA TAB | SUNLENCA TAB 300MG |
| SYMDEKO TAB | TABRECTA TAB | TAFINLAR CAP | TAFINLAR TAB |
| TAGRISSE TAB | TAKHZYRO INJ | TAKHZYRO INJ 150MG/ML | TALTZ INJ |
| TALTZ INJ 20MG/0.25ML | TALTZ INJ 40 MG/0.5ML | TALZENNA CAP 0.25MG | TALZENNA CAP 0.5MG, 0.75MG, 1MG |
| TAVNEOS CAP | TAZVERIK TAB | temozolomide cap | TEPMETKO TAB |
| teriflunomide tab | teriparatide (recombinant) soln pen-inj | tetrabenazine tab | TEZSPIRE INJ |
| THALOMID CAP | TIBSOVO TAB | tiopronin tab | tiopronin tab delayed release |
| TOBI PODHALER | tobramycin neb soln | tolvaptan tab | tolvaptan tab therapy pack |
| TREMFYA INDUCTION INJ 200MG/ML | TREMFYA INJ | TREMFYA INJ 200MG/2ML | tretinoin cap |
| trientine cap | TRIKAFTA TAB | TRIKAFTA THERAPY PACK | TRUQAP TAB |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

| | | | |
|---|---|--|--|
| TRUQAP THERAPY PACK TYENNE INJ | TRYNGOLZA INJ TYMLOS INJ | TUKYSA TAB TYVASO DPI POWDER | TURALIO CAP TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG TYVASO DPI POWDER TITRATION KIT 16-32MCG |
| TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG TYVASO INH SOLN 0.6 MG/ML VALCHLOR GEL VENCLEXTA STARTER PACK vigabatrin powder pack | TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG UPTRAVI TAB VANFLYTA TAB VENCLEXTA TAB vigabatrin tab | TYVASO DPI POWDER TITRATION KIT 16-32-48MC USTEKINUMAB-AEKN 45MG/0.5ML VANFLYTA TAB 26.5MG VENTAVIS INH SOLN vigadrone powder pack | USTEKINUMAB-AEKN 90MG/ML VANRAFIA TAB VERZENIO TAB VIJOICE GRANULES PACKET VITRAKVI CAP 25MG VONJO CAP VOSEVI TAB VOYDEYA TAB THERAPY PACK VYNDAMAX CAP WAKIX TAB XALKORI CAP XELJANZ XR TAB XOLAIR INJ 300MG/2ML XOLREMDI CAP |
| VIJOICE TAB VITRAKVI SOLN VONVENDI INJ VOWST CAP | VIJOICE TAB 250MG VIVITROL INJ VORANIGO TAB VOXZOGO INJ | VITRAKVI CAP 100MG VIZIMPRO TAB VORANIGO TAB 10MG VOYDEYA TAB | VOYDEYA TAB THERAPY PACK VYNDAMAX CAP WAKIX TAB XALKORI CAP XELJANZ XR TAB XOLAIR INJ 300MG/2ML XOLREMDI CAP |
| VYKAT XR TAB VYNDAQEL CAP WELIREG TAB XALKORI SPRINKLE CAP XEMBIFY INJ XOLAIR SYRINGE | VYKAT XR TAB 150MG VYVGART HYTRULO INJ WILATE INJ XELJANZ SOLN XOLAIR INJ XOLAIR SYRINGE 150MG/ML XPHOZAH TAB YESINTEK SYRINGE YORVIPATH INJ ZARXIO INJ ZEPOSIA STARTER PACK ZOKINVY CAP ZURZUVAE CAP 30MG | VYKAT XR TAB 75MG WAINUA INJ WINREVAIR INJ XELJANZ TAB XOLAIR INJ 150MG/ML XOLAIR SYRINGE 300MG/2ML XPOVIO PAK YESINTEK SYRINGE 90MG YORVIPATH INJ 294MCG ZEJULA TAB ZILBRYSQ INJ ZOLINZA CAP ZYDELIG TAB | XYNTHA INJ YEZTUGO INJ YORVIPATH INJ 420MCG ZELBORAF TAB ZILBRYSQ INJ 23MG ZTALMY SUSP ZYKADIA TAB |
| XOSPATA TAB YESINTEK INJ YEZTUGO TAB YUTREPIA CAP ZEPOSIA CAP ZILBRYSQ INJ 32.4MG ZURZUVAE CAP 20MG, 25MG | | | |

DRAFT

Navitus Key Traditional Formulary
Last Updated* 2/1/2026
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

| Drug Name | Step Therapy Requirements |
|---------------------------------|--|
| buprenorphine patch | QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| DEXCOM G6 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G6 SENSOR | QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G6 TRANSMITTER | QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 SENSOR | QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 SENSOR (15-DAY) | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DIFICID SUSP | QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| DIFICID TAB | QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| DISKETS TAB | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| febuxostat tab | Step Therapy requires trial of allopurinol |
| fentanyl patch | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| fidaxomicin tab | QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| fluvoxamine ER cap | Step Therapy requires trial of citalopram, escitalopram, sertraline, fluoxetine, fluvoxamine or paroxetine |
| FREESTYLE LIBRE 2 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 2 SENSOR | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 2-PLUS SENSOR | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3 READER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3 SENSOR | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3-PLUS SENSOR | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE SENSOR (14-DAY) | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| HYDROCODONE BITARTRATE ER CAP | QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Step Therapy (ST)

- The following drugs are covered on the formulary with a Step Therapy.

Step Therapy (ST) Medications

| Drug Name | Step Therapy Requirements |
|--|--|
| hydrocodone bitartrate er tab | QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid I Dependency) |
| LEVALBUTEROL INHALER, XOPENEX HF INHALER | QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA or a albuterol HFA product |
| methadone soln | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| methadone tab | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| METHADOSE CONC | |
| methadose tab | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| morphine sulfate ER tab | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| MS CONTIN TAB | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| NEXLETOL TAB | QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| NEXLIZET TAB | QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| NUCYNTA ER TAB | QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| REPATHA INJ | QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| REPATHA PUSHTRONEX INJ | QL= 1 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| risedronate DR tab | Step Therapy requires trial of alendronate |
| SPIRIVA RESPIMAT INHALER 1.25MCG/ACT | QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL) |
| tadalafil tab 2.5mg, 5mg | QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap |
| tramadol ER tab | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| TRAMADOL HCL ER TAB | Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| TRINTELLIX TAB | QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine |
| XTAMPZA ER CAP | QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Smoking Cessation Agents
Last Updated* 2/1/2026

| Drug Name | Tier # for Drug Copay |
|---|------------------------------|
| bupropion SR tab(Limited to 180 days/plan year) | \$0 |
| CHANTIX STARTER PACK | NC |
| nicotine gum(Limited to 180 days/plan year) | \$0 |
| NICOTINE KIT | \$0 |
| nicotine lozenge(Limited to 180 days/plan year) | \$0 |
| nicotine patch(Limited to 180 days/plan year) | \$0 |
| NICOTROL INHALER(Limited to 180 days/plan year) | \$0 |
| NICOTROL NASAL SPRAY(Limited to 180 days/plan year) | \$0 |
| VARENICLINE TAB(Limited to 180 days/plan year) | \$0 |
| varenicline tartrate tab(Limited to 180 days/plan year) | \$0 |
| varenicline tartrate tab starter pack(Limited to 180 days/plan year) | \$0 |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Infertility Drug List
Last Updated* 2/1/2026

| Drug Name | Tier # for Drug Copay |
|-------------------------------|------------------------------|
| cetorelix acetate for inj kit | EXC |
| CETROTIDE KIT | EXC |
| clomiphene citrate tab | EXC |
| CLOMIPHENE TAB | EXC |
| FOLLISTIM AQ INJ | EXC |
| ganirelix ac inj | EXC |
| GONAL-F RFF INJ | EXC |
| GONAL-F RFF INJ, GONAL-F INJ | EXC |
| leuprolide inj | EXC |
| MENOPUR INJ | EXC |
| OVIDREL INJ | EXC |
| PREGNYL INJ, NOVAREL INJ | EXC |

DRAFT

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---|---|
| abiraterone tab 250mg | QL= 4 tabs/day |
| ABRYSVO INJ | QL= 1 dose/lifetime |
| ACTHAR GEL INJ | QL= 4 vials/fill; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| ADALIMUMAB FKJP KIT INJ 20MG/0.4ML | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 20 MG/0.2 ML PFS (2 SYRINGE) KIT | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 40 MG/0.4 ML PEN (2 PEN) KIT | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 40 MG/0.4 ML PFS (2 SYRINGE) KIT | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 80 MG/0.8 ML PEN (2 PEN) KIT | QL= 2 inj/28 days |
| ADALIMUMAB-AATY 80MG/0.8ML PEN (3 PEN) KIT | QL= 1 kit/fill; 1 fill/plan year |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT | QL= 2 inj/28 days |
| ADALIMUMAB-FKJP AUTO-INJECTOR KIT 40MG/0.8ML | QL= 2 inj/28 days |
| ADALIMUMAB-FKJP PFS KIT 20 MG/0.4ML | QL= 2 inj/28 days |
| ADALIMUMAB-FKJP PFS KIT 40 MG/0.8ML | QL= 2 inj/28 days |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 80MG/0.8ML | QL= 2 inj/28 days; Only available through Lumicera 855-847-3553 |
| ADALIMUMAB-RYVK AUTO-INJECTOR KIT (TEVA) 40MG/0.4ML | QL= 2 inj/28 days; Only available through Lumicera 855-847-3553 |
| ADBRY INJ | QL= 4 inj/28 days |
| ADEMPAS TAB | QL= 3 tabs/day; Only available through Accredo 800-803-2523 |
| AFLURIA INJ, FLUZONE INJ | QL= 1 inj/28 days |
| AIMOVIJ INJ | QL= 1 pack/28 days |
| AJOVY INJ | QL= 1 pack/28 days |
| AKYNZEO CAP | QL= 1 cap/fill; Restricted to Oncology or Hematology Specialist |
| albuterol HFA inhaler | QL= 2 inhalers/30 days |
| ALECENSA CAP | QL= 8 caps/day |
| ALKINDI SPRINKLE CAP 0.5MG | QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older |
| ALKINDI SPRINKLE CAP 1MG | QL= 3 caps/day; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older |
| ALUNBRIG TAB 30MG | QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--------------------------------|--|
| ALUNBRIG TAB 90MG, 180MG | QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| ALYFTREK TAB | QL= 2 tabs/day; Only available through Walgreens 888-347-3416 |
| ALYFTREK TAB 4-20-50MG | QL= 3 tabs/day; Only available through Walgreens 888-347-3416 |
| ambrisentan tab | QL= 1 tab/day; Only available through Lumicera 855-847-3553 |
| AMITIZA CAP | QL= 2 caps/day |
| ANNOVERA RING | QL= 1 ring/year |
| ANZEMET TAB | QL= 9 tabs/fill |
| aprepitant cap | QL= 3 caps/fill |
| aprepitant pak | QL= 3 caps/fill |
| APRETUDE SUSP | QL= 7 inj/year |
| AQNEURSA PACKET FOR SUSPENSION | QL= 4 packets/day; Only available through CurantHealth 866-437-8040 |
| ARBLI SUSP | QL= 330mL/30 days; Prior Authorization required for members age 9 years and older |
| AREXVY INJ | QL= 1 dose/lifetime |
| ARIKAYCE SUSP | QL= 1 vial/day; Only available through Maxor Pharmacy 800-658-6046 |
| armodafinil tab | QL= 1 tab/day |
| asenapine maleate SL tab | QL= 2 tabs/day |
| ATTRUBY PACK | QL= 4 tabs/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-84 |
| AUGTYRO CAP | QL= 8 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| AUGTYRO CAP 160MG | QL= 2 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| AUSTEDO TAB | QL= 4 tabs/day |
| AUSTEDO XR TAB | QL= 1 tab/day |
| AUSTEDO XR TAB TITRATION KIT | QL= 1 pack/28 days |
| AUSTEDO XR TITRATION PACK | QL= 1 pack/28 days |
| AVMAPKI FAKZYNJA CO-PACK | QL= 1 pack/28 days; Only available through Biologics 800-850-4306 |
| AYVAKIT TAB | QL= 1 tab/day; Only available through Biologics 800-850-4306 |
| BALVERSA TAB 3MG | QL= 3 tabs/day; Only available through CVS Specialty 800-237-2767 |
| BALVERSA TAB 4MG | QL= 2 tabs/day; Only available through CVS Specialty 800-237-2767 |
| BALVERSA TAB 5MG | QL= 1 tab/day; Only available through CVS Specialty 800-237-2767 |
| BAQSIMI NASAL POWDER | QL= 2 inhalations/fill |
| BAXDELA TAB | QL= 2 tabs/day; Restricted to Infectious Disease Specialist |
| BENLYSTA AUTO-INJECTOR | QL= 4 inj/28 day |
| BENLYSTA INJ | QL= 4 inj/28 day |
| BESREMI INJ | QL= 2 inj/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| bexarotene cap | QL= 10 caps/day |
| bexarotene gel | QL= 60 grams/30 days |
| bimatoprost ophth soln | QL= 2.5ml/30 days |
| BIMZELX INJ | QL= 1 mL/28 days |
| BIMZELX INJ 320MG/2ML | QL= 2 mL/56 days |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------------------|--|
| BIMZELX SYRINGE | QL= 1 mL/28 days |
| BIMZELX SYRINGE 320MG/2ML | QL= 2 mL/56 days |
| bosentan tab | QL= 2 tabs/day; Only available through Lumicera 855-847-3553 |
| bosentan tab for oral susp | QL= 4 tabs/day; Only available through Accredo 800-803-2523 |
| BRAFTOVI CAP 75MG | QL= 6 caps/day; Only available through Diplomat Pharmacy 877-977-9118 |
| BRUKINSA CAP | QL= 4 caps/day; Only available through Lumicera 855-847-3553 |
| BRUKINSA TAB | QL= 2 tabs/day; Only available through Lumicera 855-847-3553 |
| budesonide ER tab | QL=1 tab/day |
| buprenorphine patch | QL= 4 patches/28 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| bupropion SR tab | Limited to 180 days/plan year |
| butorphanol nasal spray | QL= 1 bottle/fill, 2 fills/30 days |
| BYLVAY CAP 1200MCG | QL= 5 caps/day; Only available through PantheRx Pharmacy 855-726-8479 |
| BYLVAY CAP 400MCG | QL= 15 caps/day; Only available through PantheRx Pharmacy 855-726-8479 |
| BYLVAY SPRINKLE CAP 200MCG | QL= 8 caps/day; Only available through PantheRx Pharmacy 855-726-8479 |
| BYLVAY SPRINKLE CAP 600MCG | QL= 4 caps/day; Only available through PantheRx Pharmacy 855-726-8479 |
| CABENUVA IM SUSP | QL= 1 kit/30 days |
| CABENUVA SUSP 600MG-900MG/3ML | QL= 1 kit/30 days |
| CABLIVI INJ KIT | QL= 1 vial/day; Only available through Biologics 800-850-4306 |
| CABOMETYX TAB | QL= 1 tab/day |
| CALQUENCE TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| CAMZYOS CAP | QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| CAPRELSA TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 |
| CAPRELSA TAB 300MG | QL= 1 tab/day; Only available through Biologics 800-850-4306 |
| CERDELGA CAP | QL= 2 caps/day |
| CIBINQO TAB | QL= 1 tab/day |
| CIMZIA INJ | QL= 2 inj/28 days |
| CIMZIA INJ 200MG/ML | QL= 2 inj/28 days |
| CINRYZE INJ | QL= 16 vials/28 days; Only available through Accredo 800-803-2523 |
| CLEOCIN VAGINAL SUPP | QL= 3 suppositories/fill |
| clindamycin vaginal cream | QL=1 tube/fill |
| CLINDESSE VAGINAL CREAM | QL= 1 applicator/fill |
| COMIRNATY INJ | QL= 1 dose/17 days |
| COMIRNATY INJ 30MCG/0.3ML | QL= 1 dose/17 days |
| COPIKTRA CAP | QL= 2 caps/day; Only available through Diplomat Pharmacy 877-977-9118 |
| COTELLIC TAB | QL= 3 tabs/day |
| COVID-19 VACCINE INJ 5-11Y (PFIZER) | QL= 1 dose/17 days |
| COVID-19 VACCINE INJ 6M-11Y (MODERNA) | QL= 1 dose/24 days |
| COVID-19 VACCINE INJ 6M-4Y (PFIZER) | QL= 1 dose/17 days |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---|---|
| CRENESSITY CAP | QL= 2 caps/day; Only available through PantheRx 855-726-8479 |
| CRENESSITY SOLN | QL= 2ml/day; Only available through PantheRx 855-726-8479 |
| cyclosporine ophth emulsion | QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist |
| CYSTADROPS SOLN | QL= 4 bottles/28 days; Restricted to Ophthalmology Specialist; Only available through Anovo Specialty Pharmacy 844-288-5007 |
| CYSTARAN OPHTH SOLN | QL= 4 bottles/28 days; Restricted to Ophthalmology or Optometry Specialist; Only available through Walgreens 888-347-3416 |
| dalfampridine ER tab | QL= 2 tabs/day; Restricted to Neurology Specialist |
| DAYBUE SOLN | QL= 8 bottles/30 days; Only available through AnovoRx 844-288-5007 |
| DAYVIGO TAB | QL= 1 tab/day |
| DEPO-PROVERA INJ | |
| DEPO-PROVERA SC INJ 104MG | QL= 1 inj/90 days |
| DEXCOM G6 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G6 SENSOR | QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G6 TRANSMITTER | QL= 1 transmitter/90 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 SENSOR | QL= 3 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DEXCOM G7 SENSOR (15-DAY) | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| DIASTAT ACDL GEL | QL= 4 doses/fill |
| DIASTAT RECTAL GEL, DIAZEPAM RECTAL GEL | QL= 4 doses/fill |
| DIAZEPAM GEL | QL= 4 doses/fill |
| diazepam rectal gel | QL= 4 doses/fill |
| diclofenac gel | QL= 300gm/30 days |
| diclofenac gel 1% | QL= 5 tubes/fill; Rx Only |
| diclofenac soln 1.5% | QL= 3 bottles/fill |
| DIFICID SUSP | QL= 136 mL/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| DIFICID TAB | QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| donepezil ODT | QL= 1 tab/day |
| donepezil tab | QL= 2 tabs/day |
| donepezil tab 23mg | QL= 1 tab/day |
| DOPTELET SPRINKLE CAP | QL= 2 caps/day; Only available through Accredo 800-803-2523 |
| DOPTELET TAB | QL= 2 tabs/day; Only available through Accredo 800-803-2523 |
| DUPIXENT INJ | QL= 2 inj/28 days |
| DUPIXENT PEN INJ | QL= 2 inj/28 days |
| EBGLYSS INJ | QL= 1 inj/28 days |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--|---|
| EBGLYSS PEN INJ | QL= 1 inj/28 days |
| eletriptan tab | QL= 9 tabs/fill, 2 fills/30 days |
| eltrombopag olamine powder pack for susp | QL= 1 packet/day |
| eltrombopag olamine tab | QL= 1 tab/day |
| eltrombopag olamine tab 50MG | QL= 2 tabs/day |
| eltrombopag olamine tab 75MG | QL= 2 tabs/day |
| EMGALITY INJ | QL= 1 inj/28 days |
| EMGALITY INJ 100MG/ML | QL= 3 inj/fill, 6 fills/year |
| EMPAVELI INJ | QL= 160ml/28 days; Only available through PantheRx 855-726-8479 |
| ENBREL INJ 25MG | QL= 8 inj/28 days |
| ENBREL INJ 50MG | QL= 4 inj/28 days |
| ENBREL MINI INJ | QL= 4 inj/28 days |
| ENBREL SURECLICK INJ 50MG | QL= 4 inj/28 days |
| ENSPRYNG INJ | QL= 1 inj/28 days |
| entecavir tab | QL= 1 tab/day |
| ENTYVIO SC INJ | QL= 2 inj/28 days |
| epinephrine pen inj 0.15mg, 0.3mg | QL= 2 inj/fill |
| ERIVEDGE CAP | QL= 1 cap/day |
| ERLEADA TAB | QL= 4 tabs/day |
| ERLEADA TAB 240MG | QL= 1 tab/day |
| erlotinib tab | QL= 1 tab/day |
| erlotinib tab 25mg | QL= 3 tabs/day |
| estradiol vaginal tab, yuvafem vaginal tab | QL= 8 tabs/28 days, 18 tabs on first fill |
| estradiol valerate inj | QL= 5ml/fill |
| eszopiclone tab | QL= 1 tab/day |
| everolimus tab | QL= 1 tab/day |
| everolimus tab for oral susp | QL= 1 tab/day |
| EVRYSDI SOLN | QL= 6.67ml/day; Only available through Accredo 800-803-2523 |
| EVRYSDI TAB | QL= 1 tab/day; Only available through Accredo 800-803-2523 |
| ezetimibe/simvastatin tab | QL= 1 tab/day (10-80mg is Not Covered) |
| FARXIGA TAB | QL= 1 tab/day |
| FASENRA PEN INJ | QL= 1 inj/56 days |
| FEMALE CONDOMS | QL= 12 condoms/fill |
| fidaxomicin tab | QL= 20 tabs/fill; Step therapy requires trial of vancomycin cap or Firvanq solution |
| FILSPARI TAB | QL= 1 tab/day; Only available through Optum Frontier 855-768-9727 or Caremark/CV Specialty 800-378-0695 |
| FINTEPLA SOLN | QL= 12ml/day; Only available through Anovo Specialty Pharmacy 844-288-5007 |
| FLUAD INJ | QL= 1 inj/28 days |
| FLUBLOK INJ | QL= 1 inj/28 days |
| FLUCELVAX INJ | QL= 1 inj/28 days |
| FLULAVAL INJ, FLUARIX INJ | QL= 1 inj/28 days |
| FLUMIST NASAL | QL= 1 dose/28 days |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------------|--|
| flunisolide nasal soln | QL= 2 bottles/fill |
| fluticasone nasal spray | QL= 2 bottles/fill; Rx Only |
| FLUZONE HIGH DOSE PF INJ | QL= 1 inj/28 days |
| FOTIVDA CAP | QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| FREESTYLE LIBRE 2 RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 2 SENSOR | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 2-PLUS SENSOR | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3 READER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3 SENSOR | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE 3-PLUS SENSOR | QL= 2 sensors/30 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE RECEIVER | QL= 1 receiver/year; Prior authorization (exception) required if member is not currently utilizing insulin |
| FREESTYLE LIBRE SENSOR (14-DAY) | QL= 2 sensors/28 days; Prior authorization (exception) required if member is not currently utilizing insulin |
| FRUZAQLA CAP 1MG | QL= 84 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| FRUZAQLA CAP 5MG | QL= 21 caps/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| FUROSCIX KIT | QL= 8 inj/fill; Only available through Onco360 or CareMed 877-662-6633 |
| gabapentin cap | QL= 9 caps/day |
| gabapentin soln | QL= 72 mls/day |
| gabapentin tab 600mg | QL= 6 tabs/day |
| gabapentin tab 800mg | QL= 4.5 tabs/day |
| GALAFOLD CAP | QL= 14 caps/28 days; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| GAVILYTE-C SOLN | \$0 copay for members age 45-75 years; all other members covered at preferred branch copay; Limited to 2 fills/calendar year |
| GAVRETO CAP | QL= 4 caps/day; Only available through Lumicera 855-847-3553 |
| gefitinib tab | QL= 1 tab/day; Only available through Lumicera 855-847-3553 |
| GILOTRIF TAB | QL= 1 tab/day; Only available through Accredo 800-803-2523 |
| glucagon (rdna) for inj kit | QL= 2 inj/fill |
| GLUCAGON EMR INJ | QL= 2 inj/fill |
| GLUCAGON INJ KIT | QL= 2 inj/fill |
| GLYXAMBI TAB | QL= 1 tab/day |
| GOLYTELY SOLN | Limited to 2 fills/calendar year |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--------------------------------------|---|
| GOMEKLI CAP | QL= 84 caps/28 days; Only available through Biologics 800-850-4306 |
| GOMEKLI CAP 1MG | QL= 168 caps/28 days; Only available through Biologics 800-850-4306 |
| GOMEKLI TAB FOR ORAL SUSP | QL= 168 tabs/28 days; Only available through Biologics 800-850-4306 |
| granisetron tab | QL= 14 tabs/fill |
| GVOKE INJ | QL= 2 inj/fill |
| GVOKE INJ KIT | QL= 2 inj/fill |
| GVOKE PFS INJ | QL= 2 inj/fill |
| HYD POL/CPM SUSP | QL= 120ml/fill; 2 fills/30 days |
| HYDROCODONE BITARTRATE ER CAP | QL= 2 caps/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| HYDROCODONE BITARTRATE ER TAB | QL= 1 tab/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| hydrocodone/chlorpheniramine CR susp | QL= 120ml/fill; 2 fills/30 days |
| hydrocortisone succinate inj 100mg | QL= 2 vials/fill |
| HYFTOR GEL | QL= 10 grams/30 days; Only available through Walgreens 888-347-3416 |
| ibandronate tab 150mg | QL= 1 tab/30 days |
| IBTROZI CAP | QL= 3 caps/day; Only available through Biologics 800-850-4306 |
| ICLUSIG TAB | QL= 1 tab/day; Only available through AcariaHealth 800-511-5144 |
| icosapent ethyl cap | QL= 4 caps/day |
| IDHIFA TAB | QL= 1 tab/day |
| IMBRUVICA CAP 140MG | QL= 3 caps/day; Only available through Diplomat Pharmacy 877-977-9118 |
| IMBRUVICA CAP 70MG | QL= 1 cap/day; Only available through Diplomat Pharmacy 877-977-9118 |
| IMBRUVICA SUSP | QL= 6ml/day; Only available through Diplomat Pharmacy 877-977-9118 |
| IMBRUVICA TAB 420MG | QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118 |
| IMCIVREE INJ | QL= 1 inj/day; Only available through PantherRx Pharmacy 855-726-8479 |
| IMITREX INJ | QL= 4 inj/fill, 2 fills/30 days |
| IMITREX INJ 4MG/0.5ML | QL= 4 inj/fill, 2 fills/30 days |
| INBRIJA INH POWDER | QL= 10 caps/day |
| INGREZZA CAP | QL= 1 cap/day; Only available through PantherRx Pharmacy 855-726-8479 |
| INGREZZA PACK 40-80MG | QL= 1 pack/28 days; Only available through PantheRx Pharmacy 855-726-8479 |
| INGREZZA SPRINKLE CAP | QL= 1 cap/day; Only available through PantheRx 855-726-8479 |
| INLYTA TAB | QL=4 tabs/day |
| INLYTA TAB 1MG | QL= 8 tabs/day |
| INQOVI TAB | QL= 5 tabs/28 days |
| IQIRVO TAB | QL= 1 tab/day; Only available through Caremark/CVS Specialty 800-378-0695 or Walgreens 888-347-3416 |
| ISTURISA TAB | QL= 12 tabs/day; Only available through Anovo Specialty Pharmacy 844-288-5007 |
| IWILFIN TAB | QL= 8 tabs/day; Only available through CurantHealth 866-437-8040 |
| JAKAFI TAB | QL= 2 tabs/day |
| JANUMET TAB | QL= 2 tabs/day |
| JANUMET XR TAB | QL= 2 tabs/day |
| JANUVIA TAB | QL= 1 tab/day |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--|---|
| JARDIANCE TAB | QL= 1 tab/day |
| JAYPIRCA TAB | QL= 2 tabs/day |
| JENTADUETO TAB | QL= 2 tabs/day |
| JENTADUETO XR TAB | QL= 2 tabs/day |
| JOENJA TAB | QL= 2 tabs/day; Only available through PantherRx Pharmacy 855-726-8479 |
| KALYDECO PAK | QL= 2 packets/day; Only available through Walgreens 888-347-3416 |
| KALYDECO TAB | QL= 2 tabs/day; Only available through Walgreens 888-347-3416 |
| KERENDIA TAB | QL= 1 tab/day |
| ketorolac inj 15mg/ml | QL= 20ml/5 days |
| ketorolac inj 30mg/ml | QL= 20ml/5 days |
| ketorolac inj 60mg/2ml | QL= 20ml/5 days |
| ketorolac tab | QL= 20 tabs/5 days |
| KEVZARA INJ | QL= 2 inj/28 days |
| KHINDIVI SOLN | QL= 90ml/30 days; Only available through AnovoRx 844-288-5007; Prior Authorization required for members age 9 years and older |
| KINERET INJ | QL= 1 inj/day; Only available through Biologics 800-850-4306 |
| KISQALI PAK | QL= 91 tabs/28 days; Only available through CVS Specialty 800-238-7828 |
| KISQALI TAB | QL= 63 tabs/28 days; Only available through CVS Specialty 800-238-7828 |
| KOSELUGO CAP | QL= 4 caps/day; Only available through Onco360 877-662-6633 |
| KOSELUGO CAP 10MG | QL= 8 caps/day; Only available through Onco360 877-662-6633 |
| KOSELUGO SPRINKLE CAP | QL= 12 caps/day; Only available through Onco360 877-662-6633 |
| KOSELUGO SPRINKLE CAP 5MG | QL= 20 caps/day; Only available through Onco360 877-662-6633 |
| KRAZATI TAB | QL= 6 tabs/day; Only available through Biologics 800-850-4306 |
| LAGEVRIO CAP (EUA) | QL= 40 caps/fill |
| LAGEVRIO CAP 200MG | QL= 40 caps/fill |
| latanoprost ophth soln | QL= 2.5ml/30 days |
| LEDIPASVIR/SOFOSBUVIR TAB | QL= 1 tab/day |
| lenalidomide cap | QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416 |
| LENVIMA CAP | QL= 3 caps/day; Only available through Optum 877-445-6874 |
| LEQEMBI IQLK INJ | QL= 4 inj/28 days; Only available through Walgreens 888-347-3416 |
| LEVALBUTEROL INHALER, XOPENEX HF INHALER | QL= 2 inhalers/fill, 2 fills/30 days; Step Therapy requires trial of VENTOLIN HFA or an albuterol HFA product |
| l-glutamine powder packet | QL= 6 packets/day |
| LIDOCAINE OINT | QL= 107gm/30 days |
| lidocaine patch | QL= 3 patches/day |
| lidocaine patch 5% | QL= 3 patches/day |
| LINZESS CAP | QL= 1 cap/day |
| liraglutide soln pen-injector | QL= 9ml/30 days; Diagnosis Restricted – Type 2 Diabetes (E11) |
| LITFULO CAP | QL= 1 cap/day; Only available through Caremark/CVS Specialty 800-378-0695 |
| LIVDELZI CAP | QL= 1 cap/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-84 |
| LIVMARLI SOLN | QL= 90ml/30 days; Only available through Eversana 866-849-4481 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------|---|
| LIVMARLI SOLN 19MG/ML | QL= 60mL/30 days; Only available through Eversana 866-849-4481 |
| LIVMARLI TAB | QL= 2 tabs/day; Only available through Eversana 866-849-4481 |
| LIVMARLI TAB 30MG | QL= 1 tab/day; Only available through Eversana 866-849-4481 |
| LIVTENCITY TAB | QL= 4 tabs/day; Only available through Biologics 800-850-4306 |
| lofexidine hcl tab | QL= 96 tabs/7 days |
| LOKELMA PAK | QL= 1 packet/day |
| LOPRESSOR SOLN | QL= 45ml/day; Prior Authorization required for members age 9 years and older |
| LORBRENA TAB 100MG | QL= 1 tab/day |
| LORBRENA TAB 25MG | QL= 3 tabs/day |
| lubiprostone cap | QL= 2 caps/day |
| LUCEMYRA TAB | QL= 96 tabs/7 days |
| LUMAKRAS TAB | QL= 8 tabs/day; Only available through Biologics 800-850-4306 |
| LUMAKRAS TAB 240MG | QL= 4 tabs/day; Only available through Biologics 800-850-4306 |
| LUMAKRAS TAB 320MG | QL= 3 tabs/day; Only available through Biologics 800-850-4306 |
| LUMIGAN OPHTH SOLN | QL= 2.5ml/30 days |
| LUMRYZ PACK | QL= 1 pack/day; Only available through Accredo 800-803-2523 |
| LUMRYZ STARTER PACK | QL= 1 packet/day; Only available through Accredo 800-803-2523 |
| LUPKYNIS CAP | QL= 6 caps/day; Only available through Biologics 800-850-4306 or PantheRx Pharmacy 855-726-8479 |
| LYNPARZA TAB | QL= 4 tabs/day; Only available through Biologics 800-850-4306 |
| LYTGOBI THERAPY PACK | QL= 5 tabs/day; Only available through Onco360 877-662-6633 |
| malathion lotion | QL= 2 bottles/fill |
| MALE CONDOMS | QL= 12 condoms/fill |
| MAVYRET PAK | QL= 5 packs/day |
| MAVYRET TAB | QL= 3 tabs/day |
| medroxyprogesterone inj | QL= 1 inj/90 days |
| MEKINIST TAB 0.5MG | QL= 3 tabs/day |
| MEKINIST TAB 2MG | QL= 1 tab/day |
| MEKTOVI TAB | QL= 6 tabs/day |
| methylergonovine tab | QL= 28 tabs/fill, 1 fill/365 days |
| MIEBO OPHTH SOLN | QL= 1 bottle/30 days; Restricted to Ophthalmology or Optometry Specialist |
| mifepristone tab | QL= 4 tabs/day |
| miglustat cap | QL= 3 caps/day; Only available through Accredo 800-803-2523 |
| MNEXSPIKE INJ 10MCG/0.2ML | QL= 1 dose/24 days |
| modafinil tab | QL= 2 tabs/day |
| mometasone nasal spray | QL= 2 bottles/fill |
| MOTEGRITY TAB | QL= 1 tab/day |
| MOUNJARO INJ | QL= 4 inj/28 days; Diagnosis Restricted – Type 2 Diabetes (E11) |
| MOVANTIK TAB | QL= 1 tab/day |
| MRESVIA INJ | QL= 1 dose/lifetime |
| MYFEMBREE TAB | QL= 1 tab/day |
| NALOXONE PREFILLED INJ | QL= 2 inj/fill |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|------------------------------|--|
| naratriptan tab | QL= 9 tabs/fill, 2 fills/30 days |
| NATACYN OPHTH SUSP | QL= 15ml/fill |
| NATROBA SUSP | QL= 1 bottle/fill |
| NATROBA SUSP 0.90% | QL= 1 bottle/fill |
| NAYZILAM SPRAY | QL= 4 doses/fill |
| NEFFY SPRAY | QL= 2 doses/fill |
| NEMLUVIO INJ | QL= 1 inj/56 days |
| NERLYNX TAB | QL= 6 tabs/day; Only available through Diplomat Pharmacy 877-977-9118 |
| NEXLETOL TAB | QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| NEXLIZET TAB | QL= 1 tab/day; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| nicotine gum | Limited to 180 days/plan year |
| NICOTINE KIT | Limited to 180 days/plan year |
| nicotine lozenge | Limited to 180 days/plan year |
| nicotine patch | Limited to 180 days/plan year |
| NICOTROL INHALER | Limited to 180 days/plan year |
| NICOTROL NASAL SPRAY | Limited to 180 days/plan year |
| nitazoxanide tab | QL= 6 tabs/3 days |
| NOVAVAX INJ | QL= 1 dose/24 days |
| NUBEQA TAB | QL= 4 tabs/day |
| NUCALA INJ | QL= 1 inj/28 days |
| NUCYNTA ER TAB | QL= 2 tabs/day; Step Therapy requires step through IR opioid if opioid naïve (Opioid Dependency) |
| NUDEXTA CAP | QL= 2 caps/day |
| NUVIGIL TAB | QL= 1 tab/day |
| ODOMZO CAP | QL= 1 cap/day |
| OFEV CAP | QL= 2 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| OGSIVEO TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| OGSIVEO TAB 50MG | QL= 6 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| OHTUVAYRE SUSP | QL= 60 ampules/30 days; Only available through CVS Specialty 800-238-7828 or AcariaHealth 800-511-5144 |
| OJEMDA SUSP | QL= 96ml/28 days; Only available through Onco360 877-662-6633 |
| OJEMDA TAB | QL= 24 tabs/28 days; Only available through Onco360 877-662-6633 |
| OJJAARA TAB | QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| olopatadine ophth soln 0.2% | QL= 2.5ml/30 days; Rx Only |
| OLUMIANT TAB | QL= 1 tab/day |
| OMNIPOD 5 DEX G7G6 INTRO KIT | QL= 1 kit/year |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|------------------------------------|--|
| OMNIPOD 5 DEX G7G6 PODS | QL= 10 pods/month |
| OMNIPOD 5 G7 KIT INTRO | QL= 1 kit/year |
| OMNIPOD 5 G7 MIS PODS | QL= 10 pods/30 days |
| OMNIPOD 5 LIBRE2 PLUS G6 INTRO KIT | QL= 1 kit/year |
| OMNIPOD 5 LIBRE2 PLUS G6 PODS | QL= 10 pods/30 days |
| OMNIPOD 5 PACK PODS | QL= 10 pods/month |
| OMNIPOD DASH INTRO KIT | QL= 1 kit/year |
| OMNIPOD DASH PODS | QL= 10 pods/month |
| OMNIPOD GO KIT | QL= 10 pods/month |
| OMNIPOD STARTER KIT | QL= 1 kit/year |
| ONGENTYS CAP | QL= 1 tab/day, 30 tabs per fill |
| OPSUMIT TAB | QL= 1 tab/day; Only available through Accredo 800-803-2523 |
| OPZELURA CREAM | QL= 12 tubes/year |
| ORENCIA CLICK INJ | QL= 4 inj/28 days |
| ORENCIA SC INJ 125MG/ML | QL= 4 inj/28 days |
| ORENCIA SC INJ 50MG/0.4ML | QL= 4 inj/28 days |
| ORENCIA SC INJ 87.5MG/0.7ML | QL= 4 inj/28 days |
| ORGOVYX TAB | QL= 30 tabs/28 days; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| ORIAHNN CAP | QL= 2 caps/day |
| ORILISSA TAB 150MG | QL= 1 tab/day |
| ORILISSA TAB 200MG | QL= 2 tabs/day |
| ORKAMBI GRANULES PACKET | QL= 2 packets/day; Only available through Walgreens 888-347-3416 |
| ORKAMBI TAB | QL= 4 tabs/day; Only available through Walgreens 888-347-3416 |
| ORSERDU TAB | QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| ORSERDU TAB 345MG | QL= 1 tab/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| oseltamivir cap | QL= 10 caps/fill |
| oseltamivir cap 30mg | QL= 20 caps/fill |
| oseltamivir susp | QL= 250ml/fill |
| OTEZLA STARTER PACK | QL= 1 pack/28 days |
| OTEZLA TAB | QL= 2 tabs/day |
| OTEZLA XR TAB | QL= 1 tab/day |
| OTEZLA/OTEZLA XR STARTER PACK | QL= 1 pack/28 days |
| OXERVATE OPHTH SOLN | QL= 8 kits/affected eye/lifetime; Only available through Accredo 800-803-2523 |
| OZEMPIC INJ | QL= 1 pack/28 days; Diagnosis Restricted – Type 2 Diabetes (E11) |
| PALYNZIQ INJ | QL= 1 inj/day; Only available through Accredo 800-803-2523 |
| PAXLOVID PAK | QL= 11 tabs/90 days |
| PAXLOVID TAB 150-100MG | QL= 20 tabs/90 days |
| PAXLOVID TAB 300-100MG | QL= 30 tabs/90 days |
| pazopanib tab | QL= 4 tabs/day |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---|--|
| peg 3350 soln (100 gram Moviprep equiv) | \$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year |
| peg 3350/electrolytes soln | \$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year |
| PEMAZYRE TAB | QL= 1 tab/day; Only available through Biologics 800-850-4306 |
| PHEXXI GEL | QL= 1 box/fill |
| pirfenidone cap | QL= 9 caps/day |
| pirfenidone tab 267mg | QL= 9 tabs/day |
| pirfenidone tab 801mg | QL= 3 tabs/day |
| POMALYST CAP | QL= 21 caps/28 days |
| pregabalin cap | QL= 3 caps/day |
| pregabalin cap 225mg | QL= 2 caps/day |
| pregabalin cap 300mg | QL= 2 caps/day |
| pregabalin soln | QL= 30ml/day |
| PRETOMANID TAB | QL= 1 tab/day; Restricted to Infectious Disease Specialist |
| PREVYMIS PAK | QL= 4 packets/day; Limit 800 packets/365 days |
| PREVYMIS TAB | QL= 1 tab/day; Limit 200 tabs/365 days |
| prucalopride succinate tab | QL= 1 tab/day |
| pyrimethamine tab | QL= 3 tabs/day; Only available through Walgreens 888-347-3416 |
| PYRUKYND TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 |
| PYRUKYND TAPER PACK | QL= 1 tab/day; Only available through Biologics 800-850-4306 |
| QINLOCK TAB | QL= 3 tabs/day; Only available through Biologics 800-850-4306 |
| RADICAVA ORS STARTER KIT | QL= 70ml/365 days; Only available through Accredo 800-803-2523 |
| RADICAVA ORS SUSP | QL= 50mL/28 days; Only available through Accredo 800-803-2523 |
| ramelteon tab | QL= 1 tab/day |
| REGRANEX GEL | QL= 30gm/fill |
| RELENZA DISKHALER | QL= 1 inhaler/fill |
| REPATHA INJ | QL= 2 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| REPATHA PUSHTRONEX INJ | QL= 1 inj/28 days; Step Therapy requires trial of atorvastatin, fluvastatin, lovastatin, pravastatin, rosuvastatin, or simvastatin |
| RETEVMO CAP | QL= 2 caps/day |
| RETEVMO CAP 40MG | QL= 3 caps/day |
| RETEVMO TAB | QL= 2 tabs/day |
| RETEVMO TAB 40MG | QL= 3 tabs/day |
| REVLIMID CAP | QL= 1 cap/day; Restricted to Oncology or Hematology Specialist; Only available through Walgreens 888-347-3416 |
| REVUFORJ TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| REVUFORJ TAB 110MG | QL= 4 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------------|---|
| REVUFORJ TAB 25MG | QL= 8 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| REYVOW TAB | QL= 8 tabs/30 days, 6 fills/year |
| REZDIFFRA TAB | QL= 1 tab/day; Only available through Optum 877-445-6874 |
| REZLIDHIA CAP | QL= 2 caps/day; Only available through Biologics 800-850-4306 |
| REZUROCK TAB | QL= 1 tab/day; Only available through Lumicera 855-847-3553 |
| RINVOQ ER TAB | QL= 1 tab/day |
| RINVOQ ORAL SOLN | QL= 12ml/day |
| RIVFLOZA INJ | QL= 1 inj/30 days; Only available through Orsini 800-410-8575 |
| RIVFLOZA INJ 160MG | QL= 1 inj/30 days; Only available through Orsini 800-410-8575 |
| RIVFLOZA VIAL | QL= 2 vials/30 days; Only available through Orsini 800-410-8575 |
| rizatriptan ODT | QL= 12 tabs/fill, 3 fills/60 days |
| rizatriptan tab | QL= 12 tabs/fill, 3 fills/60 days |
| ROMVIMZA CAP | QL= 8 caps/28 days; Only available through Biologics 800-850-4306 |
| ROZLYTREK CAP | QL= 3 caps/day |
| ROZLYTREK PAK | QL= 6 packs/day |
| RUBRACA TAB | QL= 4 tabs/day; Only available through Optum 877-445-6874 |
| RYBELSUS TAB | QL=1 tab/day; Diagnosis Restricted – Type 2 Diabetes (E11) |
| RYDAPT CAP | QL= 56 caps/28 days |
| sacubitril-valsartan tab | QL= 2 tabs/day |
| SANCUSO PATCH | QL= 4 patches/fill |
| SANTYL OINT | QL= 90gm/30 days |
| SAVELLA TAB | QL= 2 tabs/day |
| SCSEMBLIX TAB | QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| SCSEMBLIX TAB 100 MG | QL= 4 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| SIGNIFOR INJ | QL= 2 vials/day; Only available through Anovo Specialty Pharmacy 844-288-5007 |
| SIMPONI AUTO-INJECTOR 100MG | QL=1 inj/28 days |
| SIMPONI INJ 100MG | QL=1 inj/28 days |
| SIVEXTRO TAB | QL= 6 tabs/fill; Restricted to Infectious Disease Specialist |
| SKYCLARYS CAP | QL= 3 caps/day; Only available through Biologics 800-850-4306 |
| SKYRIZI INJ 150MG/ML | QL= 1 inj/84 days |
| SKYRIZI INJ 180 MG/1.2ML | QL= 1 inj/56 days |
| SKYRIZI INJ 360MG/2.4ML | QL= 1 inj/56 days |
| SODIUM OXYBATE SOLN | QL= 540ml/30 days; Only available through Xyrem Certified Pharmacy 1-866-997-3668 |
| sodium/magnesium/potassium soln | \$0 copay for members age 45-75 years; All other members covered at generic copay; Limited to 2 fills/calendar year |
| SOFOSBUVIR/VELPATASVIR TAB | QL= 1 tab/day |
| SOHONOS CAP 1.5MG | QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828 |
| SOHONOS CAP 10MG | QL= 56 caps/28 days; Only available through CVS Specialty 800-238-7828 |
| SOHONOS CAP 1MG | QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--|--|
| SOHONOS CAP 2.5MG | QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828 |
| SOHONOS CAP 5MG | QL= 28 caps/28 days; Only available through CVS Specialty 800-238-7828 |
| SOLIQUA INJ | QL= 15ml/25 days |
| SOLOSEC GRANULES PACKET | QL= 1 packet/fill |
| SOLU-CORTEF INJ | QL= 1 vial/fill |
| SOLU-CORTEF INJ 100MG | QL= 2 vials/fill |
| SPEVIGO INJ | QL= 2ml/28 days; Only available through Accredo 800-803-2523 |
| SPIKEVAX INJ | QL= 1 dose/24 days |
| SPIKEVAX INJ 50MCG/0.5ML | QL= 1 dose/24 days |
| SPINOSAD SUSP | QL= 1 bottle/fill |
| SPIRIVA RESPIMAT INHALER 1.25MCG/ACT | QL= 1 inhaler/30 days; Step Therapy requires trial of ADVAIR (FLUTICASONE/SALMETEROL), BREO (FLUTICASONE/VILANTEROL), DULERA (MOMETASONE/FORMOTEROL), or SYMBICORT (BUDESONIDE/FORMOTEROL) |
| STEQEYMA INJ | QL= 1 inj/84 days |
| STEQEYMA INJ 90MG | QL= 1 inj/84 days |
| STIVARGA TAB | QL= 4 tabs/day |
| STRIVERDI RESPIMAT INHALER | QL= 1 inhaler/30 days |
| SUFLAVE SOLN | QL= 2 fills/calendar year |
| sumatriptan inj | QL= 4 inj/fill, 2 fills/30 days |
| sumatriptan nasal spray | QL= 6 sprays/fill, 2 fills/30 days |
| sumatriptan tab | QL= 9 tabs/fill, 2 fills/30 days |
| sumatriptan vial inj | QL= 5 inj/fill, 2 fills/30 days |
| sunitinib malate cap | QL= 1 cap/day |
| SUNLENCA INJ | QL= 2 vials/26 weeks; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828 |
| SUNLENCA TAB | QL= 4 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828 |
| SUNLENCA TAB 300MG | QL= 5 tabs/28 days; Restricted to Infectious Disease Specialist; Only available through CVS Specialty 800-238-7828 |
| SUNOSI TAB | QL= 1 tab/day |
| SYMDEKO TAB | QL= 2 tabs/day; Only available through Walgreens 888-347-3416 |
| SYMPROIC TAB | QL= 1 tab/day |
| SYNJARDY TAB | QL= 2 tabs/day |
| SYNJARDY XR TAB 10-1000MG, 25-1000MG | QL= 1 tab/day |
| SYNJARDY XR TAB 5-1000MG, 12.5-1000MG | QL= 2 tabs/day |
| TABRECTA TAB | QL= 4 tabs/day |
| tadalafil tab 2.5mg, 5mg | QL= 1 tab/day; Step Therapy requires trial of doxazosin tab, prazosin cap, terazosin cap, dutasteride cap, finasteride 5mg tab, alfuzosin tab, silodosin cap, or tamsulosin cap |
| TAFINLAR CAP | QL= 4 caps/day |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---|--|
| TAGRISO TAB | QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118 |
| TAKHZYRO INJ | QL= 2 inj/28 days; Only available through Accredo 800-803-2523 |
| TAKHZYRO INJ 150MG/ML | QL= 2 inj/28 days; Only available through Accredo 800-803-2523 |
| TALTZ INJ | QL= 1 inj/28 days |
| TALTZ INJ 20MG/0.25ML | QL= 1 inj/28 days |
| TALTZ INJ 40 MG/0.5ML | QL= 1 inj/28 days |
| TALZENNA CAP 0.25MG | QL= 3 caps/day |
| TALZENNA CAP 0.5MG, 0.75MG, 1MG | QL= 1 cap/day |
| TAVNEOS CAP | QL= 6 caps/day; Only available through PantheRx 855-726-8479 |
| TAZVERIK TAB | QL= 8 tabs/day; Only available through Onco360 877-662-6633 |
| TEMPO SMART BUTTON | QL= 1 button/8 months |
| TEPMETKO TAB | QL= 2 tabs/day; Only available through Biologics 800-850-4306 |
| TESTOSTERONE ENANTHATE INJ 200MG/ML | QL= 5ml/fill |
| TESTOSTERONE GEL 1% 25MG | QL= 1 packet/day |
| testosterone gel 1% 50mg | QL= 2 packets/day |
| testosterone gel 1% pump | QL= 4 bottles/30 days |
| testosterone gel 1.62% 1.25gm | QL= 1 packet/day |
| testosterone gel 1.62% 2.5gm | QL= 2 packets/day |
| TESTOSTERONE GEL 20.25MG/1.25GM | QL= 1 packet/day |
| TESTOSTERONE GEL PUMP 1% | QL= 4 bottles/30 days |
| testosterone gel pump 1.62% | QL= 2 bottles/30 days |
| testosterone soln | QL= 2 bottles/30 days |
| TEZSPIRE INJ | QL= 1 pen/28 days |
| TIBSOVO TAB | QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| TIROSINT-SOL | QL= 1ml/day; Prior Authorization required for members age 9 years and older |
| tolvaptan tab | QL= 2 tabs/day; Only available through Walgreens 888-347-3416 |
| tolvaptan tab therapy pack | QL= 2 tabs/day; Only available through Walgreens 888-347-3416 |
| TRADJENTA TAB | QL= 1 tab/day |
| travoprost ophth soln | QL= 2.5ml/30 days |
| TREMFYA INDUCTION INJ 200MG/ML | QL= 2 inj/28 days; 6 inj/year |
| TREMFYA INJ | QL= 1 inj/56 days |
| TREMFYA INJ 200MG/2ML | QL= 1 inj/28 days |
| TRIJARDY XR TAB 10-5-1000MG, 25-5-1000MG | QL= 1 tab/day |
| TRIJARDY XR TAB 5-25-1000MG, 12.5-2.5-1000MG | QL= 2 tabs/day |
| TRIKAFTA TAB | QL= 84 tabs/28 days; Only available through Walgreens 888-347-3416 |
| TRIKAFTA THERAPY PACK | QL= 2 packets/day; Only available through Walgreens 888-347-3416 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---|--|
| TRINTELLIX TAB | QL= 1 tab/day; Step Therapy requires trial of generic antidepressant: escitalopram, sertraline, fluoxetine, citalopram, paroxetine, fluvoxamine, bupropion, venlafaxine, desvenlafaxine, or duloxetine |
| TRULANCE TAB | QL= 1 tab/day |
| TRULICITY INJ | QL= 4 pens/28 days; Diagnosis Restricted – Type 2 Diabetes (E11) |
| TRUQAP TAB | QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| TRUQAP THERAPY PACK | QL= 64 tabs/28 days; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| TRYNGOLZA INJ | QL= 1 inj/28 days; Only available through PantheRx 855-726-8479 |
| TUKYSA TAB | QL= 4 tabs/day; Only available through Biologics 800-850-4306 |
| TURALIO CAP | QL= 4 caps/day; Only available through Biologics 800-850-4306 |
| TYENNE INJ | QL= 2 inj/28 days |
| TYRVAYA NASAL SPRAY | QL= 2 bottles/30 days; Restricted to Ophthalmology or Optometry Specialist |
| TYVASO DPI POWDER | QL= 4 cartridges/day; Only available through Accredo 800-803-2523 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-48MCG | QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523 |
| TYVASO DPI POWDER MAINTENANCE KIT 32-64MCG | QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523 |
| TYVASO DPI POWDER MAINTENANCE KIT 48-64MCG | QL= 224 cartridges/28 days; Only available through Accredo 800-803-2523 |
| TYVASO DPI POWDER TITRATION KIT 16-32-48MCG | QL= 252 cartridges/28 days; Only available through Accredo 800-803-2523 |
| TYVASO DPI POWDER TITRATION KIT 16-32MCG | QL= 196 cartridges/28 days; Only available through Accredo 800-803-2523 |
| TYVASO INH SOLN 0.6 MG/ML | QL= 1 ampule/day; Only available through Accredo 800-803-2523 |
| UBRELVY TAB | QL= 10 tabs/30 days, 6 fills/year |
| UPTRAVI TAB | QL= 2 tabs/day; Only available through Accredo 800-803-2523 |
| USTEKINUMAB-AEKN 45MG/0.5ML | QL= 1 inj/84 days; Only available through Lumicera 855-847-3553 |
| USTEKINUMAB-AEKN 90MG/ML | QL= 1 inj/84 days; Only available through Lumicera 855-847-3553 |
| VALCHLOR GEL | QL= 4 tubes/30 days; Only available through Accredo 800-803-2523 |
| VALTOCO NASAL SPRAY | QL= 5 doses/fill |
| VANCOCIN CAP | QL= 56 caps/fill |
| vancomycin cap | QL= 56 caps/fill |
| VANFLYTA TAB | QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| VANFLYTA TAB 26.5MG | QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| VANRAFIA TAB | QL= 1 tab/day; Only available through Biologics 800-850-4306 or CareMed 877-227-3405 |
| VARENICLINE TAB | Limited to 180 days/plan year |
| varenicline tartrate tab | Limited to 180 days/plan year |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------------------|---|
| varenicline tartrate tab starter pack | Limited to 180 days/plan year |
| VARUBI TAB | QL= 2 tabs/day; Restricted to Oncology or Hematology Specialist |
| VELTASSA POWDER | QL= 1 packet/day |
| VELTASSA POWDER 1GM | QL= 4 packets/day |
| VENTAVIS INH SOLN | QL= 9 ampules/day; Only available through Accredo 800-803-2523 |
| VENTOLIN HFA INHALER | QL= 2 inhalers/30 days |
| VEOZAH TAB | QL= 1 tab/day |
| VERQUVO TAB | QL= 1 tab/day; Restricted to Cardiology Specialist |
| VERZENIO TAB | QL= 2 tabs/day |
| V-GO INJ KIT | QL= 1 kit/day |
| VIJOICE GRANULES PACKET | QL= 1 packet/day; Only available through Biologics 800-850-4306 |
| VIJOICE TAB | QL= 1 tab/day; Only available through Biologics 800-850-4306 |
| VIJOICE TAB 250MG | QL= 2 tabs/day; Only available through Biologics 800-850-4306 |
| VITRAKVI CAP 100MG | QL= 2 caps/day; Only available through Accredo 800-803-2523 |
| VITRAKVI CAP 25MG | QL= 6 caps/day; Only available through Accredo 800-803-2523 |
| VITRAKVI SOLN | QL= 10ml/day; Only available through Accredo 800-803-2523 |
| VIZIMPRO TAB | QL= 1 tab/day |
| VOGELXO GEL PUMP 1% | QL= 4 bottles/30 days |
| VONJO CAP | QL= 4 caps/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| VORANIGO TAB | QL= 1 tab/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| VORANIGO TAB 10MG | QL= 2 tabs/day; Only available through Onco360 877-662-6633 or Biologics 800-850-4306 |
| VOSEVI TAB | QL= 1 tab/day |
| VOWST CAP | QL= 12 caps/fill; Only available through Orsini 800-410-8575 |
| VOXZOGO INJ | QL= 1 vial/day; Only available through Accredo 888-773-7376 |
| VOYDEYA TAB | QL= 6 tabs/day; Only available through Onco360 877-662-6633 |
| VOYDEYA TAB THERAPY PACK | QL= 6 tabs/day; Only available through Onco360 877-662-6633 |
| VYKAT XR TAB | QL= 4 tabs/day; Only available through PantherRx 855-726-8479 |
| VYKAT XR TAB 150MG | QL= 3 tabs/day; Only available through PantherRx 855-726-8479 |
| VYKAT XR TAB 75MG | QL= 7 tabs/day; Only available through PantherRx 855-726-8479 |
| VYNDAMAX CAP | QL= 1 cap/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| VYNDAQEL CAP | QL= 4 caps/day; Only available through Accredo 800-803-2523 or Walgreens 888-347-3416 |
| VYVGART HYTRULO INJ | QL= 4 inj/28 days; Only available through Accredo 800-803-2523 |
| WAINUA INJ | QL= 1 inj/28 days; Only available through Orsini 800-410-8575 |
| WAKIX TAB | QL= 2 tabs/day; Only available through Accredo 800-803-2523 |
| WELIREG TAB | QL= 3 tabs/day; Only available through Biologics 800-850-4306 or Onco360 877-662-6633 |
| XACIATO GEL | QL= 1 applicator/fill |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

- The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|--|---|
| XADAGO TAB | QL= 1 tab/day |
| XALKORI CAP | QL= 2 caps/day |
| XALKORI SPRINKLE CAP | QL= 4 caps/day |
| XCOPRI PAK 100-150MG | QL= 2 tabs/day |
| XCOPRI PAK 150-200MG | QL= 2 tabs/day |
| XCOPRI TAB 150MG, 200MG | QL= 2 tabs/day |
| XCOPRI TAB 25MG | QL= 1 tab/day |
| XCOPRI TAB 50MG, 100MG | QL= 1 tab/day |
| XCOPRI TITRATION PAK 12.5-25MG | QL= 1 tab/day |
| XCOPRI TITRATION PAK 150-200MG | QL= 1 tab/day |
| XCOPRI TITRATION PAK 50-100MG | QL= 1 tab/day |
| XELJANZ SOLN | QL= 10 ml/day |
| XELJANZ TAB | QL= 2 tabs/day |
| XELJANZ XR TAB | QL= 1 tab/day |
| XENLETA TAB | QL= 14 tabs/180 days; Restricted to Infectious Disease Specialist |
| XIFAXAN TAB 200MG | QL= 9 tabs/3 days |
| XIFAXAN TAB 550MG | QL= 60 tabs/30 days |
| XIGDUO XR TAB | QL= 2 tabs/day |
| XIGDUO XR TAB 10-1000MG | QL= 1 tab/day |
| XIGDUO XR TAB 2.5-1000MG, 5-1000MG | QL= 2 tabs/day |
| XIGDUO XR TAB 5-500MG, 10-500MG, 10-1000MG | QL= 1 tab/day |
| XIIDRA OPHTH SOLN | QL= 60 vials/30 days; Restricted to Ophthalmology or Optometry Specialist |
| XOFLUZA TAB | QL= 1 tab/fill |
| XOLAIR INJ | QL= 2 inj/28 days |
| XOLAIR INJ 150MG/ML | QL= 2 inj/28 days |
| XOLAIR INJ 300MG/2ML | QL= 1 inj/28 days |
| XOLAIR SYRINGE | QL= 2 inj/28 days |
| XOLAIR SYRINGE 150MG/ML | QL= 2 inj/28 days |
| XOLAIR SYRINGE 300MG/2ML | QL= 1 inj/28 days |
| XOLREMDI CAP | QL= 4 caps/day; Only available through PantherRx Pharmacy 855-726-8479 |
| XOSPATA TAB | QL= 3 tabs/day; Only available through Biologics 800-850-4306 |
| XPHOZAH TAB | QL= 2 tabs/day |
| XPOVIO PAK | QL= 32 tabs/28 days; Only available through Onco360 877-662-6633 |
| XTAMPZA ER CAP | QL= 120 caps/30 days; Step Therapy requires step through IR opioid if opioid naïve (Opioid ER Dependency) |
| XULTOPHY INJ | QL= 15ml/30 days |
| YESINTEK INJ | QL= 1 inj/84 days |
| YESINTEK SYRINGE | QL= 1 inj/84 days |
| YESINTEK SYRINGE 90MG | QL= 1 inj/84 days |
| YEZTUGO INJ | QL= 2 inj/180 days; Only available through Walgreens 888-347-3416 |
| YEZTUGO TAB | QL= 4 tabs/28 days; Only available through Walgreens 888-347-3416 |

Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.

Navitus Key Traditional Formulary Cont.
Last Updated* 2/1/2026
Quantity Limit (QL)

• The following drugs are covered on the formulary with a Quantity Limit.

Quantity Limit (QL) Medications

| Drug Name | Quantity Limit |
|---------------------------|--|
| YORVIPATH INJ | QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479 |
| YORVIPATH INJ 294MCG | QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479 |
| YORVIPATH INJ 420MCG | QL= 1 inj/day; Only available through Orsini 800-410-8575 or PantheRx 855-726-8479 |
| YUTREPIA CAP | QL= 112 caps/28 days; Only available through CVS Specialty 800-237-2767 |
| zaleplon cap | QL= 1 cap/day |
| ZAVZPRET NASAL SPRAY | QL= 6 units/fill; 60 units/365 days |
| ZEGALOGUE INJ | QL= 2 inj/fill |
| ZEJULA TAB | QL= 1 tab/day; Only available through Diplomat Pharmacy 877-977-9118 |
| ZELBORAF TAB | QL= 8 tabs/day |
| ZELSUVMI GEL | QL= 1 carton/fill, 2 fills/365 days |
| ZEPOSIA CAP | QL= 1 cap/day |
| ZEPOSIA STARTER PACK | QL= 1 cap/day |
| ZILBRYSQ INJ | QL= 1 inj/day; Only available through PantheRx 855-726-8479 |
| ZILBRYSQ INJ 23MG | QL= 1 inj/day; Only available through PantheRx 855-726-8479 |
| ZILBRYSQ INJ 32.4MG | QL= 1 inj/day; Only available through PantheRx 855-726-8479 |
| ZOKINVY CAP | QL= 4 caps/day; Only available through CVS Specialty 800-237-2767 |
| zolmitriptan nasal spray | QL= 6 sprays/fill, 2 fills/30 days |
| zolmitriptan ODT | QL= 9 tabs/fill, 2 fills/30 days |
| ZOLMITRIPTAN SPRAY | QL= 6 sprays/fill, 2 fills/30 days |
| zolmitriptan tab | QL= 9 tabs/fill, 2 fills/30 days |
| zolpidem ER tab | QL= 1 tab/day |
| zolpidem tab | QL= 1 tab/day |
| ZOMIG SPRAY | QL= 6 sprays/fill, 2 fills/30 days |
| ZORYVE CREAM | QL= 60 grams/30 days |
| ZORYVE FOAM | QL= 60 grams/30 days |
| ZTALMY SUSP | QL= 1100ml/30 days; Only available through Orsini 800-410-8575 |
| ZURZUVAE CAP 20MG, 25MG | QL= 28 caps/365 days; Only available through Caremark/CVS Specialty 800-378-069 |
| ZURZUVAE CAP 30MG | QL= 14 caps/365 days; Only available through Caremark/CVS Specialty 800-378-069 |
| ZYKADIA TAB | QL= 3 tabs/day |
| ZYLET OPHTH SUSP 0.5-0.3% | QL= 5ml/fill (10ml bottle is Not Covered) |



Coverage of medications, including those not otherwise identified by qualifiers such as QL, may be subject to safety screenings and other clinical edits in the course of claims transaction processing.** Products listed may not be all inclusive and are subject to change.